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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.

For more information about MBQIP, please see the FORHP infographic in Appendix A.

Purpose of this Guide

This guide is intended to help both CAH staff and state Flex Program Coordinators use MBQIP Hospital Data Reports to support quality improvement efforts and improve patient care.

- For CAHs:
  - Support a better understanding of the MBQIP measures and how to use the MBQIP Hospital Data Reports to identify opportunities for quality improvement activities

- For Flex Programs:
  - Assist Flex Coordinators in supporting CAH quality improvement activities through use of MBQIP data to identify and frame opportunities for improving patient care. Although all examples in this guide reference MBQIP Hospital Data Reports, the same analysis can be used to interpret MBQIP Stata Data Reports
Note: Flex Coordinators manage a wide scope of activities under the Flex Program; some programs may contract with quality improvement experts to support these efforts.

**Measures included in the MBQIP Quality Guide**

This guide focuses on how to make use of data for measures reported for MBQIP as part of the fiscal year (FY) 2014 Flex grant cycle, which ends August 31, 2015. 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.

**How to Use this Guide**

This guide is arranged into sections that summarize key information on each topic. This arrangement allows sections to be reviewed independently if an organization is seeking specific information on a particular quality measure or concept. This guide includes:

- Detailed overviews of current MBQIP measures including best practices for improvement
- Examples of how to interpret MBQIP Hospital Data Reports with a focus on improvement. The examples within the text reference notated sample MBQIP Hospital Data Reports (which can be found in Appendix H). 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
- Suggestions and considerations for identifying and prioritizing areas for improvement
- A table detailing key national quality initiatives that align with MBQIP priorities, including links to external websites for further information
- Tips for state Flex Program Coordinators to use MBQIP data to identify opportunities and provide support for state level improvement activities
- A listing of relevant resources available on the Technical Assistance and Services Center (TASC) MBQIP webpage (http://www.ruralcenter.org/tasc/mbqip), including links to specific webpages
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.

CURRENT STATE OF MBQIP

Quality Improvement Focus Areas

Individual measures for MBQIP continue to evolve to stay aligned with other federal quality reporting programs while keeping a focus on CAH relevant services. The table in Appendix B provides a quick reference guide for all measures reported for MBQIP as part of the FY 2014 Flex grant cycle and Appendix C provides a list of acronyms.

Currently, focus areas for MBQIP improvement fall into four quality domains:

- **Patient Safety (Appendix D)**
- **Outpatient Care (Appendix E)**
- **Patient Engagement (Appendix F)**
- **Care Transitions (Appendix G)**

The tables in Appendices D through G summarize the measures by focus area and include best practices for improvement for each area.

Note for Flex Coordinators

For reporting purposes, FORHP Flex grant guidance lists all of the composites from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey under the patient engagement quality domain. However, several HCAHPS composites can be utilized for improvement purposes in the areas of patient safety and care transitions. Therefore in the measures summary tables provided in this guide, HCAHPS composites are categorized based on potential to impact improvements in three quality domains: patient safety, patient engagement and care transitions.

Reporting and Using MBQIP Data

As the US 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. Not all MBQIP quality measures are relevant for all CAHs (for example, some CAHs do not provide outpatient surgery and therefore the outpatient measures related to surgery would not apply). Yet, most of the measures are relevant for the vast majority of CAHs. In today’s value focused environment, 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.** Participating in quality reporting programs, despite potentially low numbers, helps demonstrate that CAHs are providing the best care possible.

**Data Reporting Resources**
The [TASC website](#) offers resources on the following CAH MBQIP reporting topics:
- **Data Reporting and Use**, including links to key resources for reporting the Centers for Medicare & Medicaid Services (CMS) Inpatient and Outpatient Quality Measures
- **Care Transitions**
- **Outpatient**
- **Patient Engagement**
- **Patient Safety**

**New Efforts Related to Rural Relevant Quality Measures**
The US Department of Health and Human Services (HHS) has recently contracted with the National Quality Forum to launch a process specifically focused on performance measurement for rural and low-volume providers. This work is intended to provide recommendations to HHS regarding performance measurement issues for these providers, including CAHs. The work recognizes that rural providers often face unique issues, such as low volume and scarcity of resources, which can make measurement difficult.

The National Quality Forum committee will consider how to mitigate these challenges in payment incentive programs for rural providers, identify which measures are most appropriate for those programs and recommend how future development resources are best directed to address particular measurement gaps areas. For more information, or to track the progress of this committee visit the [National Quality Forum website](#).
INTERPRETING MBQIP HOSPITAL DATA REPORTS

MBQIP Hospital Data 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.

Using Inpatient and Outpatient MBQIP Hospital Data Reports

Ten years after publication of the Institute of Medicine’s report To Err Is Human, researchers identified rates of medical harm—that is, injuries to patients associated with their care—in excess of 25 events per 100 admissions. A recent study by the Office of the Inspector General (OIG) found that 13 percent of hospitalized Medicare beneficiaries experience adverse events resulting in prolonged hospital stay, permanent harm, life-sustaining intervention or death.¹ Almost half of those events are considered preventable.

The Inpatient and Outpatient MBQIP Hospital Data Reports include data from CMS Hospital Compare measures that are relevant to the priority areas of patient safety and outpatient care. The reports also include data from CAHs that submit data, but have not agreed to publicly report on Hospital Compare, as well as data from CAHs that don’t have enough cases to be reported on Hospital Compare, thus providing a more complete picture of performance across CAHs nationally.

Using Comparison Data for Process Measures

MBQIP Hospital Data Reports include state and national comparison data for all reporting CAHs. 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. Although it can be helpful to understand your comparison to those norms, averages represent the middle ground for performance and everyone should strive to be above average. For quality improvement

purposes, data benchmarks, such as the rate of the best performing CAHs or those CAHs with a rate in the top 10 percent, are more useful than average comparison data. *(Note: your state Flex Coordinator may be able to provide state specific information)*

**Interpreting 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 H.

**Example A: Lack of Consistent Process**

Reports that show a measure routinely performing low 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.

**Example B: Process May Need Adjustment**

Reports that show a measure routinely performing high but not at 100 percent indicate 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.

*Note:* There are two examples of this in the sample reports. The hyperlink above will take you to the first example; the second example can be found on the second page of the sample reports.

**Example C: Understanding Variation**

Reports that indicate a wide variation on timing measures should be reviewed to understand the cause(s) of that variation. In Example C, the median time to transfer a patient to another facility varies from 62 minutes to 237 minutes. Some things to consider:

- The state and national averages for time to transfer are 50 and 71 minutes respectively, so the values of 102 minutes in the fourth quarter of 2013 (abbreviated as 4Q13) and 237 minutes in 1Q14
appear unusually high, particularly since the median time was closer to 60 minutes in the first two quarters reported.

- In this situation, the transfer cases should be reviewed for a better understanding of what type of variation caused the median time to be so much longer and identify if there are opportunities to improve the process. 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. For example, if bad weather meant that the helicopter could not arrive to transport the patient, a hospital may not need to change its process for evaluating and triggering a transfer, but will want to ensure a back-up plan is identified to ensure best patient care for time sensitive conditions.

**Example D: Variation Outside of a Set Limit**

In this example illustrates a common cause variation in the measure across the quarters of data on the report. For this measure, median time to electrocardiogram (ECG) has specific clinical recommendations attached – that the ECG should be completed within 10 minutes of arrival. A median time of 10 minutes indicates that half of the patients received their ECG more than 10 minutes after arrival to the emergency department (ED), which is outside the set guidelines for this process of care. A review of cases and workflow is warranted to identify opportunities to improve time to ECG and ensure excellent care for all patients.

**N/A and 0 Patients on Reports**

The following are brief explanations and examples of why an Inpatient or Outpatient MBQIP Hospital Data Report might show not applicable (N/A) or zero (0) patients for some measures. For a more thorough explanation of the reporting process for CMS Inpatient and Outpatient measures, see the flowchart in Appendix I.
N/A can mean two different things:

- Data was not submitted/reported by the CAH
- Data was submitted but was rejected/not accepted into the Quality Improvement Organization (QIO) Clinical Warehouse

**Example – N/A**

A CAH may have submitted data to the QIO Clinical Warehouse, but the file could have had technical issues or a case was missing data in some of the abstraction fields. The case(s) would be rejected from the warehouse.

