MEDICARE BENEFICIARY QUALITY IMPROVEMENT PROJECT (MBQIP)

WHAT IS MBQIP?

- The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Federal Office of Rural Health Policy's (FORHP) Medicare Rural Hospital Flexibility (Flex) grant program.

- Implemented in 2011, the goal of MBQIP is to improve the quality of care provided in critical access hospitals (CAHs) by increasing quality data reporting by CAHs and then driving quality improvement activities based on the data.

- MBQIP provides an opportunity for individual hospitals to look at their own data, compare their results against other CAHs and partner with other hospitals around quality improvement initiatives to improve outcomes and provide the highest quality care to each and every one of their patients.

- As the U.S. moves rapidly toward a health care system that pays for value versus volume of care provided, it is crucial for CAHs to participate in federal, public quality reporting programs to demonstrate the quality of the care they are providing. Low numbers are not a valid reason for CAHs to not report quality data. It is important to provide evidence-based care for every patient, 100 percent of the time. MBQIP takes a proactive approach to ensure CAHs are well-prepared to meet future quality requirements.

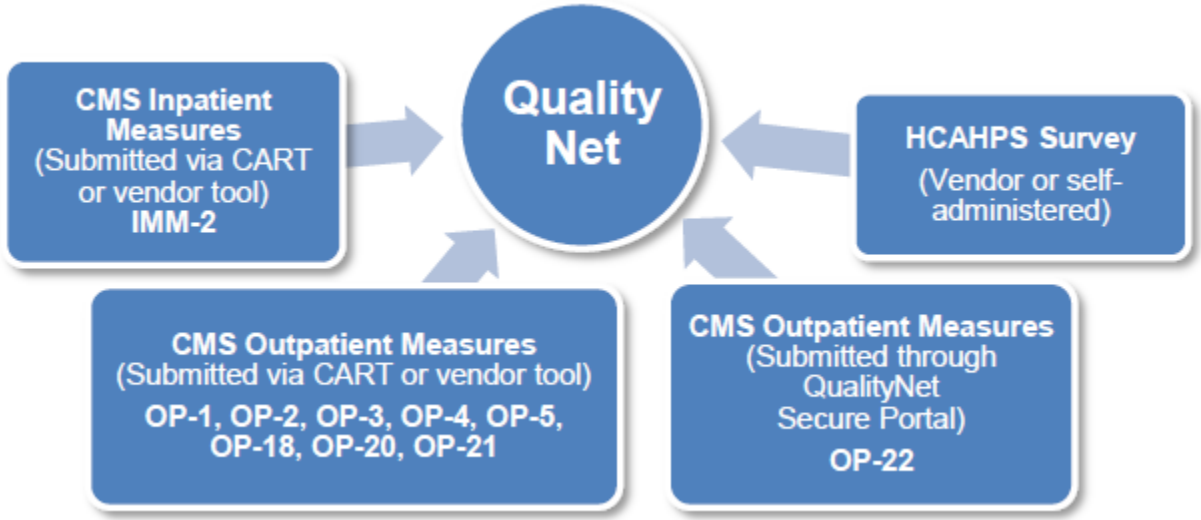
MBQIP MEASURES- REQUIRED

- **OP-1: Median Time to Fibrinolysis**
- **OP-2: Fibrinolytic Therapy Received within 30 minutes**
- **OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention**
- **OP-4: Aspirin at Arrival**
- **OP-5: Median Time to ECG**
- **OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients**
- **OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional**
- **OP-21: Median Time to Pain Management for Long Bone Fracture**
- **OP-22: Patient Left Without Being Seen**

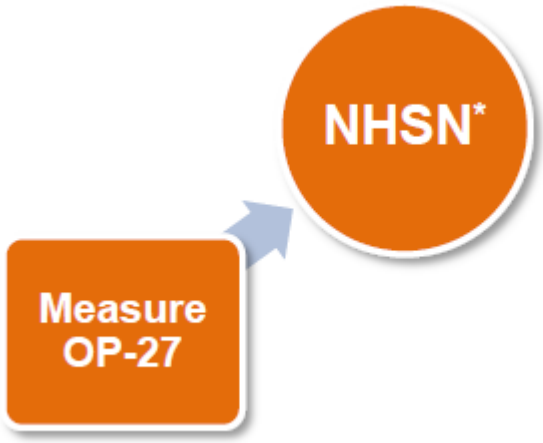
MBQIP MEASURES- REQUIRED (*cont.*)

- **IMM-2: Influenza Immunization**
- **HCAHPS Survey**
- **OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (HCP)**
- **EDTC-1: Administrative Communication (Two data elements)**
- **EDTC-2: Patient Information (Six data elements)**
- **EDTC-3: Vital Signs (Six data elements)**
- **EDTC-4: Medication Information (Three data elements)**
- **EDTC-5: Physician or Practitioner Generated Information (Two data elements)**
- **EDTC-6: Nurse Generated Information (Six data elements)**
- **EDTC-7: Procedures and Tests (Two data elements)**
- **All-EDTC: Composite of all 27 data elements**

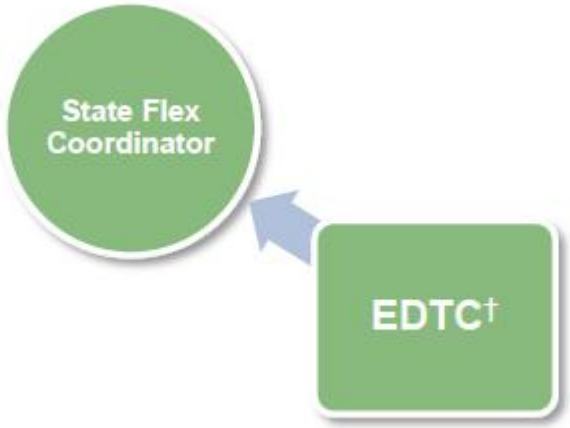
Quality Data Reporting Channels for MBQIP Required Measures



Quality Data Reporting Channels for MBQIP Required Measures *(cont.)*



Quality Data Reporting Channels for MBQIP Required Measures *(cont.)*



Influenza Vaccination Measures

- **Fact sheets for OP-27 and IMM-2**
- **HCP Influenza Vaccination Summary (NHSN)**
- **HCP Vaccination Module (CDC)**
- **OP-27 Reporting Improvement for CAHs (QIO)**

OP-27 Influenza Vaccination Coverage Among Health Care Personnel (Single Rate for Inpatient and Outpatient Settings)	
MBQIP Domain	Patient Safety
Measure Set	Web-Based (Preventive Care)
Measure Description	Percentage of health care workers given influenza vaccination.
Importance/Significance	1 in 5 people in the US 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)
Data Reported To	National Healthcare Safety Network (NHSN) Website
Data Available On	Hospital Compare (*Note:* Listed on Hospital Compare as IMM-3-OP-27-FAC-ADHPCT) MBQIP Data Reports Flex Monitoring Team Reports
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 cases
Data Collection Approach	Hospital tracking
Data Elements	NA
Encounter Period – Submission Deadline	Q4 2015 - Q1 2016 (Oct-Mar) – May 15, 2016
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 s/he works. Facilities must complete a monthly reporting plan for each year or data reporting period. All data reporting is aggregate (whether monthly, once a season, or at a different interval).

Healthcare Personnel Influenza Vaccination Summary

*required for saving, ^conditionally required for saving

Record the number of healthcare personnel (HCP) for each category below for the influenza season being tracked.

*Facility ID#:		^Location:	
*Vaccination type: Influenza	*Influenza subtype[a]: ☐ Seasonal	*Influenza Season[b]:	Date Last Modified: __/__/____

	Employee HCP	Non-Employee HCP		
	*Employees (staff on facility payroll)	*Licensed independent practitioners: Physicians, advanced practice nurses, & physician assistants	*Adult students/ trainees & volunteers	Other Contract Personnel
1. Number of HCP who worked at this healthcare facility for at least 1 day between October 1 and March 31				
2. Number of HCP who received an influenza vaccination at this healthcare facility since influenza vaccine became available this season				
3. Number of HCP who provided a written report or documentation of influenza vaccination outside this healthcare facility since influenza vaccine became available this season				
4. Number of HCP who have a medical contraindication to the influenza vaccine				
5. Number of HCP who declined to receive the influenza vaccine				
6. Number of HCP with unknown vaccination status (or criteria not met for questions 2-5 above)				

Custom Fields

Label		Label	
_____	__/__/____	_____	__/__/____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments

[a] For the purposes of NHSN, influenza subtype refers to whether seasonal or non-seasonal vaccine is used. Seasonal is the default and only current choice.
[b] For the purposes of NHSN, a flu season is defined as July 1 to June 30.

Healthcare Personnel Influenza Vaccination Summary

Question 1 (Denominator) Notes:

- Include all HCP who have worked at the facility for at least 1 working day during the reporting period, regardless of clinical responsibility or patient contact. This includes HCP who joined after October 1 or left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours a day counts as one working day.
- Include both full-time and part-time persons. If a HCW works in two or more facilities, each facility should include the HCW in their denominator. Count HCP as individuals rather than full-time equivalents.
- Licensed practitioners who receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees.
- The HCP categories are mutually exclusive. Each HCP should be counted only once in the denominator (question 1).

Questions 2-6 (Numerator) Notes:

- Questions 2-6 are mutually exclusive. The sum of the HCP in questions 2-6 should equal the number of HCP in question 1 for each HCP category. Questions 2-6 are to be reported separately for each of the three HCP categories.
- Only the following HCP should be counted in question 4: HCP with (1) a severe allergic reaction to eggs or other vaccine component(s) or (2) a history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination.
- The following should be counted in question 5 (declined to receive influenza vaccine):
  - HCP who declined vaccination because of conditions **other than** those included in question 4.
  - HCP who declined vaccination and did not provide any other information.
  - HCP who did not receive vaccination because of religious or philosophical exemptions.
  - HCP who deferred vaccination for the entire influenza season (i.e. from October 1 through March 31).

