Prospective Payment System-exempt Cancer Hospital Quality Reporting (PCHQR) Program Public Reporting Preview Help Guide

January 2024 Public Reporting Preview/
April 2024 Provider Data Catalog Release

Hospitals participating in the PCHQR Program are the target audience for this publication.

The document scope is limited to instructions for hospitals to access and interpret the data provided on the Public Reporting User Interface (UI) prior to the publication of data on Provider Data Catalog website.

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Overview

Section 1886(s)(4)(E) of the Social Security Act requires the Secretary of the United States Department of Health and Human Services to establish procedures for making the data submitted under the PCHQR Program available to the public.

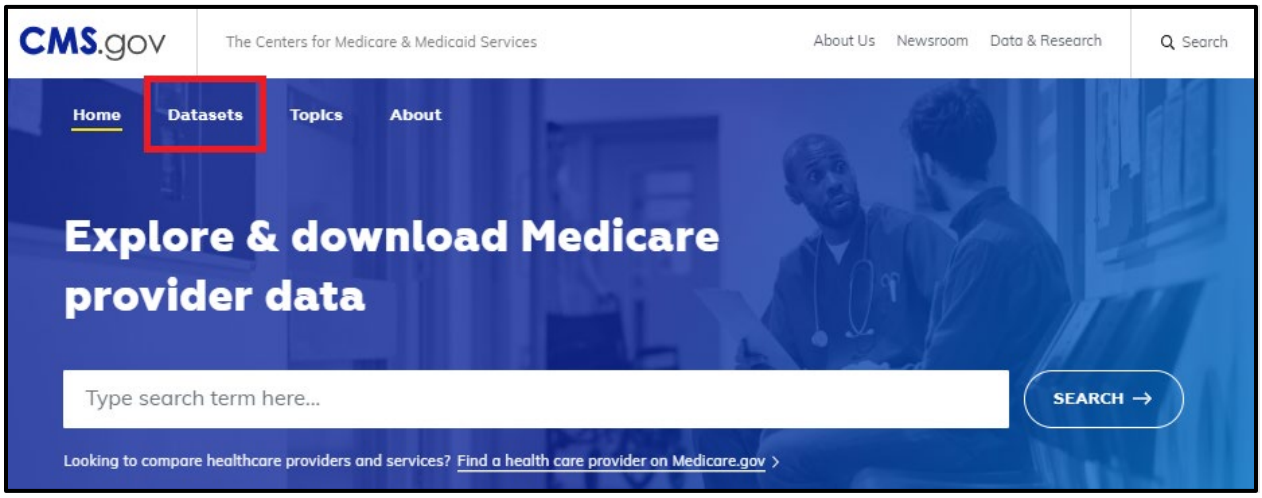
On September 3, 2020, the Centers for Medicare & Medicaid Services (CMS) announced that new Compare tools were available on Medicare.gov. They are Care Compare on Medicare.gov and Provider Data Catalog (PDC) (https://data.cms.gov/provider-data/).

On December 1, 2020, CMS retired the Hospital Compare tool, the location of PCH data. The PDC site is the location for PCH data. The PDC site can be accessed at https://data.cms.gov/provider-data/.

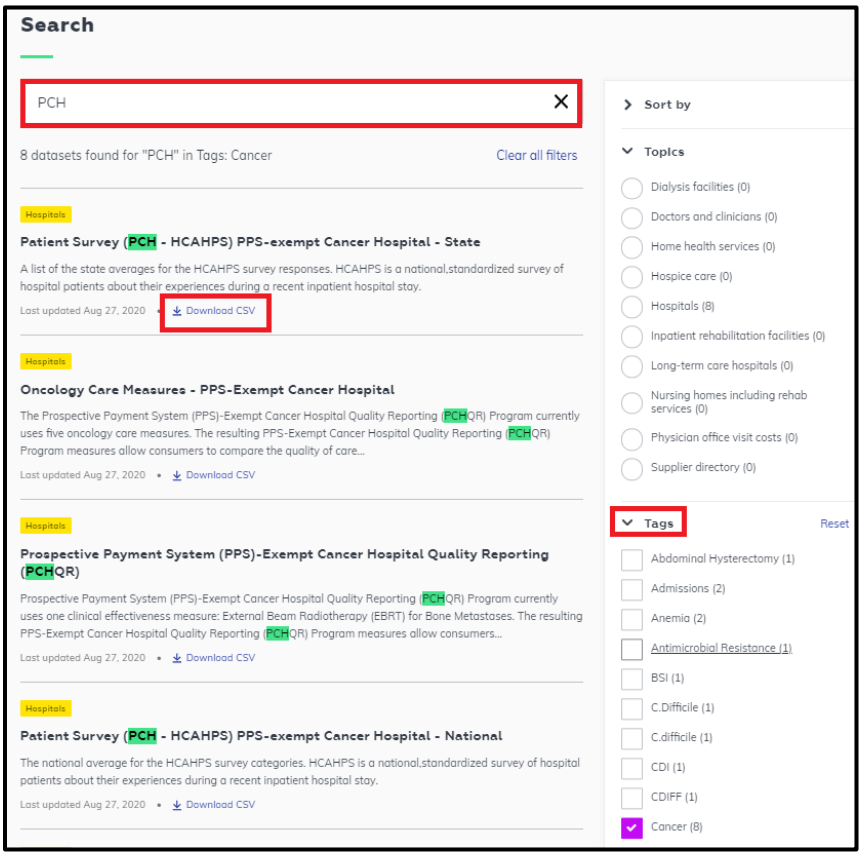
Provider Data Catalog (PDC)

Navigating the data catalog on data.cms.gov.

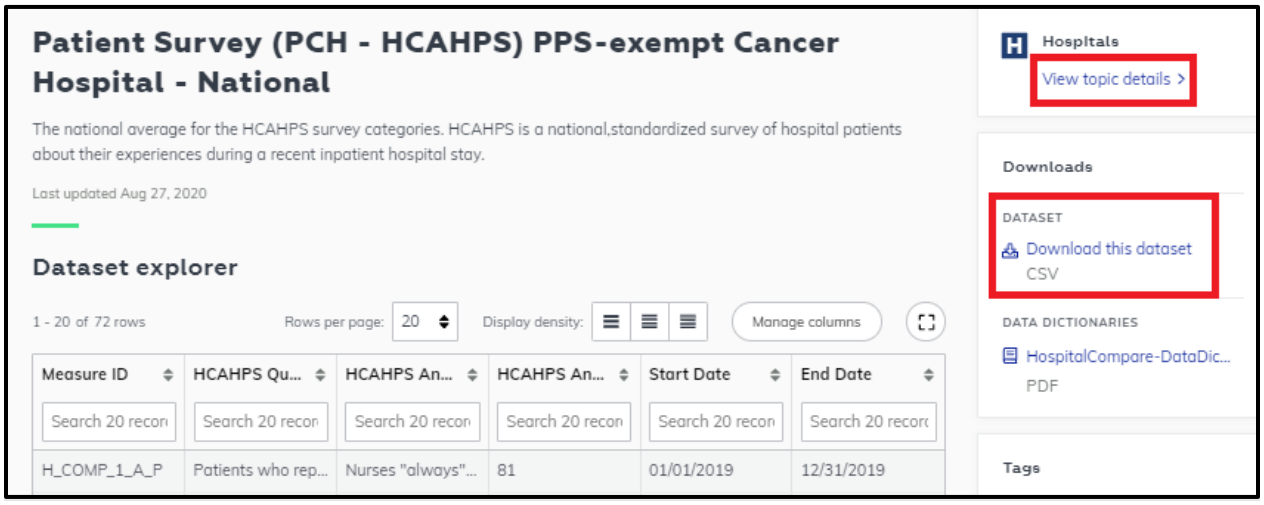
1. Select **Datasets** on the home page.