Zero (0) Patients means that data was submitted and accepted to the QIO Clinical Warehouse; however, case(s) were excluded from a particular measure.

**Example – 0 Patients**

A CAH submits one outpatient acute myocardial infarction (AMI) care case and the case is accepted into the QIO Clinical Warehouse. However, since the patient was given fibrinolytic therapy the case does not meet the criteria for inclusion in the OP-3b measure: median time to transfer to another facility for acute coronary intervention. The OP-3b measure is excluded and, if no other AMI care cases are submitted, the report would indicate 0 patients for the OP-3b measure.

**Using HCAHPS MBQIP Hospital Data Reports**

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data provides hospitals the opportunity to understand care provided from the patient’s point of view. In addition to four screening and seven demographic questions, the survey includes 21 questions that ask patients for their feedback on a variety of aspects related to their experience as an inpatient in the hospital. The 21 substantive questions are broken into seven 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 HCAHPS MBQIP Hospital Data Reports can help provide a better understanding of how your hospital compares to other like facilities in your state and nationally. If benchmark data from top performers is available (such as the top 10 percent), that can be helpful in setting targets for improvement goals, particularly if your hospital is already above the state and national averages. If your hospital is below the state or national average in an area, that also indicates an improvement opportunity.

- HCAHPS data are presented as a rolling four quarters (see the sample HCAHPS MBQIP Hospital Data Report in Appendix H), so it will take time to see improvements/changes in the data. 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.

Interpreting 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 H.

Note: There are two pages in the sample HCAHPS MBQIP Hospital Data Report: hospital specific data on the first page and average comparison data on the second page. Each example references both sets of data. The hyperlink in each example will take you to the first page of the report.

Example E: Opportunity for Improvement

In this example of the HCAHPS Responsiveness of Hospital Staff composite:

- The data shows that the percent of patients that indicated staff was “Always” responsive declined in the first three reporting periods, then stayed at 60 percent for the last reporting period.
• Even though the percent of “Always” responses was the same from the third reporting period to the fourth, the percent of responses that indicate “Sometimes or never” (the least positive response to this question) increased from 7 percent to 18 percent.

• The hospital’s percent “Always” response rate is also lower than the state and national CAH averages for this indicator as shown on page two of the report (73 percent and 67 percent respectively).

All of this data points to an opportunity for improvement in patient perceived responsiveness of hospital staff.

**Example F: Translate to 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. In the example circled, 12 percent of respondents indicated that patients did not feel they were given information about what to do during their recovery at home. Although 12 percent may seem a small percentage, it translates to six individual patients that did not feel they were given information needed to take care of themselves after going home. In this example, considering the number of patients may help make a more compelling appeal to staff to improve communication and/or processes in this area.

**Calculating the Number of Patients**

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 no to the question regarding discharge instructions. We know that 12 percent of patients said no; this is represented as 12 divided by 100. We also know that 50 people completed the survey (as listed at the top of the report). So we are solving for X where 12 divided by 100 equals X divided by 50.

\[
\frac{12}{100} = \frac{X}{50} \quad \frac{12 \times 50}{100} = 6 \text{ Patients}
\]

We find that, in this example, 12 percent is equal to 6 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.

Example G: Celebrate Gains

Improving patient experience of care is a long term investment that will involve engaging and encouraging staff over time. MBQIP Hospital Data Reports can be used to highlight and celebrate improvements. In this example, the percent of “Always” responses on the Quietness of Hospital Environment question have increased every quarter, and are now higher than the state and national averages (65 percent and 61 percent respectively, as shown on page 2 of the report). Share this information with staff and offer both congratulations and encouragement for continued improvement.

Using EDTC MBQIP Hospital Data 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

- 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.
- Since this measure is new to most CAHs, state and national averages are likely to increase consistently over the first few quarters of data collection as CAHs across the country update documentation and processes.
- In an eight-state pilot using the EDTC measure, the nearly 100 participating CAHs increased the percentage of medical records meeting all of the EDTC data elements from 28 to 44 percent, for a
relative improvement rate of 56 percent over the three quarters of data collection in the project

**Interpreting 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 EDTC MBQIP Hospital Data Report found in Appendix H.

**Example H: Opportunity for Improvement**

EDTC sub-measure 3 (Vital Signs) is the lowest performing of the EDTC categories for this hospital at 41.86 percent. It is also lower than the state and national averages (68.37 percent and 71.61 percent respectively). 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. Depending on the tool a CAH is using to collect the data, they may also be able to see results at the data element level, which can be even more useful in targeting areas for improvement. For example, the data elements for EDTC sub-measure 3 (Vital Signs) include: pulse, respiratory rate, blood pressure, oxygen saturation, temperature and neurological assessment. If results are available at the data element level it may help target improvement opportunities for documentation and/or processes to address specific information that is most commonly missing.

**Example I: Documentation or Process?**

EDTC sub-measure 7 (Procedures & Tests) is the second lowest performing of the EDTC categories for this hospital at 53.49 percent. Although the hospital’s rate is similar to the state and national average for this sub-measure (52.44 percent and 54.67 percent respectively), it may still represent a good opportunity for improvement. The hospital may need to evaluate whether the lower score in this area is 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.
Prioritizing Opportunities for Improvement

Whether at the hospital or state level, a variety of factors should be considered when identifying focus areas for improvement:

- Target low performance measures
- Focus on ‘harm’
- Measures that address multiple/broad priorities
- Align with national, state or regional level quality initiatives
- Enthusiasm in the field for the topic

**Target Low Performing Measures**

Comparisons can be made to state or national averages or high performing benchmarks (when available). Particular attention should be given to measures/services that align with core services provided by individual CAHs.

**Focus on ‘Harm’**

Consider the level of risk or patient harm for low performance on measures and prioritize improvement on processes that may have the most impact on individual patients, even if those cases are rare.

**Measures that Address Multiple/Broad Priorities**

Identify measures that align with common priorities. Examples of how various measures align with different focus areas include:

- Reducing Hospital Readmissions/Improving Care Transitions:
  - HCAHPS Discharge Information and Care Transitions [composite](#)
  - EDTC measure
- Improving Safe Medication Practices
  - HCAHPS Communication about Medicines [composite](#)
  - Pharmacist Review of Medication Orders
  - Antibiotic Selection (Pneumonia-6 and Outpatient-7)
- Time Sensitive Conditions
  - Outpatient measures 1 – 5 (AMI Care)
**Align with National, State or Regional Level Quality Initiatives**

A number of federal and national programs and their quality priorities are listed in the table below. Frequently there are state or regional level initiatives that align with these as well.

