RQITA
RESOURCE CENTER

# MBQIP Measure Core Set Information Guide

Version 2.4

5.01.2026

| Version History | | |
|---|---|---|
| **Date** | **Version Number** | **Update History** |
| September 2023 | Version 1.0 | • Initial release |
| December 2023 | Version 2.0 | • Updated the MBQIP reporting timeline for the new measures<br>• Details added for the CAH Quality Infrastructure measure<br>• Clarifying details added for OP-18 measure set ID#s<br>• Details added to the Hybrid Hospital-Wide Readmission data elements<br>• Added details for encounter periods and reporting deadlines<br>• Document name change<br>• Other non-substantive changes |
| April 2024 | Version 2.1 | • Updated with 2024 specifications<br>• Added measure resources<br>• Other non-substantive changes |
| March 2025 | Version 2.2 | • Updated with 2025 specifications<br>• Revised MBQIP Core Measures |
| September 2025 | Version 2.3 | • Revised MBQIP Core Measures<br>• Other non-substantive changes |
| May 2026 | Version 2.4 | • Updated with 2026 specifications<br>• Updated measure resources<br>• MBQIP Quick Reference added |

## Introduction

The MBQIP Core Measures is a list of quality measures the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) has adopted for use in the Medicare Beneficiary Quality Improvement Project (MBQIP) within the Medicare Rural Hospital Flexibility Program.

FORHP, at HRSA, selected the MBQIP Core Measure Set, based on alignment with CMS and CDC national quality measure standards. The MBQIP Core Measure Set was adopted after a process involving FORHP staff, State Flex Programs, Critical Access Hospitals, and public comment input. Though finalized, these measures are always subject to change as necessary to respond to federal and state health care quality program changes and support the needs of rural hospitals and the communities they serve.

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This resource is intended to be used by critical access hospital personnel involved in MBQIP quality improvement and reporting and State Flex Program coordinators. This guide is based on currently available information. Information provided and submissions dates are subject to change.

Details on the MBQIP core measure set are depicted in the following tables throughout this guide.

**Disclaimer: Measure specifications are continually updated. This information is current as of the date of publication. For the most recent information, review the specifications as linked in each measure section.**

| MBQIP Core Measure Set | | | | |
|---|---|---|---|---|
| **Global Measures** | **Patient Safety** | **Patient Experience** | **Care Coordination** | **Emergency Department** |
| **CAH Quality Infrastructure** *(annual submission)* | **HCP/IMM-3:** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(annual submission)*<br><br>**Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey *(annual submission)*<br><br>**Safe Use of Opioids (eCQM)** *(annual submission)* | **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *(quarterly submission)* | **Hybrid Hospital-Wide Readmission** *(annual submission)* | **Emergency Department Transfer Communication (EDTC)** *(quarterly submission)*:<br><br>**OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients *(quarterly submission)*<br><br>**OP-22:** Patient Left Without Being Seen *(annual submission)* |

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## Quick Reference: MBQIP Measures

| Measure | MBQIP Domain | Reporting Frequency* | Reporting Platform |
|---|---|---|---|
| CAH Quality Infrastructure | Global Measures | Annual – Fall of each year | Flex Monitoring Team via Qualtrics |
| HCP/IMM-3: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) | Patient Safety | Annual – May 15 | Centers for Disease Control National Healthcare Safety Network (CDC NHSN) |
| Antibiotic Stewardship | Patient Safety | Annual – March 1 | Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey |
| Safe Use of Opioids – Concurrent Prescribing | Patient Safety | Annual – February 28 | Centers for Medicare & Medicaid Services Hospital Quality Reporting (CMS HQR) |
| Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) | Patient Experience | Quarterly | Centers for Medicare & Medicaid Services Hospital Quality Reporting (CMS HQR) |
| Hybrid Hospital -Wide Readmission | Care Coordination | Annual – October 1 | Centers for Medicare & Medicaid Services Hospital Quality Reporting (CMS HQR) |
| Emergency Department Transfer Communication (EDTC) | Emergency Department | Quarterly | State Flex Program |
| OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients | Emergency Department | Quarterly | Centers for Medicare & Medicaid Services Hospital Quality Reporting (CMS HQR) |
| OP-22: Patient Left Without Being Seen | Emergency Department | Annual – May 15 | Centers for Medicare & Medicaid Services Hospital Quality Reporting (CMS HQR) |

** Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter excluding Antibiotic Stewardship. Refer to the Monthly MBQIP Data Submission Deadlines for detailed deadline information. Deadlines subject to change.*

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – CAH Quality Infrastructure** | |
| **MBQIP Domain** | **Global Measures** |
| Measure Description | Structural measure to assess CAH capacity, processes, and infrastructure for quality activities based on the eight core elements of CAH quality infrastructure:<br>1. Leadership Responsibility & Accountability<br>2. Quality Embedded within the Organization's Strategic Plan<br>3. Workforce Engagement & Ownership<br>4. Culture of Continuous Improvement through Behavior<br>5. Culture of Continuous Improvement through Systems<br>6. Engagement of Patients, Partners, and Community<br>7. Collecting Meaningful and Accurate Data<br>8. Using Data to Improve Quality |
| Measure Rationale | This measure will provide state and national comparison information to assess your CAH infrastructure, QI processes, and areas of improvement for each facility. Using this measure, SFPs can plan quality activities to improve CAH quality infrastructure. Data will provide timely, accurate, and useful CAH quality-related information to help inform state-level technical assistance for CAH improvement activities. This measure will provide hospital and state-specific information to help inform the future of MBQIP and national technical assistance and data analytic needs. The intention is to identify areas of need in quality infrastructure and capacity in order to implement continuous processes. |
| Population and Definitions | The unit of measurement is an individual CAH. This structural measure captures assessment data from individual CAHs as they reflect on the infrastructure capacity specific to their facility.<br><br>Answers for the measure should reflect the current point in time unless otherwise specified (e.g., if a question asks about a quarterly or an annual process, is that process in place at the current point in time). CAHs should attest to the information only where they completely meet the description in the question response(s) for the correlating criteria and elements.<br><br>Questions should be answered for the capacity of the hospital and entities owned by the hospital (e.g., an independent CAH that owns a Rural Health Clinic) but should not include the capacity of a greater health system (e.g., a health system that provides specialty care at other system-owned hospitals or clinics). |

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| **MBQIP Core Measure Set** | |
| **Measure Name – CAH Quality Infrastructure** | |
| **MBQIP Domain** | **Global Measures** |
| Calculations | Hospital score can be a total of zero (0) to eight (8) points (one point for each element, must meet each of element's criteria to receive credit).<br><br>For most criteria, there are multiple actions that can achieve completion of the criteria. |
| Measure Submission and Reporting Channel | The measure is submitted annually through the National CAH Quality Inventory and Assessment ("Assessment") via a Flex Monitoring Team (FMT)-administered Qualtrics platform.<br><br>CAHs must submit the Assessment on their own behalf through the Qualtrics platform for the measure to be accepted (emailed submissions are not accepted).<br><br>By submitting the Assessment, CAHs are submitting the CAH Quality Infrastructure measure. Submissions of the Assessment (and within it the CAH Quality Infrastructure measure) are due in November of each year, and late submissions of the Assessment and the measure within it will not be accepted. |
| Measure Resources | **CAH Quality Infrastructure Specifications**<br><br>This includes more information about how the measure is collected and how each question from the Assessment maps to the core elements and criteria of CAH Quality Infrastructure.<br><br>**CAH Quality Inventory & Assessment Resources for CAHs**<br><br>This page includes several resources for CAHs to use to complete the CAH Quality Inventory and Assessment. Included is a CAH Fact Sheet, Assessment Questions & Instructions, the Assessment National Report and an Assessment Informational Recording.<br><br>**RQITA Website: CAH Quality Infrastructure**<br><br>Listed here are measure specifications, reporting details, data submission guide, and improvement strategies |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **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. |
| Measure Program Alignment | Safe Use of Opioids is a current measure of the Medicare Promoting Interoperability (PI) Program. Critical access hospitals must meet PI Program requirements on an annual basis to avoid a downward payment. One of the program requirements is submission of electronic clinical quality measures (eCQM) data from certified electronic health record technology (CEHRT). |
| Improvement Noted As | Decreased score indicates improvement |
| Numerator | Inpatient hospitalizations where the patient is prescribed two or more opioids or an opioid and benzodiazepine at discharge. |
| Denominator | Inpatient hospitalizations that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one opioid and/or benzodiazepine at discharge. |
| Exclusions | Inpatient hospitalizations where patients have cancer pain that begins prior to or during the encounter or are ordered or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the hospitalization or in an emergency department encounter for observation stay immediately prior to hospitalization, patients receiving medication for opioid use disorder (OUD) with active OUD diagnosis or Opioid Medication Assisted Treatment (MAT), patients with sickle cell |

