RQITA
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Proposed New Measure Core Set Measure Specification Manual

Version 1.0

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Version History		
Date	**Version Number**	**Update History**
September 2023	Version 1.0	• Initial release

Introduction

The Proposed New 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) is considering adopting for use in the Medicare Beneficiary Quality Improvement Program (MBQIP) within the Medicare Rural Hospital Flexibility Program. All measures currently under consideration align with other federal programs.

Currently, the new MBQIP core set is proposed. FORHP is soliciting feedback from State Flex Programs through August 31, 2024, to enable FORHP to adjust the core set before the 'launch' date of September 1, 2025, if needed. FORHP will provide an update when the core set is finalized after reviewing all the feedback received. Please share questions, comments and feedback with your Flex Project Officer.

This resource is intended to be used by Flex Program Coordinators and critical access hospital personnel involved in MBQIP quality improvement and reporting.

Implementation Timeline and New MBQIP Core Measures Frequently Asked Questions are available at State Flex Program Key Resources | National Rural Health Resource Center (ruralcenter.org)

The proposed new MBQIP Core Measure Set is detailed in this guide.
Measures in gold denote **new measure for MBQIP reporting within the Flex Program.**
Measures in blue build upon **existing measures within the MBQIP Flex Program.**

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)*

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Measure Name – CAH Quality Infrastructure Implementation	
MBQIP Topic Area	Global Measures
Measure Description	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
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. Through this measure, SFPs can plan quality activities and understand different CAH service lines. Data will provide timely, accurate, and useful CAH quality-related information to help inform state-level technical assistance for CAH improvement activities. States will be able to compare a facility with others in your state and nationally on service line general characteristics (e.g., patient volume, EHR vendor information). This measure will provide hospital and state-specific information to help inform the future of MBQIP and national technical assistance and data analytic needs.
Calculations	Hospital score can be a total of zero to nine points (one point for each element, must attest "yes" to each of element's criteria to receive credit).
Measure Submission and Reporting Channel	Annual submission to FMT-administered Qualtrics platform
Measure Resources	**More information will be shared during the National CAH Quality Assessment and Inventory Kick-Off Call October 25, 2023**

Proposed new measure for MBQIP reporting within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Hospital Commitment to Health Equity	
MBQIP Topic Area	Global Measures
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).
Measure Rationale	The recognition of health disparities and inequities has been heightened in recent years and it is particularly relevant in rural areas. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists and subspecialists, and limited job opportunities. Rural residents are also less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid. The intent of this measure is to help ensure hospitals are considering and addressing equity in the care they provide to their community.
Measure Program Alignment	New CMS Inpatient Quality Reporting (IQR) program measure. First available reporting timeline is Spring 2024 (reflecting calendar year 2023 activity).
Reporting Timeline	Spring 2024: First available reporting timeline is Spring 2024 (reflecting CY 2023 activity. September 2024: Prepare CAHs to participate in new MBQIP core measure reporting. September 2025: Start tracking non-reporting CAHs in tracking spreadsheet provided by FORHP (to be released by Spring 2024).
Improvement Noted As	Increase in the total score (up to 5 points).
Data Elements	**Domain 1 – Equity is a Strategic Priority** Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all of the following elements (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital strategic plan identifies priority populations who currently experience health disparities. B. Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals. C. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.

	D. Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations. **Domain 2 – Data Collection** Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital collects demographic information, including self-reported race and ethnicity, and/or social determinant of health information on the majority of our patients. B. Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. C. Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using certified EHR technology. **Domain 3 – Data Analysis** Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital strategies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards. **Domain 4 – Quality Improvement** Select all that apply (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities. **Domain 5 – Leadership Engagement** Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.
Measure Population (Determines the cases to abstract/submit)	N/A – This measure assesses hospital and leadership commitment.
Sample Size Requirements	No sampling
Calculations	Hospital score can be a total of zero to five points (one point for each domain, must attest “yes” to all sub-questions in each domain, no partial credit)
Data Collection Approach	Attestation
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) secure portal – annually
Encounter Period	Calendar Year (January 1 – December 31)
Measure Resources	Measure Specification

	Attestation Guidance Rural Health Disparities Overview – Rural Health Information Hub