IMM-2 Immunization for Influenza (Inpatient)	
MBQIP Domain	Patient Safety
Measure Set	Immunization (Preventive Care)
Measure Description	Percentage of patients assessed and given influenza vaccination (inpatient)
Importance/Significance	1 in 5 people in the US get influenza each season. Combined in pneumonia, influenza is the 8th leading cause of death, with two-thirds of those attributable to patients hospitalized during the flu season. Hospitalization is an underutilized opportunity to vaccinate.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	QualityNet via Inpatient CART/Vendor
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	All patients discharged from acute inpatient care with a length of stay less than or equal to 120 days.
Sample Size Requirements	**Quarterly** 0-5 - Reporting encouraged 6-152 - 100% of initial pt. pop 153-764 - 153 765-1529 - 20% of initial pt. pop >1529 - 306 **Monthly** < 51 - 100% of initial population 51-254 - 51 255-509 - 20% of initial pt. pop >509 – 102
Data Collection Approach	Chart Abstracted
Data Elements	Admission Date Birthdate Discharge Date Discharge Disposition ICD-10-CM Other Diagnosis Codes ICD-10-PCS Other Procedure Codes ICD-10-CM Principal Diagnosis Code ICD-10-PCS Principal Procedure Code Influenza vaccination status
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 15, 2016 Q4 2015 (Oct 1 - Dec 31) – May 15, 2016 Q1 2016 (Jan 1 - Mar 31) – August 15, 2016 Q2 2016 (Apr 1 - Jun 30) – November 15, 2016 Q3 2016 (Jul 1 - Sep 30) – February 15, 2017
Other Notes	--

Outpatient Measures (OP)

- **Fact Sheets for OP-1 thru OP5; OP-18, OP-21, OP-22**
- **Abstraction Tools**

OP-1 Median Time to Fibrinolysis	
MBQIP Domain	Outpatient
Measure Set	AMI
Measure Description	Median time from ED arrival to administration of fibrinolytic therapy in patients with STEMI on the ECG performed closest to ED arrival and prior to transfer.
Importance/Significance	Time-to-fibrinolytic therapy is a strong predictor of outcome in patients with an AMI. Nearly 2 lives per 1,000 patients are lost per hour of delay. National guidelines recommend fibrinolytic therapy within 30 minutes of hospital arrival for patients with STEMI.
Improvement Noted As	Decrease in median value (time)
Data Reported To	QualityNet via Outpatient CART/Vendor
Data Available On	MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***Determines the cases to abstract/submit***	Patients seen in a Hospital Emergency Department for whom all of the following are true: • Discharged/transferred to a short-term general hospital for inpatient care or to a Federal Healthcare facility. • A patient age ≥ 18 years. • An ICD-10-CM Principal Diagnosis Code for AMI.
Sample Size Requirements	**Quarterly** 0-80 - submit all cases If you have more than 80 cases, see the specifications manual. **Monthly** Monthly sample size requirements for this measure are based on the anticipated quarterly patient population.
Data Collection Approach	Chart Abstracted
Data Elements	Arrival Time Birthdate Discharge Code E/M Code Fibrinolytic Administration Fibrinolytic Administration Date Fibrinolytic Administration Time ICD-10-CM Principal Diagnosis Code Initial ECG Interpretation Outpatient Encounter Date Reason for Delay in Fibrinolytic Therapy
Encounter Period - Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 1, 2016 Q4 2015 (Oct 1 - Dec 31) – May 1, 2016 Q1 2016 (Jan 1 - Mar 31) – August 1, 2016 Q2 2016 (Apr 1 - Jun 30) – November 1, 2016 Q3 2016 (Jul 1 - Sep 30) – February 1, 2017
Other Notes	Should be analyzed in conjunction with OP-2.

OP-2 Fibrinolytic Therapy Received Within 30 Minutes	
MBQIP Domain	Outpatient
Measure Set	AMI
Measure Description	Percentage of outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival.
Importance/Significance	Time-to-fibrinolytic therapy is a strong predictor of outcome in patients with AMI. Nearly 2 lives per 1,000 patients are lost per hour of delay. National guidelines recommend fibrinolytic therapy within 30 minutes of hospital arrival for patients with STEMI.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***Determines the cases to abstract/submit***	Patients seen in a Hospital Emergency Department for whom all of the following are true: • Discharged/transferred to a short-term general hospital for inpatient care or to a Federal Healthcare facility • A patient age ≥ 18 years • An ICD-10-CM Principal Diagnosis Code for AMI
Sample Size Requirements	**Quarterly** 0-80 - submit all cases If you have more than 80 cases, see the specifications manual. **Monthly** Monthly sample size requirements for this measure are based on the anticipated quarterly patient population.
Data Collection Approach	Chart Abstracted
Data Elements	Arrival Time Birthdate Discharge Code E/M Code Fibrinolytic Administration Fibrinolytic Administration Date Fibrinolytic Administration Time ICD-10-CM Principal Diagnosis Code Initial ECG Interpretation Outpatient Encounter Date Reason for Delay in Fibrinolytic Therapy
Encounter Period - Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 1, 2016 Q4 2015 (Oct 1 - Dec 31) – May 1, 2016 Q1 2016 (Jan 1 - Mar 31) – August 1, 2016 Q2 2016 (Apr 1 - Jun 30) – November 1, 2016 Q3 2016 (Jul 1 - Sep 30) – February 1, 2017
Other Notes	Should be analyzed in conjunction with OP-1.

OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention	
MBQIP Domain	Outpatient
Measure Set	AMI
Measure Description	Median number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital. Note: Hospital Compare described measure as "average number of minutes"
Importance/Significance	The early use of primary angioplasty in patients with STEMI results in a significant reduction in mortality and morbidity. The earlier primary coronary intervention is provided, the more effective it is. Times to treatment in transfer patients undergoing primary PCI may influence the use of PCI as an intervention. Current recommendations support a door-to-balloon time of 90 minutes or less.
Improvement Noted As	Decrease in median value (time)
Data Reported To	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population *Determines the cases to abstract/submit*	Patients seen in a Hospital Emergency Department for whom all of the following are true: • Discharged/transferred to a short-term general hospital for inpatient care or to a Federal Healthcare facility • A patient age ≥ 18 years • An ICD-10-CM Principal Diagnosis Code for AMI
Sample Size Requirements	**Quarterly** 0-80 - submit all cases If you have more than 80 cases, see the specifications manual. **Monthly** Monthly sample size requirements for this measure are based on the anticipated quarterly patient population.
Data Collection Approach	Chart Abstracted
Data Elements	Arrival Time Birthdate Discharge Code ED Departure Date ED Departure Time E/M Code Fibrinolytic Administration ICD-10-CM Principal Diagnosis Code Initial ECG Interpretation Outpatient Encounter Date Reason for Not Administering Fibrinolytic Therapy Transfer for Acute Coronary Intervention
Encounter Period - Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 1, 2016 Q4 2015 (Oct 1 - Dec 31) – May 1, 2016 Q1 2016 (Jan 1 - Mar 31) – August 1, 2016 Q2 2016 (Apr 1 - Jun 30) – November 1, 2016 Q3 2016 (Jul 1 - Sep 30) – February 1, 2017
Other Notes	--

OP-4 Aspirin at Arrival	
MBQIP Domain	Outpatient
Measure Set	AMI and Chest Pain
Measure Description	Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department.
Importance/Significance	The early use of aspirin in patients with AMI results in a significant reduction in adverse events and subsequent mortality.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***Determines the cases to abstract/submit***	Patients seen in a Hospital Emergency Department for whom all of the following are true: • Discharged/transferred to a short-term general hospital for inpatient care or to a Federal Healthcare facility • A patient age >=18 years • An ICD-10-CM Principal Diagnosis Code for AMI or ICD-10-CM Principal or Other Diagnosis Code for Chest Pain
Sample Size Requirements	**Quarterly** 0-80 - submit all cases If you have more than 80 cases, see the specifications manual. **Monthly** Monthly sample size requirements for this measure are based on the anticipated quarterly patient population.
Data Collection Approach	Chart Abstracted
Data Elements	Aspirin Received Birthdate Discharge Code E/M Code ICD-10-CM Other Diagnosis Codes ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date Probable Cardiac Chest Pain Reason for No Aspirin on Arrival
Encounter Period - Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 1, 2016 Q4 2015 (Oct 1 - Dec 31) – May 1, 2016 Q1 2016 (Jan 1 - Mar 31) – August 1, 2016 Q2 2016 (Apr 1 - Jun 30) – November 1, 2016 Q3 2016 (Jul 1 - Sep 30) – February 1, 2017
Other Notes	--

OP-5 Median Time to ECG	
MBQIP Domain	Outpatient
Measure Set	AMI and Chest Pain
Measure Description	Median number of minutes before outpatients with chest pain or possible heart attack got an ECG. Note: Hospital Compare described measure as "average number of minutes."
Importance/Significance	Guidelines recommend patients presenting with chest discomfort or symptoms suggestive of STEMI have a 12-lead ECG performed within 10 minutes of ED arrival. Timely ECGs assist in identifying STEMI patients and impact the choice of reperfusion strategy. This measure will identify the median time to ECG for chest pain or AMI patients and potential opportunities for improvement to decrease the median time to ECG.
Improvement Noted As	Decrease in median value (time)
Data Reported To	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***Determines the cases to abstract/submit***	Patients seen in a Hospital Emergency Dept. for whom all the following are true: • Discharged/transferred to a short-term general hospital for inpatient care or to a Federal Healthcare facility • A patient age ≥ 18 years • An ICD-10-CM Principal Diagnosis Code for AMI or ICD-10-CM Principal or Other Diagnosis Codes for Chest Pain
Sample Size Requirements	**Quarterly** 0-80 - submit all cases If you have more than 80 cases, see the specifications manual. **Monthly** Monthly sample size requirements for this measure are based on the anticipated quarterly patient population.
Data Collection Approach	Chart Abstracted
Data Elements	Arrival Time Birthdate Discharge Code E/M Code ECG ECG Date ECG Time ICD-10-CM Other Diagnosis Codes ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date Probable Cardiac Chest Pain
Encounter Period - Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 1, 2016 Q4 2015 (Oct 1 - Dec 31) – May 1, 2016 Q1 2016 (Jan 1 - Mar 31) – August 1, 2016 Q2 2016 (Apr 1 - Jun 30) – November 1, 2016 Q3 2016 (Jul 1 - Sep 30) – February 1, 2017
Other Notes	--

OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients	
MBQIP Domain	Outpatient
Measure Set	ED Throughput
Measure Description	Average time patients spent in the emergency department before being sent home
Importance/Significance	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.
Improvement Noted As	Decrease in median value (time)
Data Reported To	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***Determines the cases to abstract/submit***	Patients seen in a Hospital Emergency Department
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 Collection Approach	Chart Abstracted
Data Elements	Arrival Time Discharge Code E/M Code ED Departure Date ED Departure Time ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date
Encounter Period - Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 1, 2016 Q4 2015 (Oct 1 - Dec 31) – May 1, 2016 Q1 2016 (Jan 1 - Mar 31) – August 1, 2016 Q2 2016 (Apr 1 - Jun 30) – November 1, 2016 Q3 2016 (Jul 1 - Sep 30) – February 1, 2017
Other Notes	--