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| **MBQIP Core Measure Set** | |
| **Measure Name – Safe Use of Opioids – Concurrent Prescribing** | |
| **MBQIP Domain** | **Patient Safety** |
| | disease, patients discharged to another inpatient care facility or left against medical advice, and patients who expire during the inpatient stay. |
| Measure Population (Determines the cases to abstract/submit) | Inpatient hospitalizations that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one opioid and/or benzodiazepine at discharge. |
| Sample Size Requirements | No sampling – report all patients that meet data elements |
| Calculations | Numerator divided by Denominator |
| Data Source | Certified electronic health record technology (CEHRT) |
| Data Collection Approach | Electronic Extraction from EHRs via Quality Reporting Document Architecture (QRDA) Category I File |
| Measure Submission and Reporting Channel | Annually, via Hospital Quality Reporting (HQR) Secure Portal as any combination of: QRDA Category I File, zero denominator declarations and/or case threshold exemptions (<=5 cases in the reporting quarter) |
| Data Available On | CMS Care Compare<br>CMS Provider Data Catalog |
| Measure Resources | RQITA Website: Safe Use of Opioids Concurrent Prescribing<br>Safe Use of Opioid – Concurrent Prescribing Measure Specification |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – Hybrid Hospital-Wide Readmission** | |
| **MBQIP Domain** | **Care Coordination** |
| Encounter Period | July 1, 20XX - June 30th, 20XX |
| Submission Deadline | October 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 | Hospital-level, all-cause, risk-standardized readmission measure that focuses on unplanned readmissions 30 days of discharge from an acute hospitalization.<br><br>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:<br>• Clinical variables (13): Heart Rate, Systolic Blood Pressure, Respiratory Rate, Temperature, Oxygen Saturation, Weight, Hematocrit, White Blood Cell Count, Potassium, Sodium, Bicarbonate, Creatinine, Glucose<br>• Linking elements (5): CMS Certification Number (CCN), National Provider Identifier (NPI) for MA patients, Medicare beneficiary Identifier (MBI), Inpatient Admission Date, and Discharge date.<br><br>It is recommended **hospitals only report the FIRST resulted value for EACH core clinical data element** collected in the appropriate timeframe, if available. Hospitals may also choose to report ALL values on an encounter during their entire admission; however, only the first resulted values are utilized in the logic for measure calculation. |
| Measure Rationale | Returning to the hospital for unplanned care disrupts patients' lives, increases risk of harmful events like healthcare-associated infections, and results in higher costs absorbed by the health care system. High readmission rates of patients with clinically manageable conditions in primary care settings, such as diabetes and bronchial asthma, may identify quality-of-care problems in hospital settings. A measure of readmissions encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions and costs. |

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| **MBQIP Core Measure Set** | |
| **Measure Name – Hybrid Hospital-Wide Readmission** | |
| **MBQIP Domain** | **Care Coordination** |
| Measure Program Alignment | CMS Inpatient Quality Reporting (IQR) program measure. |
| Improvement Noted As | No actual measure score will be generated by hospitals. Instead, hospitals will report the data values for each of the core clinical data elements for all encounters in the Initial Population. These core clinical data elements will be linked to administrative claims data and used by CMS to calculate results for the Hybrid HWR measure. |
| Numerator | If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission. |
| Denominator | 1.Enrolled in Medicare FFS Part A for the 12 months prior to the date of admission and during the index admission or enrolled in Medicare Advantage.<br>2. Aged 65 or over.<br>3. Discharged alive from a non-federal short-term acute care hospital.<br>4. Not transferred to another acute care facility |
| Exclusions | The measure excludes index admissions for patients:<br>1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals.<br>2. Without at least 30 days post-discharge enrollment in Medicare FFS.<br>3. Discharged against medical advice (AMA).<br>4. Admitted for primary psychiatric diagnoses.<br>5. Admitted for rehabilitation; or<br>6. Admitted for medical treatment of cancer. |