Proposed New Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Safe Use of Opioids – Concurrent Prescribing	
MBQIP Topic Area	Patient Safety
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 eCQM data from certified electronic health record technology (CEHRT). Calendar year (CY) 2023 eCQM reporting requirements for PI include data reflecting all four quarters of CY 2023 for: • Three self-selected measures of the thirteen available eCQMs for each quarter • One required measure: Safe Use of Opioid Measure
Improvement Noted As	Decrease in the rate
Reporting Timeline for MBQIP Flex Program	September 2024: Prepare CAHs to participate in new MBQIP core measure reporting. September 2025: Start tracking non-reporting CAHs in tracking spreadsheet provided by FORHP (to be released by Spring 2024).
Numerator	Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge.
Denominator	Inpatient hospitalizations (inpatient stay less than or equal to 120 days) 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 or more new or continuing opioid or benzodiazepine at discharge.
Exclusions	Exclusions include patients with cancer that begin prior to or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter, patients

	discharged to another inpatient care facility, and patients who expire during the inpatient stay.
Measure Population (Determines the cases to abstract/submit)	Inpatient hospitalizations (inpatient stay less than or equal to 120 days) 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 or more new or continuing opioid 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	Chart Abstracted via QRDA Category I file
Measure Submission and Reporting Channel	Annually, QRDA Category 1 File via Hospital Quality Reporting (HQR) platform.
Data Available On	CMS Care Compare CMS Provider Data Catalog
Encounter Period	Calendar Year (January 1 – December 31)
Measure Resources	NQF: Quality Positioning System Safe Use of Opioids – Concurrent Prescribing | eCQI Resource Center (healthit.gov) Critical Access Hospital eCQM Resource List | National Rural Health Resource Center (ruralcenter.org)

Proposed New Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Hybrid All-Cause Readmissions	
MBQIP Topic Area	Care Coordination
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
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.
Measure Program Alignment	CMS Inpatient Quality Reporting (IQR) program measure. Currently available for reporting.
Reporting Timeline for MBQIP Flex Program	September 2024: Prepare CAHs to participate in new MBQIP core measure reporting. September 2025: Start tracking non-reporting CAHs in tracking spreadsheet provided by FORHP (to be released by Spring 2024).
Improvement Noted As	Decrease in the rate.
Sample Size Requirements	NA – report on all information requested.
Data Source	Chart abstraction and administrative claims
Data Collection Approach	Hybrid – chart extraction of electronic clinical data and administrative claims data.
Data Elements	**Core Clinical Data Elements** • Heart Rate • Systolic Blood Pressure • Respiratory Rate

	• Temperature • Oxygen Saturation • Weight • Hematocrit • White Blood Cell Count • Potassium • Sodium • Bicarbonate • Creatinine • Glucose **For each encounter, please also submit the following Linking Variable:** • CMS Certification Number • Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) • Date of Birth • Sex • Inpatient Admission Date • 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 – starting in July 2025
Encounter Period	July 1, 2023 – June 30, 2024
Reporting Deadline	September 30, 2024
Measure Resources	Hybrid Hospital-Wide All-Cause Readmission Measure Specification | eCQI Resource Center (healthit.gov) Reporting the Hybrid Hospital-Wide Readmission Measure to the Hospital IQR Program (qualityreportingcenter.com) Hybrid Measure Overview (cms.gov)

Proposed New Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Screening for Social Drivers of Health (SDOH Screening)	
MBQIP Topic Area	Care Coordination
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.
Measure Rationale	The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.
Improvement Noted As	Increase in the rate.
Measure Program Alignment	New CMS Inpatient Quality Reporting (IQR) program measure. First available reporting period is May 15, 2024, for calendar year (CY) 2023 data.
Reporting Timeline for MBQIP Flex Program	September 2024: Prepare CAHs to participate in new MBQIP core measure reporting. September 2025: Start tracking non-reporting CAHs in tracking spreadsheet provided by FORHP (to be released by Spring 2024).
Numerator	The number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay
Denominator	The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.
Exclusions	(1) Patients who opt- out of screening; and

	(2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay.
Measure Population (Determines the cases to abstract/submit)	The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.
Sample Size Requirements	No sampling – report on all information requested in denominator and numerator.
Calculations	The Screening for Social Drivers of Health measure is calculated by dividing the total number of hospital inpatients who are 18 and older and screened for all five health HRSNs by the total number of patients admitted to a hospital inpatient stay who are 18 or older at the time of admission.
Data Source	Chart abstraction
Measure Submission and Reporting Channel	Annual numerator and denominator submission through Hospital Quality Reporting (HQR) system
Encounter Period	Calendar Year (January 1 – December 31)
Measure Resources	Screening for Social Drivers of Health Measure Specification Frequently Asked Questions: SDOH Measures (August 2023) Listing of Various Screening Tools Guide to social needs screening (aafp.org) Rural Health Disparities Overview - Rural Health Information Hub