2. On the Landing page, users will be able to easily view data sets. This page is an interactive search window listing of all the data sets with sorting and filtering options.



3. Users can easily download the dataset into a Comma-Separated Value (CSV) format. Users should select the dataset's title for the specific dataset page. Users can view the publicly displayed data on the Dataset explorer.



4. On the view topic details page, users are able to view and download achieved dataset data as well as gather additional information and background regarding the data.

PCHQR Program

The Social Security Amendments of 1983 exempted certain classified cancer hospitals from the Medicare inpatient prospective payment system (IPPS). These PCHs were also exempted from reporting on hospital inpatient quality measures. In 2010, the Affordable Care Act required CMS to establish a specialized quality reporting program for the PCHs. The resulting PCHQR Program measures allow consumers to compare the quality of care given at the 11 PCHs currently participating in the program.

Section 3005 of the Affordable Care Act added sections 1866(a)(1)(W) and (k). Section 1866(k) of the Act established a quality reporting program for hospitals described in section 1886(d)(1)(B)(v) of the Act (referred to as "PPS-Exempt Cancer Hospitals" or "PCHs") that specifically applies to PCHs that meet the requirements under 42 CFR 412.23(f) and 42 CFR 412.24. Section 1866(k)(1) of the Act states that, for fiscal year (FY) 2014 and each subsequent fiscal year, a PCH must submit data to the Secretary in accordance with section 1866(k)(2) of the Act with respect to such fiscal year.

For additional background information, including previously finalized measures and other policies for the PCHQR Program, please refer to the following final rules: FY 2013 IPPS/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (77 *Federal Register* [FR] 53555–53567); FY 2014 IPPS/LTCH PPS final rule (78 FR 50837–50853); FY 2015 IPPS/LTCH PPS final rule (79 FR 50277–50286); FY 2016 IPPS/LTCH PPS final rule (80 FR 49713–49723); FY 2017 IPPS/LTCH PPS final Rule (81 FR 57182–57193); FY 2018 IPPS/LTCH PPS final rule (82 FR 38411–38425); FY 2019 IPPS/LTCH PPS final rule (83 FR 41609–41624); FY 2020 IPPS/LTCH PPS final rule (84 FR 42509–42524); FY 2021 IPPS/LTCH PPS final rule (85 FR 58959–58965); and the FY 2022 IPPS/LTCH PPS final rule (87 FR 49311–49314)

Preview Period

Prior to publicly reporting data, hospitals are given the opportunity to review data during a 30-day preview period. The data anticipated for the release can be accessed via QualityNet, the only CMS-approved website for secure healthcare quality data exchange, located at https://qualitynet.cms.gov/.

Public Reporting Preview UI

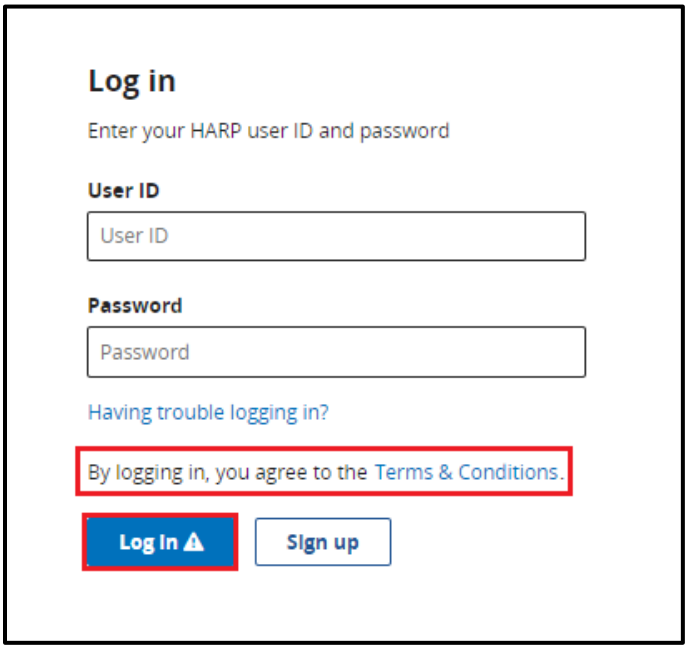
The Preview UI was developed to allow providers increased flexibility in reviewing their data.

Users must have a Health Care Quality Information Systems Access Roles and Profile (HARP) account to access the UI. If you do NOT have a HARP account, please sign into the Hospital Quality Reporting (HQR) System on QualityNet (https://qualitynet.cms.gov/) to create one.

The Centers for Medicare & Medicaid Services (CMS) announced that beginning on May 11, 2022, the HQR System no longer supports the use of Internet Explorer. To avoid technical issues when logging into the HQR System, please begin using Google Chrome or Microsoft Edge.

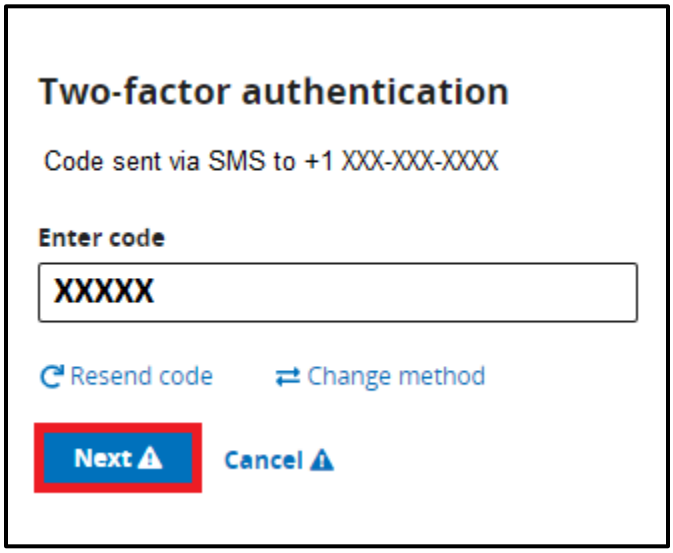
Follow the instructions below to access the UI:

1. Access the Hospital Quality Reporting page for QualityNet at https://hqr.cms.gov/hqrng/login.
2. Enter your HARP User ID and Password. By logging in, you agree to the Terms & Conditions. Then, select **Login**.

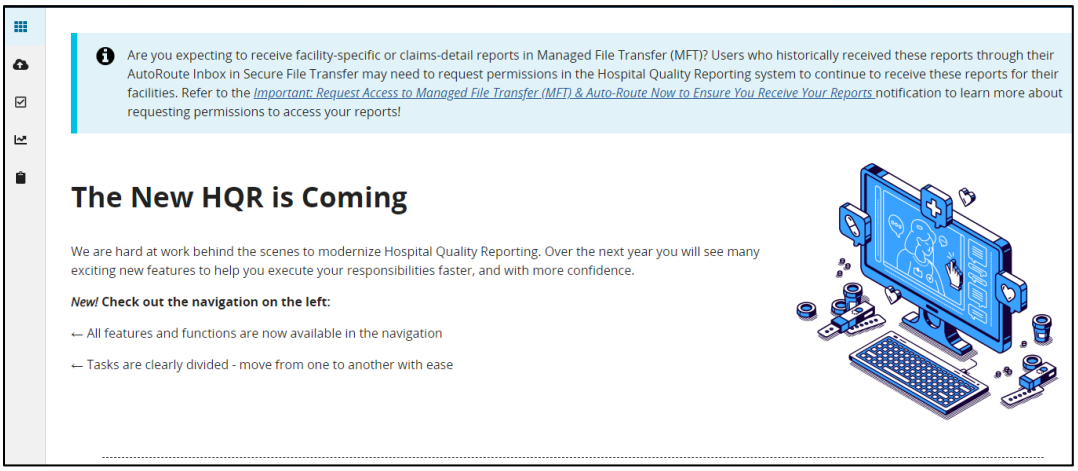


3. You will be directed to the **Two-Factor Authorization page**. Select the device you would like to verify via **Text** or **Email.** Select **Next**.