**Federal and National Quality Programs**

<table>
<thead>
<tr>
<th>Supporting Organization</th>
<th>Initiative/Program</th>
<th>Focus Area(s) &amp; Initiative/Program Website</th>
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| Centers for Medicare & Medicaid Services (CMS) | Partnership for Patients (P4P) Hospital Engagement Networks (HENs) | Reduce all cause-preventable inpatient harm by 40 percent and readmissions by 20 percent. Topics include:  
- Adverse drug events  
- Healthcare-associated infections (HAI)  
- Early elective delivery  
- Pressure ulcers  
- Venous thromboembolism (VTE)  
- Ventilator-associated events (VAE)  
- Hospital readmissions  
[Partnership for Patients website](#) |
| CMS | Quality Innovation Network – Quality Improvement Organizations (QIN-QIOs) | Hospital focused priorities include:  
- HAI  
- Hospital readmissions  
- Reporting and using clinical quality data/value based purchasing  
[QIO website](#)  
[CDC Healthcare Acquired Infections website](#) |
<table>
<thead>
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<th>Supporting Organization</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Office of the National Coordinator for Health Information Technology (ONC)</td>
<td>Meaningful Use of Electronic Health Records Clinical Quality Measures (MU)</td>
<td>Electronic medical record capability relating to processes, experience and/or outcomes of patient care, relative to one or more quality aims <a href="#">Eligible Hospital &amp; CAH Meaningful Use Table of Contents Core &amp; Menu Set Objectives</a></td>
</tr>
<tr>
<td>American Heart Association</td>
<td>Get with the Guidelines (GWTG)</td>
<td>Reporting, improvement and recognitions programs related to cardiac conditions including AMI, heart failure, stroke and atrial fibrillation <a href="#">American Heart Association – Get With the Guidelines website</a></td>
</tr>
<tr>
<td>Agency for Healthcare Research &amp; Quality (AHRQ)</td>
<td>Hospital Survey on Patient Safety Culture Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) Comprehensive Unit Based Safety Program (CUSP)</td>
<td>Wide variety of tools and resources that focus on evaluating and improving hospital patient safety culture through teamwork and communication. CUSP has a particular emphasis on HAIs <a href="#">AHRQ Hospital Survey on Patient Safety Culture website</a> <a href="#">AHRQ TeamSTEPPS website</a> <a href="#">AHRQ CUSP website</a></td>
</tr>
<tr>
<td>Supporting Organization</td>
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</table>
| Robert Wood Johnson Foundation (RWJF) and Institute for Healthcare Improvement (IHI) | Transforming Care at the Bedside (TCAB) | Improvement initiative that focuses on nursing staff. Priorities include:  
- Improve the reliability and safety of patient care on medical and surgical units  
- Increase the vitality and retention of nurses  
- Engage and improve the patients’ and family members' experience of care  
- Improve the effectiveness of the entire care team  
[RWJF TCAB website](#) |
| Centers for Disease Control and Prevention (CDC) | National Healthcare Safety Network (NHSN) | System for tracking a variety of measures related to health care associated infections  
[NHSN website](#) |

**Enthusiasm in the Field for the Topic**

This should be a secondary consideration, but topics that generate strong interest among potential staff and other stakeholders are more likely to realize improvement than areas met with resistance or indifference.

**Additional Resources**

The following resources may be helpful to CAHs and state Flex Coordinators in pursuing quality improvement initiatives:

- The [Health Resources and Services Administration (HRSA) Quality Toolkit](#) is designed to assist a health care organization with its quality improvement efforts. Included in the toolkit are explanations of basic quality improvement concepts and systematic approaches to improvement, as well as guidance for planning and implementing improvement projects.
• The Institute for Healthcare Improvement (IHI) has a free video series called “The Science of Improvement on a Whiteboard!” The series is made up of a short videos highlighting a variety of improvement concepts such as the Model for Improvement, plan do study act (PDSA) cycles and numerous ways to use data for quality improvement initiatives

• A wide variety of resources related to MBQIP can be found on the MBQIP page (http://www.ruralcenter.org/tasc/mbqip). Categories of these resources include:
  - Care Transitions
  - Data Reporting and Use
  - Emergency Department Transfer Communications
  - HCAHPS
  - Inpatient
  - Outpatient
  - Patient Engagement
  - Patient Safety
  - Pharmacist Review of Medication Orders
  - Frequently Asked Questions
  - MBQIP Monthly
USING MBQIP DATA TO TARGET FLEX ACTIVITIES

Flex Coordinators should use a few different data sources to help identify state level opportunities for improvement, including:

- MBQIP State Data Reports
- Comparison data on Hospital MBQIP Data Reports
- Inpatient and Outpatient MBQIP Excel Data Files

State Level Quality Measure Results

The Flex Monitoring Team (FMT) provides state level reports focused on a broad scope of publicly reported quality measures (not only MBQIP measures) on an approximately annual basis. The FMT reports highlight measures where the CAH average for the state is above or below the national CAH average, providing one source of information to identify areas for improvement at a state level. Because sample sizes may be small on a quarterly basis, FMT reports use longer time periods for analysis to maximize the ability to accurately and fairly compare CAH performance across states.

In addition to data publicly reported on Hospital Compare, FMT reports include data on process measures for which CAHs reported ten or fewer cases. Such data is suppressed from the Hospital Compare website by CMS, but made available to FORHP for aggregate CAH analysis. FMT reports also include data on measures not captured on the MBQIP Hospital and State Data Reports.

*Note:* The FMT reports primarily use data that is publicly reported on Hospital Compare, thus the timeframes are generally older than the data on the MBQIP Hospital and State Data Reports and are dependent on the CAHs reporting publicly to Hospital Compare. If CAHs report to QualityNet, but choose not to publicly report their data on Hospital Compare their data is not included in the FMT reports. FMT reports can be found at the [Flex Monitoring Team website](#).

Comparison Data on MBQIP Hospital Data Reports

State and national CAH averages are available on all MBQIP Hospital Data Reports and include more current data than is available in the FMT reports. This is because MBQIP data is obtained prior to becoming publicly available.
on Hospital Compare as the result of an agreement between CMS and FORHP. Measures for which the state CAH average is lower than national CAH average may indicate a potential opportunity for state-level activities.

Inpatient and Outpatient MBQIP Excel Data Files

FORHP provides Microsoft Excel files to each state Flex Program with state level data to be used in addition to the MBQIP Hospital Data Reports. These quarterly data files can be analyzed in a variety of ways to help prioritize measures, calculate benchmarks or identify groupings of hospitals for potential improvement activities. The files can be used to:

- Calculate hospital rates, averages and benchmarks (such as percentiles)
- Sort and/or group hospitals by rate on individual measures
- Create comparison graphs to help visualize improvement opportunities at a state or hospital level

Step by step instructions for how to use the MBQIP Excel files in these ways can be found in the MBQIP Excel Data User Guide.

Excel files from multiple data periods could also be combined to plot state or hospital level data on individual measures to help understand changes in the measures over time.
**Federal Office of Rural Health Policy (FORHP) Medicare Beneficiary Quality Improvement Project (MBQIP)**

**MBQIP was created:**
In 2010 as a key quality improvement activity within the Medicare Rural Hospital Flexibility grant program. The project officially kicked off in September 2011.

**There are:**
- **1328** CAHs in the U.S.
- **57 Million** People living in rural communities across the U.S.

**The GOAL of MBQIP:**
To improve the quality of care provided in small, rural Critical Access Hospitals (CAHs). Even though many CAHs have low patient volume, _every patient matters_!

**CAH Reporting:**
CAHs are not mandated to report quality data to CMS, but by 2014:
- **95%** of CAHs participate in MBQIP
- **85%** actively submit _INPATIENT_ data
- **55%** actively submit _OUTPATIENT_ data
- **54%** administer the _HCAHPS_ survey

---

**Quality Measurement + Quality Improvement = Improved patient outcomes**

---

**Collaboration**
- 9 states participated in a CMS QI special innovation project on the Emergency Department Transfer Communication Measure
- AHRQ quality improvement resources are available on the MBQIP website

**Quality Improvement**
- 20 states are supporting quality benchmarking and the implementation of QI activities around MBQIP measures
- 6 states are supporting evidence-based protocol implementation
- 8 states are focusing on Care Transitions and Readmissions

---

MBQIP@hrsa.gov
www.ruralcenter.org/tasc/mbqip

---

NATIONAL RURAL HEALTH RESOURCE CENTER 23
APPENDIX B – MEASURE QUICK REFERENCE GUIDE

The following table displays all current MBQIP measures, including the measure abbreviation, measure name and the focus area in which the measure is included within this guide. Clicking the measure abbreviation will take you to the measure in its corresponding measures summary table.

For a list of acronyms related to MBQIP measures, see Appendix C.

