Inpatient Public Reporting Preview Help Guide

The target audience for this publication is hospitals. The document scope is limited to instructions for hospitals to access and interpret the data provided on the public reporting user interface prior to publication of the data on *Hospital Compare.*

February 2020 Public Reporting Preview/April 2020 *Hospital Compare* Release

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Overview

Hospital Compare

The Centers for Medicare & Medicaid Services (CMS) and the nation's hospitals work collaboratively to publicly report hospital quality performance information on the *Hospital Compare* website located at *www.Medicare.gov/HospitalCompare* and *Data.Medicare.gov*.

Hospital Compare displays hospital performance data in a consistent, unified manner to ensure the availability of credible information about the care delivered in the nation's hospitals. Most of the participants are short-term acute care hospitals that will receive a reduction to the annual update of their Medicare fee-for-service payment rate if they do not participate by submitting data or meet other requirements of the Hospital Inpatient Quality Reporting (IQR) Program. The Hospital IQR Program was established by Section 501(b) of the Medicare Modernization Act (MMA) of 2003 and extended and expanded by Section 5001(a) of the Deficit Reduction Act of 2005.

Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (hospital insurance) based on prospectively set rates. Section 1886(g) of the Social Security Act requires the Secretary to pay for the capital-related costs of inpatient hospital services under the inpatient prospective payment system (IPPS). Under the IPPS, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of Medicare Severity Diagnosis-Related Groups (MS-DRGs). Hospitals paid under the IPPS are subject to a one-fourth reduction of the annual payment update (APU) if Hospital IQR Program requirements are not met for the applicable fiscal year. Hospitals not paid under the IPPS that voluntarily submit data for one or more measures may choose to have any or all of the information displayed on *Hospital Compare*.

Preview Period

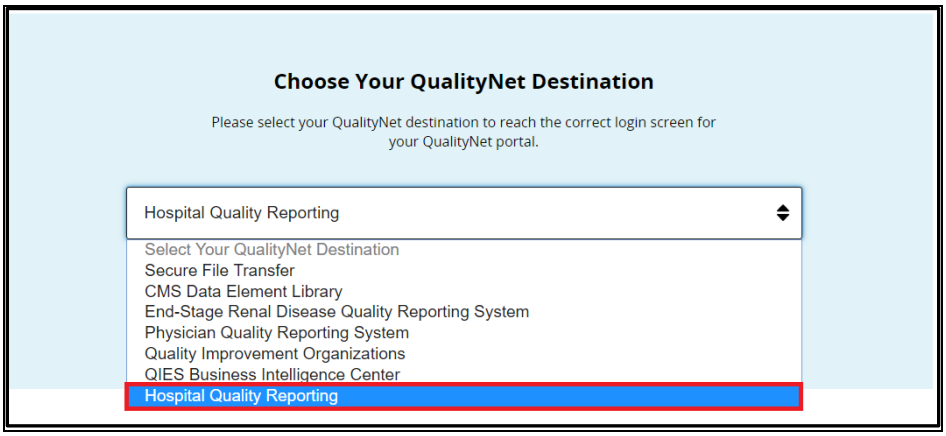
Prior to the public display of data on *Hospital Compare*, hospitals are given the opportunity to preview their data during a 30-day preview period. The data anticipated for the release can be accessed via the *QualityNet Secure Portal*, the only CMS-approved website for secure healthcare quality data exchange, at *www.QualityNet.org*.

Public Reporting Preview User Interface (UI)

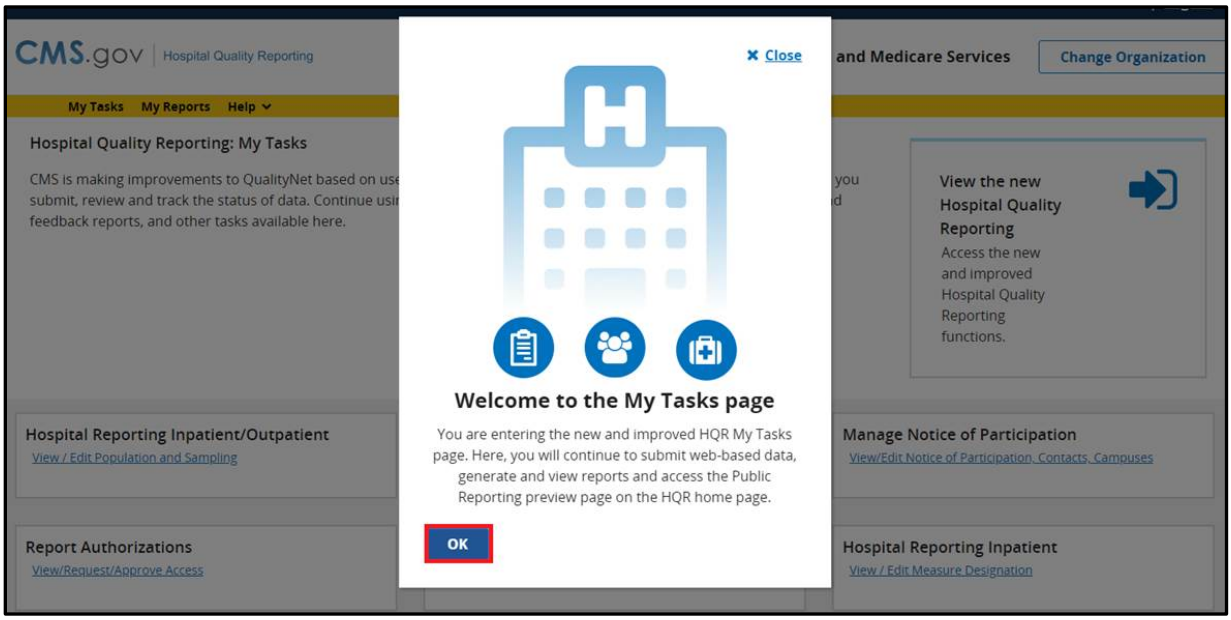
The Preview UI was developed to allow providers increased flexibility in reviewing their data. The format of the site was designed to be similar to *Hospital Compare*.

Users must be enrolled and proofed in the *QualityNet Secure Portal* in order to access the user interface. Follow the instructions below to access the UI:

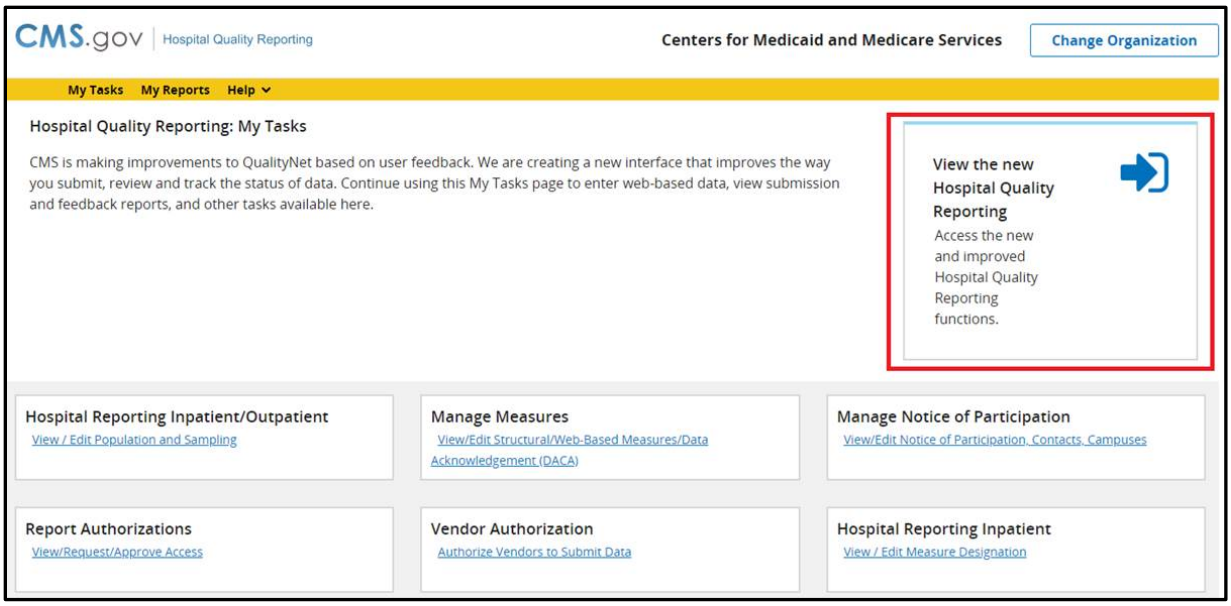
1. Access the public website for *QualityNet* at https://www.qualitynet.org.
2. Select **Login** under the *Log in to QualityNet Secure Portal* header.
3. From the **Choose Your QualityNet Destination** dashboard, select **Hospital Quality Reporting.**



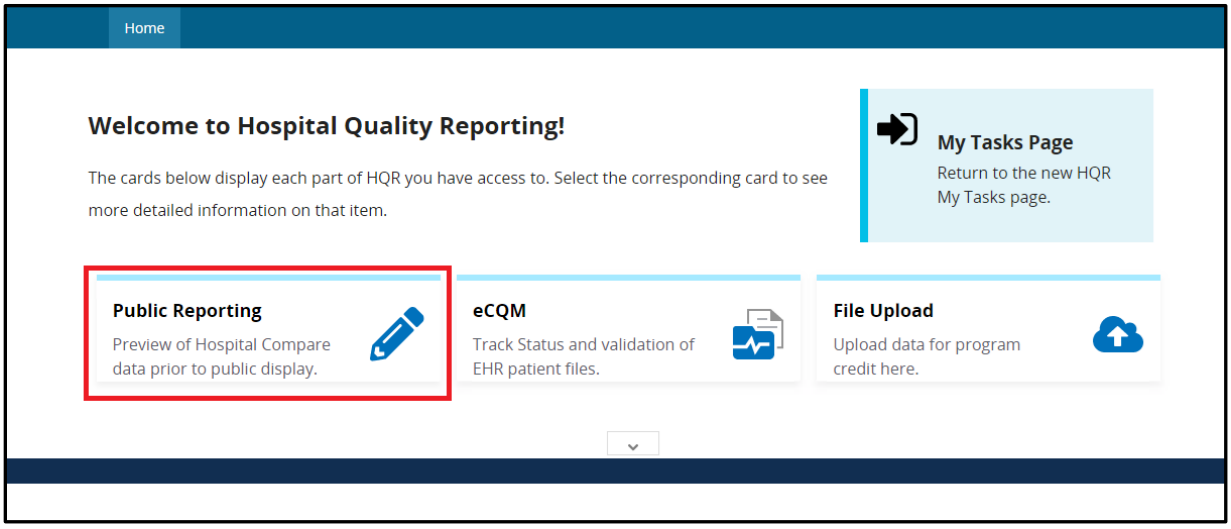
4. Enter your *QualityNet* User ID, Password, and Security Code. Then, select **Submit**.
5. Read the Terms and Conditions statement and select **I Accept** to proceed.
   NOTE: If **I Decline** is selected, the program closes.
6. You will be directed to the **My Tasks** page. Select **OK** on the pop up statement.