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|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – Hybrid Hospital-Wide Readmission** | |
| **MBQIP Domain** | **Care Coordination** |
| Measure Population (Determines the cases to abstract/submit) | All Medicare FFS and MA hospitalizations for patients aged 65 and older at the start of an inpatient admission, where the length of stay is less than 365 days, and the hospitalization ends during the measurement period.<br><br>The initial population includes patients with inpatient hospitalizations and patients from Acute Hospital Care at Home programs, who are treated and billed as inpatients but receive care in their home.<br><br>**NOTE:** All Medicare FFS and MA hospitalizations meeting the above criteria should be included, regardless of whether Medicare FFS/MA is the primary, secondary, or tertiary payer. |
| Sample Size Requirements | No sampling – report on all information requested in denominator and numerator. |
| Data Collection Approach | Hybrid – chart extraction of electronic clinical data and administrative claims data. |
| Data Elements | **Core Clinical Data Elements (13)**<br><br>Heart Rate<br>Systolic Blood Pressure<br>Respiratory Rate<br>Temperature<br>Oxygen Saturation<br>Weight<br>Hematocrit<br>White Blood Cell Count<br>Potassium<br>Sodium<br>Bicarbonate<br>Creatinine<br>Glucose<br><br>**For each encounter, please also submit the following Linking Variable:**<br>• CMS Certification Number (CCN)<br>• National Provider Identifier (NPI) for MA patients<br>• Medicare Beneficiary Identifier (MBI)<br>• Inpatient Admission Date<br>• Discharge Date |
| Measure Submission and Reporting Channel | Annual-Hospital Quality Reporting (HQR) via patient-level file in QRDA I format |
| Data Available On | CMS Care Compare |
| Measure Resources | RQITA Website: Hybrid Hospital-Wide Readmissions |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – Healthcare Personnel Influenza Immunization** | |
| **MBQIP Domain** | **Patient Safety** |
| Encounter Period | October 1, 20XX – March 31, 20XX to align with flu season |
| 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 |
| Measure Rationale | 1 in 5 people in the U.S. get influenza each season. Combined in pneumonia, influenza is the 8th leading cause of death, with two-thirds of those attributed to patients hospitalized during the flu season. |
| Improvement Noted As | Increase in the rate (percent) |
| Numerator | All HCP personnel who:<br>• Received vaccination at the facility<br>• Received vaccination outside of the facility<br>• Did not receive vaccination due to a medical contraindication<br>• Did not receive vaccination due to declination<br>• Had an unknown vaccination status |
| Denominator | All HCP that worked in the facility (part-time or full-time) for at least one day during the encounter period of October 1 – March 31. |
| Measure Population | All HCP that worked in the facility (part-time or full-time) for at least one day during the encounter period of October 1 – March 31. |
| Sample Size Requirements | No sampling - report all cases |
| Calculations | All data reporting is aggregated (whether monthly, once a season, or at a different interval) |
| Data Source | Administrative Data |
| Data Collection Approach | Hospital Tracking |