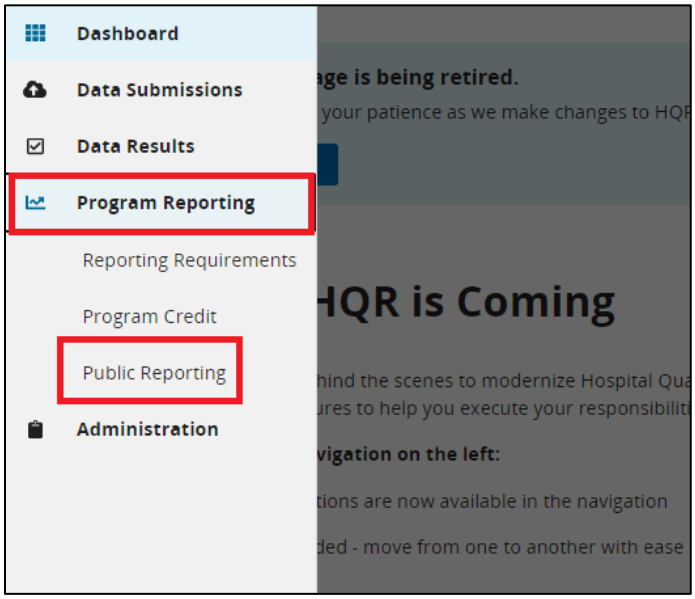
4. Once you receive the code via **Text** or **Email**, enter it. Select **Next**.



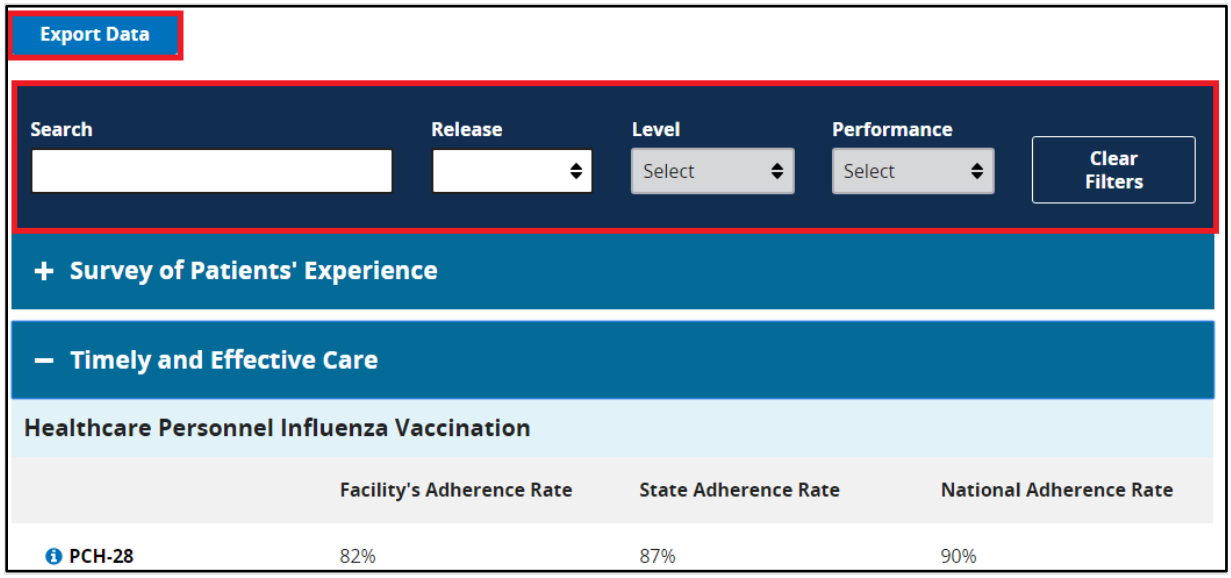
5. On the **HQR landing** page, hover over Lock Menu on the left side.



6. Select **Program Reporting.**



7. From the drop-down menu, select **Public Reporting.**
8. The page will refresh, and the data will be available to preview.
9. Your provider name and CMS Certification Number (CCN) will appear at the top of the Preview UI. The **Change Organization Button** is available to users with roles associated with multiple facilities to see a different provider's data.
10. There are two tabs: Measure Data and Star Rating.
11. Within the Preview UI, users will be able to easily view their data. This page is an interactive analogue to the traditional PDFs. On this page, users can view measures associated by Measure Group, search the entire page for individual measures, dynamically filter through data, and export measure data. The exported measure data will be in PDF format for a user-friendly printed report. Data will be retained following the 30-day preview for future reference.



Export Data - Users will be able to export measure data into a PDF format for a user-friendly printed report.

Search - Enter specific measures into this field and the table will dynamically filter for the appropriate content.

Filtering - Users will be able to filter their benchmark data in the following ways:

- Release - Select the release data to be viewed.
- Level - Filter whether your facility's data will be compared to the "State" or "National" average during filtering. This functionality is disabled currently and will be activated in a future release.
- Performance - Filter your facility's data for being "Above," "Below," or the "Same" as previous Level selections. This functionality is disabled currently and will be activated in a future release.

PR Data Details

Hospital Characteristics

The Preview UI PDF export displays your hospital CCN and name above the hospital characteristics. Hospital characteristics include your hospital's address, city, state, ZIP Code, phone number, county, type of facility, type of ownership, and emergency service provided status.

Type of ownership is publicly available only in the downloadable database on PDC.

If the displayed hospital characteristics are incorrect, your hospital should contact your state Certification and Survey Provider Enhanced Reports agency coordinator to correct the information. For questions regarding the ASPEN State Contact list for Hospitals, please refer to the CMS Minimum Data Set Contacts.