<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Measure Name</th>
<th>Focus Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPOE</td>
<td>Pharmacist Review of Medication Orders within 24 hours</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>EDTC</td>
<td>Emergency Department Transfer Communication</td>
<td>Care Transitions</td>
</tr>
<tr>
<td>HCAHPS Composite 1</td>
<td>Communication with Nurses</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td>HCAHPS Composite 2</td>
<td>Communication with Doctors</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td>HCAHPS Composite 3</td>
<td>Responsiveness of hospital staff</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>HCAHPS Composite 4</td>
<td>Pain Management</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>HCAHPS Composite 5</td>
<td>Communication about Medicines</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>HCAHPS Composite 6</td>
<td>Discharge Information</td>
<td>Care Transitions</td>
</tr>
<tr>
<td>HCAHPS Composite 7</td>
<td>Care Transition</td>
<td>Care Transitions</td>
</tr>
<tr>
<td>HCAHPS Q8</td>
<td>Cleanliness of Hospital Environment</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td>HCAHPS Q9</td>
<td>Quietness of Hospital Environment</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td>HCAHPS Q21</td>
<td>Overall Rating of This Hospital</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td>HCAHPS Q22</td>
<td>Willingness to Recommend This Hospital</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td>HF-2</td>
<td>Evaluation of Left Ventricular Systolic (LVS) Function</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>OP-1</td>
<td>Median Time to Fibrinolysis</td>
<td>Outpatient Care</td>
</tr>
<tr>
<td>OP-2</td>
<td>Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival</td>
<td>Outpatient Care</td>
</tr>
<tr>
<td>OP-3b</td>
<td>Median Time to Transfer to Another Facility for Acute Coronary Intervention</td>
<td>Outpatient Care</td>
</tr>
<tr>
<td>OP-4</td>
<td>Aspirin at Arrival</td>
<td>Outpatient Care</td>
</tr>
<tr>
<td>OP-5</td>
<td>Median Time to ECG</td>
<td>Outpatient Care</td>
</tr>
<tr>
<td>OP-6</td>
<td>Timing of Antibiotic Prophylaxis</td>
<td>Outpatient Care</td>
</tr>
<tr>
<td>OP-7</td>
<td>Prophylactic Antibiotic Selection for Surgical Patients</td>
<td>Outpatient Care</td>
</tr>
<tr>
<td>PN-6</td>
<td>Appropriate Initial Antibiotic Selection</td>
<td>Patient Safety</td>
</tr>
</tbody>
</table>
APPENDIX C - MBQIP ACRONYM GUIDE

The following is a list of acronyms used throughout the MBQIP measure summaries in Appendices D through G.

**AMI**  Acute Myocardial Infarction
**CPOE**  Computerized Provider Order Entry
**ECG**  Electrocardiogram
**ED**  Emergency Department
**EDTC**  Emergency Department Transfer Communication
**EMR**  Electronic Medical Record
**EMS**  Emergency Medical Service
**HCAHPS**  Hospital Consumer Assessment of Healthcare Providers and Systems
**HF**  Heart Failure
**INR**  International Normalized Ratio
**LVS**  Left Ventricular Systolic
**MBQIP**  Medicare Beneficiary Quality Improvement Project
**OP**  Outpatient
**PN**  Pneumonia
**PT**  Prothrombin Time
**STEMI**  ST Segment Elevation Myocardial Infarction
APPENDIX D – PATIENT SAFETY MEASURES SUMMARY

Substantial scientific evidence indicates that the Centers for Medicare & Medicaid (CMS) Inpatient Process of Care measures that are a part of the Medicare Beneficiary Quality Improvement Project (MBQIP) represent the best practices for the treatment of heart failure and pneumonia. Some patient reported composites from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey also align directly with patient safety practices, as does pharmacist review of all medication orders.

Note: In the table below, unless otherwise noted, the provided “Technical Description” is taken from the Inpatient CMS Measures Specification Manual; the “HCAHPS Survey Question” descriptions are taken from the HCAHPS website; and the “Description for Consumer” is taken from Hospital Compare.

For a list of acronyms related to MBQIP measures, see Appendix C.

<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Technical Description/ HCAHPS Survey Questions</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF-2*</td>
<td>Evaluation of left ventricular systolic (LVS) function</td>
<td>Heart failure patients with documentation in the hospital record that left ventricular systolic (LVS) function was evaluated before arrival, during hospitalization or is planned for after discharge</td>
<td>An evaluation of the LVS function checks how the left chamber of the heart is pumping</td>
<td>• Create a universal tab in the electronic medical record (EMR) to ensure easy access to past tests</td>
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<td></td>
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<td></td>
<td>• Upon admission assign responsibility to either track down tests from old records or contact external partners (e.g., primary clinic or specialty provider that conduct LVS function tests in that region)</td>
</tr>
<tr>
<td>PN-6*</td>
<td>Appropriate Initial Antibiotic Selection</td>
<td>Immunocompetent patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen</td>
<td>Antibiotics are medicines that treat infection, and each one is different. Hospitals should choose the</td>
<td>• Establish a system for educating providers with every change in guidelines</td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>Technical Description/ HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
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</tbody>
</table>
| Computerized Provider Order Entry (CPOE)** | Pharmacist Review of Medication Orders within 24 hours | Number of electronically entered medication orders for an inpatient admitted to a critical access hospital (CAH) (acute or swing-bed), verified by a pharmacist or directly entered by a pharmacist within 24 hours *(Note: Taken from the TASC MBQIP Pharmacist Review of Medication Orders webpage)* | Not reported on Hospital Compare | • Consider sharing pharmacy coverage with other CAHs or regional facilities  
• Consider contracting for remote pharmacy services to address coverage gaps |
| HCAHPS Composite 3 | Responsiveness of hospital staff | During this hospital stay...  
• After you pressed the call button, how often did you get help as soon as you wanted it? (Q4)  
• How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted? (Q11) | Patients who reported that they "Always" received help as soon as they wanted | • Establish protocols and identify accountability for responding to inpatient calls  
• Track the type and timing of inpatient call requests to target support and response processes  
• Implement intentional hourly rounding  
• Establish processes and expectations regarding communication for nurses |
<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Technical Description/ HCAHPS Survey Questions</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>During this hospital stay...</td>
<td>Patients who reported that their pain was &quot;Always&quot; well controlled</td>
<td>when stepping away from the floor or when assistance is needed</td>
</tr>
<tr>
<td>HCAHPS Composite 4</td>
<td>Pain Management</td>
<td>• How often was your pain well controlled? (Q13)</td>
<td></td>
<td>• Consistently use a pain scale to evaluate patient perception of pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How often did the hospital staff do everything they could to help you with your pain? (Q14)</td>
<td></td>
<td>• Implement <a href="#">intentional hourly rounding</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Use whiteboards for communication regarding timing and dose of pain medication</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Offer alternative methods to manage pain and engage family and caregivers in communication about pain management</td>
</tr>
<tr>
<td>HCAHPS Composite 5</td>
<td>Communication about Medicines</td>
<td>During this hospital stay...</td>
<td>Patients who reported that staff &quot;Always&quot; explained about medicines before giving it to them</td>
<td>• Implement triggers and prompts in care processes to ensure education about medications.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? (Q16)</td>
<td></td>
<td>• Use <a href="#">‘teach-back’</a> to assess patient understanding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Before giving you any new medicine, how often did hospital staff describe</td>
<td></td>
<td>• Limit use of jargon and technical terms</td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>Technical Description/ HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
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<td></td>
<td></td>
<td>possible side effects in a way you could understand? (Q17)</td>
<td></td>
<td>• Provide nurses ready access to resources and tools regarding information about medications in patient friendly terms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Share best practices and processes among staff for communicating in difficult situations (e.g., patient doesn’t speak English or has difficulty hearing)</td>
</tr>
</tbody>
</table>

* Measures HF-2 and PN-6 have been retired by CMS. CAHs can voluntarily report on these measures through October, 2015. These measures will no longer be a part of MBQIP starting in September, 2015.

** The CPOE measure will no longer be a part of MBQIP starting in September, 2015; however, CPOE will remain an optional measure under Flex Grant Program Area 2, Financial and Operational Improvement.
APPENDIX E - OUTPATIENT MEASURES SUMMARY

The Hospital Outpatient Quality Reporting (OQR) Program is a quality data reporting program for outpatient hospital services implemented by Centers for Medicare & Medicaid Services (CMS). CMS focuses on reporting measure data that have high impact and support national priorities for improved quality and efficiency of care. The outpatient measures evaluate the regularity with which a health care provider administers the outpatient treatment known to provide the best results for most patients with a particular condition. Hence, the below measures are relevant to critical access hospitals (CAHs) and are included in the Medicare Beneficiary Quality Improvement Project (MBQIP).