OP-20 Door to Diagnostic Evaluation by a Qualified Medical Professional	
MBQIP Domain	Outpatient
Measure Set	ED Throughput
Measure Description	Median time patients spent in the emergency department before they were seen by a healthcare professional. Note: Hospital Compare described measure as "average number of minutes."
Importance/Significance	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.
Improvement Noted As	Decrease in median value (time)
Data Reported To	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***Determines the cases to abstract/submit***	Patients seen in a Hospital Emergency Department
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 Collection Approach	Chart Abstracted
Data Elements	Arrival Time Discharge Code E/M Code Outpatient Encounter Date Provider Contact Date Provider Contact Time
Encounter Period - Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 1, 2016 Q4 2015 (Oct 1 - Dec 31) – May 1, 2016 Q1 2016 (Jan 1 - Mar 31) – August 1, 2016 Q2 2016 (Apr 1 - Jun 30) – November 1, 2016 Q3 2016 (Jul 1 - Sep 30) – February 1, 2017
Other Notes	--

OP-21 Median Time to Pain Management for Long Bone Fracture	
MBQIP Domain	Outpatient
Measure Set	Pain Management
Measure Description	Median time patients who came to the emergency department with broken bones had to wait before receiving pain medication. Note: Hospital Compare described measure as "average number of minutes."
Importance/Significance	Patients with bone fractures continue to lack administration of pain medication as part of treatment regimens. When performance measures are implemented for pain management of these patients, administration and treatment rates for pain improve. Disparities continue to exist in the administration of pain medication for minorities and children.
Improvement Noted As	Decrease in median value (time)
Data Reported To	QualityNet via Outpatient CART/Vendor
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population ***Determines the cases to abstract/submit***	Patients seen in a Hospital Emergency Department for whom the following are also true: • Patient age ≥ 2 years • An ICD-10-CM Principal Diagnosis Code for Long Bone Fracture
Sample Size Requirements	**Quarterly** 0-80 - submit all cases If you have more than 80 cases, see the specifications manual. **Monthly** Monthly sample size requirements for this measure are based on the anticipated quarterly patient population.
Data Collection Approach	Chart Abstracted
Data Elements	Birthdate Discharge Code E/M Code Arrival Time ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date Pain Medication Pain Medication Date Pain Medication Time
Encounter Period - Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – February 1, 2016 Q4 2015 (Oct 1 - Dec 31) – May 1, 2016 Q1 2016 (Jan 1 - Mar 31) – August 1, 2016 Q2 2016 (Apr 1 - Jun 30) – November 1, 2016 Q3 2016 (Jul 1 - Sep 30) – February 1, 2017
Other Notes	--

OP-22 Patient Left Without Being Seen	
MBQIP Domain	Outpatient
Measure Set	ED Throughput
Measure Description	Percentage of patients who left the emergency department before being seen.
Importance/Significance	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.
Improvement Noted As	Decrease in the rate (percent)
Data Reported To	QualityNet via Online Tool
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	NA -This measure uses administrative data and not claims data to determine the measure's denominator population.
Sample Size Requirements	No sampling - report all cases
Data Collection Approach	Hospital tracking
Data Elements	NA
Encounter Period – Submission Deadline	Q1-Q4 2015 (Jan-Dec) – May 15, 2016 Q1-Q4 2016 (Jan-Dec) – May 15, 2017
Other Notes	Definition of provider includes: • Residents/interns • Institutionally credentialed provider • APN/APRNs

ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

This paper abstraction tool is provided as an informal mechanism to aid hospital outpatient departments in the collection of Hospital Outpatient Quality Measures. It should be noted that skip logic is not contained within the paper abstraction tool. If there are any questions or concerns regarding use of this paper abstraction tool, please contact the Hospital Outpatient Quality Reporting Program Support Contractor (Hospital OQR Program SC) at oqrsupport@hsag.com.

What was the date the patient arrived in the hospital outpatient setting? (*Outpatient Encounter Date* _____Dates are in MM-DD-YYYY. UTD is not an allowable entry.

What was the earliest documented time the patient arrived at the outpatient or emergency department? (*Arrival Time*) _____HH:MM (with or without colon) or ☐ UTD

First Name _____

Last Name_____

What was the patient's sex on arrival? (*Sex*) ☐ Female ☐ Male ☐ Unknown

What is the patient's date of birth? (*Birthdate*)_____
MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What is the patient's race? (*Race*) (Select one option)

☐ 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
☐ 2 Black or African American: Patient's race is Black or African American.
☐ 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.
☐ 4 Asian: Patient's race is Asian.
☐ 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander.
☐ 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (*Hispanic Ethnicity*)

☐ Yes Patient is of Hispanic ethnicity or Latino.
☐ No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What is the postal code of the patient's residence? (*Postal Code*) _____
Five or nine digits, HOMELESS or NON-US

What was the number used to identify this outpatient encounter? (*Patient Identifier*)
_____

CMS Certification Number (Format six digits) _____

ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

1. **What was the E/M Code documented for this outpatient encounter? (EMCODE)**
   - ☐ 99281 Emergency department visit, new or established patient
   - ☐ 99282 Emergency department visit, new or established patient
   - ☐ 99283 Emergency department visit, new or established patient
   - ☐ 99284 Emergency department visit, new or established patient
   - ☐ 99285 Emergency department visit, new or established patient
   - ☐ 99291 Critical care, evaluation and management

2. **What was the patient's discharge code from the outpatient setting? (DISCHGCODE?)** (Select option)
   - ☐ 1 Home
   - ☐ 2 Hospice – Home
   - ☐ 3 Hospice – Health Care Facility
   - ☐ 4a Acute Care Facility – General Inpatient Care
   - ☐ 4b Acute Care Facility – Critical Access Hospital
   - ☐ 4c Acute Care Facility – Cancer Hospital or Children's Hospital
   - ☐ 4d Acute Care Facility – Department of Defense or Veteran's Administration
   - ☐ 5 Other Health Care facility
   - ☐ 6 Expired
   - ☐ 7 Left Against Medical Advice/AMA
   - ☐ 8 Not Documented or Unable to Determine (UTD)

3. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)** (Format eight digits, without a decimal point)

   _____

4. **What were the ICD-10-CM other diagnoses codes selected for this medical record? (OTHRDX#)** (Format eight digits, without a decimal point)

   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

5. **What is the patient's source of payment for this outpatient encounter? (PMTSRCE)**
   - ☐ 1 Source of payment is Medicare
   - ☐ 2 Source of payment is Non-Medicare

6. **What is the patient's Medicare/HIC number? (PTHIC)** (Required for patients with a Payment Source of Medicare who have a standard HIC#. All alpha characters must be upper case.)

   _____

ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

7. Is there documentation of ST-segment elevation on the electrocardiogram (ECG) performed closest to emergency department arrival? (INITECGINT)

☐ Yes ST-segment elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival.

☐ No No ST-segment elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival, no interpretation or report available for the ECG performed closest to emergency department arrival, or unable to determine from medical record documentation.

8. Did the patient receive fibrinolytic therapy at this emergency department? (FIBADMIN)

☐ Yes Fibrinolytic therapy was initiated at this emergency department.

☐ No There is no documentation fibrinolytic therapy was initiated at this emergency department, or unable to determine from medical record documentation.

9. What was the date primary fibrinolytic therapy was initiated during this hospital stay? (FIBADMINDT)

_____ MM-DD-YYYY (includes dashes) or ☐ UTD

10. What was the time (military time) primary fibrinolytic therapy was initiated during this hospital stay? (FIBADMINTM)

_____ HH:MM (with or without colon) or ☐ UTD

11. Is there a reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival? (REASONDELFIB)

☐ Yes Reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival.

☐ No No reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival, or unable to determine from medical record documentation.

12. Was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention? (TRANSFERCORINT)

☐ 1 There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention.

☐ 2 There was documentation the patient was admitted to observation status prior to transfer.

☐ 3 There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention, or the specific reason for transfer was unable to be determined from medical record documentation.

13. What is the date the patient departed from the emergency department? (EDDEPARTDT)

_____ MM-DD-YYYY (includes dashes) or ☐ UTD

14. What is the time (military time) the patient departed from the emergency department? (EDDEPARTTM) _____ HH:MM (with or without colon) or ☐ UTD

ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

15. Select one of the following potential contraindications or reasons for not administering fibrinolytic therapy. (REASONNOFIBADMIN)

- ☐ 1 Documented contraindication/reason
- ☐ 2 Cardiogenic Shock
- ☐ 3 No documented contraindication/reason or UTD

16. Was the patient's chest pain presumed to be cardiac in origin? (PROBCARDCP)

- ☐ Yes There was nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin.
- ☐ No There was no nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin, or unable to determine from medical record documentation.

17. Was aspirin received within 24 hours before emergency department arrival or administered prior to transfer? (ASPIRINRCVD)

- ☐ Yes Aspirin was received within 24 hours before emergency department arrival or administered in the emergency department prior to transfer.
- ☐ No Aspirin was not received within 24 hours before emergency department arrival or administered in the emergency department prior to transfer, or unable to determine from medical record documentation.

18. Select one of the following documented reasons for not administering aspirin on arrival. (CTRASPRN)

- ☐ 1 Allergy/Sensitivity to aspirin
- ☐ 2 Documentation of Coumadin/Warfarin or Pradaxa/dabigatran, apixaban/Eliquis, or rivaroxaban/Xarelto and Jantoven prescribed pre-arrival
- ☐ 3 Other documented reasons
- ☐ 4 No documented reason or UTD

19. Was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer? (ECGDONE)

- ☐ Yes There was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer.
- ☐ No There was not an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer, or unable to determine from medical record documentation.

20. What is the date the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGDT)

_____MM-DD-YYYY (includes dashes) or ☐ UTD

21. What is the time (military time) the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGTM)

_____HH:MM (with or without colon) or ☐ UTD

22. What is the first physician identifier? (PHYSICIAN_1)

_____

23. What is the second physician identifier? (PHYSICIAN_2)

_____

CHEST PAIN (CP) CART PAPER TOOL

This paper abstraction tool is provided as an informal mechanism to aid hospital outpatient departments in the collection of Hospital Outpatient Quality Measures. It should be noted that skip logic is not contained within the paper abstraction tool. If there are any questions or concerns regarding use of this paper abstraction tool, please contact the Hospital Outpatient Quality Reporting Program Support Contractor (Hospital OQR Program SC) at oqrsupport@hsag.com.