Rounding Rules

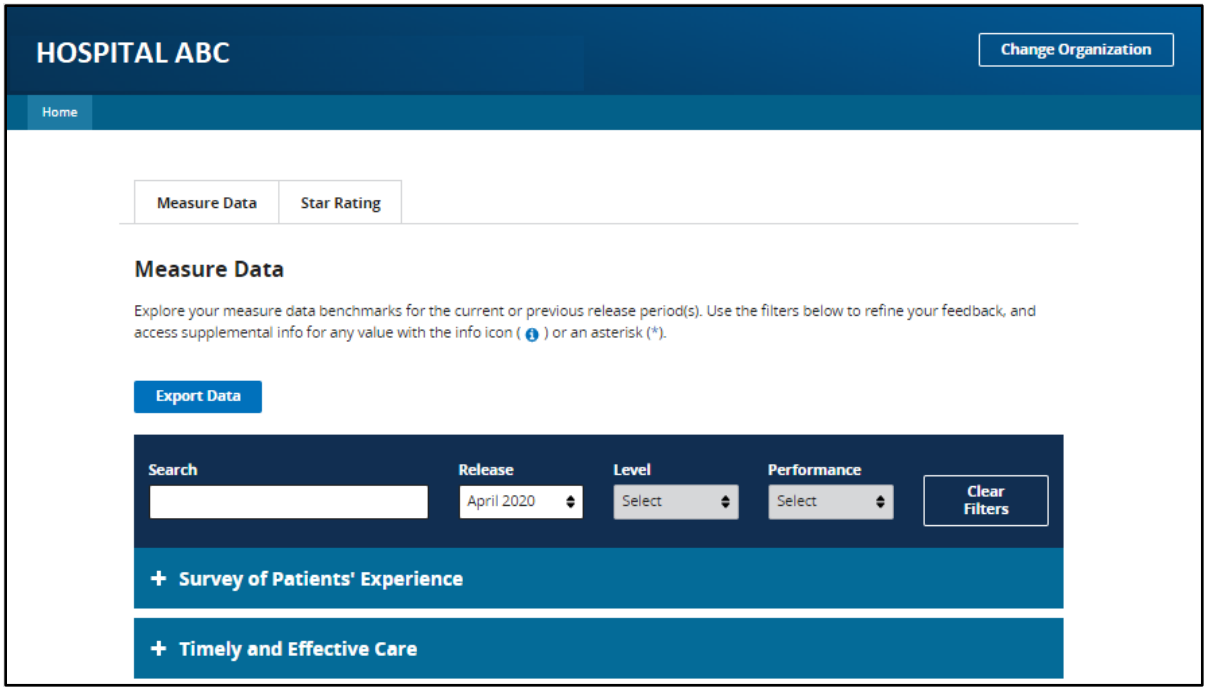
All percentage and median time calculations (provider, state, and national) are rounded to the nearest whole number using the following rounding logic, unless otherwise stated:

- Above **[x.5]**, round up to the nearest whole number.
- Below **[x.5]**, round down to the nearest whole number.
- Exactly **[x.5]** and "x" is an even number, round down to the nearest whole, even number. (Rounding to the even number is a statistically accepted methodology.)
- Exactly **[x.5]** and "x" is an odd number, round up to the nearest whole, even number. (Rounding to the even number is a statistically accepted methodology.)

PCH Preview Details

Measure Data Tab

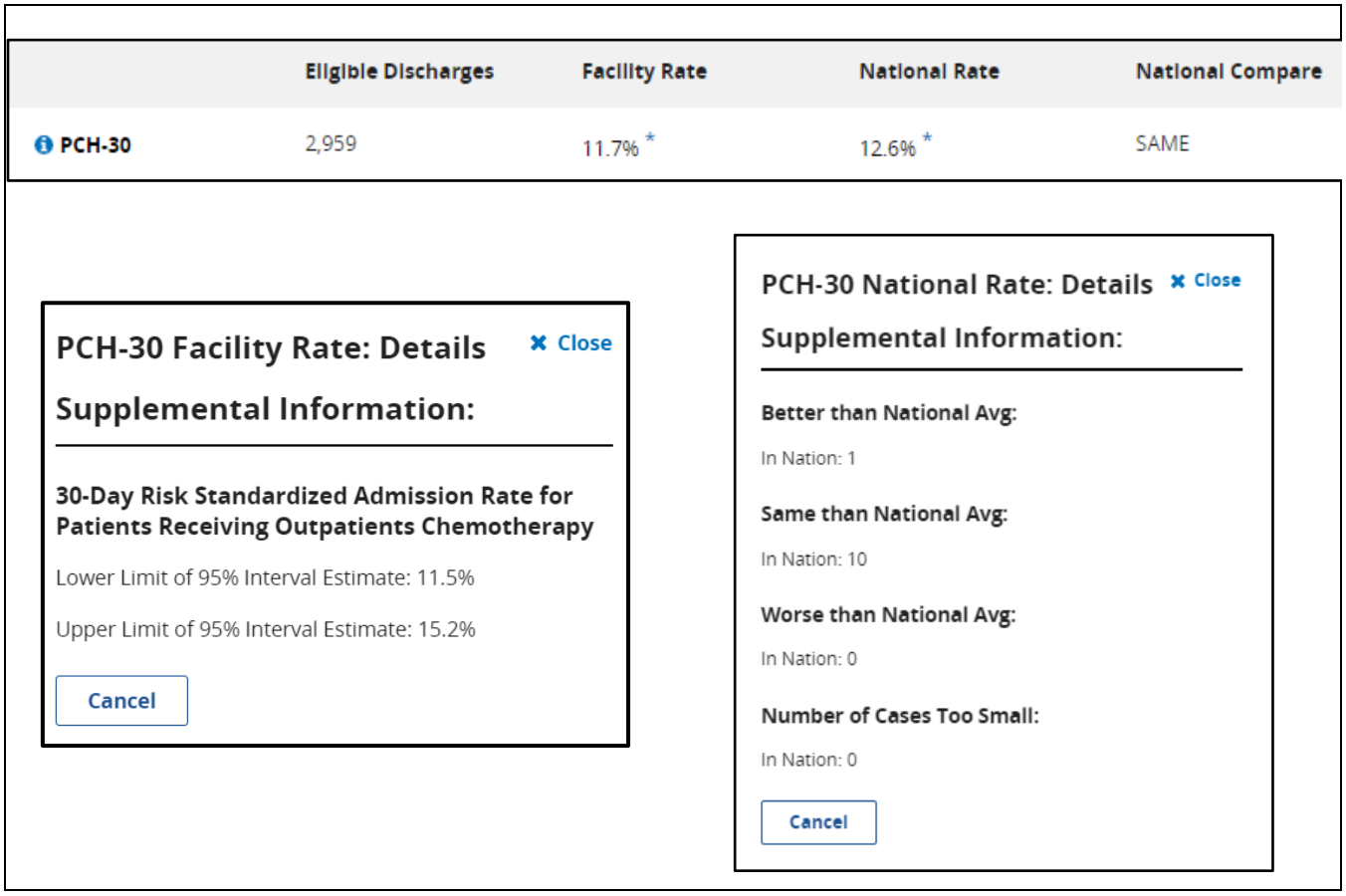
The **Measure Data** tab will display accordions and measures based on the user's HQR portal access.



The accordions can be expanded by selecting the (+) to the left of the title. Selecting the (-) will collapse the table. Once the accordion is expanded, the measures and data will display.

Select the info icon ( ) to the left of the measure ID to display the full measure description in a modal.

Data will display with an asterisk (*). Selecting the data value by the asterisk will pop up a modal with additional details about the data, such as a footnote.



Accordions

+SURVEY OF PATIENT'S EXPERIENCE
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Patient Experience Data (HCAHPS)

All IPPS hospitals must continuously collect and submit HCAHPS data in order to qualify for the full annual payment update. All participating hospitals receive a preview report. Non-IPPS hospitals have the option of withholding HCAHPS results from being publicly reported on Care Compare on Medicare.gov. Hospitals participating in the Hospital Inpatient Quality Reporting Program may not withhold HCAHPS results.

The HCAHPS Survey data contain survey results that display as aggregate results. Each hospital's aggregate results are compared to state and national averages. Also, the preview data contain each hospital's number of completed surveys and survey response rate for the reporting period.

Note: The HCAHPS scores contained in the April 2024 Public Reporting Preview Report are based on patients discharged between July 1, 2022, and June 30, 2023.

HCAHPS Star Ratings

HCAHPS Star Ratings are based on the quarters of survey data in the preview. Hospitals will receive an HCAHPS Star Rating (1, 2, 3, 4, or 5 stars) for each of the 10 HCAHPS measures plus the HCAHPS Summary Star Rating, which is a single summary of all the HCAHPS Star Ratings. The Preview data also contain the linear mean scores that are used in the calculation of the HCAHPS Star Ratings. For additional information on HCAHPS Star Ratings and linear mean scores, please see the HCAHPS Star Ratings section on the official HCAHPS website, http://www.hcahpsonline.org.

