Understanding Changes to MBQIP

GETTING TO KNOW THE NEW MEASURES AND STRATEGIES TO COLLECT THEM

Understanding New Measures for MBQIP Series

- Webinars every two weeks
  - Total of 6 webinars
  - Last webinar August 27, 2024
- Each webinar will focus on one measure
- All webinars will be recorded
- Post-webinar survey to gather questions to be answered

Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

MBQIP measures are divided into two categories:

- **Core MBQIP Measures** are those that all state Flex Programs are expected to support. Reporting on these measures contributes towards a CAH's Flex eligibility requirements.
- **Additional MBQIP Measures** are those that state Flex Programs can elect to support in addition to the Core measures, particularly in alignment with other partners or initiatives. While these measures are also rural relevant, they may not be as widely applicable across all CAHs. The MBQIP Measures resource includes a list of potential additional measures, but that list is not meant to be exhaustive. Flex programs can propose to work on other quality improvement topics within the four MBQIP domains. If there is not a nationally standardized or standardly reported measure currently available, Flex programs can propose a data collection mechanism.

Core MBQIP Measures			
Patient Safety/Inpatient	***Patient Engagement***	***Care Transitions***	***Outpatient***
HCP/IMM-3 (formerly OP-27): Influenza Vaccination Coverage Among Healthcare Personnel (HCP) **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass eight key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes screener questions and demographic items. The survey is 29 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *1 composite; 8 elements* • **All EDTC Composite** • Home Medications • Allergies and/or Reactions • Medications Administered in ED • ED provider Note • Mental Status/Orientation Assessment • Reason for Transfer and/or Plan of Care • Tests and/or Procedures Performed • Test and/or Procedure Results	**AMI:** • **OP-2:** Fibrinolytic Therapy Received within 30 minutes • **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **ED Throughput** • **OP-18:** Median Time from ED Arrival to ED Departure for *Discharged* ED Patients • **OP-22:** Patient Left Without Being Seen

Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

Additional MBQIP Measures			
Patient Safety/Inpatient	***Patient Engagement***	***Care Transitions***	***Outpatient***
Healthcare-Associated Infections (HAI) • **CLABSI:** Central Line-Associated Bloodstream Infection • **CAUTI:** Catheter-Associated Urinary Tract Infection • **CDI:** *Clostridioides difficile* (*C.diff*) Infection • **MRSA:** Methicillin-resistant *Staphylococcus aureus* • **SSIs:** Surgical Site Infections Colon or Hysterectomy **Perinatal Care** • **PC-01:** Elective Delivery • **PC-05**: Exclusive Breast Milk Feeding (eCQM) **Falls** • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk **Adverse Drug Events (ADE)** • Opioids • Glycemic Control • Anticoagulant Therapy **Patient Safety Culture Survey** **Inpatient Influenza Vaccination** **eCQMs** • **VTE-1:** Venous Thromboembolism Prophylaxis • **Safe Use of Opioids**: Concurrent Prescribing • **ED-2:** Median Admit Decision Time to ED Departure Time for Admitted Patients	**Emergency Department Patient Experience**	**Discharge Planning** **Medication Reconciliation** **Swing Bed Care** **Claims-Based Measures** *Measures are automatically calculated for hospitals using Medicare Administrative Claims Data* • **Readmissions** • **Complications** • **Hospital Return Days**	**Chest Pain/AMI** • Aspirin at Arrival • Median Time to ECG **ED Throughput** • Door to Diagnostic Evaluation by a Qualified Medical Professional

New Core Measure Set

Proposed New MBQIP Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
▪ CAH Quality Infrastructure Implementation *(annual submission)* ▪ Hospital Commitment to Health Equity (required CY 2025) *(annual submission)*	▪ Healthcare Personnel Influenza Immunization *(annual submission)* ▪ Antibiotic Stewardship Implementation *(annual submission)* ▪ Safe Use of Opioids (eCQM) *(annual submission)*	▪ Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) *(quarterly submission)*	▪ Hybrid All-Cause Readmissions (required starting in 2025) *(annual submission)* ▪ SDOH Screening (required CY 2025) *(annual submission)* ▪ SDOH Screening Positive (required CY 2025) *(annual submission)*	▪ Emergency Department Transfer Communication (EDTC) *(quarterly submission)* ▪ OP-18 Time from Arrival to Departure *(quarterly submission)* ▪ OP-22 Left without Being Seen *(annual submission)*