Note: In the table below, the provided “Technical Description” is taken from the Outpatient CMS Measures Specification Manual and the “Description for Consumer” is taken from Hospital Compare.

For a list of acronyms related to MBQIP measures, see Appendix C.

<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Technical Description</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-1</td>
<td>Median time to Fibrinolysis (AMI Care)</td>
<td>Median time from emergency department (ED) arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation on the electrocardiogram (ECG) performed closest to ED arrival and prior to transfer</td>
<td>Not reported on Hospital Compare</td>
<td>See OP-2 below</td>
</tr>
<tr>
<td>OP–2</td>
<td>Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival</td>
<td>Emergency Department AMI patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to</td>
<td>Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival</td>
<td>• Diagnose the patient as early in the patient flow as possible (e.g., enable EMS to diagnose ST segment elevation myocardial infarction (STEMI) patients and/or notify ED of possible</td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>Technical Description</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
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</tr>
<tr>
<td></td>
<td>(AMI Care)</td>
<td>fibrinolysis of 30 minutes or less</td>
<td></td>
<td>STEMI to initiate preparation processes)</td>
</tr>
</tbody>
</table>
| OP-3b                | Median Time to Transfer to Another Facility for Acute | Median time from emergency department arrival to time of transfer to another facility for acute coronary intervention | Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were | • Ensure the emergency physician on duty activates the reperfusion plan according to established local guidelines and care pathways.  
• Treat registration for patients with AMI in a fashion similar to trauma patients with the ability to fast-track critical labs, such as creatinine and Prothrombin Time (PT)/International Normalized Ratio (INR) test  
• Store fibrinolytic agent in the ED and/or establish ability to reconstitute and administer fibrinolytic in the ED  
• Diagnose the patient as early in the patient flow as possible (e.g., enable emergency medical service |
<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Technical Description</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coronary Intervention (AMI Care)</td>
<td>transferred to another hospital</td>
<td></td>
<td>(EMS) to diagnose STEMI patients</td>
</tr>
</tbody>
</table>
| OP-4*                | Aspirin at Arrival (AMI Care) | Emergency Department AMI patients or chest pain patients (with Probable Cardiac Chest Pain) who received aspirin within 24 hours before ED arrival or prior to transfer | Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival | - Raise awareness among general population regarding heart attack symptoms, calling 911 and taking aspirin  
- Work with EMS providers to ensure standard |
<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Technical Description</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>protocol/process for giving aspirin if suspected AMI</td>
</tr>
<tr>
<td>OP-5</td>
<td>Median Time to ECG (AMI Care)</td>
<td>Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for AMI or Chest Pain patients (with Probable Cardiac Chest Pain)</td>
<td>Average number of minutes before outpatients with chest pain or possible heart attack got an ECG</td>
<td>• Diagnose the patient as early in the patient flow as possible (e.g., enable EMS to diagnose STEMI patients and/or notify ED of possible STEMI to initiate preparation/processes)</td>
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<td></td>
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<td></td>
<td></td>
<td>• Promptly identify patients requiring ECG through nurse interview prior to registration or provide necessary training to registration personnel</td>
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<td></td>
<td>• Specify processes and protocol for rapidly acquiring ECG, including having ECG equipment in the ED and specifying a</td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>Technical Description</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
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</table>
| OP-6**               | Timing of Antibiotic Prophylaxis (Surgical Care) | Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. (Patients who received vancomycin or a fluoroquinolone for prophylaxis should have the antibiotic initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.) | Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery) | • Establish protocols and processes that link antibiotic administration to processes just prior to incision/surgical start time  
• Assign accountability for administering prophylactic antibiotic to a key team position (e.g., anesthesia staff or circulating nurse)  
• Incorporate antibiotic delivery check process into surgical time-out |
<p>| OP-7**               | Prophylactic Antibiotic Selection for Surgical Patients (Surgical Care) | Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure) | Outpatients having surgery who got the right kind of antibiotic | • Establish a pharmacy and therapeutics committee (or equivalent) that meets annually and as needed to review standard formulary for antimicrobial prophylaxis |</p>
<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
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<th>Description for Consumer</th>
<th>Best Practices</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Ensure availability of formulary antibiotics or physician approved prophylactic antibiotics in or near operating room</td>
</tr>
</tbody>
</table>

* Measure OP-4 will no longer be a part of MBQIP starting in September, 2015.

** Measures OP-6 and OP-7 have been retired by CMS and data submission through QualityNet is no longer an option as of January, 2015. Critical access hospitals and state Flex Programs may still wish to use the data they have available to them from previous reporting periods to identify opportunities for improvement in these areas. These measures will no longer be a part of MBQIP starting in September, 2015.
APPENDIX F - PATIENT ENGAGEMENT MEASURES SUMMARY

Patients and their families are essential partners in the effort to improve the quality and safety of health care. Their participation as active members of their own health care team is an essential component of making care safer and reducing readmission.

Studies have demonstrated measurable benefits to providing patient-centered care with a positive impact on patient satisfaction, length of stay and cost per case. By improving communication with patients, whether via providers at the bedside or institutionally through committees focused on systemic changes in patient care, patient outcomes can and will improve. Broad improvement efforts focusing on patient-centered care, organizational culture, communication strategies and staff engagement/satisfaction are critical for comprehensive improvement. For the above stated reasons, patient satisfaction survey results from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) are included in the Medicare Beneficiary Quality Improvement Project (MBQIP).

Note: In the table below, the “HCAHPS Survey Question” descriptions are taken from the HCAHPS website and the “Description for Consumer” is taken from Hospital Compare.

For a list of acronyms related to MBQIP measures, see Appendix C.