What was the date the patient arrived in the hospital outpatient setting? (*Outpatient Encounter Date*)
_____MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What was the earliest documented time the patient arrived at the outpatient or emergency department? (*Arrival Time*)
_____ HH:MM (with or without colon) or ☐ UTD

First Name _____

Last Name_____

What was the patient's sex on arrival? (*Sex*) ☐ Female ☐ Male ☐ Unknown

What is the patient's date of birth? (*Birthdate*)
_____MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What is the patient's race? (*Race*) (Select one option)

☐ 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
☐ 2 Black or African American: Patient's race is Black or African American.
☐ 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.
☐ 4 Asian: Patient's race is Asian.
☐ 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander.
☐ 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (*Hispanic Ethnicity*)

☐ Yes Patient is of Hispanic ethnicity or Latino.
☐ No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What is the postal code of the patient's residence? (*Postal Code*)_____
Five or nine digits, HOMELESS or NON-US

What was the number used to identify this outpatient encounter? (*Patient Identifier*)
_____

CMS Certification Number (CCN) (Format six digits) _____

CHEST PAIN (CP) CART PAPER TOOL

1. **What was the E/M Code documented for this outpatient encounter? (EMCODE)**

   ☐ 99281 Emergency department visit, new or established patient
   ☐ 99282 Emergency department visit, new or established patient
   ☐ 99283 Emergency department visit, new or established patient
   ☐ 99284 Emergency department visit, new or established patient
   ☐ 99285 Emergency department visit, new or established patient
   ☐ 99291 Critical care, evaluation and management

2. **What was the patient's discharge code from the outpatient setting? (DISCHGCODE?)** (Select one option)

   ☐ 1 Home
   ☐ 2 Hospice – Home
   ☐ 3 Hospice – Health Care Facility
   ☐ 4a Acute Care Facility – General Inpatient Care
   ☐ 4b Acute Care Facility – Critical Access Hospital
   ☐ 4c Acute Care Facility – Cancer Hospital or Children's Hospital
   ☐ 4d Acute Care Facility – Department of Defense or Veteran's Administration
   ☐ 5 Other Health Care facility
   ☐ 6 Expired
   ☐ 7 Left Against Medical Advice/AMA
   ☐ 8 Not Documented or Unable to Determine (UTD)

3. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)** (Format eight digits, without a decimal point)

   _____

4. **What were the ICD-10-CM other diagnoses codes selected for this medical record? (OTHRDX#)** (Format eight digits, without a decimal point)

   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

5. **What is the patient's source of payment for this outpatient encounter? (PMTSRCE)**

   ☐ 1 Source of payment is Medicare
   ☐ 2 Source of payment is Non-Medicare

6. **What is the patient's Medicare/HIC number? (PTHIC)** (Required for patients with a Payment Source of Medicare who have a standard HIC#. All alpha characters must be upper case.)

   _____

CHEST PAIN (CP) CART PAPER TOOL

7. Was the patient's chest pain presumed to be cardiac in origin? (PROBCARDCP)

☐ Yes There was nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin

☐ No There was no nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin, or unable to determine from medical record documentation.

8. Was aspirin received within 24 hours before emergency department arrival or administered prior to transfer? (ASPIRINRCVD)

☐ Yes Aspirin was received within 24 hours before emergency department arrival or administered in the emergency department prior to transfer.

☐ No Aspirin was not received within 24 hours before emergency department arrival or administered in the emergency department prior to transfer, or unable to determine from medical record documentation.

9. Select one of the following documented reasons for not administering aspirin on arrival. (CTRASPRN)

☐ 1 Allergy/Sensitivity to aspirin

☐ 2 Documentation of Coumadin/Warfarin or Pradaxa/dabigatran, apixaban/Eliquis, or rivaroxaban/Xarelto and Jantoven prescribed pre-arrival

☐ 3 Other documented reasons

☐ 4 No documented reason or UTD

10. Was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer? (ECGDONE)

☐ Yes There was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer.

☐ No There was not an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer, or unable to determine from medical record documentation.

11. What is the date the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGDT)

_____MM-DD-YYYY (includes dashes) or ☐ UTD

12. What is the time the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGTM)

_____HH:MM (with or without colon) or ☐ UTD

13. What is the first physician identifier? (PHYSICIAN_1)

_____

14. What is the second physician identifier? (PHYSICIAN_2)

_____

ED-THROUGHPUT CART PAPER TOOL

This paper abstraction tool is provided as an informal mechanism to aid hospital outpatient departments in the collection of Hospital Outpatient Quality Measures. It should be noted that skip logic is not contained within the paper abstraction tool. If there are any questions or concerns regarding use of this paper abstraction tool, please contact the Hospital Outpatient Quality Reporting Program Support Contractor (Hospital OQR Program SC) at oqrsupport@hsag.com.

What was the date the patient arrived in the hospital outpatient setting? (*Outpatient Encounter Date*)
_____MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What was the earliest documented time the patient arrived at the outpatient or emergency department? (*Arrival Time*)
_____HH:MM (with or without colon) or ☐ UTD

First Name _____

Last Name_____

What was the patient's sex on arrival? (*Sex*) ☐ Female ☐ Male ☐ Unknown

What is the patient's date of birth? (*Birthdate*)_____
MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What is the patient's race? (*Race*) (Select one option)

☐ 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
☐ 2 Black or African American: Patient's race is Black or African American.
☐ 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.
☐ 4 Asian: Patient's race is Asian.
☐ 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander.
☐ 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (*Hispanic Ethnicity*)

☐ Yes Patient is of Hispanic ethnicity or Latino.
☐ No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What is the postal code of the patient's residence? (*Postal Code*)_____
Five or nine digits, HOMELESS or NON-US

What was the number used to identify this outpatient encounter? (*Patient Identifier*)

_____

CMS Certification Number (Format six digits) _____

ED-THROUGHPUT CART PAPER TOOL

1. **What was the E/M Code documented for this outpatient encounter? (EMCODE)**

   ☐ 99281 Emergency department visit, new or established patient
   ☐ 99282 Emergency department visit, new or established patient
   ☐ 99283 Emergency department visit, new or established patient
   ☐ 99284 Emergency department visit, new or established patient
   ☐ 99285 Emergency department visit, new or established patient
   ☐ 99291 Critical care, evaluation and management

2. **What was the patient's discharge code from the outpatient setting? (DISCHGCODE?)** (Select one option)

   ☐ 1 Home
   ☐ 2 Hospice – Home
   ☐ 3 Hospice – Health Care Facility
   ☐ 4a Acute Care Facility – General Inpatient Care
   ☐ 4b Acute Care Facility – Critical Access Hospital
   ☐ 4c Acute Care Facility – Cancer Hospital or Children's Hospital
   ☐ 4d Acute Care Facility – Department of Defense or Veteran's Administration
   ☐ 5 Other Health Care facility
   ☐ 6 Expired
   ☐ 7 Left Against Medical Advice/AMA
   ☐ 8 Not Documented or Unable to Determine (UTD)

3. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)** (Format eight digits, without a decimal point) _____

4. **What is the patient's source of payment for this outpatient encounter? (PMTSRCE)**

   ☐ 1 Source of payment is Medicare
   ☐ 2 Source of payment is Non-Medicare

5. **What is the patient's Medicare/HIC number? (PTHIC)** (Required for patients with a Payment Source of Medicare who have a standard HIC#. All alpha characters must be upper case.)

   _____

6. **What is the date the patient departed from the emergency department? (EDDEPARTDT)**

   _____ MM-DD-YYYY (includes dashes) or ☐ UTD

7. **What is the time the patient departed from the emergency department? (EEDDEPARTTM)**

   _____ HH:MM (with or without colon) or ☐ UTD

8. **What is the date the patient first had direct personal exchange with the physician/APN/PA or institutionally credentialed provider to initiate the medical screening examination in the emergency department? (PROVCONTDT)**

   _____MM-DD-YYYY (includes dashes) or ☐ UTD

ED-THROUGHPUT CART PAPER TOOL

9. What is the time the patient first had direct personal exchange with the physician/APN/PA or institutionally credentialed provider to initiate the medical screening examination in the emergency department? (PROVCONTTM)

   _____ HH:MM (with or without colon) or ☐ UTD

10. What is the first physician identifier? (PHYSICIAN_1)

    _____

11. What is the second physician identifier? (PHYSICIAN_2)

    _____

PAIN MANAGEMENT CART PAPER TOOL

This paper abstraction tool is provided as an informal mechanism to aid hospital outpatient departments in the collection of Hospital Outpatient Quality Measures. It should be noted that skip logic is not contained within the paper abstraction tool. If there are any questions or concerns regarding use of this paper abstraction tool, please contact the Hospital Outpatient Quality Reporting Program Support Contractor (Hospital OQR Program SC) at oqrsupport@hsag.com.

What was the date the patient arrived in the hospital outpatient setting? (*Outpatient Encounter Date*)
_____MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What was the earliest documented time the patient arrived at the outpatient or emergency department? (*Arrival Time*)_____HH:MM (with or without colon) or ☐ UTD

First Name _____

Last Name_____

What was the patient's sex on arrival? (*Sex*) ☐ Female ☐ Male ☐ Unknown

What is the patient's date of birth? (*Birthdate*)_____
MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What is the patient's race? (*Race*) (Select one option)

☐ 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
☐ 2 Black or African American: Patient's race is Black or African American.
☐ 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.
☐ 4 Asian: Patient's race is Asian.
☐ 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander.
☐ 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (*Hispanic Ethnicity*)

☐ Yes Patient is of Hispanic ethnicity or Latino.
☐ No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What is the postal code of the patient's residence? (*Postal Code*)_____
Five or nine digits, HOMELESS or NON-US

What was the number used to identify this outpatient encounter? (*Patient Identifier*)

_____

CMS Certification Number (Format six digits) _____

PAIN MANAGEMENT CART PAPER TOOL

1. **What was the E/M Code documented for this outpatient encounter? (EMCODE)**

   - ☐ 99281 Emergency department visit, new or established patient
   - ☐ 99282 Emergency department visit, new or established patient
   - ☐ 99283 Emergency department visit, new or established patient
   - ☐ 99284 Emergency department visit, new or established patient
   - ☐ 99285 Emergency department visit, new or established patient
   - ☐ 99291 Critical care, evaluation and management

2. **What was the patient's discharge code from the outpatient setting? (DISCHGCODE?)** (Select one option)

   - ☐ 1 Home
   - ☐ 2 Hospice – Home
   - ☐ 3 Hospice – Health Care Facility
   - ☐ 4a Acute Care Facility – General Inpatient Care
   - ☐ 4b Acute Care Facility – Critical Access Hospital
   - ☐ 4c Acute Care Facility – Cancer Hospital or Children's Hospital
   - ☐ 4d Acute Care Facility – Department of Defense or Veteran's Administration
   - ☐ 5 Other Health Care facility
   - ☐ 6 Expired
   - ☐ 7 Left Against Medical Advice/AMA
   - ☐ 8 Not Documented or Unable to Determine (UTD)

3. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)** (Format eight digits, without a decimal point)

   _____

4. **What is the patient's source of payment for this outpatient encounter? (PMTSRCE)**

   - ☐ 1 Source of payment is Medicare
   - ☐ 2 Source of payment is Non-Medicare

5. **What is the patient's Medicare/HIC number? (PTHIC)** (Required for patients with a Payment Source of Medicare who have a standard HIC#. All alpha characters must be upper case.)