Suggested Additional Quality Measures for Flex Improvement Activities

Global Measures	Patient Safety	Patient Experience	Care Coordination	Emergency Department
Quality Improvement Basics **Quality Related Certification**	**Antibiotic Use (AU)** **COVID Vaccination** **Healthcare-Associated Infections (HAI)** **Perinatal Care** • **Birthing-Friendly Hospital Designation** • **PC-01:** Elective Delivery • **PC-05**: Exclusive Breast Milk Feeding (eCQM) **Falls** • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk **Adverse Drug Events (ADE)** • Opioids • Glycemic Control • Anticoagulant Therapy **Patient Safety Culture Survey** **Inpatient Influenza Immunization** **eCQMs** • **VTE-1:** Venous Thromboembolism Prophylaxis • **ED-2:** Median Admit Decision Time to ED Departure Time for Admitted Patients	**Emergency Department Patient Experience** **Swing Bed Patient Experience** **Clinic Group CAHPS**	**Discharge Planning** **Medication Reconciliation** **Swing Bed Care** **Claims-Based Measures:** The following Measures are automatically calculated for hospitals using Medicare Administrative Claims Data • Complications • Hospital Return Days **Global Malnutrition Composite Score (eCQM)**	**OP-40**: ST-Segment Elevation Myocardial Infarction (eCQM) **Chest Pain/Acute Myocardial Infarction** **ED Throughput** • Door to Diagnostic Evaluation by a Qualified Medical Professional **American Heart Association Get with the Guidelines (Stroke, Heart Failure, AMI)**

eCQM

Critical Access Hospital Electronic Clinical Quality Measure (eCQM) Resource List

August 2023

eCQM Reporting requirements are aligned between two CMS programs:

Promoting Interoperability (PI) Program	Inpatient Quality Reporting (IQR)
• CAHs must participate in the Medicare PI Program to avoid a downward payment adjustment. • Hospitals are required to submit eCQM data from certified electronic health record technology (CEHRT) • eCQMs submission is one component of the Medicare PI Program • For a complete summary of PI requirements, see 2023 Promoting Interoperability Program Requirements | CMS	• Critical access hospitals (CAHs) are not held to the IQR program requirements but meeting the Hospital IQR Program eCQM requirement also satisfies the eCQM electronic reporting requirement for the Medicare PI Program. • CAHs are not included in the CMS eCQM data validation process.

Calendar Year (CY) 2023 eCQM Reporting Requirements:

- All four quarters of CY 2023
- Four measures:
  - Safe Use of Opioids – Concurrent Prescribing (mandatory)
  - Self-select Three (3) of the thirteen available eCQMs for each quarter
- Submission period deadline: **February 29, 2024**

eCQM Measure Options

Available eCQMs:

Short Name	Available Measures by Reporting Year	CY 2023	CY 2024
ED-2	Median Admit Decision Time to ED Departure Time for Admitted Patients	X	
VTE-1	Venous Thromboembolism Prophylaxis	X	X
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	X	X
PC-05	Exclusive Breast Milk Feeding	X	
STK-2	Discharged on Antithrombotic Therapy	X	X
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	X	X
STK-5	Antithrombotic Therapy By End of Hospital Day 2	X	X
STK-6	Discharged on Statin Medication	X	
ePC-02	Cesarean Birth*	X	Required
ePC-07	Severe Obstetric Complications*	X	Required
HH-01	Hospital Harm—Severe Hypoglycemia	X	X
HH-02	Hospital Harm—Severe Hyperglycemia	X	X
HH-ORAE	Hospital Harm – Opioid-Related Adverse Events		X
GCMS	Global Malnutrition Composite Score		X
Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing	Required	Required

*All hospitals, except those that do not have OB or do not perform deliveries, are required to report ePC-02 and ePC-07 starting with the CY 2024 reporting period.

Timeline

- Currently in prep mode – time for gathering questions
- September 2024
  - Prepare to begin collecting new measures
  - SORH/THA/RCHI Share questions / feedback with FORHP
- September 2025
  - SORH/THA/RCHI begin tracking non-reporting CAHs
  - Report to FORHP
- September 2026
  - Continue tracking non-reporting CAHs
- November 2026
  - Report to FORHP list of non-reporting CAHs for CY2025

Measures

Quality Infrastructure
Data Source: Annual submission National CAH Quality Inventory

Measure Name – CAH Quality Infrastructure	
MBQIP Domain	Global Measures
Measure Description	**Specification for CAH Quality Infrastructure Measure will be released in 2024 and are dependent on data collection via the National CAH Quality Inventory and Assessment.** Structural measure to assess CAH quality infrastructure based on the nine core elements of CAH quality infrastructure: 1. Leadership Responsibility & Accountability 2. Quality Embedded within the Organization's Strategic Plan 3. Workforce Engagement & Ownership 4. Culture of Continuous Improvement through Behavior 5. Culture of Continuous Improvement through Systems 6. Integrating Equity into Quality Practices 7. Engagement of Patients, Partners, and Community 8. Collecting Meaningful and Accurate Data 9. Using Data to Improve Quality

Hospital Commitment to Health Equity Data Source: Attestation

Measure Name – Hospital Commitment to Health Equity	
MBQIP Domain	Global Measures
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	May 15, 20XX; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	This structural measure assesses hospital commitment to health equity. Hospitals will receive points for responding to questions in five (5) different domains of commitment to advancing health equity: • Domain 1 – Equity is a Strategic Priority • Domain 2 – Data Collection • Domain 3 – Data Analysis • Domain 4 – Quality Improvement • Domain 5 – Leadership Engagement Hospital score can be a total of zero (0) to five (5) points (one point for each domain, must attest "yes" to all sub-questions in each domain, no partial credit).