<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>HCAHPS Survey Questions</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAHPS Composite 1</td>
<td>Communication with Nurses</td>
<td>During this hospital stay...</td>
<td>Patients who reported that their nurses &quot;Always&quot; communicated well</td>
<td>• Provide staff training and promote awareness relating to empathy and effective communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How often did nurses treat you with courtesy and respect? (Q1)</td>
<td></td>
<td>• Use teach-back, limit jargon and employ other health literacy principles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How often did nurses listen carefully to you? (Q2)</td>
<td></td>
<td>• Standardize shift change processes and/or bedside</td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
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<td></td>
<td>- How often did nurses explain things in a way you could understand? (Q3)</td>
<td></td>
<td>report and use as an opportunity to engage the patient and family in care</td>
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<td></td>
<td>Implement <a href="https://www.nationalruralhealthresource.org">intentional hourly rounding</a></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use scripting for key messages and/or employ a communication frameworks such as <a href="https://www.nationalruralhealthresource.org">AIDET</a>™</td>
</tr>
<tr>
<td>HCAHPS Composite 2</td>
<td>Communication with Doctors</td>
<td>During this hospital stay...</td>
<td>Patients who reported that their doctors &quot;Always&quot; communicated well</td>
<td>Provide staff training and promote awareness relating to empathy and effective communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- How often did doctors treat you with courtesy and respect? (Q5)</td>
<td></td>
<td>Implement peer to peer mentoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- How often did doctors listen carefully to you? (Q6)</td>
<td></td>
<td>Use <a href="https://www.nationalruralhealthresource.org">teach-back</a>, limit jargon and employ other health literacy principles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- How often did doctors explain things in a way you could understand? (Q7)</td>
<td></td>
<td>Engage patients and families in care conferences and/or interdisciplinary rounds</td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
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</table>
| HCAHPS Q8            | Cleanliness of Hospital Environment       | During this hospital stay...  
• How often were your room and bathroom kept clean? (Q8)                             | Patients who reported that their room and bathroom were "Always" clean | • Use scripting for key messages and/or employ a communication framework such as AIDET™  
• Clarify roles and responsibilities in responding to patient or staff concerns regarding cleanliness  
• Designate a housekeeping quality assurance supervisor and trainer  
• Inspect an agreed number of patient rooms on a regular basis, and follow up with cleaning staff to correct deficiencies  
• Provide visible information in the room to let patients and families know who to contact if they have a housekeeping concern or request  
• Provide training on communication standards                                                                 |
<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>HCAHPS Survey Questions</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>During this hospital stay...</td>
<td></td>
<td>and processes to cleaning staff as part of orientation and ongoing evaluations (e.g., AIDET™)</td>
</tr>
<tr>
<td>HCAHPS Q9</td>
<td>Quietness of Hospital Environment</td>
<td>- How often was the area around your room quiet at night? (Q9)</td>
<td>Patients who reported that the area around their room was &quot;Always&quot; quiet at night</td>
<td>- Use logs to identify patients who communicate cleaning concerns. Follow-up with those patients at least daily to ensure that their room and their bathroom is cleaned to their satisfaction</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>- Implement intentional hourly rounding</td>
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<td></td>
<td>- Utilize single patient rooms if feasible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Close doors to patient rooms whenever possible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Use &quot;Quiet Zone&quot; signs and reminders in the corridors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Eliminate use of overhead paging, particularly at night</td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Designate zones for staff conversation (e.g., nurses station) to help avoid hallway discussions that may be disruptive to nearby rooms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Evaluate transport carts and replace noisy wheels and casters</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Turn down the alarm sound level on monitoring equipment if feasible or have telemetry equipment monitoring away from the patient (e.g., in the nurses station)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Request that work involving heavy machinery only be done during the daytime. (e.g., use of battery powered scrubbers, buffers and other loud equipment)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• In the evening/nighttime, use a portable lantern or flashlight to illuminate the area in which the</td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>HCAHPS Q21</td>
<td>Overall Rating of This Hospital</td>
<td>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? (Q21)</td>
<td>Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The following areas are most strongly correlated with a high overall hospital rating and therefore most likely to support improvement in the overall rating of the hospital:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Scores on Nurse Communication (see best practices above)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Pain Management (see best practices in the Patient Safety Measures Summary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Responsiveness of Hospital Staff (see best practices in the Patient Safety Measures Summary)</td>
<td></td>
</tr>
<tr>
<td>HCAHPS Q22</td>
<td>Willingness to Recommend This Hospital</td>
<td>Would you recommend this hospital to your friends and family? (Q22)</td>
<td>Patients who reported “Yes”, they would definitely recommend the hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The following areas are most strongly correlated with a high willingness to recommend:</td>
<td></td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
</tr>
<tr>
<td>----------------------</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Scores on Nurse Communication (see best practices above)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Pain Management (see best practices in the Patient Safety Measures Summary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Responsiveness of Hospital Staff (see best practices in the Patient Safety Measures Summary)</td>
</tr>
</tbody>
</table>
APPENDIX G – CARE TRANSITIONS MEASURES SUMMARY

Care transitions refer to the movement of patients from one health care provider or setting to another. For people living with serious and complex illnesses, transitions in setting of care are prone to errors. For example, one in five patients discharged from the hospital to home experience an adverse event within three weeks of discharge. The current rate for hospital readmissions among Medicare beneficiaries within 30 days of discharge is nearly 20%, contributing to lower patient satisfaction and rising health care costs.2

Note: In the table below, the “Technical Description” of the Emergency Department Transfer Communication (EDTC) measure and sub-measures is taken from the Stratis Health Data Collection Guide: Emergency Department Transfer Communication Measures; the “Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Question” descriptions are taken from the HCAHPS website; and the “Description for Consumer” is taken from Hospital Compare.

For a list of acronyms related to MBQIP measures, see Appendix C.

<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Technical Description/HCAHPS Survey Questions</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
</table>
| EDTC                 | Emergency Department Transfer Communication | Composite of seven sub-measures; 27 data elements. Patients who are transferred from an Emergency Department (ED) to another health care facility have... | Not reported on Hospital Compare | • Identify and implement a standardized process for documentation and transfer of information to the next setting of care  
• Update paper transfer forms to ensure capture of all the required data elements and documentation that the information was                                                                                           |

<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
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<th>Technical Description/ HCAHPS Survey Questions</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>physician communication and nurse to nurse communication prior to discharge</td>
<td>communicated to the next setting of care</td>
<td>• Implement prompts and documentation in the electronic medical record (EMR) to ensure elements are captured and communicated to the receiving facility, whether electronically or via a printed-paper form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EDTC-SUB 2: Patient Information (six data elements) – Patient identification information sent to the receiving facility within 60 minutes of discharge</td>
<td></td>
<td>• Initiate discussions with organizations, both hospitals and long-term care centers that frequently receive patients from the ED, regarding opportunities for improved transfer communication and care for patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EDTC-SUB 3: Vital Signs (six data elements) – Communication with the receiving facility within 60 minutes of discharge for patient’s vital signs</td>
<td></td>
<td>• Develop standardized setting of care processes to report outstanding test or lab results to the next setting of care if not available prior to transfer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EDTC-SUB 4: Medication Information (three data elements) – Communication with the receiving facility within 60 minutes of discharge for medication information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>Technical Description/ HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
</tr>
<tr>
<td>----------------------</td>
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<td>------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication with the receiving facility within 60 minutes of discharge for history and physical and physicians orders and plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EDTC-SUB 6: Nurse Generated Information (six data elements) – Communication with the receiving facility within 60 minutes of discharge for key nurse documentation elements</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EDTC-SUB 7: Procedures and Tests (two data elements) – Communication with the receiving facility within 60 minutes of discharge of tests done and results sent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EDTC-All: Number of patients transferred to another health care facility whose medical record documentation indicated that all of the relevant elements for each of the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure Abbreviation</td>
<td>Name</td>
<td>Technical Description/HCAHPS Survey Questions</td>
<td>Description for Consumer</td>
<td>Best Practices</td>
</tr>
<tr>
<td>----------------------</td>
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<td>-----------------------------------------------</td>
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<td>----------------</td>
</tr>
</tbody>
</table>
| HCAHPS Composite 6   | Discharge Information | 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? (Q19)  
- Did you get information in writing about what symptoms or health problems to look out for after you left the hospital? (Q20) | Patients who reported that “Yes”, they were given information about what to do during their recovery at home | • Conduct pre-discharge assessment of ability of patient and/or family to provide self-care, including: problem solving, decision making, early symptom recognition and taking action, quality of life, depression and other cognitive and functional ability factors  
• Develop a comprehensive shared care plan using a shared decision making approach. Consider patient values and preferences, social and medical needs  
• Throughout patient stay, work with patient and family to prepare for discharge and follow-up planning, including goals, questions and concerns |
<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Technical Description/ HCAHPS Survey Questions</th>
<th>Description for Consumer</th>
<th>Best Practices</th>
</tr>
</thead>
</table>
| HCAHPS Composite 7   | Care Transition | 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. (Q23)  
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. (Q24)  
- When I left the hospital, I clearly understood the purpose for taking each of my medications. (Q25) | Patients who “Strongly Agree” they understood their care when they left the hospital | - Ensure written discharge plan is easy to read and includes only essential education on health condition, using plain language and health literacy principles  
- In addition to the above strategies:  
  - Use personal health records or patient portals to ensure patients have access to necessary information, including: lab results, radiology results, prescription refills requests and ability to email doctors, nurses and staff with questions  
  - Whenever possible, make follow-up appointments or arrangements for other services prior to discharge, always with patient and family input regarding availability and preferences |

**Note:** This is a newly added CMS measure; it will be included on HCAHPS MBQIP Hospital Data Reports starting in early 2015.
<table>
<thead>
<tr>
<th>Measure Abbreviation</th>
<th>Name</th>
<th>Technical Description/ HCAHPS Survey Questions</th>
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<th>Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Use teach-back and health literacy principles in patient education</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Conduct follow-up phone calls within 48 hours post-discharge to clarify patient and family understanding of medications and follow-up services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Provide a written listing of medications to the patient and family including the name of the medication, dose, route, purpose, side effects and special considerations in language that is easy to understand for the patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• For patients with complicated medication regimes, whenever possible, engage pharmacy staff in performing patient education, medication review and follow-up phone calls</td>
</tr>
</tbody>
</table>
## Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information