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| **MBQIP Core Measure Set** | |
| **Measure Name – Healthcare Personnel Influenza Immunization** | |
| **MBQIP Domain** | **Patient Safety** |
| Data Elements | Three categories (all with separate denominators) of HCP working in the facility at least one day between 10/1-3/31:<br>• Employees on payroll<br>• Licensed independent practitioners<br>• Students, trainees, and volunteers 18yo+<br><br>A fourth optional category is available for reporting other contract personnel<br><br>HCP workers who:<br>• Received vaccination at the facility<br>• Received vaccination outside of the facility<br>• Did not receive vaccination due to medical contraindication<br>• Did not receive vaccination due to declination<br>• Had an unknown vaccination status |
| Measure Submission and Reporting Channel | This data is reported annually through the Healthcare Personnel Safety Component of National Healthcare Safety Network (NHSN) website. |
| Data Available On | MBQIP Data Reports |
| Other Notes | Each facility in a system needs to be registered separately and HCPs should be counted in the sample population for every facility at which they work. Facilities must complete a monthly reporting plan for each year or data reporting period. |
| Measure Resources | RQITA Website: Vaccinations |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **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 |
| Measure Rationale | Improving antibiotic use in hospitals is imperative to improving patient outcomes, decreasing antibiotic resistance, and reducing healthcare costs. According to the Centers for Disease Control and Prevention (CDC), 20-50 percent of all antibiotics prescribed in U.S. acute care hospital are either unnecessary or inappropriate, which leads to serious side effects such as adverse drug reactions and Clostridium difficile infection. Overexposure to antibiotics also contributes to antibiotic resistance, making antibiotics less effective.<br><br>In 2014, CDC released the "Core Elements of Hospital Antibiotic Stewardship Programs" that identifies key structural and functional aspects of effective programs and elements designed to be flexible enough to be feasible in hospitals of any size. |
| Improvement Noted As | Increase in the number of core elements met |
| Measure Population | NA – This measure uses administrative data and not claims to determine the measure's denominator population. |
| Sample Size Requirements | No sampling – report all information as requested |
| Data Collection Approach | Hospital tracking |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – Antibiotic Stewardship Implementation** | |
| **MBQIP Domain** | **Patient Safety** |
| Data Elements | Questions as answered on the Patient Safety Component Annual Hospital Survey inform whether the hospitals have successfully implemented the following core elements of antibiotic stewardship:<br>• Leadership<br>• Accountability<br>• Drug Expertise<br>• Action<br>• Tracking<br>• Reporting<br>• Education |
| Measure Submission and Reporting Channel | National Healthcare Safety Network (NHSN) website |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: Antibiotic Stewardship |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – Emergency Department Transfer Communication (EDTC)** | |
| **MBQIP Domain** | **Emergency Department** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1- December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) DUE April 30<br>Q2 encounters (April 1 – June 30) DUE July 31<br>Q3 encounters (July 1 – September 30) DUE October 31<br>Q4 encounters (October 1- December 31) DUE January 31<br><br>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. |
| Measure Rationale | Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care and avoids medical errors and redundant tests. |
| Numerator | Number of patients discharged, transferred, or returned to another healthcare facility whose medical record documentation indicated that ALL 8 data elements were documented and communicated to the receiving hospital in a timely manner. |
| Denominator | ED patients who are discharged, transferred, or returned to another healthcare facility |
| Exclusions | • AMA (left against medical advice)<br>• Expired<br>• Discharged to Home includes Assisted Living Facilities, Board and care, foster or residential care, group or personal care homes, and homeless shelters<br>• Discharged to Court/Law Enforcement includes detention facilities, jails, and prison<br>• Discharged Home with Home Health Services<br>• Discharged to Outpatient Services includes outpatient procedures at another hospital, Outpatient Chemical Dependency Programs, and Partial Hospitalization<br>• Discharged to Hospice-at home<br>• Not Documented/Unable to determine discharge location<br>• Discharged to Observation Status |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – Emergency Department Transfer Communication (EDTC)** | |
| **MBQIP Domain** | **Emergency Department** |
| Improvement Noted As | Increase in the rate |
| Measure Population (Determines the cases to abstract/submit) | Patients admitted to the emergency department who were then discharged, transferred, or returned to any type of acute care facility, or other care facility |
| Sample Size Requirements | Quarterly<br>0-44 - submit all cases<br>> 45 - submit 45 cases<br>Monthly<br>0-15 - submit all cases<br>> 15 - submit 15 cases<br><br>The following measure-specific sampling requirements exist:<br>Hospitals need to submit a minimum of 45 cases per quarter from the required population. A hospital may choose to sample and submit more than 45 cases. Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. Hospitals whose initial patient population size is less than the minimum number of 45 cases per quarter for the measure cannot sample and should submit all cases for the quarter |
| Calculations | This measure is calculated using an all or none approach.<br>The overall EDTC Measure can be calculated as the percent of patients that met all the eight data elements divided by all transfers from ED to another healthcare facility. |
| Data Source | Manual Chart Abstraction<br>Retrospective data sources for required data elements include administrative data and medical records. |
| Data Collection Approach | Chart Abstracted, composite of EDTC data elements 1-8, using an all or none approach |
| Data Elements | 1. Home Medications<br>2. Allergies and/or Reactions<br>3. Medications Administered in ED<br>4. ED Provider Note<br>5. Mental Status/Orientation Assessment<br>6. Reason for Transfer and/or Plan of Care<br>7. Tests and/or Procedures Performed<br>8. Tests and/or Procedures Results |
| Measure Submission and Reporting Channel | Submission process directed by state Flex Program |
| Data Available On | MBQIP Data Reports |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – Emergency Department Transfer Communication (EDTC)** | |
| **MBQIP Domain** | **Emergency Department** |
| Measure Resources | Data specifications, data collection resources, and additional information: RQITA Website: Emergency Department Transfer Communication (EDTC) |