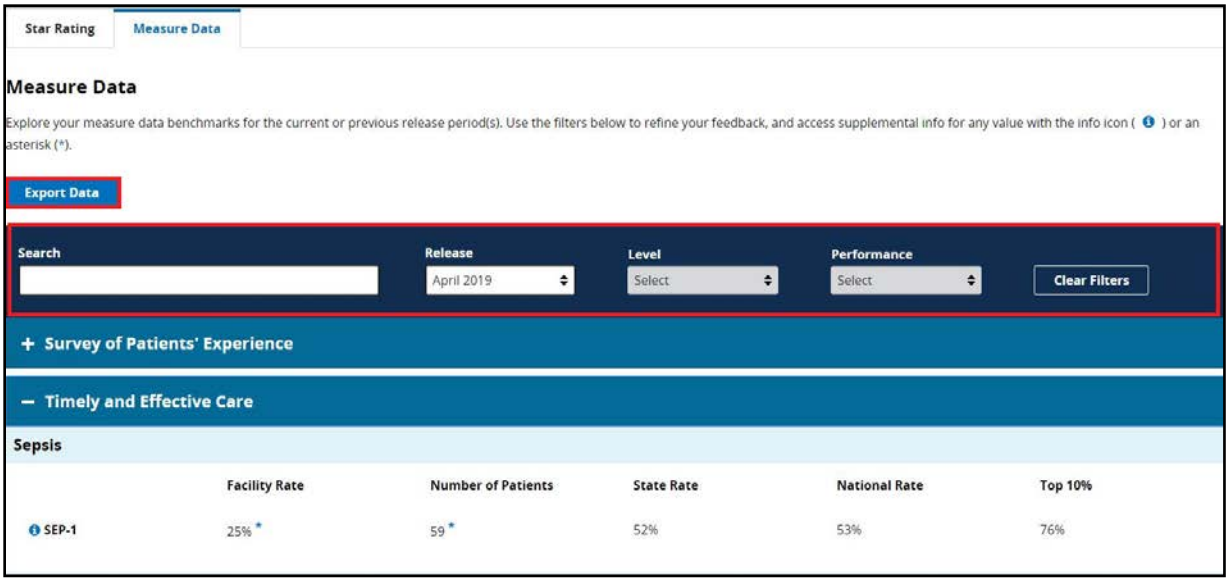
7. On the **My Tasks** page, select **View the New Hospital Quality Reporting** card in the top-right corner of the page.



8. Select **Public Reporting.**



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: Star Rating and Measure Data.
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:

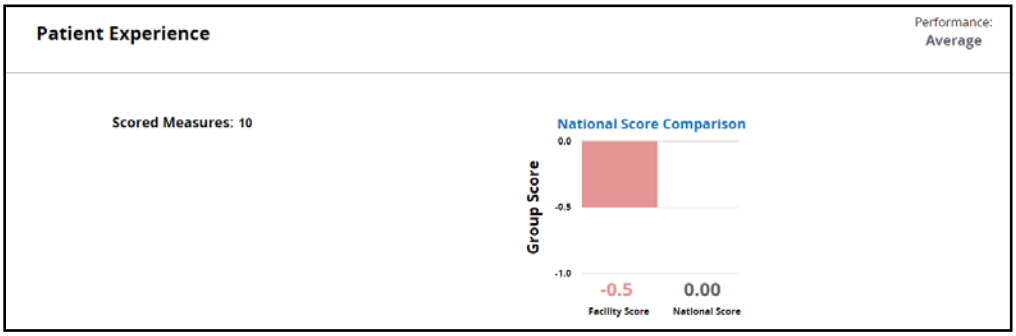
- Release - Select the release data to be viewed.
- Level - Filter whether your facility's data will be compared to the "State" or "National" average during filtering. This functionality is disabled currently and will be activated in a future release.
- Performance - Filter your facility's data for being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

Public Reporting Data Details

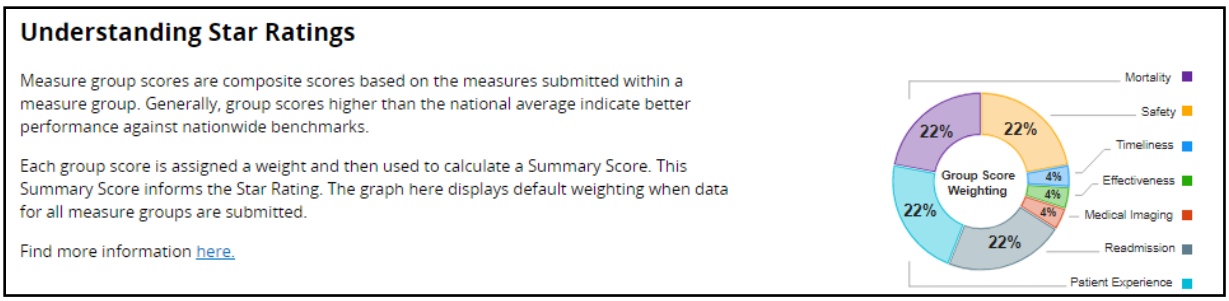
Star Rating Tab

The Star Rating tab displays the Overall Hospital Quality Star Ratings, facility details (i.e., hospital characteristics), and measure group scores for January 2020. Each group accordion displays the performance for the group and expands to provide additional information.

Each group score accordion expands to display the number of scored measures in that group as well as a National Score Comparison graph.



Additional information at the bottom of the Star Ratings tab includes the weight of each group score and a link to additional information on the *Hospital Compare* web page.



The Overall Hospital Quality Star Ratings summarize hospital quality data on the *Hospital Compare* website. These ratings reflect measures across seven aspects of quality on *Hospital Compare*: mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging. The Overall Hospital Quality Star Rating methodology is a scientifically rigorous and valid process to summarize the quality information available on *Hospital Compare*. The Overall Hospital Quality Star Rating supplements, rather than replaces, the information on *Hospital Compare*.

CMS updates the Overall Hospital Quality Star Ratings on an annual schedule during the January *Hospital Compare* release. The Overall Hospital Quality Star Ratings in the April, July and October *Hospital Compare* releases generally maintain the same rating from the January release, unless otherwise noted.

Hospitals receive an Overall Hospital Quality Star Rating (i.e., 1, 2, 3, 4, or 5 stars) and a performance category for each measure group (i.e., above the national average, same as the national average, or below the national average). The tab contains supplemental information for hospitals to better understand the Overall Hospital Quality Star Rating calculations, which include: a summary score (i.e., the weighted average of a hospital's available group scores), the hospital's measure group scores, the national group scores, the number of measures in the hospital's group score calculation, and the weighting of each group that contributed to the summary score.

Please refer to the Overall Hospital Quality Star Ratings methodology resources on *QualityNet.org* on the Overall Hospital Ratings Overview page at this link.

Overall Hospital Quality Star Rating Details

- **Your Hospital's Overall Star Rating** – 1, 2, 3, 4, or 5 stars. A hospital will only receive a Star Rating if it has at least three group scores. One of those group scores must be an outcomes measure group (i.e., mortality, safety of care, or readmission) with at least three measures in each group.
- **Your Hospital's Summary Score** – The weighted average of the hospital's group scores. This score is generally recalculated for the January and July releases and is not recalculated for the April and October releases, unless otherwise stated.
- **Measure Groups** − Hospital quality is represented by several dimensions, including clinical care processes, initiatives focused on care transitions, and patient experiences. The *Hospital Compare* Overall Star Rating includes seven groups:
    - Mortality
    - Safety of care
    - Readmission
    - Patient experience

  - Effectiveness of care
  - Timeliness of care
  - Efficient use of medical imaging

- **Number of Measures** – The number of measures used to calculate the hospital's group scores is based on the data the hospital reported.

The Overall Hospital Quality Star Rating aims to be as inclusive as possible of measures displayed on *Hospital Compare*; however, the following types of measures will not be incorporated in the Overall Hospital Quality Star Rating:

- Measures suspended, retired, or delayed from public reporting on *Hospital Compare*
- Measures with no more than 100 hospitals reporting performance publicly
- Structural measures
- Non-directional measures (i.e., unclear whether a higher or lower score is better)
- Duplicative measures (e.g., individual measures that make up a composite measure that is already reported or measures that are identical to another measure)

The tables below include a full list of the measures included in each group that, if reported by the hospital, were used in calculating the Overall Star Rating for January 2020.

Mortality (N=7)

Measure	Description
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
MORT-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Mortality Rate
MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate
MORT-30-STK	Acute Ischemic Stroke (STK) 30-Day Mortality Rate
PSI 4 SURG-COMP	Death Among Surgical Inpatients with Serious Treatable Complications

Safety of Care (N=8)

Measure	Description
HAI-1	Central Line-associated Bloodstream Infection (CLABSI)
HAI-2	Catheter-Associated Urinary Tract Infection (CAUTI)
HAI-3	Surgical Site Infection from colon surgery (SSI-colon)
HAI-4	Surgical Site Infection from abdominal hysterectomy (SSI-abdominal hysterectomy)
HAI-5	Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia
HAI-6	*Clostridium Difficile* (*C. difficile*)
COMP-HIP-KNEE	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
PSI-90 Safety	Patient Safety and Adverse Events Composite

Readmission (N=8)

Measure	Description
READM-30-CABG	Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate
READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate
READM-30-HIP-KNEE	Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)
READM-30-HOSP-WIDE	Hospital-Wide All-Cause Unplanned Readmission (HWR)
EDAC-30-PN	Excess Days in Acute Care (EDAC) after hospitalization for Pneumonia (PN)
EDAC-30-AMI	Excess Days in Acute Care (EDAC) after hospitalization for Acute Myocardial Infarction (AMI)
EDAC-30-HF	Excess Days in Acute Care (EDAC) after hospitalization for Heart Failure (HF)
OP-32*	Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy

Patient Experience (N=10)

Measure	Description
H-COMP-1	Communication with Nurses (Q1, Q2, Q3)
H-COMP-2	Communication with Doctors (Q5, Q6, Q7)
H-COMP-3	Responsiveness of Hospital Staff (Q4, Q11)
H-COMP-5	Communication About Medicines (Q16, Q17)
H-CLEAN-HSP	Cleanliness of Hospital Environment (Q8)
H-QUIET-HSP	Quietness of Hospital Environment (Q9)
H-COMP-6	Discharge Information (Q19, Q20)
H-COMP-7	Care Transition (Q23, Q24, Q25)
H-HSP-RATING	Hospital Rating (Q21)
H-RECMND	Recommend the Hospital (Q22)

Effectiveness of Care (N=10)

Measure	Description
SEP-1	Sepsis
IMM-2	Influenza Immunization
IMM-3*	Healthcare Personnel (HCP) Influenza Vaccination
OP-22	ED-Patient Left Without Being Seen
OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival
OP-29	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
OP-30	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
OP-33	External Beam Radiotherapy
PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation
VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism

Timeliness of Care (N=9)

Measure	Description
ED-1b	Median Time from Emergency Department (ED) Arrival to ED Departure for Admitted ED Patients
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients
OP-1	Median Time to Fibrinolysis
OP-2**	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-5	Median Time to electrocardiogram (ECG)
OP-18b/ED-3	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	ED-Median Time to Pain Management for Long Bone Fracture

Efficient Use of Medical Imaging (N=5)

Measure	Description
OP-8	MRI Lumbar Spine for Low Back Pain
OP-10	Abdomen Computed Tomography (CT) Use of Contrast Material
OP-11	Thorax CT Use of Contrast Material
OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery
OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)

*Measures were removed from Star Rating calculation due to statistically significant negative loading.
**Measure were removed from Star Rating calculation due to too few hospitals reporting.