### Hospital IQR Hospital Performance

**Reporting Period for Clinical Process Measures:** Second Quarter 2013 through First Quarter 2014 Discharges

<table>
<thead>
<tr>
<th>MBQIP Quality Measures</th>
<th>Your Hospital Performance by Quarter</th>
<th>Aggregate Rate for All Four Quarters</th>
<th>State Average Current Quarter</th>
<th>National Average Current Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2Q13</td>
<td>3Q13</td>
<td>4Q13</td>
<td>1Q14</td>
</tr>
<tr>
<td>Heart Failure (HF)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Instructions *</td>
<td>0% of 1 patients</td>
<td>100% of 2 patients</td>
<td>14% of 7 patients</td>
<td>0% of 4 patients</td>
</tr>
<tr>
<td>HF-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation of LVS Function</td>
<td>25% of 4 patients</td>
<td>100% of 2 patients</td>
<td>44% of 9 patients</td>
<td>25% of 4 patients</td>
</tr>
<tr>
<td>HF-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACEI or ARB for LVSD *</td>
<td>0 patients</td>
<td>0 patients</td>
<td>100% of 1 patient</td>
<td>0 patients</td>
</tr>
<tr>
<td>PN-3b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital *</td>
<td>100% of 4 patients</td>
<td>0 patients</td>
<td>88% of 8 patients</td>
<td>100% of 9 patients</td>
</tr>
<tr>
<td>PN-6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Antibiotic Selection for CAP in Immunocompetent Patient</td>
<td>40% of 5 patients</td>
<td>100% of 4 patients</td>
<td>67% of 3 patients</td>
<td>100% of 8 patients</td>
</tr>
</tbody>
</table>

* Hospitals were able to voluntarily report these measures until October 1, 2014

**Example A:** Lack of Consistent Process

**Example B:** Process May Need Adjustment
### Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information

**Hospital OQR Hospital Performance**

**Reporting Period for Clinical Process Measures:** Second Quarter 2013 through First Quarter 2014 Discharges

<table>
<thead>
<tr>
<th>MBQIP Quality Measures</th>
<th>Your Hospital Performance by Quarter</th>
<th>State Average Current Quarter</th>
<th>National Average Current Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2Q13</td>
<td>3Q13</td>
<td>4Q13</td>
</tr>
<tr>
<td><strong>AMI Cardiac Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-1 Median Time to Fibrinolysis</td>
<td>0 Patients</td>
<td>0 Patients</td>
<td>0 Patients</td>
</tr>
<tr>
<td>OP-2 Fibrinolytic Therapy Received</td>
<td>0 Patients</td>
<td>0 Patients</td>
<td>0 Patients</td>
</tr>
<tr>
<td>Within 30 Minutes of ED Arrival</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-3b Median Time to Transfer to Another Facility for Acute Coronary Intervention</td>
<td>62 Minutes based on 2 patients</td>
<td>60 Minutes based on 1 patients</td>
<td>102 Minutes based on 8 patients</td>
</tr>
<tr>
<td>OP-4 Aspirin at Arrival</td>
<td>93% of 14 patients</td>
<td>78% of 9 patients</td>
<td>100% of 16 patients</td>
</tr>
<tr>
<td>OP-5 Median Time to ECG</td>
<td>6 Minutes based on 14 patients</td>
<td>6 Minutes based on 9 patients</td>
<td>8 Minutes based on 18 patients</td>
</tr>
<tr>
<td><strong>Surgical Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OP-6 Timing of Antibiotic Prophylaxis</td>
<td>100% of 7 patients</td>
<td>67% of 3 patients</td>
<td>100% of 4 patients</td>
</tr>
<tr>
<td>OP-7 Prophylactic Antibiotic Selection for Surgical Patients</td>
<td>100% of 7 patients</td>
<td>67% of 3 patients</td>
<td>100% of 4 patients</td>
</tr>
</tbody>
</table>

**Example C:** Understanding Variation

**Example D:** Variation Outside of a Set Limit

**Example B:** Process May Need Adjustment
# Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information

## Hospital IQR Hospital Performance – Survey Completion and Response Rate

### Hospital CAHPS (HCAHPS) Survey

### HCAHPS Composites and Individual Items

<table>
<thead>
<tr>
<th>HCAHPS Composites</th>
<th>Reporting Period 4Q11-3Q12</th>
<th>Reporting Period 1Q12-4Q12</th>
<th>Reporting Period 2Q12-1Q13</th>
<th>Reporting Period 3Q12-2Q13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Completed Surveys</td>
<td>48</td>
<td>36</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>Survey Response Rate</td>
<td>41</td>
<td>22</td>
<td>38</td>
<td>37</td>
</tr>
</tbody>
</table>

#### HCAHPS Composites

- **Composite 1 (Q1 to Q3): Communication with Nurses**
  - % Sometimes to Never: 1
  - % Usually: 11
  - % Always: 88

- **Composite 2 (Q5 to Q7): Communication with Doctors**
  - % Sometimes to Never: 1
  - % Usually: 13
  - % Always: 86

- **Composite 3 (Q9 & Q10): Responsiveness of Hospital Staff**
  - % Sometimes to Never: 10
  - % Usually: 12
  - % Always: 78

- **Composite 4 (Q13 & Q14): Pain Management**
  - % Sometimes to Never: 10
  - % Usually: 24
  - % Always: 66

- **Composite 5 (Q16 & Q17): Communication about Medicines**
  - % Sometimes to Never: 22
  - % Usually: 15
  - % Always: 63

#### Hospital Environment Items

- **Q8: Cleanliness of Hospital Environment**
  - % Sometimes to Never: 82
  - % Usually: 4
  - % Always: 86

- **Q9: Quietness of Hospital Environment**
  - % Sometimes to Never: 4
  - % Usually: 43
  - % Always: 53

#### Discharge Composite Information

- **Composite 6 (Q19 & Q20): Discharge Information**
  - % Yes: 81
  - % No: [not shown]

### HCAHPS Global Items

<table>
<thead>
<tr>
<th>HCAHPS Global Items</th>
<th>Reporting Period 4Q11-3Q12</th>
<th>Reporting Period 1Q12-4Q12</th>
<th>Reporting Period 2Q12-1Q13</th>
<th>Reporting Period 3Q12-2Q13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Completed Surveys</td>
<td>48</td>
<td>36</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>Survey Response Rate</td>
<td>41</td>
<td>22</td>
<td>38</td>
<td>37</td>
</tr>
</tbody>
</table>

- **Q21: Overall Rating of Hospital**
  - % 0 to 6 rating: 12
  - % 7 and 8 rating: 19

- **Q22: Willingness to Recommend this Hospital**
  - % No: Definitely or Probably Not Recommend: 9
  - % Yes: Probably Recommend: 29

### Example E: Opportunity for Improvement

- **Q21: Overall Rating of Hospital**
  - % 0 to 6 rating: 12
  - % 7 and 8 rating: 19

#### Example F: Translate to Number of Patients

- **How do you calculate how many patients are 12% of completed surveys?**
  - \[ 12 = \frac{X}{100} \] (completed surveys)
  - Multiply and divide to solve for X:
    - \[ 12 \times 50/100 = 6 \text{ patients} \]

#### General Information:

**Data is presented over rolling four quarters.**

**Example G: Celebrate Gains**

- **Q8: Cleanliness of Hospital Environment**
  - % Sometimes to Never: 82
  - % Usually: 4
  - % Always: 86

- **Q9: Quietness of Hospital Environment**
  - % Sometimes to Never: 4
  - % Usually: 43
  - % Always: 53

**Translate to Number of Patients**

- **Q22: Willingness to Recommend this Hospital**
  - % No: Definitely or Probably Not Recommend: 9
  - % Yes: Probably Recommend: 29

**General Information:**

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.
### Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information