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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients** | |
| **MBQIP Domain** | **Emergency Department** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1- December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) DUE August 1<br>Q2 encounters (April 1 – June 30) DUE November 1<br>Q3 encounters (July 1 – September 30) DUE February 1<br>Q4 encounters (October 1- December 31) DUE May 1<br><br>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 arrival to time of departure from the emergency room for patients discharged from the emergency department. |
| Measure Rationale | Empirical evidence demonstrates that emergency department (ED) throughput is an indicator of hospital quality of care and shows that shorter lengths of stay in the ED lead to improved clinical outcomes. Significant ED overcrowding has numerous downstream effects, including prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes (Gardner, 2018). Quality improvement efforts aimed at reducing ED overcrowding and length of stay have been associated with an increase in ED patient volume, decrease in number of patients who leave without being seen, reduction in costs, and increase in patient satisfaction |
| Exclusions | Patients who expired in the emergency department |
| Improvement Noted As | Decrease in median value (time) |
| Measure Population (Determines the cases to abstract/submit) | Patients seen in a Hospital Emergency Department that have an E/M code in Appendix A, OP Table 1.0 of the CMS Hospital OQR Specifications Manual. |
| Set Measure ID # and Measure Category Assignment | Measure ID# OP-18 has 4 Set Measure ID numbers: |

| OP-18 Set Measure ID#s | Performance Measure Name | Measure Category Assignment | OP-18 Algorithm Stratification Table** |
|---|---|---|---|
| **OP-18** | Median Time from ED Arrival to ED Departure for Discharged ED Patients | | |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients** | |
| **MBQIP Domain** | **Emergency Department** |

| | | | |
|---|---|---|---|
| • OP-18a | Median Time from ED Arrival to ED Departure for Discharged ED Patients – Overall Rate | Rate used to identify stratified populations of specific measures. | (D1) Overall Measure |
| • OP-18b | Median Time from ED Arrival to ED Departure for Discharged ED Patients – Reporting Measure | The measure population for MBQIP reports.* | (D) Reporting Measure |
| • OP-18c | Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients | In the measure population but only the Psychiatric/Mental Health Patients. | (D2) Psych/Mental Health Measure |
| • OP-18d | Median Time from ED Arrival to ED Departure for Discharged ED Patients – Transfer Patients | In the measure population but only the Transfer Patients. | (D3) Transfer Measure |

*For MBQIP abstracting purposes, the ED-Throughput Abstraction Tools automatically calculate the measure algorithm and measure categories for the abstractor.

**The OP-18 Measure Algorithms and Stratification Tables can be found in the QualityNet CMS Hospital Outpatient Specifications Manuals