   _____

6. **Was there documentation the patient received oral, intranasal or parenteral pain medication during this emergency department visit? (PAINMED)**

   - ☐ Yes There is documentation the patient received pain medication by an appropriate route during this emergency department visit.
   - ☐ No There is no documentation the patient received pain medication by an appropriate route during this emergency department visit, or unable to determine from medical record documentation.

7. **What is the date the earliest oral, intranasal or parenteral pain medication was administered? (PAINMEDDT)**_____MM-DD-YYYY (includes dashes) or ☐ UTD

PAIN MANAGEMENT CART PAPER TOOL

8. **What is the time the earliest oral, intranasal or parenteral pain medication was administered? (PAINMEDTM)**_____HH:MM (with or without colon) or ☐ UTD

9. **What is the first physician identifier? (PHYSICIAN_1)**

   _____

10. **What is the second physician identifier? (PHYSICIAN_2)**

    _____

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

- **Fact Sheets for HCAHPS Composites/Questions**
- **The HCAHPS Survey – Frequently Asked Questions (CDC)**

HCAHPS Composite 1 Communication with Nurses	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that their nurses "Always" communicated well.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: 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?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Composite 2 Communication with Doctors	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that their doctors "Always" communicated well.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: 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?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Composite 3 Responsiveness of Hospital Staff	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that they "Always" received help as soon as they wanted.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: 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?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Composite 4 Pain Management	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that their pain was "Always" well controlled.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: During this hospital stay, how often was your pain well controlled? During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Composite 5 Communication about Medicines	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that staff "Always" explained about medicines before giving them.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: 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?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Composite 6 Discharge Information	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that "Yes" they were given information about what to do during their recovery at home.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: 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?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Composite 7 Care Transitions	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who "Strongly Agree" they understood their care when they left the hospital.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: 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.
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Question 8 Cleanliness of Hospital Environment	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that their room and bathroom were "Always" clean.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: During this hospital stay, how often were your room and bathroom kept clean?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Question 9 Quietness of Hospital Environment	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported that the area around their room was "Always" quiet at night.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: During this hospital stay, how often was the area around your room quiet at night?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Question 21 Overall Rating of Hospital	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
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).
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: 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?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

HCAHPS Question 22 Willingness to Recommend	
MBQIP Domain	Patient Engagement
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who reported "Yes" they would definitely recommend the hospital.
Importance/Significance	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.
Improvement Noted As	Increase in percent always
Data Reported To	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	Hospital Compare MBQIP Data Reports Flex Monitoring Team Reports
Measure Population	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: Would you recommend this hospital to your friends and family?
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – January 6, 2016 Q4 2015 (Oct 1 - Dec 31) – April 6, 2016 Q1 2016 (Jan 1 - Mar 31) – July 6, 2016 Q2 2016 (Apr 1 - Jun 30) – October 5, 2016 Q3 2016 (Jul 1 - Sep 30) - TBD
Other Notes	--

The HCAHPS Survey – Frequently Asked Questions

What is the purpose of the HCAHPS Survey?

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care. While many hospitals collect information on patient satisfaction, HCAHPS (pronounced "*H-caps*") created a national standard for collecting and public reporting information that enables valid comparisons to be made across all hospitals to support consumer choice. The HCAHPS sampling protocol is designed to capture uniform information on hospital care from the patient's perspective.

Three broad goals shape the HCAHPS Survey. First, the survey is designed to produce comparable data on patients' perspectives of care that allows objective and meaningful comparisons among hospitals on topics that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve quality of care. Third, public reporting serves to enhance public accountability in health care by increasing transparency. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful, and practical. This methodology and the information it generates are available to the public. More information about the HCAHPS Survey can be found at http://www.hcahpsonline.org/home.aspx.

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. Government agency.

What items are on the HCAHPS Survey?

The HCAHPS Survey is composed of 27 items: 18 substantive items that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness of the hospital environment, quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and recommendation of hospital); four items to skip patients to appropriate questions; three items to adjust for the mix of patients across hospitals; and two items to support congressionally-mandated reports. The HCAHPS Survey is available in English, Spanish, Chinese, Russian and Vietnamese in the mail format, and in English and Spanish in the telephone and Interactive Voice Response formats. On average, it takes respondents about seven minutes to complete the HCAHPS survey items. The core set of HCAHPS questions can be combined with customized, hospital-specific items to complement the data hospitals collect to support internal customer service and quality-related activities.

The actual wording of the HCAHPS questions and response categories, as well as the scripts for conducting the survey in the Telephone and Active Interactive Voice Response (IVR) modes, can be found under "Survey Instruments" on the HCAHPS On-line website, http://www.hcahpsonline.org/home.aspx. Complete information about how to implement the HCAHPS survey can be found in the HCAHPS Quality Assurance Guidelines, also available on this Web site.

How was the HCAHPS Survey developed?

The Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ), another agency in the federal Department of Health and Human Services, to develop HCAHPS. AHRQ carried out a rigorous, scientific process to develop and test the HCAHPS instrument. This process entailed multiple steps, including a public call for measures; literature review; cognitive interviews; consumer testing and focus groups; stakeholder input; a large-scale pilot test and a number of small-scale field tests. In addition, CMS responded to hundreds of public comments generated by several Federal Register notices.

In May 2005, the National Quality Forum (NQF)—which represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, Federal agencies, and research and quality organizations—endorsed the HCAHPS. In December 2005, the federal Office of Management and Budget gave its final approval for the national implementation of HCAHPS. HCAHPS was also endorsed by the Hospital Quality Alliance. CMS commissioned an independent research firm, Abt Associates Inc., to conduct an analysis of the benefits and costs of HCAHPS. The Abt report, which includes detailed cost estimates for hospitals, can be found at:
http://www.cms.gov/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf.

When did hospitals begin to implement the HCAHPS Survey?

Voluntary collection of HCAHPS data for public reporting began in 2006, and public reporting of HCAHPS scores began in 2008. Since July 2007, hospitals subject to IPPS payment provisions ("subsection (d) hospitals") must collect, submit and publicly report HCAHPS data in order to receive their full IPPS annual payment update (APU). IPPS hospitals that fail to report the required quality measures, which include the HCAHPS survey, may receive an APU that is reduced by 2.0 percentage points. Non-IPPS hospitals, such as Critical Access Hospitals, can voluntarily participate in HCAHPS. HCAHPS Survey results also form the basis for the Patient Experience of Care domain in the Hospital Value-Based Purchasing program.

Which modes of survey administration can be used for HCAHPS?

Because hospitals and survey vendors survey patients a number of ways, HCAHPS is available in four different modes: Mail Only, Telephone Only, Mail with Telephone follow-up (also known as Mixed mode), and Active Interactive Voice Response (IVR). Detailed information on the proper use of each mode of survey administration can be found in the HCAHPS Quality Assurance Guidelines manual, which is located at "Quality Assurance" at www.hcahpsonline.org.

CMS recognizes that patients' responses to the survey may be affected by the mode of survey administration. For instance, respondents typically give somewhat more positive responses when surveyed by telephone, as compared to mail. Thus, choice of mode of survey administration could potentially affect comparisons of hospitals. CMS conducted a large-scale experiment to test for mode effects, and based on this research an adjustment has been built into the calculation of HCAHPS scores to remove the effect of survey mode on how patients respond to HCAHPS survey items.

The Mode Experiment was based on a nationwide random sample of short-term acute care hospitals. Participating hospitals contributed patient discharges from a four-month period in 2006. Within each hospital, equal numbers of patients were randomly assigned to each of the four modes of survey administration. In total, 27,229 discharges from 45 hospitals were surveyed.

In general, patients randomized to the Telephone Only and active IVR provided more positive evaluations than those randomized to the Mail Only and Mixed modes. Mode effects varied little by hospital. More information, as well as an overview of the results of the mode experiment, can be found under "Mode Adjustment" at http://www.hcahpsonline.org/home.aspx.

What must hospitals do in order to participate in HCAHPS?

CMS has developed detailed Rules of Participation and Minimum Survey Requirements for hospitals that either self-administer the survey or administer the survey for multiple hospital sites, and for survey vendors that conduct HCAHPS for client hospitals. The HCAHPS Rules of Participation include the following activities:

- Attend HCAHPS Introduction and Update Training
- Follow the Quality Assurance Guidelines and Policy Updates
- Attest to the accuracy of the organization's data collection process
- Develop a HCAHPS Quality Assurance Plan
- Become a QualityNet Exchange Registered User for data submission
- Participate in oversight activities conducted by the HCAHPS Project Team.

Hospitals and survey vendors administering the survey must also meet HCAHPS Minimum Survey Requirements with respect to survey experience, survey capacity, and quality control procedures. Details about these activities and requirements can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

Note: If a hospital, or its survey vendor, is found to be non-compliant with these rules or requirements, the hospital's HCAHPS data may not be publicly reported and the hospital may be at risk for an annual payment update (APU) reduction.

Which patients are eligible to participate in HCAHPS?

The HCAHPS survey is broadly intended for patients of all payer types that meet the following criteria:

- 18 years or older at the time of admission
- At least one overnight stay in the hospital as an inpatient
- Non-psychiatric MS-DRG/principal diagnosis at discharge
- Alive at the time of discharge

Patients who meet these criteria (except those that fall into an exclusion category, described below) should be included in the sample frame from which the survey sample is drawn.

A patient's principal diagnosis at discharge is used to determine whether he or she falls into one of the three service line categories (medical, surgical or maternity care) for HCAHPS eligibility. The Medicare Severity-Diagnosis Related Group (MS-DRG) is the preferred method for determining whether the service line is Medical, Surgical or Maternity Care.

Pediatric patients (under 18 years old at admission) and psychiatric patients are ineligible because the current HCAHPS instrument is not designed to address the unique situation of pediatric patients and their families, or the behavioral health issues pertinent to psychiatric patients. Patients whose MS-DRG/principal diagnosis is Medical, Surgical or Maternity Care but who also have psychiatric comorbidities are eligible for the survey. Patients who did not have an overnight stay are ineligible because their experiences and interactions with the staff during the hospital visit may be limited.

There are a few categories of otherwise eligible patients who, because of logistical difficulties in collecting data, are excluded from the sample frame before the random sample is selected. These are:

- Patients discharged to hospice care
- Patients discharged to nursing homes and skilled nursing facilities
- Court/Law enforcement patients (i.e., prisoners)
- Patients with a foreign home address (excluding U.S. territories—Virgin Islands, Puerto Rico, and Northern Mariana Islands)
- "No-Publicity" patients (see below)
- Patients who are excluded because of rules or regulations of the state in which the hospital is located

Complete information about patient eligibility and exclusions for the HCAHPS survey can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

Note: A "No publicity patient" is a patient who requests at admission that the hospital: 1) not reveal that he or she is a patient; and/or 2) not survey him or her.

Note: Hospitals must document their use of all patient exclusions.

How are patients sampled for the HCAHPS survey?