Proposed New Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Screen Positive for Social Drivers of Health (SDOH Screening Positive)	
MBQIP Topic Area	Care Coordination
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.
Measure Rationale	The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.
Improvement Noted As	This measure is not an indication of performance.
Measure Program Alignment	New CMS Inpatient Quality Reporting (IQR) program measure.
Reporting Timeline for MBQIP Flex Program	The first available reporting period is May 15, 2024, for CY 2023 data. September 2024: Prepare CAHs to participate in new MBQIP core measure reporting. September 2025: Start tracking non-reporting CAHs in tracking spreadsheet provided by FORHP (to be released by Spring 2024).
Numerator	The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety.
Denominator	The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.
Exclusions	The following patients would be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

Measure Population (Determines the cases to abstract/submit)	The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.
Sample Size Requirements	No sampling – report on all information requested in denominator and numerator.
Calculations	The result of this measure would be calculated as **five separate rates.** Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.
Data Source	Chart abstraction
Measure Submission Reporting Channel	Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.
Data Elements	CMS is not recommending specific value sets currently.
Encounter Period	Calendar Year (January 1 – December 31)
Measure Resources	Screen Positive Rate for Social Drivers of Health Measure Specification Frequently Asked Questions: SDOH Measures (August 2023) Listing of Various Screening Tools Guide to social needs screening (aafp.org) Rural Health Disparities Overview - Rural Health Information Hub

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Healthcare Personnel Influenza Immunization	
MBQIP Topic Area	Patient Safety
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: • Received vaccination at the facility • Received vaccination outside of the facility • Did not receive vaccination due to contraindication Did not receive vaccination due to declination
Denominator	All HCP* that worked in the facility (part-time or full-time) for at least one day during the encounter period of October 1st, 2023 – March 31st, 2024. **Please see definition for HCP in MBQIP measure specification manual**
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 1st, 2023 – March 31st, 2024. **Please see definition for HCP in MBQIP measure specification manual**
Sample Size Requirements	No sampling - report all cases
Calculations	All data reporting is aggregate (whether monthly, once a season, or at a different interval)
Data Source	Administrative Data
Data Collection Approach	Hospital Tracking
Data Elements	Three categories (all with separate denominators) of HCP working in the facility at least one day b/w 10/1-3/31: • Employees on payroll • Licensed independent practitioners • Students, trainees, and volunteers 18yo+ A fourth optional category is available for reporting other contract personnel HCP workers who: • Received vaccination at the facility • Received vaccination outside of the facility • Did not receive vaccination due to contraindication Did not receive vaccination due to declination
Data Reported To	This data is reported annually through the Healthcare Personnel Safety Component of National Healthcare Safety Network (NHSN) website.

Data Available On	Care Compare (Note: Listed as IMM-3 in CMS data sets) MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period	Encounter Period October 1,20YY – March 1, 20YY (Aligns with flu season)
Reporting Deadline	See MBQIP Data Submission Deadlines
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. All data reporting is aggregated (whether monthly, once a season, or at a different interval).

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Antibiotic Stewardship Implementation	
MBQIP Topic Area	Patient Safety
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. 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
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: • Leadership • Accountability • Drug Expertise • Action • Tracking • Reporting Education
Data Reported To	National Healthcare Safety Network (NHSN) website
Data Available On	MBQIP Data Reports
Encounter Period	Calendar Year (January 1, 20YY– December 31, 20YY)
Reporting Deadline	See MBQIP Data Submission Deadlines
Measure Resources	Patient Safety/Inpatient | National Rural Health Resource Center (ruralcenter.org)

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Emergency Department Transfer Communication (EDTC)	
MBQIP Topic Area	Emergency Department
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	ED patients AMA (left against medical advice) Expired Discharged to Home includes: Assisted Living Facilities, Board and care, foster or residential care, group or personal care homes, and homeless shelters Discharged to Court/Law Enforcement – includes detention facilities, jails, and prison Discharged Home with Home Health Services Discharged to Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs, and Partial Hospitalization Discharged to Hospice-at home Not Documented/Unable to determine discharge location Discharged to Observation Status
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 0-44 - submit all cases > 45 - submit 45 cases Monthly