Measures with less than 100 hospitals reporting are not included in the Overall Hospital Quality Star Ratings calculation. A complete list of the measures that will be individually reported, including the measures excluded from the *Hospital Compare* Star Ratings, is available on *QualityNet*.

- **Weight** is used for the specified group to calculate the hospital's summary score, which is then translated into the hospital's Overall Star Rating. CMS assigns a weight to each group score to calculate a hospital summary score. The following criteria were applied to determine how each measure group is weighted:
  - Measure importance, including prioritizing outcome measures over process measures
  - Consistency with other CMS programs, such as Hospital Value-Based Purchasing
  - Alignment with CMS priorities, as outlined in the Meaningful Measures framework
  - Stakeholder input, including the prioritization of measure groups by the Technical Expert Panel, public comment periods, the hospital dry run, and additional sources of patient and consumer feedback.

  If a hospital does not report at least one measure for a given group, the weight (or percentage) assigned to that group is redistributed proportionally among the groups with a sufficient number of measures.
- **Group Score** is the estimate of the latent variable model used to produce a group score for each group.
- **National Average Group Score** is the national average group score for each group based on the distribution of group scores across all hospitals.
- **Category** is the group performance category, which provides a hospital with a national comparison across a three-point scale for each hospital's available group scores. These performance categories are: above the national average, same as the national average, and below the national average.

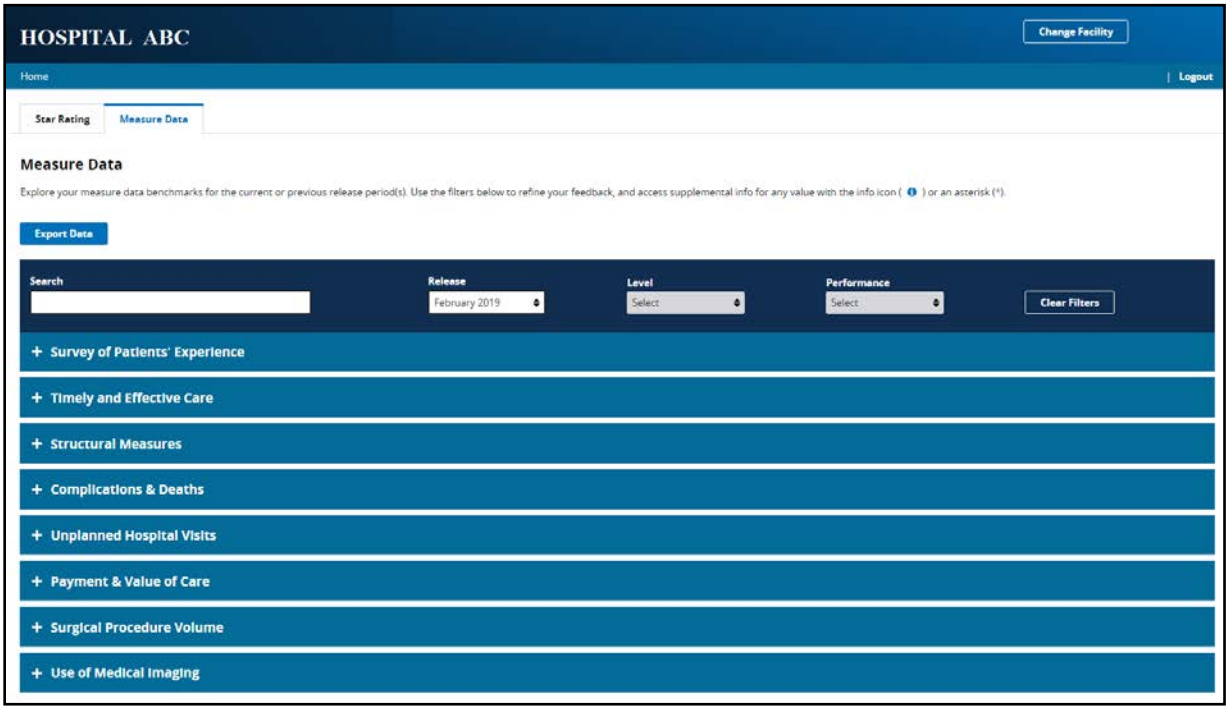
Overall Hospital Quality Star Rating Hospital-Specific Reports (HSRs)

The Overall Hospital Quality Star Rating HSR contains hospital-specific rating and national results, hospital-specific measure group score results, hospital-specific measure score results, and measure loadings for the reporting period. Hospitals are encouraged to review their Overall Hospital Star Rating HSRs along with the Hospital Inpatient and Outpatient Quality Reporting Program Preview data.

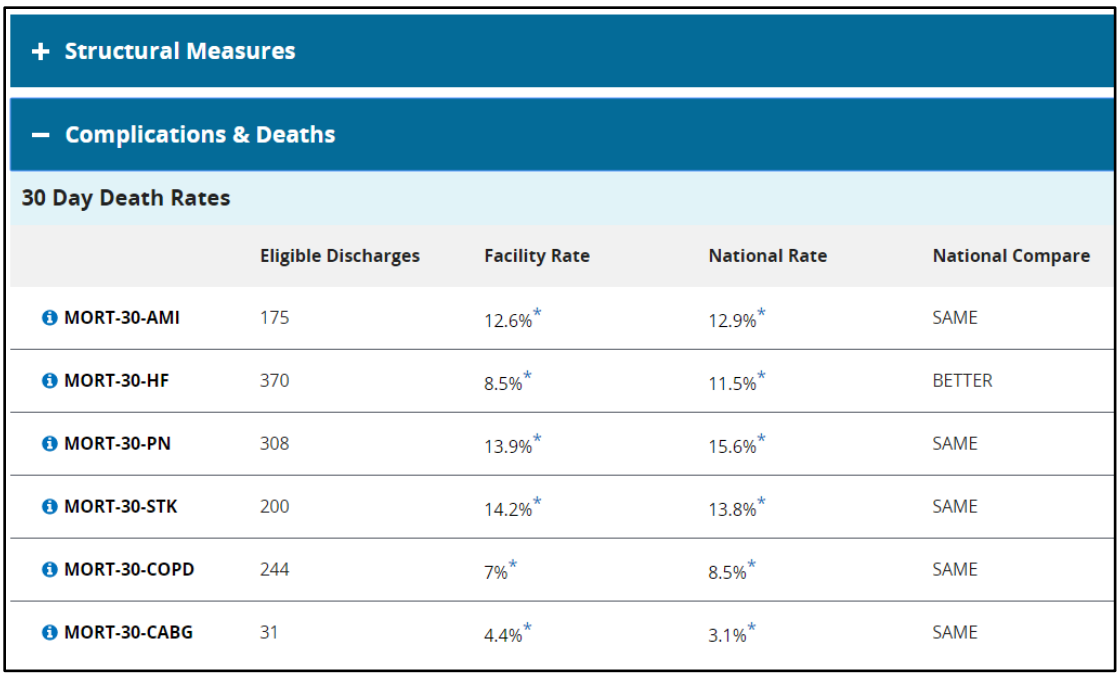
These HSRs are provided when the Overall Hospital Star Rating is recalculated.

Measure Data Tab

The **Measure Data** tab will display accordions and measures based on the *QualityNet Secure Portal* access of the user. If the user has access to inpatient and outpatient data, then the measures for both programs will display for review.



The accordions are labeled similarly to the tabs on *Hospital Compare* and 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.



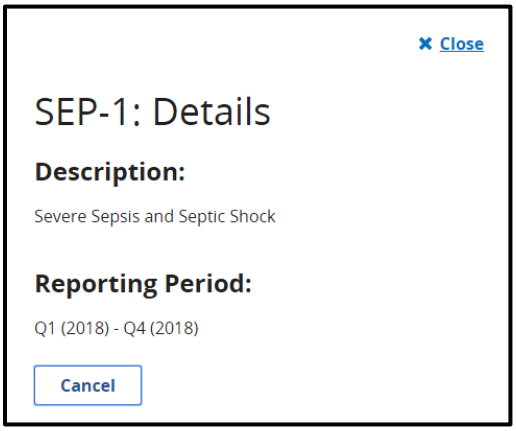
+ Structural Measures

− Complications & Deaths

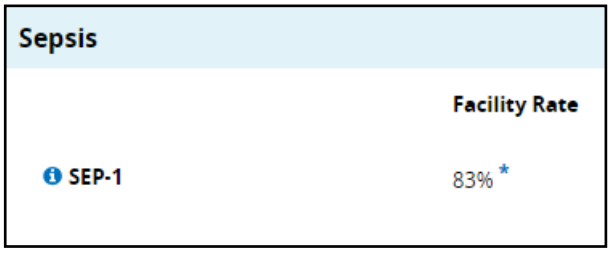
30 Day Death Rates

	Eligible Discharges	Facility Rate	National Rate	National Compare
MORT-30-AMI	175	12.6%*	12.9%*	SAME
MORT-30-HF	370	8.5%*	11.5%*	BETTER
MORT-30-PN	308	13.9%*	15.6%*	SAME
MORT-30-STK	200	14.2%*	13.8%*	SAME
MORT-30-COPD	244	7%*	8.5%*	SAME
MORT-30-CABG	31	4.4%*	3.1%*	SAME

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



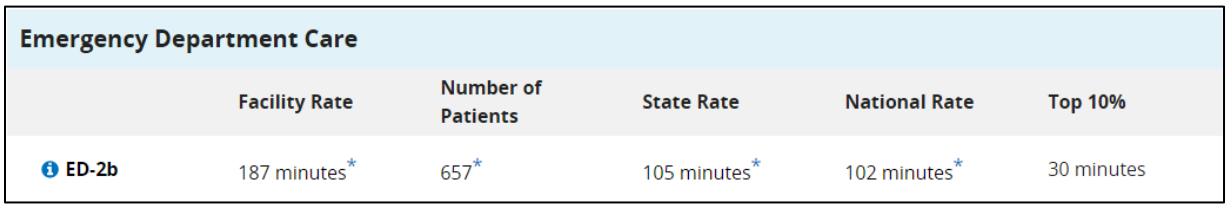
Data display with an asterisk (*). Selecting the data value by the asterisk will reveal a modal with additional details about the data (e.g., a footnote).