Note: Beginning with October 2019 public reporting, Composite 4 (Pain Communication) and the two associated individual questions (Q13 and Q14) was removed from the Public Reporting Preview UI. As a result, subsequent questions were renumbered and are consistent with the October 2019 survey questions. HCAHPS Composites, Individual Items, Global Items, and individual questions in the accordion include:

- HCAHPS Composites
  - Composite 1 – Communication with Nurses (Question Q1, Q2, Q3)
    - Q1 – Nurse Courtesy & Respect
    - Q2 – Nurse Listen
    - Q3 – Nurse Explain
  - Composite 2 – Communication with Doctors (Q5, Q6, Q7)
    - Q5 – Doctor Courtesy & Respect
    - Q6 – Doctor Listen
    - Q7 – Doctor Explain
  - Composite 3 – Responsiveness of Hospital Staff (Q4, Q11)
    - Q4 – Call Button
    - Q11 – Bathroom Help

  - Composite 5 – Communication about Medicines (Q13, Q14)
    - Q13 – Medicine Explain
    - Q14 – Side Effects

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

- Discharge Information Composite
  - Composite 6 – Discharge Information (Q16, Q17)
    - Q16 – Help After Discharge
    - Q17 – Symptoms

- Care Transition Composite
  - Composite 7 – Care Transition (Q20, Q21, Q22)
    - Q20 – Preferences
    - Q21 – Understanding
    - Q22 – Medicine Purpose

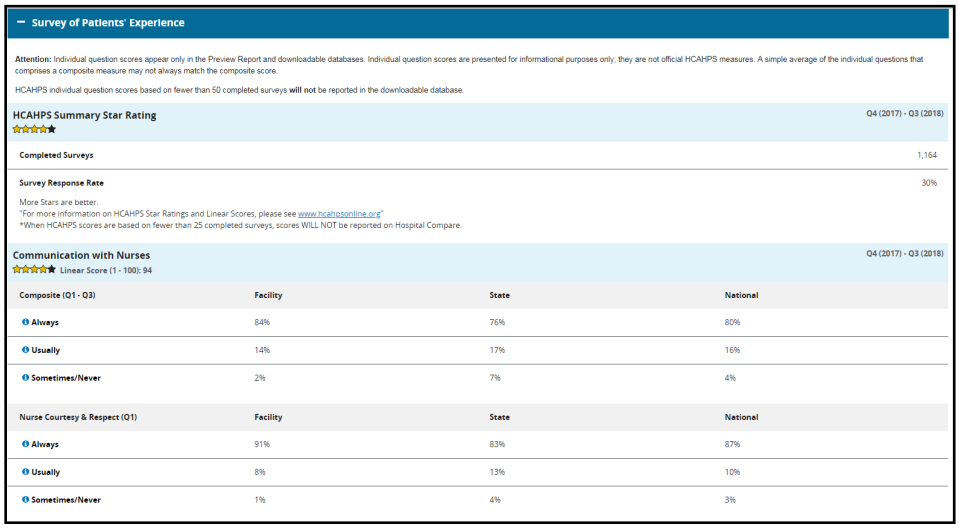
The HCAHPS Global Items include:

- Hospital Rating (Q18)
- Recommend this Hospital (Q19)

Hospitals must have at least 100 completed surveys in order to receive HCAHPS Star Ratings.

- HCAHPS Star Ratings are provided for each of the six composite measures, two environment items, and two global items.
- Whole stars (1, 2, 3, 4, or 5) are assigned to each of the 10 HCAHPS measures, plus the HCAHPS Summary Star Rating.

Linear Mean Scores: HCAHPS linear mean scores are provided for each of the six composite measures, two environment items, and two global items. The scores are available in the downloadable database on PDC.



Survey of Patients' Experience

Attention: Individual question scores appear only in the Preview Report and downloadable databases. Individual question scores are presented for informational purposes only; they are not official HCAHPS measures. A simple average of the individual questions that comprises a composite measure may not always match the composite score.

HCAHPS individual question scores based on fewer than 50 completed surveys **will not** be reported in the downloadable database.

HCAHPS Summary Star Rating — Q4 (2017) - Q3 (2018)

Completed Surveys	1,164
Survey Response Rate	30%

More Stars are better.
"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"
*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

Communication with Nurses — Q4 (2017) - Q3 (2018)
Linear Score (1 - 100): 94

Composite (Q1 - Q3)	Facility	State	National
Always	84%	76%	80%
Usually	14%	17%	16%
Sometimes/Never	2%	7%	4%

Nurse Courtesy & Respect (Q1)	Facility	State	National
Always	91%	83%	87%
Usually	8%	13%	10%
Sometimes/Never	1%	4%	3%

State and National Average Rates

State and national un-weighted average rates for each HCAHPS measure are calculated based on all data available in the HCAHPS Data Warehouse. State and national averages are not reported for the HCAHPS Star Ratings. The state and national averages include data from Department of Defense (DoD) hospitals and Veterans Health Administration (VHA) hospitals.

HCAHPS Individual Question Scores

Scores for the 15 individual questions on the HCAHPS Survey that are used to form the six HCAHPS composite measures will be included in the Public Reporting Preview UI.

- Hospitals must have at least 50 completed surveys for individual question scores to be shown in the downloadable database.
- HCAHPS individual question scores will NOT be reported on Care Compare.
- These individual question scores are included in the Preview UI and downloadable database:
  - Q1 – Nurse Courtesy & Respect
  - Q2 – Nurse Listen
  - Q3 – Nurse Explain
  - Q4 – Call Button
  - Q5 – Doctor Courtesy & Respect
  - Q6 – Doctor Listen
  - Q7 – Doctor Explain
  - Q11 – Bathroom Help
  - Q13 – Medicine Explain
  - Q14 – Side Effects
  - Q16 – Help After Discharge
  - Q17 – Symptoms
  - Q20 – Preferences
  - Q21 – Understanding
  - Q22 – Medicine Purpose

Note: HCAHPS individual question scores are presented for informational purposes only. They are not official HCAHPS measures. A simple average of the individual questions that comprise a composite measure may not match the composite score due to rounding, item weighting, and patient-mix adjustment.

+Timely and Effective Care

Healthcare Personnel Vaccination (PCH-28, PCH-38)

Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (PCH-28) includes the number of healthcare personnel contributing towards successful influenza vaccination adherence within the displayed time frame, regardless of clinical responsibility or patient contact. The Influenza Vaccination Adherence Percentage is calculated as the total number of healthcare personnel contributing to successful vaccination adherence divided by the total number of healthcare personnel who physically worked in the facility for at least one working day between October 1 through March 31 per the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) protocol.

COVID-19 Vaccination Coverage Among HCP (PCH-38) reflects data provided by the CDC for public reporting. Each quarter, the CDC will calculate quarterly COVID-19 HCP vaccination coverage rates for each facility by taking the average of the data from three weekly rates submitted by the facility for that quarter. For facilities that report more than one week per month, the last week of the reporting month will be used. The data will reflect a single quarter of data in each quarterly release and were first reported for the October 2022 Care Compare release reflecting Q4 2021 data. The April 2024 release displays Q2 2023 data.

Note: For the CDC to provide a facility's COVID-19 HCP data for public reporting, there must be at least one week per month submitted for the reporting quarter. For NHSN, the last day of the reported week determines the month. For example, data submitted for the week of January 29–February 4, 2023, counts for February, not January. For Quarter 1 of 2023, NHSN will only send a hospital's COVID-19 HCP data to CMS if there is at least one week of data that ends in January, one week of data that ends in February, and one week of data that ends in March.