Safe Use of Opioids
Data Source: EHR

Measure Name – Safe Use of Opioids – Concurrent Prescribing	
MBQIP Domain	Patient Safety
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	February 28, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on two or more opioids, or an opioid and benzodiazepine concurrently at discharge.
Measure Rationale	Unintentional opioid overdose fatalities have become an epidemic and major public health concern in the United States. Concurrent prescriptions of opioids, or opioids and benzodiazepines, places patients at a greater risk of unintentional overdose due to increased risk of respiratory depression. Patients who have multiple opioid prescriptions have an increased risk for overdose, and rates of fatal overdose are ten (10) times higher in patients who are co-dispensed opioid analgesics and benzodiazepines than opioids alone. A measure that calculates the proportion of patients with two or more opioids or opioids and benzodiazepines concurrently has the potential to reduce preventable mortality and reduce costs associated with adverse events related to opioids.

Hybrid All Cause Hospital Wide Readmission
Data Source: Chart abstraction of clinical data and administrative claims data

Measure Name – Hybrid Hospital-Wide Readmission	
MBQIP Domain	Care Coordination
Encounter Period	July 1st, 20XX - June 30th, 20XX
Submission Deadline	September 30, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Hospital-level, all-cause, risk-standardized readmission measure that focuses on unplanned readmissions 30 days of discharge from an acute hospitalization. Hybrid measures differ from the claims-only measures in that they merge electronic health record (EHR) data elements with claims-data to calculate the risk-standardized readmission rate. The Hybrid HWR was developed to address complex and critical aspects of care that cannot be derived through claims data alone. The Hybrid HWR uses EHR data including clinical variables and linking elements for each patient: • Clinical variables (13): Heart Rate, Systolic Blood Pressure, Respiratory Rate, Temperature, Oxygen Saturation, Weight, Hematocrit, White Blood Cell Count, Potassium, Sodium, Bicarbonate, Creatinine, Glucose • Linking elements (6): CMS Certification Number (CCN), Health Insurance Claims Number or Medicare Beneficiary Identifier, Date of birth, Sex, Admission date, Discharge date

Screening for Social Determinants of Health

Data Source: Chart Abstraction

Measure Name – Screening for Social Drivers of Health (SDOH Screening)	
MBQIP Domain	Care Coordination
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	May 15, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. To report on this measure, hospitals will provide: (1) The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; **and** (2) the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted. A specific screening tool is not required to be used, but all areas of health-related social needs must be included.

- Looking at 5 health related social needs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety

Patients Screening Positive for Social Drivers of Health
Data Source: Chart Abstraction

Measure Name – Screen Positive for Social Drivers of Health (SDOH Screening Positive)	
MBQIP Domain	Care Coordination
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	May 15, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the following five health-related social needs (HSRNs): Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Healthcare Personnel Influenza Immunization
Data Source: Administrative data

Measure Name – Healthcare Personnel Influenza Immunization	
MBQIP Domain	Patient Safety
Encounter Period	October 1, 20XX – March 31, 20XX (Aligns with flu season, for example: October 1, 2023 – March 31, 2024)
Submission Deadline	May 15, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Influenza Vaccination Coverage among Healthcare Personnel

Antibiotic Stewardship Data Source: NHSN Annual Survey

Measure Name – Antibiotic Stewardship Implementation	
MBQIP Domain	Patient Safety
Encounter Period	Calendar Year (January 1, 20XX– December 31, 20XX)
Submission Deadline	March 1, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Annual Survey

Emergency Department Transfer Communication
Data Source: Chart Abstraction / EHR

Measure Name – Emergency Department Transfer Communication (EDTC)	
MBQIP Domain	Emergency Department
Encounter Periods	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1- December 31)
Submission Deadlines	Q1 encounters (January 1 – March 31) DUE April 30 Q2 encounters (April 1 – June 30) DUE July 31 Q3 encounters (July 1 – September 30) DUE October 31 Q4 encounters (October 1- December 31) DUE January 31 Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Percent of Patients who are transferred from an ED to another healthcare facility that have all necessary communication made available to the receiving facility in a timely manner.

OP – 18 Time from ED Arrival to ED Discharge
Data Source: Chart Abstration

Measure Name – OP-18 Time from ED Arrival to ED Departure	
MBQIP Domain	Emergency Department
Encounter Periods	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1- December 31)
Submission Deadlines	Q1 encounters (January 1 – March 31) DUE August 1 Q2 encounters (April 1 – June 30) DUE November 1 Q3 encounters (July 1 – September 30) DUE February 1 Q4 encounters (October 1- December 31) DUE May 1 Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Median time from Emergency Department (ED) arrival to time of departure from the emergency room for patients discharged from the ED.

OP – 22 Left Without Being Seen
Data Source: Hospital Tracking

Measure Name – OP-22 Left Without Being Seen	
MBQIP Domain	Emergency Department
Encounter Periods	Encounter Period - Calendar Year (January 1 – December 31)
Submission Deadlines	May 15, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Percent of patients who leave the Emergency Department (ED) without being evaluated by a physician/advanced practice nurse/physician's assistant (physician/APN/PA.