The basic sampling procedure for HCAHPS is the drawing of a random sample of eligible discharges on a monthly basis. Smaller hospitals should survey all HCAHPS-eligible discharges. Data are collected from patients throughout each month of the 12-month reporting period. Data are then aggregated on a quarterly basis to create a rolling 4-quarter data file for each hospital. The most recent four quarters of data are used in public reporting. To ensure comparability, hospitals may not switch type of sampling, mode of survey administration, or survey vendor within a calendar quarter. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

How is the sample drawn for the HCAHPS Survey?

The basic sampling procedure for HCAHPS entails drawing a random sample of all eligible discharges from a hospital on a monthly basis. Sampling may be conducted either continuously throughout the month, or at the end of the month, as long as a random sample is generated from the entire month.

The target for the statistical precision of the publicly reported hospital scores is based on a reliability criterion. In brief, higher reliability means a higher ratio of "signal to noise" in the data. The reliability target for the HCAHPS global items and most composites is 0.8 or higher. Based on this target, hospitals must obtain at least 300 completed HCAHPS surveys over the 12-month reporting period.

The HCAHPS sample must be drawn according to this uninterrupted random sampling protocol. Hospitals/Survey vendors must sample from every month throughout the entire reporting period and not stop sampling or curtail ongoing interview activities once a certain number of completed surveys has been attained. All completed surveys should be submitted to the HCAHPS data warehouse. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

Note: Smaller hospitals that are unable to reach the target of 300 completes in a 12-month reporting period must survey ALL eligible discharges and attempt to obtain as many completes as possible.

When are patients surveyed?

Sampled patients are surveyed between 48 hours and six weeks after discharge, regardless of the mode of survey administration. Interviewing or distributing surveys to patients while they are still in the hospital is not permitted.

Data collection for sampled patients must end no later than six weeks following the date the first survey is mailed (Mail Only and Mixed Modes) or the first telephone attempt (Telephone Only and IVR Modes) is made. More information about the HCAHPS sampling protocol can be found in the Quality Assurance Guidelines under "Quality Assurance" at www.hcahpsonline.org.

How is the HCAHPS Survey data analyzed?

Data submitted to the HCAHPS data warehouse is cleaned and analyzed by CMS, which then calculates hospitals' HCAHPS scores and publicly reports them on the Hospital Compare website.

Which results from the HCAHPS Survey are publicly reported?

Hospital-level HCAHPS results are publicly reported on the Hospital Compare website at http://www.hospitalcompare.hhs.gov. Results are reported for four quarters on a rolling basis, which means that the oldest quarter of survey data is rolled off as the newest quarter is rolled on. Ten HCAHPS measures are publicly reported on Hospital Compare:

Composite Topics

- Nurse Communication (Question 1, Q2, Q3)
- Doctor Communication (Q5, Q6, Q7)
- Responsiveness of Hospital Staff (Q4, Q11)
- Pain Management (Q13, Q14)
- Communication About Medicines (Q16, Q17)
- Discharge Information (Q19, Q20)

Individual Items

- Cleanliness of Hospital Environment (Q8)
- Quietness of Hospital Environment (Q9)

Global Items

- Overall Rating of Hospital (Q21)
- Willingness to Recommend Hospital (Q22)

All ten HCAHPS measures are publicly reported for each participating hospital, as well as the national and state averages for each measure. The survey response rate and the number of completed surveys (in broad categories) are also publicly reported on Hospital Compare. CMS publicly reports HCAHPS results for hospitals that obtain fewer than 100 completed surveys. However, a footnote is added when public reporting these results to denote the lower level of precision. Additional information about hospital performance on HCAHPS is available under "Summary Analyses" on the HCAHPS On-Line Web site, http://www.hcahpsonline.org/home.aspx.

How are HCAHPS results adjusted prior to public reporting?

To ensure that differences in HCAHPS results reflect differences in hospital quality only, HCAHPS survey results are adjusted for patient-mix and mode of data collection. Only the adjusted results are publicly reported and considered the official results. Several questions on the survey, as well as items drawn from hospital administrative data, are used for the patient-mix adjustment. Neither patient race nor ethnicity is used to adjust HCAHPS results; these items are included on the survey to support congressionally-mandated reports. The adjustment model also addresses the effects of non-response bias.

More information about the mode experiment, as well as patient-mix adjustment coefficients for publicly reported HCAHPS results, can be found under "Mode and Patient-Mix Adjustment" at http://www.hcahpsonline.org/home.aspx.

Emergency Department Transfer Communication (EDTC)

- **Fact Sheets for EDTC Measures**
- **EDTC Reporting**
- **Sample EDTC Report/Tool**

EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) All or None Composite Calculation	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have all necessary communication with the receiving facility.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population	Patients admitted to the emergency department and transferred from the emergency department to another health care facility (e.g., other hospital, nursing home, hospice, etc.)
Sample Size Requirements	**Quarterly** 0-44 - submit all cases > 45 - submit 45 cases **Monthly** 0-15 - submit all cases > 15 - submit 15 cases
Data Collection Approach	Chart Abstracted, composite of EDTC sub-measures 1-7
Data Elements	EDTC-SUB 1 Administrative communication EDTC-SUB 2 Patient information EDTC-SUB 3 Vital signs EDTC-SUB 4 Medication information EDTC-SUB 5 Physician or practitioner generated information EDTC-SUB 6 Nurse generated information EDTC-SUB 7 Procedures and tests
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – October 31, 2015 Q4 2015 (Oct 1 - Dec 31) – January 31, 2016 Q1 2016 (Jan 1 - Mar 31) – April 30, 2016 Q2 2016 (Apr 1 - Jun 30) – July 31, 2016 Q3 2016 (Jul 1 - Sep 30) – October 31, 2016
Other Notes	This measure is a composite of all 27 data elements in EDTC sub-measures 1-7, and can be used as an overall evaluation of performance on this measure set.

EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) - SUB 1 Administrative Communication	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have physician to physician communication and healthcare facility to healthcare facility communication prior to discharge.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population	Patients admitted to the emergency department and transferred from the emergency department to another health 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
Data Collection Approach	Chart Abstracted
Data Elements	Patient Discharge Status Code Date of Patient Encounter Healthcare Facility to Healthcare Facility Communication Physician to Physician Communication
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – October 31, 2015 Q4 2015 (Oct 1 - Dec 31) – January 31, 2016 Q1 2016 (Jan 1 - Mar 31) – April 30, 2016 Q2 2016 (Apr 1 - Jun 30) – July 31, 2016 Q3 2016 (Jul 1 - Sep 30) – October 31, 2016
Other Notes	--

EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) - SUB 2 Patient Information	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have patient identification information sent to the receiving facility within 60 minutes of discharge.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population	Patients admitted to the emergency department and transferred from the emergency department to another health 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
Data Collection Approach	Chart Abstracted
Data Elements	Patient Discharge Status Code Date of Patient Encounter Patient Name Patient Address Patient Age Patient Gender Patient Contact Information Patient Insurance Information
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – October 31, 2015 Q4 2015 (Oct 1 - Dec 31) – January 31, 2016 Q1 2016 (Jan 1 - Mar 31) – April 30, 2016 Q2 2016 (Apr 1 - Jun 30) – July 31, 2016 Q3 2016 (Jul 1 - Sep 30) – October 31, 2016
Other Notes	--

EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) - SUB 3 Vital Signs	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have communication with the receiving facility within 60 minutes of discharge for patient's vital signs.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population	Patients admitted to the emergency department and transferred from the emergency department to another health 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
Data Collection Approach	Chart Abstracted
Data Elements	Patient Discharge Status Code Date of Patient Encounter Pulse Respiratory rate Blood pressure Oxygen saturation Temperature Neurological Assessment
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – October 31, 2015 Q4 2015 (Oct 1 - Dec 31) – January 31, 2016 Q1 2016 (Jan 1 - Mar 31) – April 30, 2016 Q2 2016 (Apr 1 - Jun 30) – July 31, 2016 Q3 2016 (Jul 1 - Sep 30) – October 31, 2016
Other Notes	--

EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) - SUB 4 Medication Information	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have communication with the receiving facility within 60 minutes of discharge for medication information.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population	Patients admitted to the emergency department and transferred from the emergency department to another health 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
Data Collection Approach	Chart Abstracted
Data Elements	Patient Discharge Status Code Date of Patient Encounter Medications Administered in ED Allergies/Reactions Home Medication
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – October 31, 2015 Q4 2015 (Oct 1 - Dec 31) – January 31, 2016 Q1 2016 (Jan 1 - Mar 31) – April 30, 2016 Q2 2016 (Apr 1 - Jun 30) – July 31, 2016 Q3 2016 (Jul 1 - Sep 30) – October 31, 2016
Other Notes	--

EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) - SUB 5 Physician and Practitioner Generated Information	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have communication with the receiving facility within 60 minutes of discharge for history and physical and physician orders and plan.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population	Patients admitted to the emergency department and transferred from the emergency department to another health 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
Data Collection Approach	Chart Abstracted
Data Elements	Patient Discharge Status Code Date of Patient Encounter History and Physical Reason for Transfer Plan of Care
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – October 31, 2015 Q4 2015 (Oct 1 - Dec 31) – January 31, 2016 Q1 2016 (Jan 1 - Mar 31) – April 30, 2016 Q2 2016 (Apr 1 - Jun 30) – July 31, 2016 Q3 2016 (Jul 1 - Sep 30) – October 31, 2016
Other Notes	--

EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) - SUB 6 Nurse Generated Information	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have communication with the receiving facility within 60 minutes of discharge for key nurse documentation elements.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population	Patients admitted to the emergency department and transferred from the emergency department to another health 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
Data Collection Approach	Chart Abstracted
Data Elements	Patient Discharge Status Code Date of Patient Encounter Nursing Notes Sensory Status (formerly impairments) Catheters Immobilizations Respiratory Support Oral Restrictions
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – October 31, 2015 Q4 2015 (Oct 1 - Dec 31) – January 31, 2016 Q1 2016 (Jan 1 - Mar 31) – April 30, 2016 Q2 2016 (Apr 1 - Jun 30) – July 31, 2016 Q3 2016 (Jul 1 - Sep 30) – October 31, 2016
Other Notes	--

EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) - SUB 7 Procedures and Tests	
MBQIP Domain	Care Transitions
Measure Set	EDTC
Measure Description	Percentage of patients who are transferred from an ED to another health care facility that have communication with the receiving facility within 60 minutes of discharge of tests done and results sent.
Importance/Significance	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care, and avoids medical errors and redundant tests.
Improvement Noted As	Increase in the rate (percent)
Data Reported To	State Flex Office
Data Available On	MBQIP Data Reports
Measure Population	Patients admitted to the emergency department and transferred from the emergency department to another health 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
Data Collection Approach	Chart Abstracted
Data Elements	Patient Discharge Status Code Date of Patient Encounter Tests/Procedures Performed Tests/Procedure Results
Encounter Period – Submission Deadline	Q3 2015 (Jul 1 - Sep 30) – October 31, 2015 Q4 2015 (Oct 1 - Dec 31) – January 31, 2016 Q1 2016 (Jan 1 - Mar 31) – April 30, 2016 Q2 2016 (Apr 1 - Jun 30) – July 31, 2016 Q3 2016 (Jul 1 - Sep 30) – October 31, 2016
Other Notes	--

Emergency Department Transfer Communication (EDTC) Reporting

- **Identify Measure Population**
  Hospitals need to identify which Emergency Department cases fit in the measure population for reporting. The information on how to determine the patient population for the measure is found on the Population and Sampling page of the EDTC Data Specifications Manual available http://www.stratishealth.org/providers/ED_Transfer_Resources.html

- **Abstract the EDTC Measure Data**
  Hospitals must chart abstract the EDTC data elements to determine the numerator and denominator for the MBQIP program submission on a quarterly basis. Data can be collected via a third party vendor or by the use of an Excel-based data collection tool. The free Excel-based Data Collection Tool for EDTC measure, along with instructions for using the tool, can be found http://www.stratishealth.org/providers/ED_Transfer_Resources.html

- **Submit the EDTC Data**
  Numerator and denominator data is submitted to the State Flex Coordinator or their designee. Contact your Flex Coordinator to determine how the EDTC data should be submitted.