PCH-28 and PCH-38 displays the following data:

- Facility's Adherence Rate
- State Adherence Rate
- National Adherence Rate

Timely and Effective Care			
Healthcare Personnel Vaccination			
	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
PCH-28 Q4 (2021) - Q1 (2022) Influenza Vaccination Coverage among Healthcare Personnel	98%	95%	80%
PCH-38 Q4 (2021) - Q4 (2021) COVID-19 Vaccination Coverage Among Healthcare Personnel	99.7%	95.2%	87.7%

Facility's Adherence Rate

The PCH-28 Facility's Adherence Rate is calculated as the total number of healthcare personnel in your hospital contributing to successful vaccination adherence divided by the total number of healthcare personnel who physically worked in the facility for at least one working day between October 1 through March 31 per NHSN protocol.

The PCH-38 Adherence Percentage is calculated as the total number of healthcare personnel who received complete primary series vaccination against COVID-19 since the date the vaccine was first available divided by the total number of eligible healthcare personnel among whom COVID-19 vaccination was not contraindicated per CDC's NHSN data collection instructions. Eligible healthcare personnel are defined as the number of healthcare personnel who are scheduled to work in the facility at least one day every week regardless of clinical responsibility or patient contact.

State Adherence Rate

State Adherence Rates are calculated as the total number of healthcare personnel in the state contributing to successful vaccination adherence divided by the total number of healthcare personnel in the state eligible to receive the vaccine per NHSN protocol.

For the COVID-19 HCP Vaccination State Adherence Rate, the denominator excludes HCP for whom COVID-19 vaccination was contraindicated per CDC's NHSN data collection instructions.

National Adherence Rate

National Adherence Rates are calculated as the total number of healthcare personnel in the nation contributing to successful vaccination adherence divided by the total number of healthcare personnel in the nation eligible to receive the vaccine per NHSN protocol. For the COVID-19 HCP Vaccination National Adherence Rate, the denominator excludes HCP for whom COVID-19 vaccination was contraindicated per CDC's NHSN data collection instructions.

+Complications & Deaths
Infections (PCH-4, PCH-5, PCH-6, PCH-7, PCH-26, PCH-27)

INFECTIONS MEASURES

Healthcare-Associated Infections (HAIs)

Hospitals submit HAI data to the CDC's NHSN system. The CDC provides the HAI data to CMS for display on PDC.

The Infections Measures section of the Preview UI includes the following measures:

- PCH-4 Central Line-associated Bloodstream Infection (CLABSI)
- PCH-5 Catheter-associated Urinary Tract Infection (CAUTI)
- PCH-6 Surgical Site Infection: Colon
- PCH-7 Surgical Site Infection: Abdominal Hysterectomy
- PCH-26 *Clostridioides difficile* Infection (CDI)
- PCH-27 Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia

Measure Definitions

PCH-4 — Central Line-associated Bloodstream Infection (CLABSI)

The CLABSI measure for the PCHQR Program includes oncology intensive care unit (ICU), ward, and step-down unit patients for events identified within the displayed time frame. Bloodstream infection (BSI) events that were identified in patients with mucosal barrier injury, Extracorporeal life support and Ventricular Assist Device BSI events, Munchausen Syndrome by Proxy, Epidermolysis bullosa, patient self-injection, and pus at vascular access site are excluded.

PCH-5 — Catheter-associated Urinary Tract Infection (CAUTI)

The CAUTI measure for the PCHQR Program includes oncology ICU, ward, and step-down unit patients for events identified within the displayed time frame.

PCH-6 — Surgical Site Infections (SSI) for Colon Surgery

The SSI-Colon Surgery measure includes the number of SSIs identified among adults that occur within 30 days following criteria-specific colon surgeries performed for events identified within the displayed time frame. SSIs that were present at time of surgery (PATOS) are excluded.

PCH-7 — Surgical Site Infections for Abdominal Hysterectomy Surgery

The SSI-Abdominal Hysterectomy measure includes the number of SSIs identified among adults that occur within 30 days following criteria-specific abdominal hysterectomy surgeries performed for events identified within the displayed time frame. SSIs that were PATOS are excluded.

PCH-26 — *Clostridioides difficile* (*C. difficile*) Infections

The *C. difficile* measure includes the number of hospital-onset *C. difficile* LabID events that occur in all inpatient locations, facility-wide **minus** neonatal ICUs, well-baby nurseries, or well-baby clinics within the displayed time frame.

PCH-27 — Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia Blood Infections

The MRSA bacteremia measure includes the number of hospital-onset MRSA bacteremia LabID events that occur in all inpatient locations facility-wide within the displayed time frame.

HAI Measure Display

As noted in the image below, HAI measure information is displayed in the following columns:

- Predicted
- Reported
- Days/Procedure
- Facility Ratio
- National Ratio
- National Compare

Infections

	Predicted	Reported	Days / Procedure	Facility Ratio (95% conf. int.)	State Ratio (95% conf. int.)	National Ratio	National Compare
PCH-4 Q1 (2021) - Q4 (2021) Central Line Associated Bloodstream Infection (ICU + select Wards)	5.840	4	6,404	0.685 (0.218, 1.652)	0.779 (0.702, 0.863)	0.983	SAME
PCH-5 Q1 (2021) - Q4 (2021) Catheter Associated Urinary Tract Infections (ICU + select Wards)	1.038	2	1,017	1.927 (0.323, 6.366)	0.941 (0.862, 1.026)	0.793	SAME
PCH-6 Q1 (2021) - Q4 (2021) Surgical Site Infection from colon surgery (SSI: Colon)	N/A(12)	N/A(12)	N/A(12)	N/A(12) (N/A(12), N/A(12))	0.907 (0.782, 1.048)	0.845	N/A(12)
PCH-7 Q1 (2021) - Q4 (2021) Surgical Site Infection from abdominal hysterectomy (SSI: Hysterectomy)	N/A(12)	N/A(12)	N/A(12)	N/A(12) (N/A(12), N/A(12))	1.457 (1.072, 1.938)	0.986	N/A(12)
PCH-26 Q1 (2021) - Q4 (2021) Clostridium Difficile (C.Diff)	8.968	9	10,085	1.004 (0.489, 1.842)	0.660 (0.626, 0.696)	0.498	SAME
PCH-27 Q1 (2021) - Q4 (2021) MRSA Bacteremia	0.650(13)	0(13)	10,085(13)	N/A(13) (N/A(13), N/A(13))	0.829 (0.721, 0.948)	1.085	N/A(13)

Predicted

Your hospital's predicted number of infections is the predicted number of infections in scope for quality reporting. The predicted number of infections is calculated using national aggregate NHSN data from 2015 (resulting in the updated Standardized Infection Ratio [SIR] baseline described above) and is risk adjusted for your hospital based on several factors. The predicted number of infections is used by NHSN as the denominator to calculate your hospital's SIR.

REPORTED

Your hospital's reported number of infections is the observed number of infections reported by your hospital in scope for quality reporting. The observed number of infections is used as the numerator by NHSN to calculate your hospital's SIR.

Any data submitted to NHSN after the CMS submission deadline will **not** be included in the data reported for the Preview or on PDC.

Days/Procedure

PCH-4 (CLABSI): The number of central line days in hospital locations in scope (oncology ICU, ward, and step-down unit) for quality reporting.

PCH-5 (CAUTI): The number of urinary catheter days in hospital locations in scope (oncology ICU, ward, and step-down unit) for quality reporting.

PCH-6 (SSI-Colon): The procedure count field on this preview and PDC displays the total number of in-plan, inpatient colon procedures performed in the facility on adults 18 years and older with no considerations to the exclusion and inclusion criteria applied to NHSN's Complex 30-day SSI SIR model.