Sepsis

	Facility Rate
SEP-1	83% *

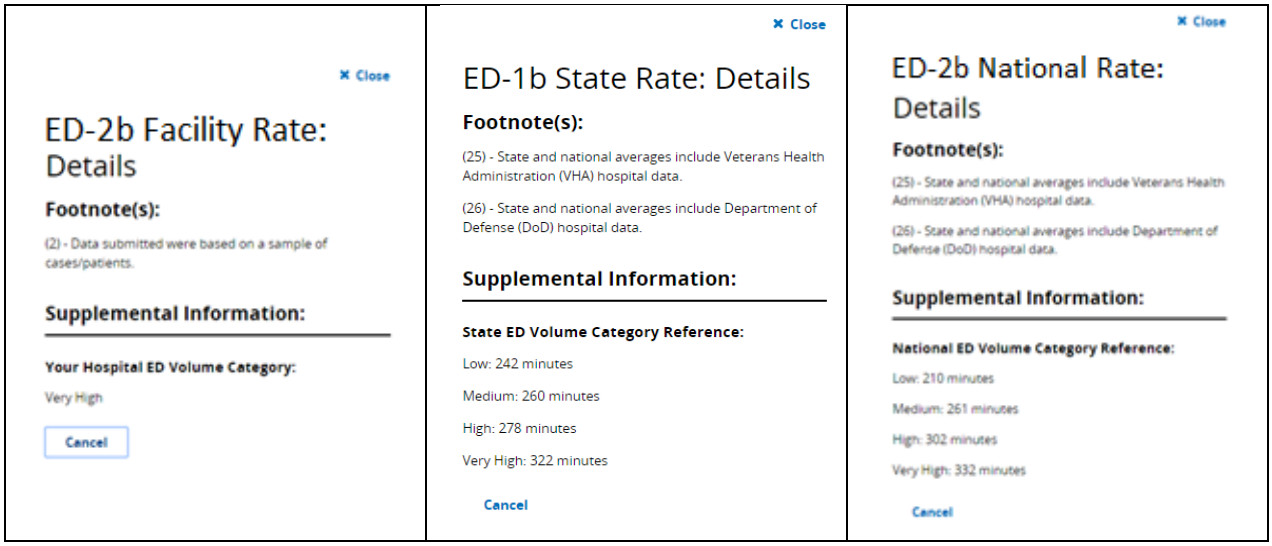
To view the state information, select the **State** data next to the asterisk. To view the national information, select the **National** data next to the asterisk.



Emergency Department Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
ED-2b	187 minutes*	657*	105 minutes*	102 minutes*	30 minutes

For the Emergency Department Care measures, information regarding the number of patients seen annually in a facility (Emergency Department Volume [EDV]) is provided with a comparison of like facility EDV times for reference within the state and the nation.



Close

ED-2b Facility Rate: Details

Footnote(s):

(2) - Data submitted were based on a sample of cases/patients.

Supplemental Information:

Your Hospital ED Volume Category:

Very High

Cancel

Close

ED-1b State Rate: Details

Footnote(s):

(25) - State and national averages include Veterans Health Administration (VHA) hospital data.

(26) - State and national averages include Department of Defense (DoD) hospital data.

Supplemental Information:

State ED Volume Category Reference:

Low: 242 minutes

Medium: 260 minutes

High: 278 minutes

Very High: 322 minutes

Cancel

Close

ED-2b National Rate: Details

Footnote(s):

(25) - State and national averages include Veterans Health Administration (VHA) hospital data.

(26) - State and national averages include Department of Defense (DoD) hospital data.

Supplemental Information:

National ED Volume Category Reference:

Low: 210 minutes

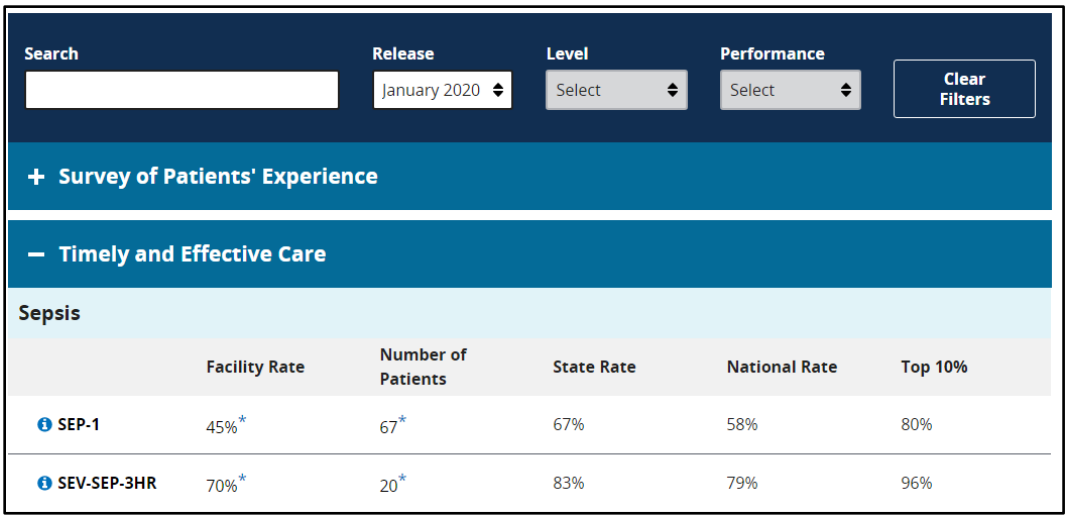
Medium: 261 minutes

High: 302 minutes

Very High: 332 minutes

Cancel

Within the Preview UI, facilities have the ability to filter. In the below scenario, the filters for Release, State level, and Better performance are selected. The accordions will then appear, and facilities can see which measures meet these requirements. The system compares the State Rate to the Facility Rate and reflects those measures where the Facility Rate is better than the State Rate. The same functionality is available to compare the national-level data.



Search | Release: January 2020 | Level: Select | Performance: Select | Clear Filters

+ Survey of Patients' Experience

− Timely and Effective Care

Sepsis

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SEP-1	45%*	67*	67%	58%	80%
SEV-SEP-3HR	70%*	20*	83%	79%	96%

Data Details

Hospital Characteristics

The Preview UI 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 *Hospital Compare*.

If the displayed hospital characteristics are incorrect, your hospital should contact your state Certification and Survey Provider Enhanced Reports (CASPER) agency coordinator to correct the information. The state CASPER contact list is available from the *Hospital Compare* home page by selecting the **Resources** button, located between the **About the Data** and **Help** buttons, directly above the *Find a Hospital* selection area. Select the **Information for hospitals.** Once the screen refreshes, select the **CASPER/ASPEN** (Automated Survey Processing Environment) contacts link from the left-side navigation pane: http://www.medicare.gov/HospitalCompare/Resources/CASPER.aspx. If your hospital's state CASPER agency is unable to make the needed change, your hospital should contact its CMS regional office.

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.)

Accordions

+Survey of Patients' 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 and non-IPPS hospitals have the option of withholding HCAHPS results from being publicly reported on *Hospital Compare*. The HCAHPS measure data are updated quarterly.

Hospitals participating in the Hospital IQR Program may not withhold HCAHPS results.

The HCAHPS Survey data contain survey results from four quarters of data, which 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.

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 the October 2019 public reporting, the new Composite 4 (Pain Communication) and the two associated individual questions will be displayed only in the Public Reporting Preview UI. However, Composite 4 (Pain Communication) and the two associated individual questions will not be displayed on *Hospital Compare* or included in the downloadable database.

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 4- Pain Communication (Q13, Q14)
    - Q13 – Pain Talk
    - Q14 – Pain Treat
  - Composite 5 – Communication about Medicines (Q16, Q17)
    - Q16 – Medicine Explain
    - Q17 – Side Effects
- Hospital Environment Items
  - Cleanliness of Hospital Environment (Q8)
  - Quietness of Hospital Environment (Q9)
- Discharge Information Composite
  - Composite 6 – Discharge Information (Q19, Q20)
    - Q19 – Help After Discharge
    - Q20 – Symptoms
- Care Transition Composite
  - Composite 7 – Care Transition (Q23, Q24, Q25)
    - Q23 – Preferences
    - Q24 – Understanding
    - Q25 – Medicine Purpose

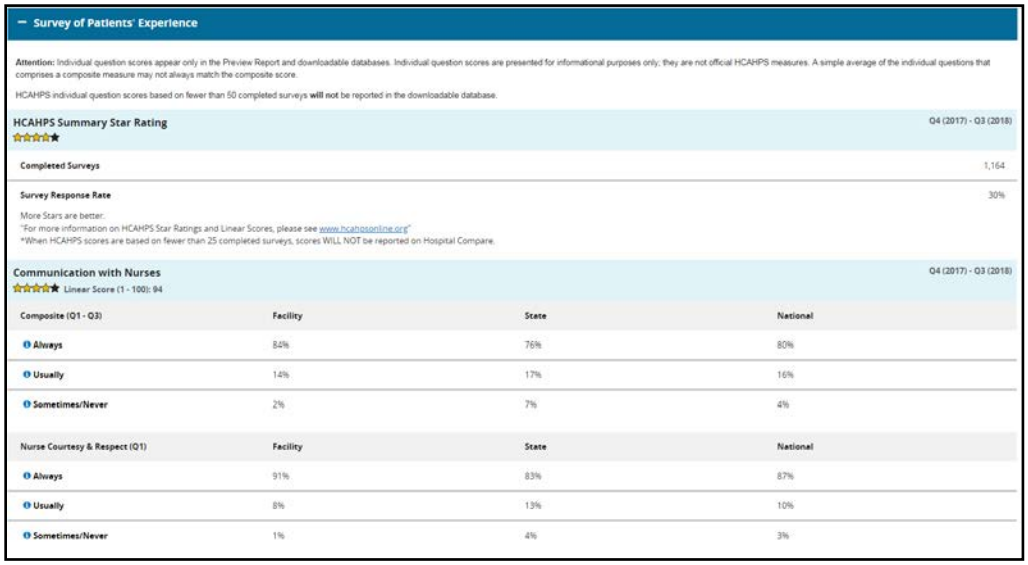
The HCAHPS Global Items includes:

- Hospital Rating (Q21)
- Recommend this Hospital (Q22)

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 *Hospital Compare*.