	0-15 - submit all cases > 15 - submit 15 cases The following measure specific sampling requirements exist: 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. 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 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 2. Allergies and/or Reactions 3. Medications Administered in ED 4. ED Provider Note 5. Mental Status/Orientation Assessment 6. Reason for Transfer and/or Plan of Care 7. Tests and/or Procedures Performed 8. Tests and/or Procedures Results
Data Reported To	As directed by State Flex Program
Data Available On	Aggregate project results are available http://www.flexmonitoring.org/wp-content/uploads/2014/02/ds8.pdf and http://www.flexmonitoring.org/publications/ds3/
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September30) Q4 (October 1- December 31)
Reporting Deadline	DUE January 31 Q1 (January 1 – March 31) DUE April 30 Q2 (April 1 – June 30) DUE July 31 (July 1 – September30) DUE October 31 (October 1- December 31) See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – OP-18 Time for Arrival to Departure	
MBQIP Topic Area	Emergency Department
Measure Description	Median time from Emergency Department (ED) arrival to time of departure from the emergency room for patients discharged from the ED.
Measure Rationale	Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care, potentially improves access to care specific to the patient condition, and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.
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.
Sample Size Requirements	Quarterly 0-900 Submit 63 cases > 900 - Submit 96 cases Monthly Note: Monthly sample size requirements for this measure are based on the quarterly patient population. 0-900 - submit 21 cases > 900 - submit 32 cases
Data 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 Discharge Code E/M Code ED Departure Date ED Departure Time ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date
Data Reported To	Hospital Quality Reporting (HQR) via Outpatient CART/Vendor

Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period	Encounter Period Q1 (January 1 - March 31) Q2 (April 1 - June 30) Q3 (July 1 - September 30) Q4 (October 1 – December 31)
Reporting Deadline	DUE May 1st Q4/20YY (October 1 – December 31) DUE August 1st Q1/20YY (January 1-March 31) DUE November 1st Q2/20YY (April 1 – June 30) DUE February 1st Q3/20YY (July 1 – September 30) See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – OP-22 Left Without Being Seen	
MBQIP Topic Area	Emergency Department
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
Data Reported To	Hospital Quality Reporting (HQR) via Online Tool (HARP)
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period	Encounter Period - Calendar Year (January 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) – Composite 1: Communication with Nurses	
MBQIP Topic Area	Patient Experience
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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, how often did nurses treat you with courtesy and respect? • During this hospital stay, how often did nurses listen carefully to you? During this hospital stay, how often did nurses explain things in a way you could understand?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period/Monitoring Periods/Reporting Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Composite 2: Communication with Doctors	
MBQIP Topic Area	Patient Experience
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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, how often did doctors treat you with courtesy and respect? • During this hospital stay, how often did doctors listen carefully to you? During this hospital stay, how often did doctors explain things in a way you could understand?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Composite 3: Responsiveness of Hospital Staff	
MBQIP Topic Area	Patient Experience
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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Composite 5: Communications About Medicines	
MBQIP Topic Area	Patient Experience
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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Question 8: Cleanliness of Hospital Environment	
MBQIP Topic Area	Patient Experience
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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: During this hospital stay, how often were your room and bathroom kept clean?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Question 9: Quietness of Hospital Environment	
MBQIP Topic Area	Patient Experience
Measure Description	Percentage of patients surveyed who reported that the area around their room was "Always" quiet at night.
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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: During this hospital stay, how often was the area around your room quiet at night?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period/Monitoring Periods/Reporting Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Composite 6: Discharge Information	
MBQIP Topic Area	Patient Experience
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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Composite 7: Care Transitions	
MBQIP Topic Area	Patient Experience
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who "Strongly Agree" they understood their care when 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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. • When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. When I left the hospital, I clearly understood the purpose for taking each of my medications.
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period/Monitoring Periods/Reporting Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Question 21: Overall Rating of Hospital	
MBQIP Topic Area	Patient Experience
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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period/Monitoring Periods/Reporting Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines

Builds Upon Existing Measure for MBQIP Reporting Within the Flex Program	
Proposed New MBQIP Core Measure Set	
Measure Name – HCAHPS – Question 22: Willingness to Recommend	
MBQIP Topic Area	Patient Experience
Measure Description	Percentage of patients surveyed who reported "Yes" they would definitely 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. **FORHP identified an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: Would you recommend this hospital to your friends and family?
Data Reported To	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Care Compare MBQIP Data Reports Flex Monitoring Team Reports
Encounter Period/Monitoring Periods/Reporting Period	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1 – December 31)
Reporting Deadline	See MBQIP Data Submission Deadlines