HCAHPS
Data Source: Certified Vendor

Existing Measure for MBQIP Reporting Within the Flex Program
MBQIP 2025 Core Measure Set

- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Communication about medications
- Cleanliness of hospital environment
- Quietness of hospital environment
- Discharge Information
- Care Transitions
- Overall Rating of Hospital

FORHP will be identifying HCAHPS low volume threshold option that applies to SHIP and Flex

MBQIP Data Portal

HOW TO GET YOUR REPORTS

MBQIP Portal HOME MEASURES RESOURCES DEADLINES NEWS DICTIONARY

Welcome to the MBQIP Portal

All the MBQIP Information You Need

in One Location

QNet

QualityNet

LOGIN

Established by the Centers for Medicare & Medicaid Services

NHSN

National Hea Safety Network

LOGIN

MBQIP-DB

MBQIP Datab

LOGIN

ARCHI is working in collaboration with the State Office of Rural Health

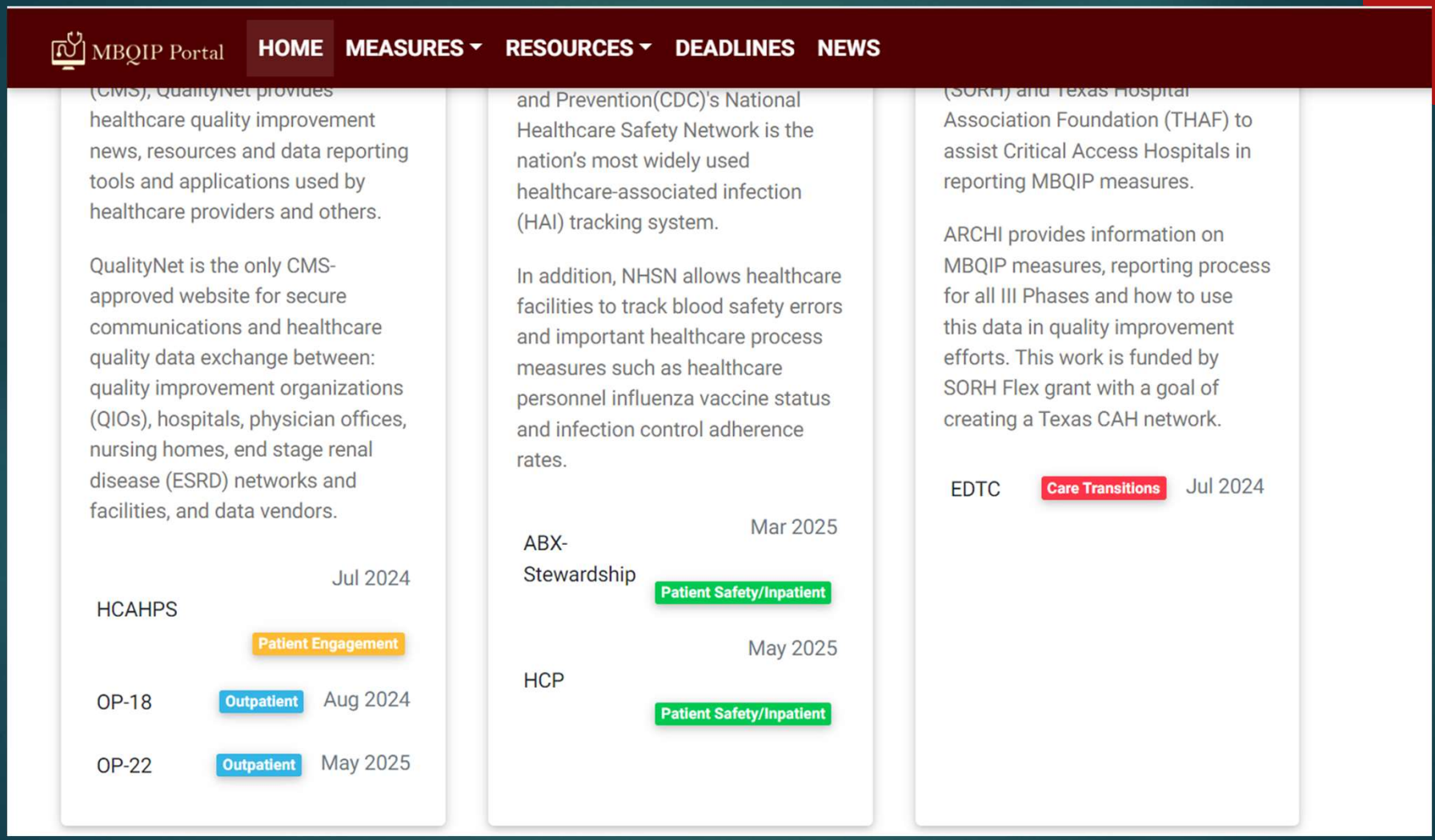
Upcoming Deadlines

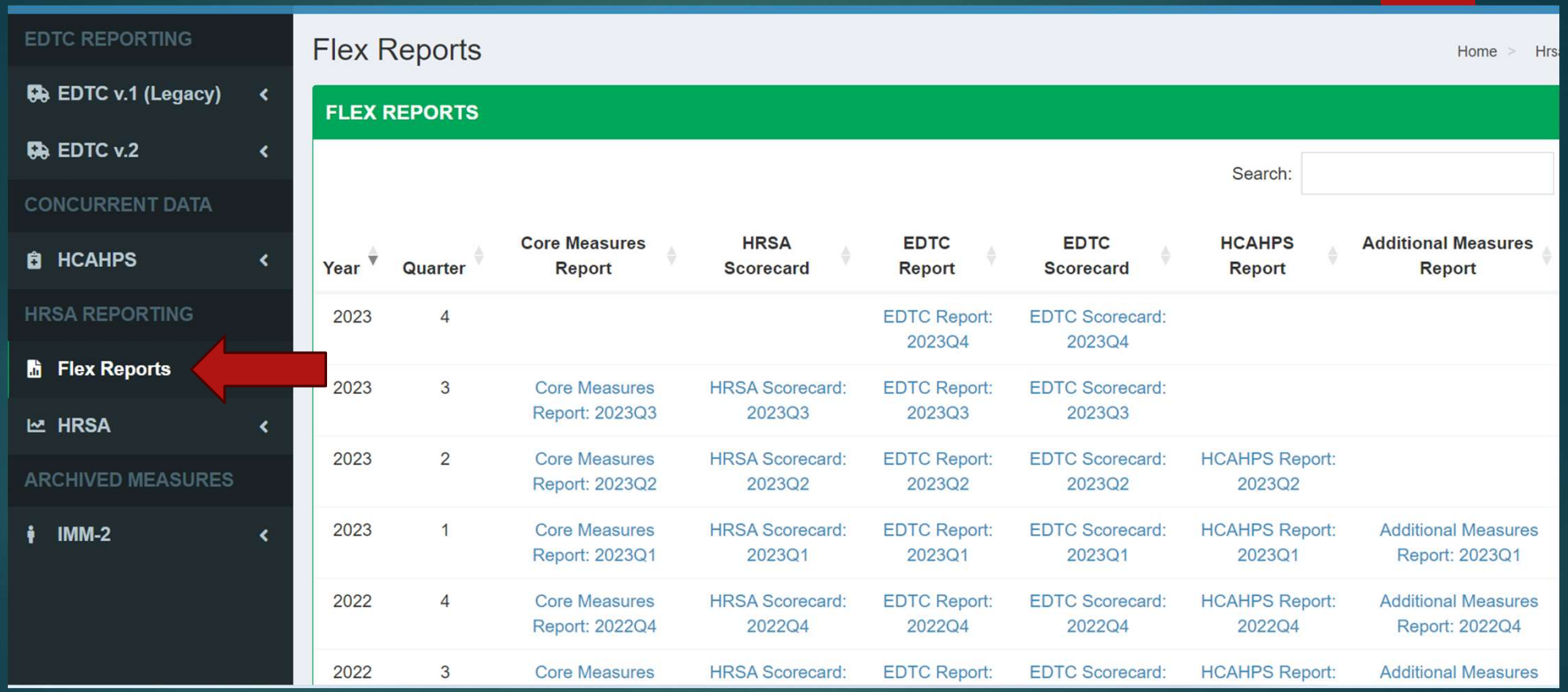
HCAHPS »
Apr 3rd

EDTC »
Apr 15th

OP-18 »
May 1st

OP-22 »
May 15th


MBQIP Portal
HOME
MEASURES
RESOURCES
DEADLINES
NEWS
(CMS), QualityNet provides healthcare quality improvement news, resources and data reporting tools and applications used by healthcare providers and others.
QualityNet is the only CMS-approved website for secure communications and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end stage renal disease (ESRD) networks and facilities, and data vendors.
HCAHPS
Patient Engagement
Jul 2024
OP-18
Outpatient
Aug 2024
OP-22
Outpatient
May 2025
and Prevention(CDC)'s National Healthcare Safety Network is the nation's most widely used healthcare-associated infection (HAI) tracking system.
In addition, NHSN allows healthcare facilities to track blood safety errors and important healthcare process measures such as healthcare personnel influenza vaccine status and infection control adherence rates.
ABX-Stewardship
Patient Safety/Inpatient
Mar 2025
HCP
Patient Safety/Inpatient
May 2025
(SORH) and Texas Hospital Association Foundation (THAF) to assist Critical Access Hospitals in reporting MBQIP measures.
ARCHI provides information on MBQIP measures, reporting process for all III Phases and how to use this data in quality improvement efforts. This work is funded by SORH Flex grant with a goal of creating a Texas CAH network.
EDTC
Care Transitions
Jul 2024