Enter Hospital, State, Patient and Data Collection, Date and Time Period Information

*All elements are required

CMS Certified Number (CCN) of Critical Access Hospital	
Enter Name of the State (Please enter the two letter state abbreviation)	
****Enter Patient Name**	
****Enter Patient Medical Record Number**	
Select Patient Discharged Disposition (from drop down list)	
Enter the Date of Patient Encounter (MM/DD/YYYY)	
Enter Name of the Person Doing Data Collection	
Year of Data Collection	

DATA ENTRY FORM

ED Transfer Communication Quality Measure 1 (EDTC-1): Administrative Communication

Does the medical record documentation indicate that the following communication occurred prior to departure of the patient from ED to another healthcare facility?

1	**Nurse to Nurse Communication** (Data Specifications) • Select Y (Yes) if there is documentation of the ED nurse communicating with the nursing staff of the receiving facility. • Select N (No) if there is no documentation of the ED nurse communicating with to the nursing staff of the receiving facility.	○ Yes ○ No
2	**Physician/Advanced Practice Nurse/Physician Assistant (Physician/APN/PA) to Physician/APN/PA communication** (Data Specifications) • Select Y (Yes) if there is documentation of the ED physician/APN/PA discussion of the patient's condition with physician/APN/PA staff at the receiving facility. • Select N (No) if there is no documentation of the ED physician/APN/PA discussion of the patient's condition with physician/APN/PA at the receiving facility.	○ Yes ○ No

ED Transfer Communication Quality Measure 2 (EDTC-2): Patient Information

Does the medical record documentation indicate that the following patient information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

3	**Patient Name** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's name was sent to the receiving facility. • Select N (No) if there is no documentation that the patient's name was sent to the receiving facility. • Select N/A (Not Applicable) if this information was not available.	○ Yes ○ No ○ N/A
4	**Patient Address** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's address was sent to the receiving facility. • Select N (No) if there is no documentation that the patient's address was sent to the receiving facility. • Select N/A (Not Applicable) if this information was not available.	○ Yes ○ No ○ N/A
5	**Patient Age** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's age was sent to the receiving facility. • Select N (No) if there is no documentation that the patient's age was sent to the receiving facility. • Select N/A (Not Applicable) if this information was not available.	○ Yes ○ No ○ N/A
6	**Patient Gender** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's gender was sent to the receiving facility. • Select N (No) if there is no documentation that the patient's gender was sent to the receiving facility. • Select N/A (Not Applicable) if this information was not available or unable to be determined.	○ Yes ○ No ○ N/A
7	**Patient Contact Information (family member/significant other/friend)** (Data Specifications) • Select Y (Yes) if there is documentation that contact information was sent to the receiving facility. • Select N (No) if there is no documentation that contact information was sent to the receiving facility. • Select N/A (Not Applicable) if this information was not available.	○ Yes ○ No ○ N/A
8	**Patient Insurance Information** (Data Specifications) • Select Y (Yes) if there is documentation that insurance information was sent to the receiving facility. • Select N (No) if there is no documentation that insurance information was sent to the receiving facility. • Select N/A (Not Applicable) if this information was not available.	○ Yes ○ No ○ N/A

ED Transfer Communication Quality Measure 3 (EDTC-3): Vital Signs

Does the medical record documentation indicate that the following patient's vital signs were taken and the information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

9	**Pulse** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's pulse was taken and sent to the receiving facility. • Select N (No) if there is no documentation that the patient's pulse was taken and or sent to the receiving facility.	○ Yes ○ No
10	**Respiratory Rate** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's respiratory rate was taken and sent to the receiving facility. • Select N (No) if there is no documentation that the patient's respiratory rate was taken and sent to the receiving facility.	○ Yes ○ No
11	**Blood Pressure** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's blood pressure was taken and sent to the receiving facility. • Select N (No) if there is no documentation that the patient's blood pressure was taken and sent to the receiving facility. • Select N/A (Not Applicable) if the patient is less than or equal to 3 years of age. Select this option if a Blood Pressure is unable to be assessed due to patients' behavior or mental status.	○ Yes ○ No ○ N/A
12	**Oxygen Saturation** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's oxygen saturation (O2 Sat) was taken and was sent to the receiving facility. • Select N (No) if there is no documentation that the patient's oxygen saturation (O2 Sat) was taken and sent to the receiving facility.	○ Yes ○ No
13	**Temperature** (Data Specifications) • Select Y (Yes) if there is documentation that the patient's temperature was taken and the temperature was sent to the receiving facility. • Select N (No) if there is no documentation that the patient's temperature was taken and sent to the receiving facility. • Select N/A (Not Applicable) if the temperature is not required. See notes for abstraction.	○ Yes ○ No ○ N/A
14	**Neurological Assessment** (Data Specifications) • Select Y (Yes) if there is documentation that a neuro assessment was done and sent to the receiving facility. • Select N (No) if there is no documentation that a neuro assessment for the condition was done and sent to the receiving facility. • Select N/A (Not Applicable) if a neurologic assessment is not required due to no documentation of altered consciousness, possible brain/head injury, trauma or post seizure, stroke, TIA.	○ Yes ○ No ○ N/A

ED Transfer Communication Quality Measure 4 (EDTC-4): Medication Information

Does the medical record documentation indicate that the following patient's medication information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

15	**Medications Administered in ED** (Data Specifications) • Select Y (Yes) if there is documentation that medications administered were sent to the receiving facility. • Select N (No) if there is no documentation that the medications administered were sent to the receiving facility.	○ Yes ○ No
16	**Allergies/Reactions** (Data Specifications) • Select Y (Yes) if there is documentation the patient's allergy information was sent to the receiving facility. • Select N (No) if there is no documentation the patient's allergy information was sent to the receiving facility.	○ Yes ○ No
17	**Home Medications** (Data Specifications) • Select Y (Yes) if there is documentation medication history was sent to the receiving facility. • Select N (No) if there is no documentation medication history was sent to the receiving facility.	○ Yes ○ No

ED Transfer Communication Quality Measure 5 (EDTC-5): Physician or Practitioner Generated Information

Does the medical record documentation indicate that the following physician or practitioner generated information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

18	**History and Physical** (Data Specifications) • Select Y (Yes) if there is documentation a history and physical was done and sent to the receiving facility. • Select N (No) if there is no documentation that a history and physical was done and sent to the receiving facility.	○ Yes ○ No
19	**Reason for Transfer/Plan of Care** (Data Specifications) • Select Y (Yes) if there is documentation a reason for transfer or plan of care was done and sent to the receiving facility. • Select N (No) if there is no documentation that a reason for transfer or plan of care was done and sent to the receiving facility.	○ Yes ○ No

ED Transfer Communication Quality Measure 6 (EDTC-6): Nurse Generated Information

Does the medical record documentation indicate that the following nurse generated information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

20	**Nursing Notes** (Data Specifications) • Select Y (Yes) if there is documentation that nursing notes were sent to the receiving facility. • Select N (No) if there is no documentation that nursing notes were sent to the receiving facility.	○ Yes ○ No
21	**Sensory Status (formerly Impairments)** (Data Specifications) • Select Y (Yes) if there is documentation that assessment of impairment was done and information was sent to the receiving facility. • Select N (No) if there is no documentation that assessment of impairment was done and information was sent to the receiving facility.	○ Yes ○ No
22	**Catheters/IV** (Data Specifications) • Select Y (Yes) if there is documentation that catheter information was sent to the receiving facility. • Select N (No) if there is no documentation that catheter information was sent to the receiving facility. • Select N/A (Not Applicable) if no catheters were placed.	○ Yes ○ No ○ N/A
23	**Immobilizations** (Data Specifications) • Select Y (Yes) if there is documentation that immobilization was done and information was sent to the receiving facility. • Select N (No) if there is documentation that immobilization was done and information was not sent to the receiving facility. • Select N/A (Not Applicable) if no immobilization was done.	○ Yes ○ No ○ N/A
24	**Respiratory Support** (Data Specifications) • Select Y (Yes) if there is documentation that respiratory support was provided and information was sent to the receiving facility. • Select N (No) if documentation that respiratory support was provided and information was not sent to the receiving facility. • Select N/A (Not Applicable) if no respiratory support was provided.	○ Yes ○ No ○ N/A
25	**Oral Restrictions** (Data Specifications) • Select Y (Yes) if there is documentation that oral restriction were placed and information was sent to the receiving facility. • Select N (No) if there is no documentation that oral restriction were placed and information was sent to the receiving facility. • Select N/A (Not Applicable) if no oral restrictions were placed.	○ Yes ○ No ○ N/A

ED Transfer Communication Quality Measure 7 (EDTC-7): Procedures and Tests

Does the medical record documentation indicate that the following procedures and tests information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient's discharge?