#### Hospital IQR Hospital Performance – Survey Completion and Response Rate

**Hospital CAHPS (HCAHPS) Survey**

<table>
<thead>
<tr>
<th>HCAHPS Composites and Individual Items</th>
<th>State Average</th>
<th>U.S. Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCAHPS Composites</strong></td>
<td>% Sometimes to Never</td>
<td>% Usually</td>
</tr>
<tr>
<td>Composite 1 (Q1 to Q3)</td>
<td>Communication with Nurses</td>
<td>3</td>
</tr>
<tr>
<td>Composite 2 (Q5 to Q7)</td>
<td>Communication with Doctors</td>
<td>83</td>
</tr>
<tr>
<td>Composite 3 (Q4 &amp; Q11)</td>
<td>Responsiveness of Hospital Staff</td>
<td>5</td>
</tr>
<tr>
<td>Composite 4 (Q13 &amp; Q14)</td>
<td>Communication about Medicines</td>
<td>15</td>
</tr>
<tr>
<td><strong>Hospital Environment Items</strong></td>
<td>% Sometimes to Never</td>
<td>% Usually</td>
</tr>
<tr>
<td>Composite 5</td>
<td>% Sometimes to Never</td>
<td>% Usually</td>
</tr>
<tr>
<td>Q8</td>
<td><strong>Opportunity for Improvement</strong></td>
<td>Cleanliness of Hospital Environment</td>
</tr>
<tr>
<td>Q9</td>
<td>Quietness of Hospital Environment</td>
<td>7</td>
</tr>
<tr>
<td><strong>Discharge Information Composite</strong></td>
<td>% Yes</td>
<td>% No</td>
</tr>
<tr>
<td>Composite 6 (Q19 &amp; Q20)</td>
<td>Discharge Information</td>
<td>87</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCAHPS Global Items</th>
<th>State Average</th>
<th>U.S. Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q21</td>
<td>% 7 and 8 rating</td>
<td>% 9 and 10 rating</td>
</tr>
<tr>
<td>Overall Rating of Hospital (1 = Worst Hospital 10 = Best Hospital)</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Q22</td>
<td>Willingness to Recommend this Hospital</td>
<td>% No: Definitely or Probably Not Recommend</td>
</tr>
<tr>
<td>Willingness to Recommend this Hospital</td>
<td>3</td>
<td>25</td>
</tr>
</tbody>
</table>

**General Information:**
Timeframe for the state and national comparisons are from the most recent four quarters of data.

---

**Example E:** Opportunity for Improvement

**Example G:** Celebrate Gains

**Example F:** Translate to Number of Patients

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NATIONAL RURAL HEALTH RESOURCE CENTER
Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information

Emergency Department Transfer Communication

Sample Hospital

<table>
<thead>
<tr>
<th>MBQIP Quality Measures</th>
<th>Your Hospital Performance by Quarter</th>
<th>Aggregate Rate for All Four Quarters</th>
<th>State Average Current Quarter</th>
<th>National Average Current Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4Q14</td>
<td>1Q15</td>
<td>2Q15</td>
<td>3Q15</td>
</tr>
<tr>
<td>Total Records</td>
<td>N = 43</td>
<td>N =</td>
<td>N =</td>
<td>N =</td>
</tr>
<tr>
<td>EDTC-1 Administrative Communication</td>
<td>81.4% (n = 35)</td>
<td>% (n = )</td>
<td>% (n = )</td>
<td>% (n = )</td>
</tr>
<tr>
<td>EDTC-2 Patient Information</td>
<td>90.7% (n = 39)</td>
<td>% (n = )</td>
<td>% (n = )</td>
<td>% (n = )</td>
</tr>
<tr>
<td>EDTC-3 Vital Signs</td>
<td>41.86% (n = 18)</td>
<td>% (n = )</td>
<td>% (n = )</td>
<td>% (n = )</td>
</tr>
<tr>
<td>EDTC-4 Medication Information</td>
<td>88.37% (n = 38)</td>
<td>% (n = )</td>
<td>% (n = )</td>
<td>% (n = )</td>
</tr>
<tr>
<td>EDTC-5 Practitioner Information</td>
<td>81.4% (n = 35)</td>
<td>% (n = )</td>
<td>% (n = )</td>
<td>% (n = )</td>
</tr>
<tr>
<td>EDTC-6 Nurse Information</td>
<td>88.37% (n = 38)</td>
<td>% (n = )</td>
<td>% (n = )</td>
<td>% (n = )</td>
</tr>
<tr>
<td>EDTC-7 Procedures &amp; Tests</td>
<td>53.49% (n = 23)</td>
<td>% (n = )</td>
<td>% (n = )</td>
<td>% (n = )</td>
</tr>
<tr>
<td>All EDTC</td>
<td>20.93% (n = 9)</td>
<td>% (n = )</td>
<td>% (n = )</td>
<td>% (n = )</td>
</tr>
</tbody>
</table>

**General Information:**
As additional quarters of data are submitted, this column will **aggregate** data for each quarter that is available. The total number of records will be all cases reviewed in the prior year.

**Example H: Opportunity for Improvement**

**Example I: Documentation or Process?**

**General Information:**
The All EDTC measure is the percentage of cases that have every data element from every sub-measure (a total of 27 data elements). Thus, this indicator will never be higher than the lowest of the sub-measures.

**Note:** The data in this example were modified from an eight state pilot of approximately 100 critical access hospitals (CAHs). The MBQIP state and national comparisons will include all CAHs that are reporting this measure. This example only includes one quarter of data and therefore looks similar to the first EDTC MBQIP Hospital Data Report that hospitals will receive. As additional quarters of data are submitted the data will be added in the respective quarter. MBQIP Hospital Data Reports on the emergency department transfer communication (EDTC) measure are anticipated to be available in Spring of 2015.
APPENDIX I – QIO CLINICAL WAREHOUSE DATA FLOW

Hospital submits case to the Quality Improvement Organization (QIO) Clinical Warehouse for a specific Centers for Medicare & Medicaid Services (CMS)

Is the case accepted into the warehouse?

Yes

No

The case is rejected from the warehouse and will not be counted in the hospital’s denominator for the measure

Does the case meet the CMS inclusion definition for the measure?

Yes

The case is included and will be counted in the hospital’s denominator for the measure

No

The case is excluded and will not be included in the hospital’s denominator for the measure

Does the case meet the criteria of the measure?

Yes

The case passed and will be included in the hospital’s numerator for the measure

No

The case failed and will not be included in the hospital’s numerator for the measure
APPENDIX J - 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.

**Accepted**: Individual case(s) submitted and accepted into the [QIO Clinical Warehouse](#).

**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.

**CART**: The Centers for Medicare & Medicaid Services (CMS) Abstraction & Reporting Tool; a free tool that hospitals can utilize to collect and submit the chart abstracted inpatient and outpatient [Hospital Compare](#) measures.

**CMS Measure Specifications Manuals**: Manuals created by the Centers for Medicare & Medicaid Services (CMS) to provide definitions for a uniform set of quality measures to be implemented in hospital settings. The inpatient and outpatient manuals can be found on the [QualityNet website](#).

**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 [QIO Clinical Warehouse](#) that did not meet the criteria to be included in a specific quality indicator; not included in the **denominator**.

**Failed**: Individual case(s) accepted into the [QIO Clinical Warehouse](#) that met the criteria to be included in a specific quality indicator, but did not meet the measure criteria; included in the **denominator**, but not in the **numerator**.

**Hospital 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 Hospital Compare website.

**Included:** Individual case(s) accepted into the QIO Clinical Warehouse and met the criteria to be included in specific quality indicator; included in the denominator.

**Intentional hourly rounding:** A practice used by nursing and care teams in which routine rounds on patients are conducted hourly employing an intentional approach with the goal of improving patient care, safety and experience; also known as purposeful hourly rounding.

**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.

**Passed:** Individual case(s) accepted into the QIO Clinical Warehouse, met the criteria to be included in a specific quality indicator and met the measure criteria; included in the denominator and the numerator.

**QIO Clinical Warehouse:** The Quality Improvement Organization (QIO) 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 QIO Clinical Warehouse via the QualityNet website.

**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 the only 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 QIO 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](http://www.qualitynet.org). 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. For more information visit the [Data Submission webpage of the QualityNet website](http://www.qualitynet.org).

**Teach-back**: A communication method for ensuring that a patient understands what a provider has told them. For more information and resources visit the [Always Use Teach-back website](http://www.alwaysuse教back.org).

**Time-out**: A step in a medical process in which all activity stops to allow the team to focus fully on communication with and about the patient. For example, surgical time-outs are a time to confirm which body part is being operated on.

**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.