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 17 individual questions on the HCAHPS Survey that are used to form the seven 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 *Hospital Compare*
- The following 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
  - Q16 – Medicine Explain
  - Q17 – Side Effects
  - Q19 – Help After Discharge
  - Q20 – Symptoms
  - Q23 – Preferences
  - Q24 – Understanding
  - Q25 – Medicine Purpose
- The following individual question scores are included in the Preview UI but will not be in the downloadable database:
  - Q13 – Pain Talk
  - Q14 – Pain Treat

Please 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
Sepsis (SEP-1, SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR)
Emergency Department (ED-2b)
Healthcare Personnel Influenza Vaccination (IMM-3)
Perinatal Care (PC-01)

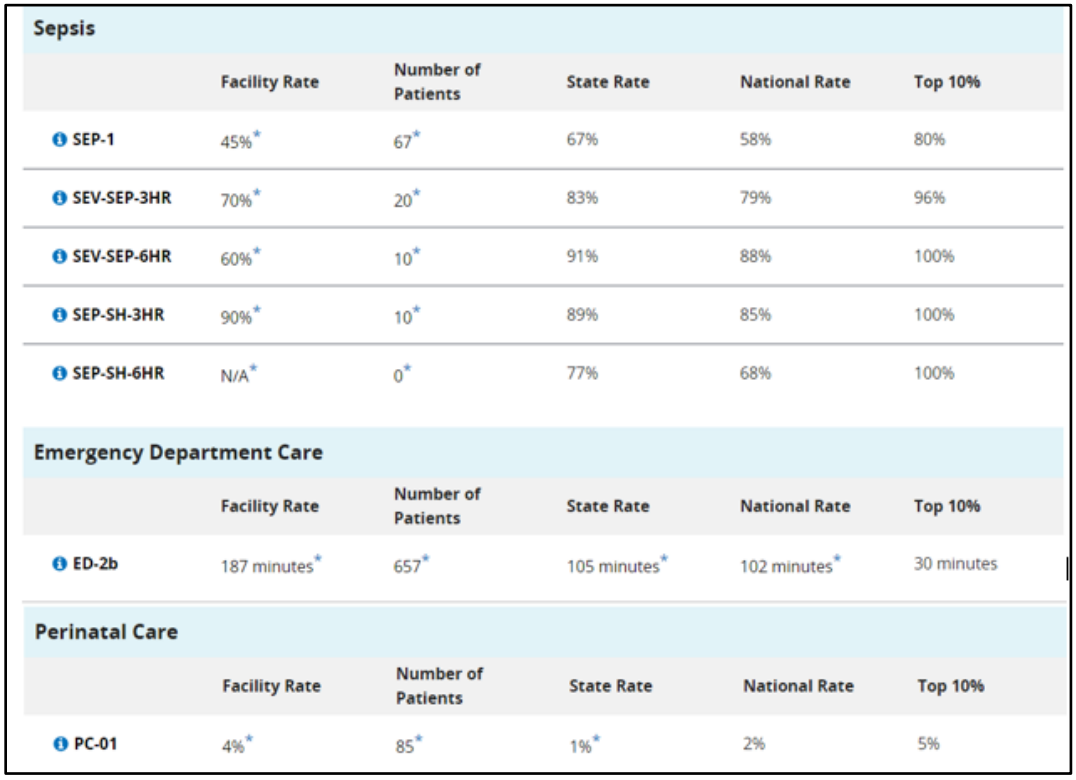
The measures contain up to four quarters of data and display as an aggregate rate.

In addition to the Severe Sepsis and Septic Shock (Sepsis [SEP-1]) measure, three-hour and six-hour bundles are displayed for Severe Sepsis and for Septic Shock. The bundle data includes first quarter and second quarter 2019 data only for this release and will have additional quarters added with each release until a full four quarters are available. Once four quarters are available, the data in the bundles will match the reporting quarters of the overall SEP-1 measure. The bundles will be included only in the downloadable databases and facility-level reports on *Hospital Compare* beginning with the January 2020 release.

Data displayed are for a full influenza season, quarter four through quarter one of the following year. IMM-3 reflects the same time period but is updated with data from the Centers for Disease Control and Prevention (CDC) for public reporting each year during the October *Hospital Compare* release.

SEP-1, SEV-SEP-3HR, SEV-SEP-6HR, SEP-SH-3HR, SEP-SH-6HR, ED-2b and PC-01 display the following data:

- Facility Rate
- Number of Patients
- State Rate
- National Rate
- Top 10%



Sepsis

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SEP-1	45%*	67*	67%	58%	80%
SEV-SEP-3HR	70%*	20*	83%	79%	96%
SEV-SEP-6HR	60%*	10*	91%	88%	100%
SEP-SH-3HR	90%*	10*	89%	85%	100%
SEP-SH-6HR	N/A*	0*	77%	68%	100%

Emergency Department Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
ED-2b	187 minutes*	657*	105 minutes*	102 minutes*	30 minutes

Perinatal Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
PC-01	4%*	85*	1%*	2%	5%

Denominators greater than zero and less than 11 will display on the Preview UI but will not be reported on *Hospital Compare*.

The state and national rates are calculated based on the data in the CMS Clinical Data Warehouse, regardless of whether your hospital elected to opt-out of publicly reporting data on *Hospital Compare*.

State Rate

The state performance rate is derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state. Median times are identified using all cases in the state. ED-2b display the state's average minutes for hospitals that fall in the Low, Medium, High, and Very High ED Volume Categories, plus the overall average minutes for all hospitals in the state.

National Rate

The national performance rate is derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation. Median times are identified using all cases in the nation. ED-2b display the national average minutes for hospitals that fall in the Low, Medium, High, and Very High ED Volume Categories, plus the overall average minutes for all hospitals in the nation.

Top 10%

The 90th percentile is calculated for each measure using the un-weighted average or median for each eligible hospital and identifying the top 10 percent of hospitals.

The EDV measure displays in the state or national modal and is based on the volume of patients submitted by a hospital as the denominator used for the Hospital OQR Program measure OP-22 (Patient Left without Being Seen). Category assignments are:

- Very High – values of 60,000 patients or more per year
- High – values ranging from 40,000 to 59,999 patients per year
- Medium – values ranging from 20,000 to 39,999 patients per year
- Low – values of 19,999 patients or less per year

Healthcare Personnel Influenza Vaccination

IMM-3 includes the number of healthcare workers contributing towards successful influenza vaccination adherence within the displayed time frame, (October 1 through March 31) regardless of clinical responsibility or patient contact.

The Influenza Vaccination Adherence Percentage is calculated as the total number of healthcare workers contributing to successful influenza vaccination adherence (i.e., the number of healthcare workers who were vaccinated at the facility or provided written documentation of vaccination elsewhere) divided by the total number of healthcare workers among whom influenza vaccination is measured per the CDC's National Healthcare Safety Network (NHSN) protocol. IMM-3 displays the following data:

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

Healthcare Personnel Influenza Vaccination

	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
IMM-3	97%	81%	90%

Facility's Adherence Rate

Facility's Adherence Rate is calculated as the total number of healthcare workers in your hospital contributing to successful vaccination adherence divided by the total number of healthcare workers in your hospital among whom influenza vaccination is measured per NHSN protocol.

State Adherence Rate

State Adherence Rate is calculated as the total number of healthcare workers in the state contributing to successful vaccination adherence divided by the total number of healthcare workers in the state among whom influenza vaccination is measured per NHSN protocol.

National Adherence Rate

National Adherence Rate is calculated as the total number of healthcare workers in the nation contributing to successful vaccination adherence divided by the total number of healthcare workers in the nation among whom influenza vaccination is measured per NHSN protocol.

+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-3, PSI-4, PSI-6, PSI-8, PSI-9, 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)

Surgical Complications (Comp-HIP-KNEE)

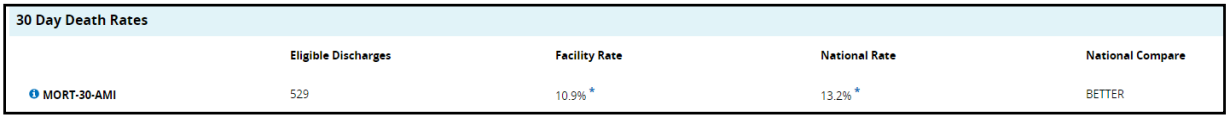
The 30-Day Death Rate measures, also referred to as the 30-Day Risk-Standardized Mortality measures, are typically updated annually during the July *Hospital Compare* release.

Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

- Hospitals with fewer than 25 eligible cases for the mortality measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing" and are included in the measure calculation but will not be reported on *Hospital Compare*.

30 Day Death Rate measures display the following data:

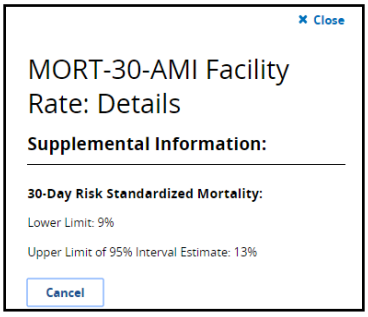
- Eligible [Medicare] Discharges
- Facility Rate
- National Rate
- National Compare



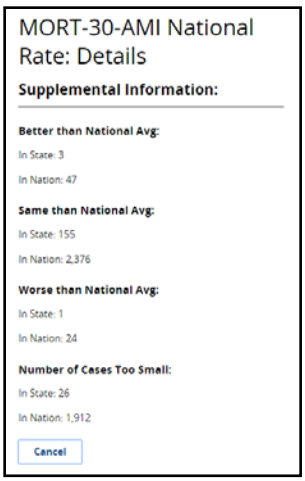
30 Day Death Rates

	Eligible Discharges	Facility Rate	National Rate	National Compare
MORT-30-AMI	529	10.9% *	13.2% *	BETTER

Additional details, including your hospital's Risk-Standardized Mortality Rate (RSMR) and 95% Interval Estimates, can be found by selecting the data next to the asterisk in the Facility Rate column.



State rates do not display for the Mortality measures. However, for each of the measures the national observed result and the number of hospitals in the state and the nation whose performance was categorized as Better, No Different, or Worse than the National Rate can be found by selecting the data next to the asterisk in the National Rate column in the accordion.