Year	Quarter	Core Measures Report	HRSA Scorecard	EDTC Report	EDTC Scorecard	HCAHPS Report	Additional Measures Report
2023	4			EDTC Report: 2023Q4	EDTC Scorecard: 2023Q4		
2023	3	Core Measures Report: 2023Q3	HRSA Scorecard: 2023Q3	EDTC Report: 2023Q3	EDTC Scorecard: 2023Q3		
2023	2	Core Measures Report: 2023Q2	HRSA Scorecard: 2023Q2	EDTC Report: 2023Q2	EDTC Scorecard: 2023Q2	HCAHPS Report: 2023Q2	
2023	1	Core Measures Report: 2023Q1	HRSA Scorecard: 2023Q1	EDTC Report: 2023Q1	EDTC Scorecard: 2023Q1	HCAHPS Report: 2023Q1	Additional Measures Report: 2023Q1
2022	4	Core Measures Report: 2022Q4	HRSA Scorecard: 2022Q4	EDTC Report: 2022Q4	EDTC Scorecard: 2022Q4	HCAHPS Report: 2022Q4	Additional Measures Report: 2022Q4
2022	3	Core Measures	HRSA Scorecard:	EDTC Report:	EDTC Scorecard:	HCAHPS Report:	Additional Measures

Core Measure Report

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report
Quarter 3 - 2023

Generated on 03/06/24

		Your Hospital's Performance by Quarter				State Current Quarter			National Current Quarter		Bench-mark
	Emergency Department – Quarterly Measure	Q4 2022	Q1 2023	Q2 2023	Q3 2023	# CAHs Reporting	Median Time	90th Percentile	# CAHs Reporting	Median Time	Median Time
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	90	92	122	N/A	53	111	79	1,004	114	85
	Number of Patients (N)	N=94	N=99	N=96	N/A						

		Your Hospital's Performance by Calendar Year			State Current Year			National Current Year		Bench-mark
	Emergency Department – Annual Measure	CY 2020	CY 2021	CY 2022	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	CAH Overall Rate
OP-22	Patient Left Without Being Seen	N/A	N/A	N/A	29	1%	0%	963	1%	0%
	Number of Patients (N)	N/A	N/A	N/A						

		Your Hospital's Reported Adherence Percentage			State Current Flu Season			National Current Flu Season		Bench-mark
	NHSN Immunization Measure	4Q20 - 1Q21	4Q21 - 1Q22	4Q22 - 1Q23	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	CAH Overall Rate
HCP/IMM-3	Healthcare Provider Influenza Vaccination	94%	N/A	88%	32	79%	91%	1,063	79%	100%

"N/A" indicates that a CAH either:

- Did not submit any measure data, or
- Submitted data that was rejected/not accepted into the CMS Clinical Warehouse.

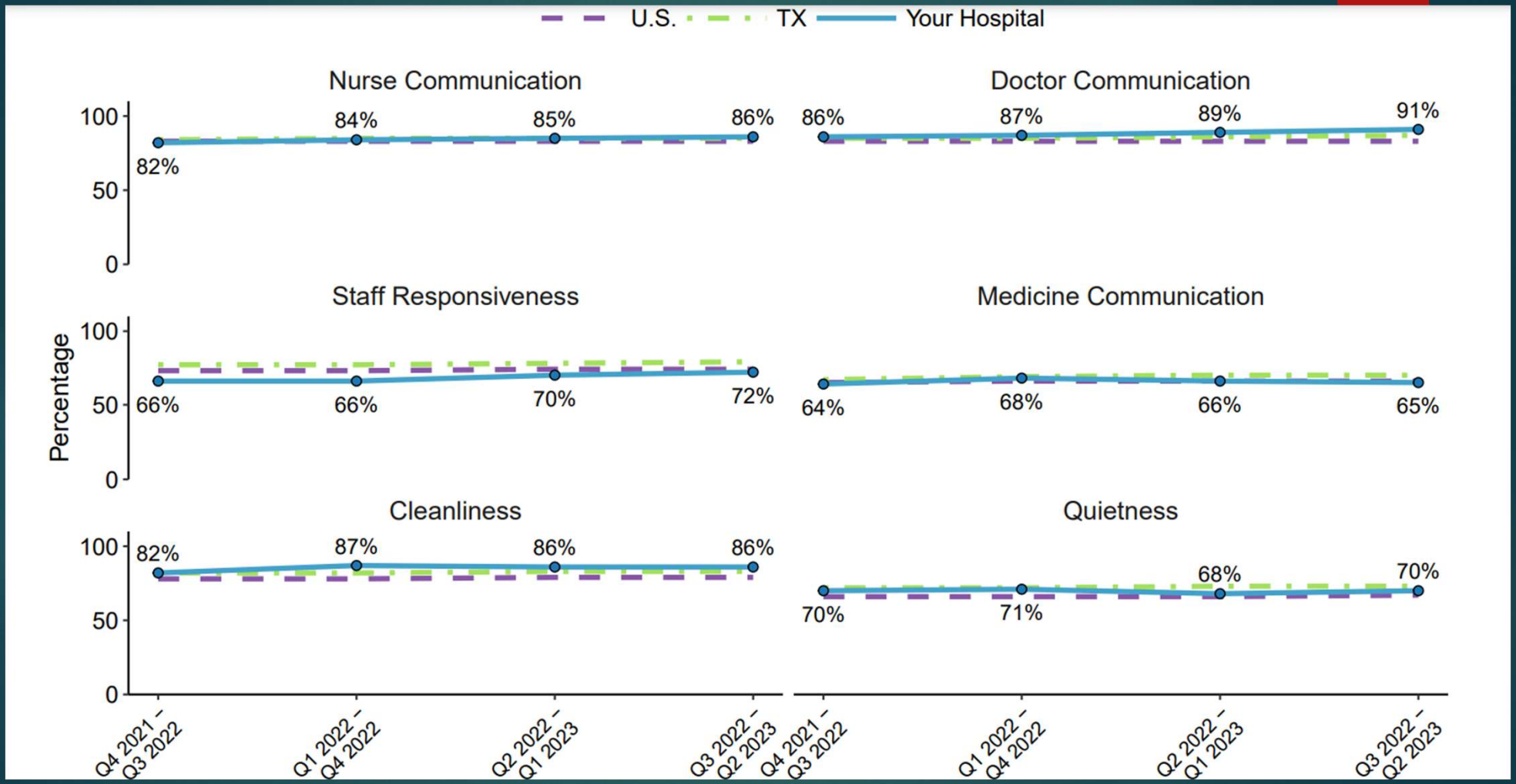
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