A subset of the procedure count field is used in the calculation of the number of predicted infections. This procedure count may not match the procedure count shown on NHSN's SIR Report, as NHSN's SIR Report shows the number of procedures included in the SIR calculation.

More information on the procedures included in the calculation of the SIR can be found at this direct link: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf.

PCH-7 (SSI-Abdominal Hysterectomy): The procedure count field on this preview and on PDC displays the total number of in-plan, inpatient abdominal hysterectomy procedures performed in the facility on adults 18 years and older with no considerations to the exclusion and inclusion criteria applied to NHSN's Complex 30-day SSI SIR model. A subset of the procedure count field is used in the calculation of the number of predicted infections.

This procedure count may not match the procedure count shown on NHSN's SIR Report, as NHSN's SIR Report shows the number of procedures included in the SIR calculation. More information on the procedures included in the calculation of the SIR can be found at this direct link: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf.

PCH-26 (*C. difficile*): The total number of patient days in hospital facility-wide inpatient locations, minus neonatal ICUs, well-baby nurseries, or well-baby clinics in scope for quality reporting.

PCH-27 (MRSA): The total number of patient days in hospital facility-wide inpatient locations in scope for quality reporting.

Facility Ratio SIR

The SIR is a summary measure used to track HAIs at a facility or national level over time. The SIR is calculated as observed number of infections (numerator) divided by the predicted number of infections (denominator). The number of predicted infections is adjusted based on several factors specific to your hospital. The following link provides more information regarding SIR calculations: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

When a hospital's SIR cannot be calculated for a HAI measure because there is less than one predicted infection, or because the hospital's *C. difficile* prevalence rate is above the allowed threshold, the SIR displays "N/A (with Footnote 13)" to indicate the results could not be calculated.

The upper and lower confidence intervals for the facility ratio are provided in the associated modal by selecting the data next to the Facility Ratio. The modal lists your hospital's lower-bound limit and upper-bound limit around the hospital's SIR. The lower- and upper-bound limits of the confidence interval (95%) for your hospital's SIR are an indication of precision and allow interpretation in terms of statistical significance.

When the lower limit of the confidence interval cannot be calculated due to the number of observed infections equaling zero, Footnote 8 is applied.

State Ratio

The State Ratio SIR is calculated by dividing the state numerator in scope for quality reporting by the state denominator in scope for quality reporting, for a specific infection type. The State Ratio will be provided on the Preview UI but will not be publicly displayed on PDC.

National Ratio

The National Ratio SIR is based on current aggregated data in scope for quality reporting from acute care facilities to meet the CMS rule from the same time period as the facility's data. It is shown to demonstrate where the most recent overall national SIR stands. This ratio is not shown on PDC to avoid confusion with the National SIR Benchmark used to compare hospital performance.

National Comparison

Your hospital's performance phrase is determined by comparing your facility's SIR to a national benchmark of 1. A confidence interval with a lower and upper limit is displayed around each SIR to indicate a high degree of confidence (95%) that the true value of the SIR lies within that interval.

Performance phrases displayed are:

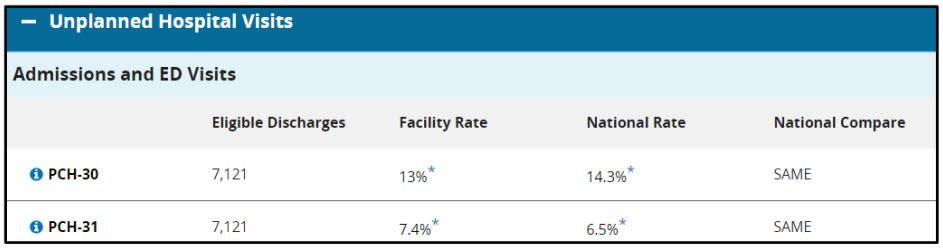
- **Better** (Better than the National Benchmark): Displays if your hospital's SIR has an upper limit that is less than the National Benchmark of one
- **Same** (No Different than National Benchmark): Displays if your hospital's SIR has a confidence interval (lower to upper limit) that includes the National Benchmark of one
- **Worse** (Worse than the National Benchmark): Displays if your hospital's SIR has a lower limit that is greater than the National Benchmark of one.

+UNPLANNED HOSPITAL VISITS
Procedure Specific Outcomes (PCH-30, PCH-31) Readmission Measures (PCH-36)

Admission and ED Visits

The Procedure Specific Measures section of the Preview UI includes the following measures:

- PCH-30 Admission Visits for Patients Receiving Outpatient Chemotherapy - Risk Standardized Admission Rate
- PCH-31 Emergency Department Visits for Patients Receiving Outpatient Chemotherapy - Risk Standardized Emergency Department Visits Rate



Unplanned Hospital Visits				
Admissions and ED Visits				
	Eligible Discharges	**Facility Rate**	**National Rate**	**National Compare**
PCH-30	7,121	13%*	14.3%*	SAME
PCH-31	7,121	7.4%*	6.5%*	SAME

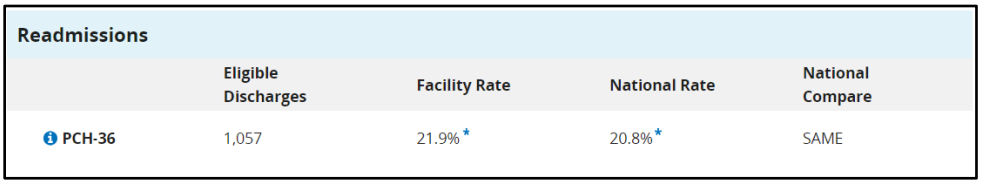
Admission and Emergency Department (ED) Visit Details

The Preview UI displays four quarters of data. The data are updated annually in July. Each measure displays:

- Eligible Cases
- Facility Rate/ Ratio
- National Rate/ Ratio
- National Compare

Readmissions

The readmission outcome measure section of the Preview UI includes PCH-36 30-Day Unplanned Readmission for Cancer Patients.



Readmissions				
	Eligible Discharges	**Facility Rate**	**National Rate**	**National Compare**
PCH-36	1,057	21.9%*	20.8%*	SAME

Readmissions Details

The Preview UI displays four quarters of data. The data are updated annually in October. Each measure displays:

- Eligible Discharges
- Facility Rate
- National Rate
- National Compare

Measure IDs Included in Measure Accordions

Measure Accordion	Measure IDs Included
Survey of Patient's Experience	HCAHPS HCAHPS Summary Star Ratings Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Communication About Medicines Cleanliness of Hospital Environment Quietness of Hospital Environment Discharge Information Care Transition Hospital Rating Recommend this Hospital
Timely and Effective Care	Sepsis (SEP-1 SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR) Emergency Department Care (ED-2-Strata-1, ED-2-Strata-2, OP-18b, OP-18c, OP-22, OP-23) Healthcare Personnel Vaccination (IMM-3, HCP COVID-19, IPFQR-HCP COVID-19, PCH-28. PCH-38) Perinatal Care (PC-01, PC-05) Cataract (OP-31) Colonoscopy (OP-29) Opioid Use (Safe Use of Opioids-Concurrent Prescribing) Venous Thromboembolism (VTE-1, VTE-2) Stroke Care (STK-02, STK-03, STK-05, STK-06)
Structural Measure	Maternal Morbidity Structural Measure (SM-7)
Complications & Deaths	30-Day Death Rates (MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-STK, MORT-30-COPD, MORT-30-CABG) CMS Patient Safety Indicators (PSI 03, PSI 04, PSI 06, PSI 08, PSI 09, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, PSI 15, PSI 90) Infections (HAI-1, HAI-2, HAI-3, HAI-4, HAI-5, HAI-6, PCH-4, PCH-5, PCH-6, PCH-7, PCH-26, PCH-27) Surgical Complications (COMP-HIP-KNEE)