26	**Tests/Procedures Performed** (Data Specifications) • Select Y (Yes) if there is documentation that information on all tests and procedures completed in the ED prior to transfer was sent to the receiving facility. • Select N (No) if there is no documentation that information on all tests and procedures completed in the ED prior to transfer was sent to the receiving facility. • Select N/A (Not Applicable) if no tests or procedures were done.	○ Yes ○ No ○ N/A
27	**Tests/Procedures Results** (Data Specifications) • Select Y (Yes) if there is documentation of results being sent either with the patient or communicated to the receiving facility when available. • Select N (No) if there is no documentation of results being sent either with the patient or communicated to the receiving facility when available. • Select N/A (Not Applicable) if no tests or procedures were done.	○ Yes ○ No ○ N/A

Emergency Department Transfer Communication
Hospital Report

CMS Certified Number (CCN):

Measures	Data Elements	#VALUE! 1/1/ #NAME?	#VALUE! 4/1/ #NAME?	#VALUE! 7/1/ #NAME?	#VALUE! 10/1/ #NAME?
EDTC-1: Administrative Communication	Percentage of medical records that indicated the following occurred prior to patient departure from ED:				
	1. Nurse to Nurse Communication	#NAME?	#NAME?	#NAME?	#NAME?
	2. Physician to Physician Communication	#NAME?	#NAME?	#NAME?	#NAME?
	All EDTC-1 Data Elements	#NAME?	#NAME?	#NAME?	#NAME?
EDTC - 2 Patient Information	Percentage of medical records that indicated the communication of following patient information within 60 minutes of patient's departure from ED:				
	1. Patient Name	#NAME?	#NAME?	#NAME?	#NAME?
	2. Patient Address	#NAME?	#NAME?	#NAME?	#NAME?
	3. Patient Age	#NAME?	#NAME?	#NAME?	#NAME?
	4. Patient Gender	#NAME?	#NAME?	#NAME?	#NAME?
	5. Patient Contact Information	#NAME?	#NAME?	#NAME?	#NAME?
	6. Patient Insurance Information	#NAME?	#NAME?	#NAME?	#NAME?
	All EDTC-2 Data Elements	#NAME?	#NAME?	#NAME?	#NAME?
EDTC - 3 Vital Signs	Percentage of medical records that indicated the communication of following patient's vital signs information within 60 minutes of patient's departure from ED:				
	1. Pulse	#NAME?	#NAME?	#NAME?	#NAME?
	2. Respiratory Rate	#NAME?	#NAME?	#NAME?	#NAME?
	3. Blood Pressure	#NAME?	#NAME?	#NAME?	#NAME?
	4. Oxygen Saturation	#NAME?	#NAME?	#NAME?	#NAME?
	5. Temperature	#NAME?	#NAME?	#NAME?	#NAME?
	6. Neurological Assessment	#NAME?	#NAME?	#NAME?	#NAME?
	All EDTC-3 Data Elements	#NAME?	#NAME?	#NAME?	#NAME?
EDTC - 4 Medication Information	Percentage of medical records that indicated the communication of following patient's medication information within 60 minutes of patient's departure from ED:				
	1. Medication Given in ED	#NAME?	#NAME?	#NAME?	#NAME?
	2. Allergies/Reactions	#NAME?	#NAME?	#NAME?	#NAME?
	3. Medication History	#NAME?	#NAME?	#NAME?	#NAME?
	All EDTC-4 Data Elements	#NAME?	#NAME?	#NAME?	#NAME?
EDTC - 5: Physician or Practitioner Generated Information	Percentage of medical records that indicated the communication of following physician generated information within 60 minutes of patient's departure from ED:				
	1. History and Physical	#NAME?	#NAME?	#NAME?	#NAME?
	2. Reason for Transfer/Plan of Care	#NAME?	#NAME?	#NAME?	#NAME?
	All EDTC-5 Data Elements	#NAME?	#NAME?	#NAME?	#NAME?
EDTC - 6 Nurse Generated Information	Percentage of medical records that indicated the communication of following nurse generated information within 60 minutes of patient's departure from ED:				
	1. Nursing Notes	#NAME?	#NAME?	#NAME?	#NAME?
	2. Sensory Status (formerly Impairments)	#NAME?	#NAME?	#NAME?	#NAME?
	3. Catheters/IV	#NAME?	#NAME?	#NAME?	#NAME?
	4. Immobilizations	#NAME?	#NAME?	#NAME?	#NAME?
	5. Respiratory Support	#NAME?	#NAME?	#NAME?	#NAME?
	6. Oral Restrictions	#NAME?	#NAME?	#NAME?	#NAME?
	All EDTC-6 Data Elements	#NAME?	#NAME?	#NAME?	#NAME?
EDTC - 7 Procedures and Tests	Percentage of medical records that indicated the communication of following procedures and tests information within 60 minutes of patient's departure from ED:				
	1. Tests/Procedures Performed	#NAME?	#NAME?	#NAME?	#NAME?
	2. Tests/Procedures Results	#NAME?	#NAME?	#NAME?	#NAME?
	All EDTC-7 Data Elements	#NAME?	#NAME?	#NAME?	#NAME?
All EDTC Measures	Percentage of medical records that indicated the communication of all necessary patient's data upon patient's departure from ED:				
	All EDTC Measures	#NAME?	#NAME?	#NAME?	#NAME?

Public Data Reporting Systems

- **QualityNet Registration**
- **CART Outpatient User Guide**
- **NHSN Facility Administrator Enrollment Guide**

Getting Started in QualityNet

- **Register with QualityNet**

  First, a hospital must register for a QualityNet Account. That is done by going to QualityNet and setting up at least one QualityNet Security Administrator (SA). It is highly recommended that hospitals designate at least two QualityNet SAs – one to serve as the primary QualityNet SA and the other to serve as backup.

  Download and complete the registration packet and mail to the address indicated in the instructions. You will be notified by e-mail when registration is complete and your QualityNet account has been activated. The e-mail will also contain your User ID. A Temporary Password will be sent in a separate e-mail. You will need both to complete enrollment for access to the QualityNet Secure Portal.

QualityNet Security Administrator Registration

Hospitals
It is highly recommended that each organization designate **two** people as **QualityNet Security Administrators**.
To register as a QualityNet Security Administrator:
1.Download the **QualityNet Security Administrator Registration Packet** (PDF-78 KB).

2.Follow the instructions for completing the Registration Form and Authorization Form. The Registration Form. The Authorization Form must be completed by the highest level executive at your organization.

3.Mail the original, completed forms (keeping a copy for your records) to:
QualityNet Help Desk
12000 Ridgemont Drive
Urbandale, IA 50323-2317
You will be notified by e-mail when registration is complete and your QualityNet account has been activated. The e-mail will also contain your **User ID**. A **Temporary Password** will be sent in a separate e-mail. You will need both to complete enrollment for access to the QualityNet Secure Portal.

Getting Started in QualityNet (cont.)

- **Access the Quality Net Portal**

  For access to the QualityNet Secure Portal, complete the New User Enrollment Process. As part of the process, you'll be asked to change your password and answer a set of security questions.

- **Maintain an Active QualityNet Security Administrator (SA)**

  Hospitals are required to maintain an active QualityNet SA. To maintain an active account it is recommended that QualityNet SAs log into their account at least once per month. If an account is not logged into for 120 days it will be disabled. Once an account is disabled, the user will need to contact the QualityNet Help Desk to have their account reset.

QualityNet Secure Portal
New User Enrollment

The QualityNet Secure Portal houses various applications for the Center for Medicare & Medicaid Services' (CMS's) quality reporting programs.

To access the portal, you must first complete registration as a **QualityNet user.** (Select the appropriate user community from the QualityNet Registration sidebar at the upper left of the QualityNet Home page.) After receiving your User ID and Temporary Password, sign in to the QualityNet Secure Portal to change your password and answer the security questions. The **User ID** and **Password** will be required for logging in to the portal.

Next, complete the New User Enrollment Process and first-time login procedure outlined below. (See Section 5 of the QualityNet User Guide for more detailed instructions.)

Enrollment, first-time login

To enroll for access to the QualityNet Secure Portal:

From the **Symantec ID Protection Center**, download the Symantec **VIP Access Desktop application** to your computer, tablet, and/or smartphone. (Enter **m.vip.symantec.com** in the browser on your mobile device). This may require the approval and assistance of your organization's information technology staff. You will need the static Credential ID and the dynamic Security Code generated by this application to complete your enrollment.

Log in to the **QualityNet Secure Portal**

Click **Start/Complete New User Enrollment** in the yellow **Help** box.

Follow the six-step process to verify your identity. You will use the PreciseID service from Experian, an external service selected by CMS, to confirm your identity by providing personal information via a safe, encrypted process that, in turn, produces verification questions. (See the Experian PreciseID℠ website for more information on this verification process.)

After completing identity verification, enter the **Credential ID** and the **Security Code** (within 30 seconds) generated by the Symantec VIP Access application. This will link your QualityNet user ID to your Symantec VIP Access credential.

You may now log in to the **QualityNet Secure Portal**.

Getting Started in QualityNet (cont.)

- **Complete a Notice of Participation (NoP)**

  In order for a hospital to have their data publicly reported a NoP must be completed. A NoP must be completed for both inpatient and outpatient reporting. NoPs are not required for participation in the Medicare Beneficiary Quality Improvement Project (MBQIP), but must be completed for data submitted to QualityNet to appear on Hospital Compare. To verify if your hospital has completed a NoP, or needs to complete a NoP for the first time:

  a. Log into the QualityNet Secure Portal.

  b. Under Quality Programs select Hospital Quality Reporting. This will bring up the My Tasks page.

  c. In the box titled Manage Notice of Participation click on View/Edit Notice of Participation, Contacts and Campuses.

  d. Follow the instructions to see your hospital's status. Once your hospital's NoP is accepted, it remains active unless your hospital changes its pledge status.

National Helathcare Safety Network (NHSN) Reporting

- **Enroll Hospital in NHSN**
  To report these measures, your hospital must be enrolled in NHSN. If you are unsure of your hospital's status with NHSN, email them at: nhsn@cdc.gov

  If your hospital is not already enrolled in NHSN, the instructions for enrollment are located http://www.cdc.gov/nhsn/acute-care-hospital/enroll.html

- **Gather Influenza Vaccination Data**
  Hospitals report healthcare personnel (HCP) influenza vaccination coverage in the Healthcare Personnel Safety Component of NHSN. The HCP Influenza Vaccination Summary Protocol is a guide to collecting and reporting influenza vaccination summary data for the HCP Vaccination Module.

- **Submit HCP Influenza Vaccination Summary Data**
  Hospitals are only required to report HCP Influenza Vaccination Summary Data in NHSN once a year, at the conclusion of the reporting period (October 1 through March 31). Resources and instructions on how hospitals submit HCP influenza data can be found Surveillance for Healthcare Personnel Vaccination webpage.

Using Data Reports to Improve Hospital Outcomes

- Quality Improvement Toolkit for EDTC Measures (Sratis Health)
- HCAHPS Survey
- EDTC Report
- Hospital Compare

REFERENCES

CMS Outpatient Specification Manual: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244

National Healthcare Safety Network - Healthcare Personnel Vaccination: http://www.cdc.gov/nhsn/acute-care-hospital/hcp-vaccination/index.html#cms

CMS Inpatient Specification Manual: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099

Emergency Department Transfer Communication Measure Data Collection Guide and Resources: http://www.stratishealth.org/providers/ED_Transfer.html

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): http://www.hcahpsonline.org/home.aspx