	HCAHPS Star Rating	Your Hospital's Adjusted Score		Your State's CAH Data		National CAH Data		Benchmark
Discharge Information Composite	Star Rating (0-5)	No	Yes	No	Yes	No	Yes	Yes
Composite 6 (Q16 & Q17) Discharge Information	N/C	14%	86%	12%	88%	12%	88%	92%

	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data			Benchmark
Care Transition Composite	Star Rating (0-5)	Disagree to Strongly Disagree	Agree	Strongly Agree	Disagree to Strongly Disagree	Agree	Strongly Agree	Disagree to Strongly Disagree	Agree	Strongly Agree	Strongly Agree
Composite 7 (Q20 to Q22) Care Transition	N/C	6%	45%	49%	4%	38%	58%	4%	41%	55%	64%

	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data			Benchmark
HCAHPS Global Items	Star Rating (0-5)	0-6 rating	7-8 rating	9-10 rating	0-6 rating	7-8 rating	9-10 rating	0-6 rating	7-8 rating	9-10 rating	9-10 rating
Q18 Overall Rating of Hospital (0 = worst hospital, 10 = best hospital)	N/C	4%	12%	84%	6%	15%	80%	5%	18%	77%	86%
	Star Rating (0-5)	Definitely Not or Probably Not	Probably	Definitely	Definitely Not or Probably Not	Probably	Definitely	Definitely Not or Probably Not	Probably	Definitely	No Benchmark
Q19 Willingness to Recommend This Hospital	N/C	2%	25%	73%	3%	20%	77%	4%	22%	74%	

"N/A" indicates that a CAH did not report data in at least 10 of the 12 months for the current reporting period.


U.S.
TX
Your Hospital
Nurse Communication
82%
84%
85%
86%
Doctor Communication
86%
87%
89%
91%
Staff Responsiveness
66%
66%
70%
72%
Medicine Communication
64%
68%
66%
65%
Cleanliness
82%
87%
86%
86%
Quietness
70%
71%
68%
70%
Percentage
100
50
0
Q4 2021 – Q3 2022
Q1 2022 – Q4 2022
Q2 2022 – Q1 2023
Q3 2022 – Q2 2023

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

Quarter 1 - 2023

Generated on 09/13/23

		Your Hospital's Performance by Quarter								State Current Quarter			National Current Quarter		
		Q2 2022		Q3 2022		Q4 2022		Q1 2023							
	Healthcare-Associated Infection	# Cases	SIR	# Cases	SIR	# Cases	SIR	# Cases	SIR	# CAHs Report-ing	Total # Cases	Overall SIR	# CAHs Report-ing	Total # Cases	Overall SIR
CAUTI	Catheter-associated urinary tract infections	0	N/C	0	N/C	0	N/C	0	N/C	56	0	0.0	1,160	53	0.6
CDI	Clostridium difficile (C.diff) intestinal infections	0	N/C	N/A	N/A	1	N/C	0	N/C	53	8	0.9	951	151	0.8
CLABSI	Central-line associated bloodstream infections	0	N/C	0	N/C	0	N/C	0	N/C	55	0	N/C	1,122	7	0.6
MRSA	Methicillin-resistant Staphylococcus aureus blood infections	1	N/C	N/A	N/A	0	N/C	0	N/C	53	0	N/C	929	9	0.6
SSI:C	Surgical site infections from colon surgery	0	N/C	0	N/C	0	N/C	0	N/C	15	0	N/C	460	17	1.1
SSI:H	Surgical site infections from abdominal hysterectomy	0	N/C	0	N/C	0	N/C	0	N/C	14	1	N/C	420	8	2.3

"N/A" indicates that the CAH did not submit data for this measure.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this period.
"N/C" indicates that a SIR was not able to be calculated.