Measure Accordion	Measure IDs Included
Unplanned Hospital Visits	Condition Specific Readmission (READM-30-AMI, READM-30-HF, READM-30-PN, READM-30-COPD) Procedure Specific Readmission (READM-30-CABG, READM-30-HIP-KNEE) Hospital Wide Readmission (READM-30-HOSPWIDE) Inpatient Psychiatric Facility Readmission (READM-30-IPF) Procedure Specific Outcomes (PCH-30, PCH-31, OP-32, OP-35 ADM, OP-35 ED, OP-36) Readmission Measure (PCH-36) Excess Days in Acute Care (EDAC-30-AMI, EDAC-30-HF, EDAC-30-PN)
Payment & Value of Care	Payment (PAYM-30-AMI, PAYM-30-HF, PAYM-30-PN, PAYM-90-HIP-KNEE) Medicare Spending per Beneficiary (MSPB-1)
Follow-Up Care	Transition Record (TR1) Hospital-Based Inpatient Psychiatric Services (HBIPS-5) Follow-Up After Hospitalization for Mental Illness (FAPH-7, FAPH-30)
Substance Use Treatment	Substance Use (SUB-2, SUB-2a, SUB-3, SUB-3a) Tobacco Use (TOB-2, TOB-2a, TOB-3, TOB-3a)
Patient Experience	Hospital-Based Inpatient Psychiatric Services (HBIPS-2, HBIPS-3)
Preventative Care and Screening	Screening (SMD) Immunization (IPFQR-IMM-2)
Use of Medical Imaging	Imaging Efficiency (OP-8, OP-10, OP-13, OP-39)

Footnote Table

Number	Description	Application
1	The number of cases/ patients is too few to report	Applied to any measure rate where the denominators are greater than 0 and less than 11. Data will not display on Care Compare. For HCAHPS: • This is applied when a hospital has zero cases, or five or fewer eligible HCAHPS patient discharges. • HCAHPS scores based on fewer than 25 completed surveys will display on the Preview UI. • Data will not display on Care Compare. Measures based on claims data and eCQM data: Applied to any hospital where the number of cases reported is too small (less than 25 and greater than zero) to reliably tell how well a hospital is performing.
2	Data submitted were based on a sample of cases/patients	Applied when any case submitted to the CMS Clinical Data Warehouse was sampled for a reported quarter for a topic; applied at the topic level (e.g., VTE)
3	Results are based on a shorter time period than required	Applied when a hospital elected not to submit data, had no data to submit, or did not successfully submit data to the CMS Clinical Data Warehouse for a measure for one or more, but not all possible quarters.
4	Data suppressed by CMS for one or more quarters	Reserved for CMS use.
5	Results are not available for this reporting period	Applied when a hospital either elected not to submit data, or the hospital had no data to submit for a particular measure, or when a hospital elected to suppress a measure. For HCAHPS: • When a hospital did not participate in HCAHPS reporting during the period covered by the applicable Preview UI • When a hospital only participated in HCAHPS reporting for a portion of the period covered by the applicable Preview UI • When a hospital chooses to suppress HCAHPS results (A hospital will see HCAHPS results on its Preview UI, but not on Care Compare.)

Number	Description	Application
6	Fewer than 100 patients completed HCAHPS survey (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS surveys is 50–99.
7	No cases met the criteria for this measure	Applied when a hospital treated patients for a particular topic, but no patients met the criteria for inclusion in the measure calculation.
8	The lower limit of the confidence interval cannot be calculated if the number of observed infections equals 0	For HAI measures: Applied when the lower limit of the confidence interval cannot be calculated.
9	No data are available from the state/territory for this reporting period.	This footnote is applied when: • Too few hospitals in a state/territory had data available. OR • No data was reported for this state/territory.
10	• Very few patients were eligible for the HCAHPS survey. • The scores shown reflect fewer than 50 completed surveys. (Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)	Applied when the number of completed HCAHPS surveys is fewer than 50.
11	There were discrepancies in the data collection process	Applied when there have been deviations from HCAHPS data collection protocols.
12	This measure does not apply to this hospital for this reporting period	Applied to the measure when either the hospital has a waiver, or the hospital submitted to NHSN: • Zero Central Line Days • Zero Catheter Days • Zero Surgical Procedures

Number	Description	Application
13	Results cannot be calculated for this reporting period	Applied to emergency department measures when the average minutes cannot be calculated for a volume category. For HAI measures: Applied when the hospital's SIR cannot be calculated because: • The number of predicted infections is less than one. • The C. difficile prevalence rate is greater than the established threshold. Note: The number of predicted infections will not be calculated for those facilities with an outlier C. difficile prevalence rate. Applied when the provider was excluded from the measure calculation as a non-IPPS hospital. Applied to the value of care display if one of the two measures that assess value of care is unavailable.
14	The results for this state are combined with nearby states to protect confidentiality.	This footnote is applied when a state has fewer than 10 hospitals to protect confidentiality. Results are combined as follows: (1) the District of Columbia and Delaware are combined; (2) Alaska and Washington are combined; (3) North Dakota and South Dakota are combined; and (4) New Hampshire and Vermont are combined. Hospitals located in Maryland and U.S. territories are excluded from the measure calculation.
15	The number of cases/patients is too few to report a Star Rating.	Applied when CMS has determined there are too few cases or patients to report an HCAHPS Star Rating.
16	There are too few measures or measure groups reported to calculate an overall rating or measure group score.	This footnote is applied when a hospital: • Reported data for fewer than three measures in any measure group used to calculate overall ratings or • Reported data for fewer than three of the measure groups used to calculate ratings or • Did not report data for at least one outcomes measure group.
17	This hospital's overall rating only includes data reported on inpatient services.	This footnote is applied when a hospital only reports data for inpatient hospital services.

Number	Description	Application
22	Overall star ratings are not calculated for Department of Defense (DoD) hospitals.	. DoD hospitals are not included in the calculations of the overall star rating.
23	The data are based on claims that the hospital or facility submitted to CMS. The hospital or facility has reported discrepancies in their claims data.	This footnote is applied when a hospital or facility alerts CMS of a possible issue with the claims data used to calculate results for this measure. Calculations are based on a "snapshot" of the administrative claims data and changes that hospitals or facilities make to their claims after the snapshot are not reflected in the data. Issues with claims data include but are not limited to the use of incorrect billing codes or inaccurate dates of service.
25	State and national averages include VHA hospital data.	Applied to state and national data when VHA data is included in the calculation.
26	State and national averages include DoD hospital data.	Applied to state and national data when DoD data is included in the calculation.
27	The DoD TRICARE Inpatient Satisfaction Survey (TRISS) does not represent official HCAHPS results and are not included in state and national averages.	The DoD TRISS uses the same questions as the HCAHPS survey but is collected and analyzed independently.
28	The results are based on the hospital or facility's data submissions. CMS approved the hospital or facility's Extraordinary Circumstances Exception request suggesting that results may be impacted.	This footnote is applied when a hospital or facility alerts CMS of a possible concern with data used to calculate the results of this measure via an approved Extraordinary Circumstances Exception form. Calculated values should be used with caution.

Resources

Questions should be directed to the subject matter experts listed below.

Timely and Effective Care Measure, Complications and Death Measures, Procedure-Specific Outcome Measures

Please direct questions to the QualityNet Question & Answer Tool.

HCAHPS Measures

Contact the HCAHPS Project Team by email at hcahps@hsag.com.