The Hospital-Specific Reports (HSRs) distributed to hospitals via the *QualityNet Secure Portal* provide the average state risk-standardized outcome rates and national-observed (unadjusted) rates for all of the mortality and readmission measures. The state and national averages include data from VHA hospitals for the following measures:

- MORT-30-AMI
- MORT-30-HF
- MORT-30-PN
- READM-30-AMI
- READM-30-HF
- READM-30-PN

CMS Patient Safety Indicators (PSIs)

The following are the CMS PSI measures reported on *Hospital Compare*:

- PSI-4 Rate of Death Among Surgical Inpatients with Serious Treatable Complications
- PSI-90 Patient Safety and Adverse Events Composite (CMS PSI-90 measure)

The following indicators are individual components of the CMS PSI-90 measure and are included in the accordion; however, these indicators will only display in the downloadable database on *Hospital Compare*:

- PSI-3 Pressure Ulcer Rate
- PSI-6 Iatrogenic Pneumothorax Rate
- PSI-8 In-Hospital Fall with Hip Fracture Rate
- PSI-9 Perioperative Hemorrhage or Hematoma Rate
- PSI-10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI-11 Postoperative Respiratory Failure Rate
- PSI-12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- PSI-13 Postoperative Sepsis Rate
- PSI-14 Postoperative Wound Dehiscence Rate
- PSI-15 Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

CMS PSIs display the following data:

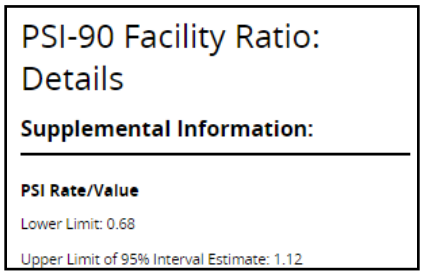
- Eligible [Medicare] Discharges
- Facility Ratio/Value (per 1,000 discharges)

- National Ratio/Value
- National Compare

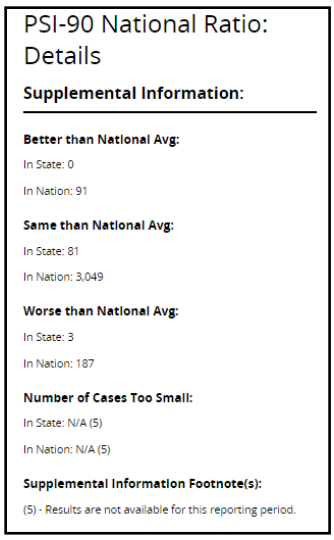
CMS Patient Safety Indicators

	Eligible Discharges	Facility Ratio	National Ratio	National Compare
PSI-3	10,822	0.17 *	0.41 *	SAME
PSI-4	145	161.31 *	161.73 *	SAME
PSI-6	14,020	0.38 *	0.29 *	SAME
PSI-8	11,457	0.14 *	0.11 *	SAME
PSI-9	3,760	2.65 *	2.6 *	SAME
PSI-10	1,683	0.65 *	1.32 *	SAME
PSI-11	1,205	6.02 *	7.88 *	SAME
PSI-12	3,973	5.57 *	3.86 *	WORSE
PSI-13	1,624	4.45 *	5.23 *	SAME
PSI-14	897	0.57 *	0.86 *	SAME
PSI-15	2,635	1.13 *	1.29 *	SAME
PSI-90	N/A *	0.9 *	1 *	SAME

Additional details, including your hospital's CMS PSI Rate/Value and 95% Interval Estimates, can be found by selecting the data next to the asterisk in the Facility Ratio column.



State ratios do not display for the CMS PSIs. However, for each of the measures, the national observed result and the number of hospitals in the state and the nation whose performance was categorized as Better than, Same as, or Worse than the National Ratio/Value can be found by selecting the data next to the asterisk in the National Ratio/Value column in the accordion.


PSI-90 National Ratio: Details

Supplemental Information:

Better than National Avg:

In State: 0

In Nation: 91

Same than National Avg:

In State: 81

In Nation: 3,049

Worse than National Avg:

In State: 3

In Nation: 187

Number of Cases Too Small:

In State: N/A (5)

In Nation: N/A (5)

Supplemental Information Footnote(s):

(5) - Results are not available for this reporting period.

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 *Hospital Compare.*

HAI Measure Definitions

HAI-1 — Central Line-associated Bloodstream Infection (CLABSI)

The CLABSI measure includes the number of laboratory-confirmed cases of CLABSI among adult, pediatric, neonatal intensive care unit (ICU), and selected ward patients for events identified within the displayed time frame. CLABSIs identified in patients with mucosal-barrier injury (MBI) are excluded.

HAI-2 — Catheter-associated Urinary Tract Infection (CAUTI)

The CAUTI measure includes the number of laboratory-confirmed cases of CAUTI among adult and pediatric ICU and selected ward patients for events identified within the displayed time frame.

HAI-3 — Surgical Site Infections 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.

HAI-4 — 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 present at time of surgery (PATOS) are excluded.

HAI-5 — 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.

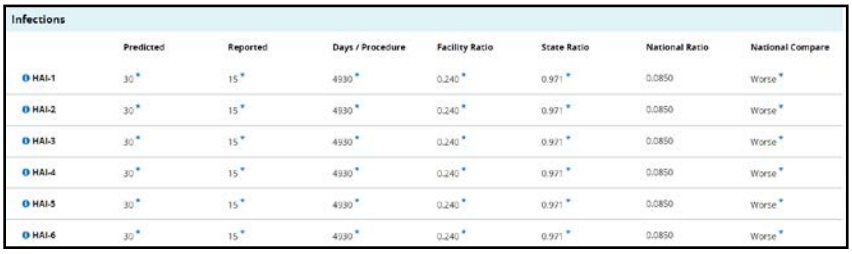
HAI-6 —Clostridium difficile (C. difficile) Infections

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.

HAI Measure Display

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

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



Infections	Predicted	Reported	Days / Procedure	Facility Ratio	State Ratio	National Ratio	National Compare
HAI-1	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-2	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-3	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-4	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-5	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *
HAI-6	30 *	15 *	4930 *	0.240 *	0.971 *	0.0850	Worse *

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 *Hospital Compare.*

Days/Procedure

HAI-1 (CLABSI): The number of central line days in hospital locations in scope (adult, pediatric, and neonatal ICUs, and selected wards) for quality reporting.

HAI-2 (CAUTI): The number of urinary catheter days in hospital locations in scope (adult and pediatric ICUs and selected wards) for quality reporting.

HAI-3 (SSI-Colon): The procedure count field on this preview and on *Hospital Compare* 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.

HAI-4 (SSI-Abdominal Hysterectomy): The procedure count field on this preview and on *Hospital Compare* 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.

HAI-5 (MRSA): The total number of patient days in hospital facility-wide inpatient locations in scope for quality reporting.

HAI-6 (*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.

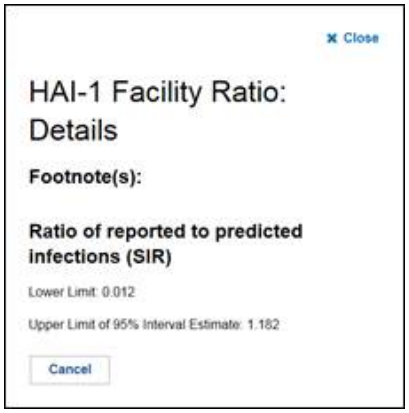
Facility Ratio (SIR)

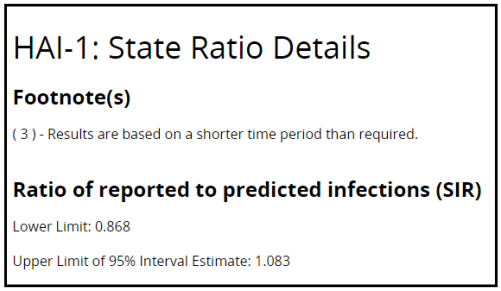
The SIR is a summary measure used to track HAIs at a facility, state, or national level over time. The SIR is calculated as observed number of infections (numerator) divided by the predicted number of infections (denominator). The number of predicted infections is adjusted based on several factors specific 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 and state ratios are provided in the associated modal by selecting the data next to the Facility Ratio or the State 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.

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 *Hospital Compare* 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

Surgical Complications

The following surgical complications measure is reported on *Hospital Compare*:

- Comp-HIP-KNEE - Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

This risk-standardized complication measure is typically updated annually during the July *Hospital Compare* release.

The surgical complications portion of the expanded accordion displays the RSCR Following Elective Primary THA and/or TKA measure. This measure is also referred to as the THA/TKA Complication measure.

Hospitals are not required to submit these data because CMS calculates the measure from claims and enrollment data.

- The measure is calculated using three years of data.
  - The performance period for the THA/TKA Complication measure starts and ends one quarter before the THA/TKA Readmission measure.
- Hospitals with fewer than 25 eligible cases for the THA/TKA Complication measure are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing" and are included in the measure calculation but will not be reported on *Hospital Compare*.

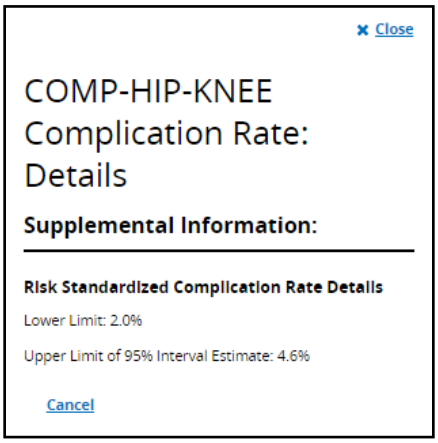
The Complication measure display includes the following data:

- Eligible [Medicare] Discharges
- Complication Rate
- National Rate
- National Compare

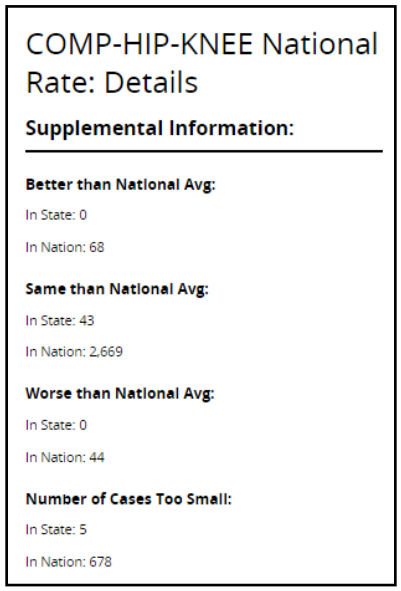
Surgical Complications

	Eligible Discharges	Complication Rate	National Rate	National Compare
COMP-HIP-KNEE	315	3% *	2.6% *	SAME

Additional details, including your hospital's RSCR and 95% Interval Estimates, can be found by selecting the data next to the asterisk in the Complication Rate column.