| | |
|---|---|
| Sample Size Requirements | Quarterly<br>0-900 Submit 63 cases<br>> 900 - Submit 96 cases<br><br>Monthly<br>Note: Monthly sample size requirements for this measure are based on the quarterly patient population.<br>0-900 - submit 21 cases |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients** | |
| **MBQIP Domain** | **Emergency Department** |
| | > 900 - submit 32 cases |
| Data Source | Hospital tracking |
| Data Collection Approach | Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10-CM diagnosis and procedure codes, which require retrospective data entry. |
| Data Elements | Arrival Time<br>Discharge Code<br>E/M Code<br>ED Departure Date<br>ED Departure Time<br>ICD-10-CM Principal Diagnosis Code<br>Outpatient Encounter Date |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via Outpatient CART/Vendor |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: ED Throughput<br><br>Hospital Outpatient Quality Reporting (OQR) Overview |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – OP-22 Left Without Being Seen** | |
| **MBQIP Domain** | **Emergency Department** |
| Encounter Periods | Calendar Year (January 1, 20XX – December 31, 20XX) |
| 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). |
| Measure Rationale | Reducing patient wait time in the ED helps improve access to care, increase capability to provide treatment, reduce ambulance refusals/diversions, reduce rushed treatment environments, reduce delays in medication administration, and reduce patient suffering. |
| Numerator | The total number of patients who left without being evaluated by a physician/APN/PA |
| Denominator | The total number of patients who presented to the ED |
| Improvement Noted As | Decrease in rate (percent) |
| Sample Size Requirements | No sampling - report all cases |
| Data Collection Approach | Hospital Tracking |
| Measure Submission and Reporting Channel | Data will be completed through the Hospital Quality Reporting (HQR) system at https://hqr.cms.gov via an online tool available to authorized users. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: ED Throughput<br><br>Hospital Outpatient Quality Reporting (OQR) Overview |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) – Composite 1: Communication with Nurses** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1- December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who reported that their nurses "Always" communicated well. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Questions:<br>• During this hospital stay, how often did nurses treat you with courtesy and respect?<br>• During this hospital stay, how often did nurses listen carefully to you?<br>• During this hospital stay, how often did nurses explain things in a way you could understand? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Composite 2: Communication with Doctors** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who reported that their doctors "Always" communicated well. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Questions:<br>• During this hospital stay, how often did doctors treat you with courtesy and respect?<br>• During this hospital stay, how often did doctors listen carefully to you?<br>• During this hospital stay, how often did doctors explain things in a way you could understand? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Composite 3: Restfulness of Hospital Environment** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who reported "Always" and "Yes, definitely" to restfulness of environment. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Question:<br>• During this hospital stay, how often were you able to get the rest you needed?<br>• During this hospital stay, how often was the area around your room quiet at night?<br>• During this hospital stay, did doctors, nurses and other hospital staff help you to rest and recover? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Composite 4: Care Coordination** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 Set | HCAHPS |
| Measure Description | Percentage of patients surveyed who responded "Yes, definitely" and "Always" for care coordination elements. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Questions:<br>• During this hospital stay, how often were doctors, nurses and other hospital staff informed and up-to-date about your care?<br>• During this hospital stay, how often did doctors, nurses and other hospital staff work well together to care for you?<br>• Did doctors, nurses or other hospital staff work with you and your family or caregiver in making plans for your care after you left the hospital? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Composite 5: Responsiveness of Hospital Staff** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who reported that they "Always" received help as soon as they wanted. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Questions:<br>• How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?<br>• During this hospital stay, when you asked for help right away, how often did you get help as soon as you needed? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Composite 6: Communications About Medicines** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who reported that staff "Always" explained about medicines before giving them. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Questions:<br>• Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?<br>• Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Question 7: Cleanliness of Hospital Environment** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who reported that their room and bathroom were "Always" clean. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Question:<br>• During this hospital stay, how often were your room and bathroom kept clean? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Composite 7: Discharge Information** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who reported that "Yes" they were given information about what to do during their recovery at home. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Questions:<br>• 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?<br>• During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Question 20: Information About Symptoms** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who responded "Yes" they received information about symptoms or health problems after they left the hospital. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Question:<br>• Did doctors, nurses or other hospital staff give your family or caregiver enough information about what symptoms or health problems to watch for after you left the hospital? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Question 24: Overall Rating of Hospital** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest). |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Question:<br>• 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? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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| Measure for MBQIP Reporting Within the Flex Program | |
|---|---|
| **MBQIP Core Measure Set** | |
| **Measure Name – HCAHPS – Question 5: Willingness to Recommend** | |
| **MBQIP Domain** | **Patient Experience** |
| Encounter Periods | Q1 (January 1 – March 31)<br>Q2 (April 1 – June 30)<br>Q3 (July 1 – September 30)<br>Q4 (October 1 – December 31) |
| Submission Deadlines | Q1 encounters (January 1 – March 31) due first Wednesday in July<br>Q2 encounters (April 1 – June 30) due first Wednesday in October<br>Q3 encounters (July 1 – September 30) due first Wednesday in January<br>Q4 encounters (October 1- December 31) due first Wednesday in April<br><br>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 | Percentage of patients surveyed who reported "Yes" they would recommend the hospital. |
| Measure Rationale | Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care. |
| Measure Population (Determines the cases to abstract/submit) | Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge. |
| Sample Size Requirements | Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Collection Approach | Survey (typically conducted by a certified vendor) |
| Data Elements | Question:<br>• Would you recommend this hospital to your friends and family? |
| Measure Submission and Reporting Channel | Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements. |
| Data Available On | MBQIP Data Reports |
| Measure Resources | RQITA Website: HCAHPS |

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