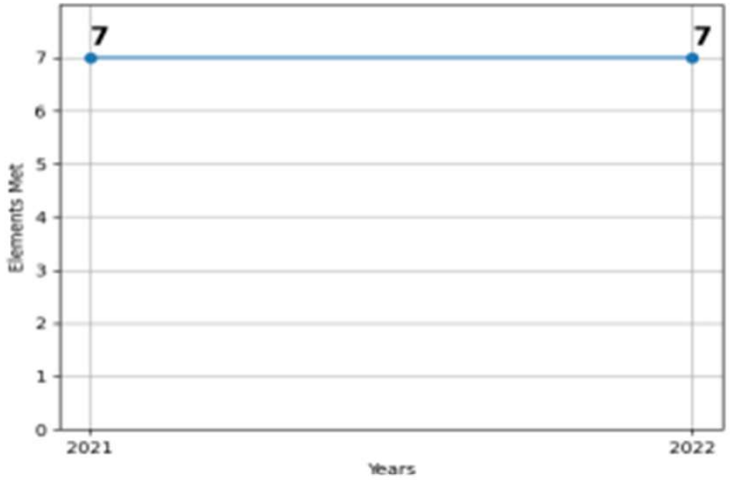
Trending Scorecard

Antibiotic Stewardship

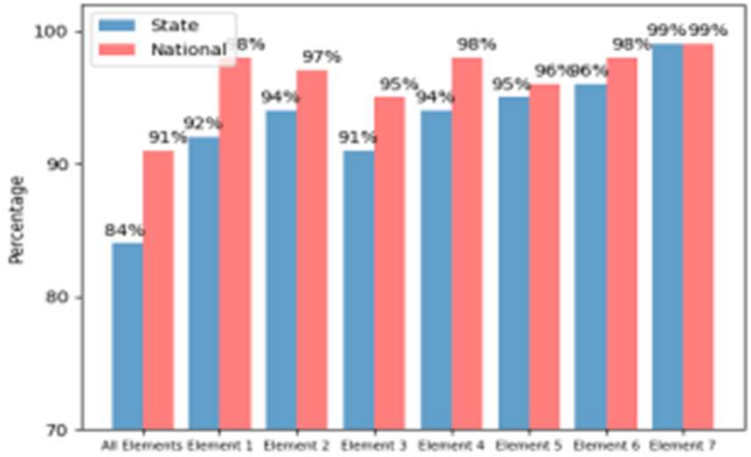
Positive Outcome: High Core Elements Met

(Reported Annually)
2021 through 2022

Your Hospital's Performance



Current Survey Year



CDC Core Elements Across Time	2021	2022
Elements Met	7	7
Element 1: Leadership	Y	Y
Element 2: Accountability	Y	Y
Element 3: Drug Expertise	Y	Y
Element 4: Action	Y	Y

Percentage of CAHs Meeting Elements	Facility	State	National
All Elements Met	Y	84%	91%
Element 1: Leadership	Y	92%	98%
Element 2: Accountability	Y	94%	97%
Element 3: Drug Expertise	Y	91%	95%
Element 4: Action	Y	94%	98%

Going Forward

- Start evaluating your data
  - What measures you currently collect
  - What measures you need to start collecting
- Discuss with organizational leadership
  - Must have engagement from top down
- Discuss with your QI Committee
  - Don't try to do all the work alone – It Takes Everyone!!!
  - Develop plan of action
- We are here to help you!!!!
  - Technical assistance
  - Site Visits

Webinar Series Schedule

- **July 2 - Quality Infrastructure**
- **July 16 - Hospital commitment to health equity**
- **July 30 - Safe use of opioids**
- **Aug 13 - Hybrid all cause readmissions**
- **Aug 27 - Screening for social determinants of health / Positive screening for social determinants of health**


Questions???

Upcoming Events

- CNO Bootcamp
  - August 1-2, 2024 – Austin, Tx
- Frontline / Physician Documentation Workshop
  - Date TBD
- Frontline webinar series on Quality Improvement
  - July 24 – Social Determinants of Health / Health Literacy
  - July 31 – Basics of Quality Improvement
  - Aug – Healthcare Mistakes and Their Impact
  - Aug – Trauma Informed Care
  - Aug – Workplace Violence

Who To Contact

- Regional Coordinator with SORH
- Need access or have issues with MBQIP Portal?
  - **Sherry Jennings, MSN, RN** | Director Quality Texas A&M Rural and Community Health Institute | Texas A&M Health
  - ph: 979.436.0391 | sherry.jennings@tamu.edu
- Need quality improvement technical assistance or want to schedule a site visit?
  - **Sheila Dolbow, MSN, RN, CFN, CPHQ /** Quality Improvement Manager
  - Texas Hospital Association Foundation
  - 512-970-9829 / sdolbow@tha.org

Thank you for joining us!!!