State rates do not display for the THA/TKA Complication measure. However, the national observed result and the number of hospitals in the state and the nation whose performance was categorized as Better than, Same as, Worse than the National Rate or Number of Cases Too Small to report can be found by selecting the data next to the asterisk in the National Rate column in the accordion.



+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)
Excess Days in Acute Care (EDAC-30-AMI, EDAC-30-HF, EDAC-30-PN)

The 30-Day Risk-Standardized Readmission Measures are typically updated annually during the July *Hospital Compare* release. Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

- With the exception of the Hospital-Wide Readmission measure, which is calculated using one year of data, the measures are all calculated using three years of data.
- Hospitals with fewer than 25 eligible cases for the readmission measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing" and are included in the measure calculation but will not be reported on *Hospital Compare*.

As shown in the image below, the readmission measures display:

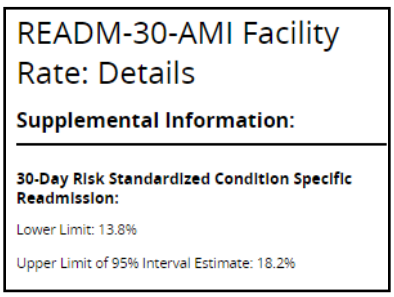
- Eligible [Medicare] Discharges
- Facility Rate
- National Rate
- National Compare

− Unplanned Hospital Visits

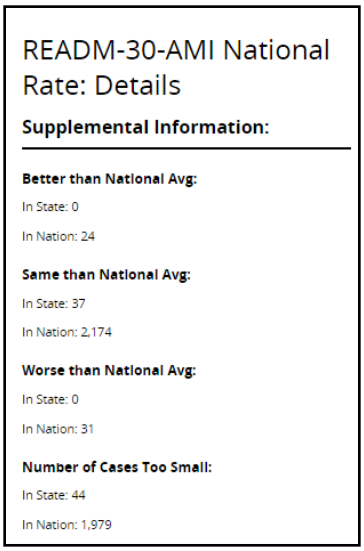
Condition Specific Readmission

	Eligible Discharges	Facility Rate	National Rate	National Compare
READM-30-AMI	198	16.8%*	15.7%*	SAME
READM-30-HF	502	23%*	21.6%*	SAME
READM-30-PN	332	16.9%*	16.6%*	SAME
READM-30-COPD	308	20.6%*	19.5%*	SAME

Your facility's Risk-Standardized Readmission Rate (RSRR) and 95% Interval Estimates are provided in a modal that can be viewed by selecting the data value for the measure in the Facility Rate column.



State rates do not display for the readmission measures. However, for each of the measures, the national observed result and the number of hospitals in the state and the nation whose performance was categorized as Better than, Same as, Worse than the National Rate or Number of Cases Too Small to report can be found by selecting the data next to the asterisk in the National Rate column in the accordion.



Excess Days in Acute Care

The Excess Days in Acute Care (EDAC) measures are typically updated annually during the July *Hospital Compare* release. Hospitals are not required to submit these data because CMS calculates the measures from claims and enrollment data.

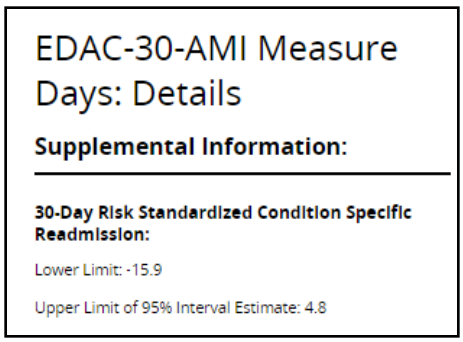
- The measures are calculated using three years of data.
- *Hospital Compare* will report EDAC as "Hospital Return Days" measures.
- Hospitals with fewer than 25 eligible cases for the EDAC measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing" and are included in the measure calculation but will not be reported on *Hospital Compare*.
- The EDAC measures incorporate the time spent in acute care (ED visits, observation stays, and unplanned readmissions) after discharge from the hospital.

EDAC measures display:

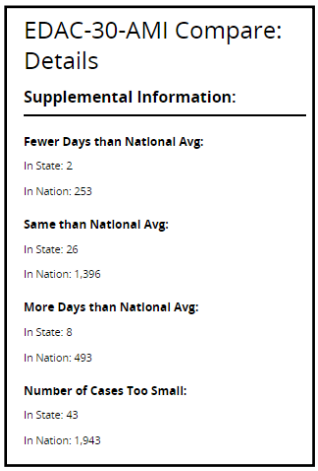
- Eligible [Medicare] Discharges
- Patients Included (number of patients included in the EDAC measure)
- Returning to a Hospital (number of patients who returned to a hospital)
- Measure Days (Your hospital's Excess Days)
- Compare (Your hospital's performance category)

	Eligible Discharges	Patients Included	Returned to a Hospital	Measure Days	Compare
EDAC-30-AMI	798	754	200	-5.9 *	SAME *

Your hospital's Measure Days and 95% Interval Estimates are provided in a modal that can be viewed by selecting the data next to the asterisk in the Measure Days column.



State rates are not calculated for the EDAC measures. However, for each of the measures, the number of hospitals in the state and the nation whose performance was categorized as Fewer Days than Average, Same as National Average Days, More Days than Average, or Number of Cases Too Small to report can be found by selecting the data next to the asterisk in the Compare column.



+Payment & Value of Care

Payment (PAYM-30-AMI, PAYM-30-HF, PAYM-30-PN, PAYM-90-HIP-KNEE)

Medicare Spending per Beneficiary (MSPB-1)

Medicare Payment Measure

The results for the Medicare condition- and procedure-specific payment measures are typically updated annually during the July *Hospital Compare* release. Hospitals are not required to submit payment measure data because CMS calculates the measure from claims and enrollment data.

- Measure results are calculated using three years of data.
- Hospitals with fewer than 25 eligible cases for the payment measures are assigned to a separate category described as "the number of cases is too small (fewer than 25) to reliably estimate the hospital's Risk-Standardized Payment (RSP)." Those hospitals are included in the measure calculation but will not be reported on *Hospital Compare*.
- These measures are hospital-level measures of payments for an episode of care that begins with an inpatient admission for the condition or procedure of interest and ends either 30 days for AMI, HF, and Pneumonia or 90 days for THA/TKA post-admission.

- These payment measures calculate Risk-Standardized Payments (RSPs), which add up payments for patients across multiple care settings, services, and supplies (i.e., inpatient, outpatient, skilled nursing facility, home health agency, hospice, physician/clinical laboratory/ambulance services, durable medical equipment, prosthetics/orthotics, and supplies) during the designated episode of care.
- While these payment measures only include Medicare fee-for-service beneficiaries, they capture payments made by Medicare, other health insurers, and the patients themselves.

Many of the specifications of these payment measures were closely aligned with the specifications of the corresponding mortality measures for AMI, HF, and Pneumonia. The THA/TKA payment measure aligns with the corresponding surgical complication measure. The payment measures risk-adjust for patient age and comorbid conditions. These measures also remove differences due to geographic variation or policy adjustments. A lower or higher RSP does not, by itself, imply that a hospital is providing better care. As the AMI, HF, and Pneumonia payment measure specifications align with those of the mortality measures, and, as the THA/TKA payment measure specifications align with those of the surgical complication measure, RSPs for AMI, HF, Pneumonia, or THA/TKA should be considered alongside hospital performance on the corresponding outcome measure for that condition or procedure.

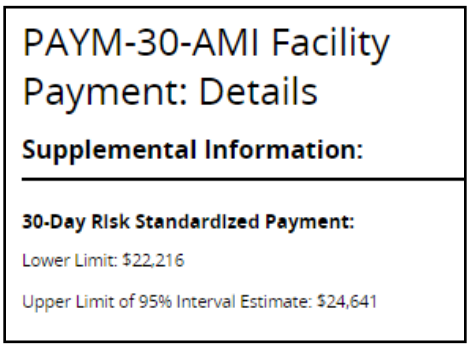
Payment measure display:

- Eligible [Medicare] Discharges
- Facility Payment
- National Average Payment
- National Compare

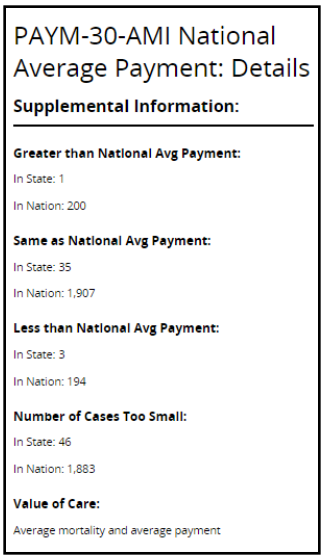
Payment

	Eligible Discharges	Facility Payment	National Average Payment	National Compare
PAYM-30-AMI	715	$23,394 *	$23,745 *	SAME
PAYM-30-HF	813	$17,041 *	$16,632 *	SAME
PAYM-30-PN	534	$18,281 *	$17,415 *	SAME
PAYM-90-HIP-KNEE	310	$25,812 *	$21,953 *	WORSE

The Preview UI will display the Eligible Discharges, Facility Payment, National Average Payment, and National Compare payment category (Greater than, Same as, or Less than the National Average Payment) for each measure. The RSP and 95% Interval Estimates can be viewed by selecting the data next to the asterisk in the Facility Payment column.



State payment averages are not calculated for the payment measures. However, for each of the measures, the national average payment and the number of hospitals in the state and the nation whose performance was categorized as Greater than National Avg Payment, Same as National Avg Payment, Less than National Avg Payment, or Number of Cases Too Small to report can be found by selecting the data next to the asterisk in the National Average Payment column.


PAYM-30-AMI National Average Payment: Details

Supplemental Information:

Greater than National Avg Payment:

In State: 1

In Nation: 200

Same as National Avg Payment:

In State: 35

In Nation: 1,907

Less than National Avg Payment:

In State: 3

In Nation: 194

Number of Cases Too Small:

In State: 46

In Nation: 1,883

Value of Care:

Average mortality and average payment

The Value of Care category displays the mortality/complication and payment values for each hospital and can be found in the National Average Payment Detail Modal.

Medicare Spending per Beneficiary

The Medicare Spending per Beneficiary (MSPB) measure assesses Medicare Part A and Part B payments for services provided to a Medicare beneficiary during an episode that spans from three days prior to an inpatient hospital admission through 30 days after discharge. The payments included in this measure are price-standardized and risk-adjusted. Price standardization removes sources of variation that are due to geographic payment differences, such as wage index, geographic practice cost differences, indirect medical education (IME), or disproportionate share hospital (DSH) payments. Risk adjustment accounts for variation due to patient age and health status.

By measuring cost of care through this measure, CMS hopes to increase the transparency of care for consumers and recognize hospitals for the provision of high-quality care.

- MSPB-1 Medicare Spending per Beneficiary

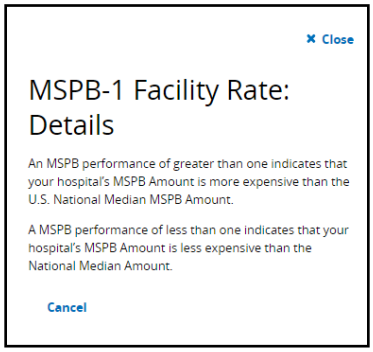
The results for the MSPB measure will be updated annually during the January *Hospital Compare* release. Hospitals are not required to submit data for the measure because CMS calculates the measure from claims and enrollment data.

- Measure results are calculated using one year of data.
- A performance of greater than one indicates that your hospital's MSPB Amount is more expensive than the U.S. National Median Amount.
- A performance of less than one indicates that your hospital's MSPB Amount is less expensive than the U.S. National Median Amount.

- Your hospital's MSPB performance is the ratio of your hospital's price-standardized, risk-adjusted MSPB Amount to the episode-weighted median MSPB Amount across all hospitals.

MSPB measure will display:

- Facility Rate
- State Rate
- National Rate
- National Median Amount



Medicare Spending per Beneficiary

	Facility Rate	State Rate	National Rate	National Median Amount
MSPB-1	0.99 *	1	0.99	$21,127.95

Withholding Data from *Hospital Compare*

Hospitals participating in the Hospital IQR Program agree to have data publicly reported on *Hospital Compare*.

Hospitals voluntarily submitting data to the Hospital IQR Program have an option to withhold data from public reporting on *Hospital Compare*. The option to request withholding of data from *Hospital Compare* is only available during the 30-day preview period.

Withholding Overview

To withhold publication of data, your hospital must complete and fax or email an **Inpatient *Hospital Compare* Request for Withholding Data from Public Reporting Form** on or before the last day of the preview period to the Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor.

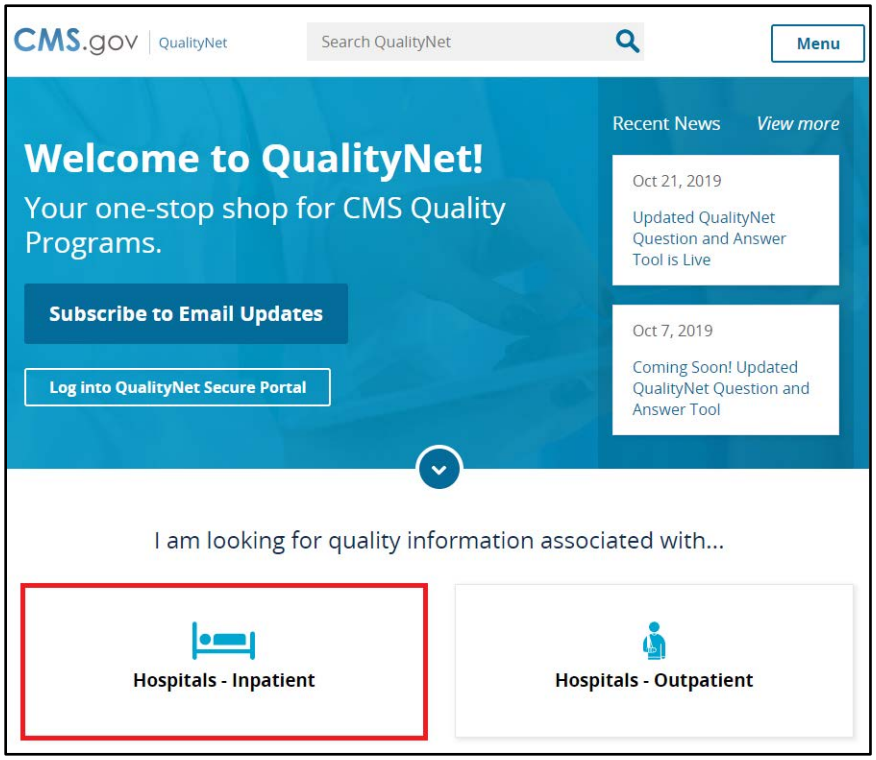
Hospitals that do not have an appropriate Notice of Participation, or pledge, display only the CCN, hospital name and the following message: "You do not have an Inpatient Notice of Participation to publicly report data for the Preview period."

NOTE: If you received this message in error, contact the Inpatient VIQR Support Contractor prior to the last day of the preview period.

Questions regarding the Hospital IQR Program may be directed to the Inpatient VIQR Support Contractor through the *QualityNet* Question and Answer Tool, or by calling, toll-free, (844) 472-4477 or (866) 800-8765 weekdays from 8 a.m. to 8 p.m. ET.

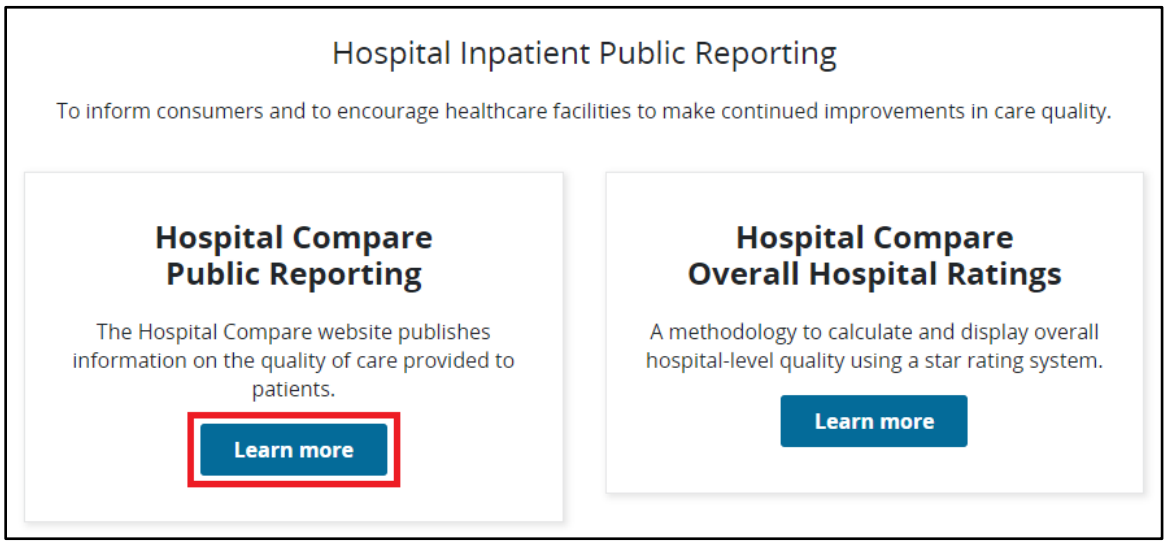
Procedure to Withhold Data

1. Access the public website for *QualityNet* at https://www.qualitynet.org.
2. Click on the **Hospitals - Inpatient** card.



3. Select the **Public Reporting** tab.

4. Select **Learn more** under Hospital Compare Public Reporting.



5. Select the **Resources** tab.

6. Select the **Request for Withholding Data from Public Reporting** form. Your hospital must complete the form and fax or email to the Inpatient VIQR Support Contractor prior to the last day of the preview period at secure fax 1 (877) 789-4443 or email QRFormsSubmission@hsag.com.

Any forms received after the preview period **will not have the requested measures withheld** for that *Hospital Compare* release.

Measure IDs Included in Measure Accordions

Measure Accordion	Measure IDs Included
Survey of Patient's Experience	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) HCAHPS Summary Star Ratings Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Pain Communication 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 (ED-2b, OP-18b, OP-18c, OP-22, OP-23) Immunization (IPFQR-IMM-2) Healthcare Personnel Influenza Vaccination (IMM-3, PCH-28) Perinatal Care (PC-01) Cardiac Care (OP-2, OP-3b) Cancer Care (OP-33) Cataract (OP-31) Colonoscopy (OP-29, OP-30)
Structural Measures	Structural Measures (OP-12, OP-17)
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-3, PSI-4, PSI-6, PSI-8, PSI-9, 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-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) 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)
Continuity of Care	Transition Record (TR1, TR2) Hospital-Based Inpatient Psychiatric Services (HBIPS-5) Follow-Up After Hospitalization for Mental Illness (FUH-7, FUH-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)
Use of Medical Imaging	Imaging Efficiency (OP-8, OP-9, OP-10, OP-11, OP-13, OP-14)
Process Measures	Oncology Care (PCH-14, PCH-15, PCH-16, PCH-17, PCH-18) External Beam Radiotherapy (PCH-25)

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 zero and less than eleven. Data will not display on *Hospital 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 *Hospital Compare.* Measures based on claims 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 *Hospital Compare.)*

Number	Description	Application
6	Fewer than 100 patients completed the 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 zero	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.
22	Overall star ratings are not calculated for VHA or DoD hospitals.	VHA hospitals are not included in the calculations of the *Hospital Compare* overall rating. DoD hospitals are not included in the calculations of the *Hospital Compare* overall rating or the HCAHPS star ratings.

Number	Description	Application
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.

Question Resources

NOTE: Questions should be directed to the subject matter experts listed below. Secure File Transfer is not intended for question submission.

Clinical Process, HAI, and HCP Influenza Vaccination Measures

Contact the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contract Team via the *QualityNet* Question and Answer Tool, or call, toll-free, (844) 472-4477 or (866) 800-8765 weekdays from 8 a.m. to 8 p.m. ET

CMS PSI Measures

For questions regarding the CMS PSIs, refer to CMS Patient Safety Indicators v9.0 Fact Sheet (on the Resources page on *QualityNet*), or contact the *QualityNet* Help Desk via the *QualityNet* Question and Answer Tool.

HCAHPS Measures

Contact the HCAHPS Project Team via the hcahps@hsag.com.

MSPB Measures

Please direct all MSPB inquiries to the *QualityNet* Help Desk via the *QualityNet* Question and Answer Tool

Outcome Measures

Please contact the:

- Mortality Measures Implementation Team by email at cmsmortalitymeasures@yale.edu
- Readmission Measures Implementation Team by email at cmsreadmissionmeasures@yale.edu
- THA/TKA Complication Measures Implementation Team by email at cmscomplicationmeasures@yale.edu
- EDAC Measure Implementation Team by email at cmsedacmeasures@yale.edu.
- Payment Measure Implementation Team by email at cmsepisodepaymentmeasures@yale.edu.

Overall Hospital Quality Star Ratings

Please contact the Overall Hospital Quality Star Ratings Team via the *QualityNet* Question and Answer Tool.

Sepsis Measures

For questions regarding Sepsis, refer to the Specifications Manual page on *QualityNet*.