Inpatient Hospital Compare
Preview Report Help Guide

The target audience for this publication is hospitals. The document scope is limited to instructions for hospitals on how to access and understand the data provided on the Preview Report prior to publication of data on Hospital Compare.

January 2016 Preview/April 2016 Hospital Compare Release
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Inpatient Hospital Compare

Preview Report Help Guide

Section 1: Overview

Hospital Compare

The Centers for Medicare & Medicaid Services (CMS) and the nation's hospitals worked collaboratively to create and publicly report hospital quality performance information on the Hospital Compare website located at http://www.medicare.gov/hospitalcompare.

Hospital Compare presents 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 eligible to receive a reduction in their annual Medicare payment if they do not participate by submitting data initially established by Section 501(b) of the Medicare Modernization Act (MMA), which was extended and expanded by Section 5001(a) of the Deficit Reduction Act.

A substantial proportion of hospitals volunteer to provide information for Hospital Compare on measures not initially included in the reduction of the annual Medicare payment arrangement. Hospitals that volunteer to participate and submit cases for one or more measures may choose to have any or all of the information displayed on Hospital Compare.

Hospital Inpatient Prospective Payment Systems (IPPS)

Section 1886(d) of the Social Security Act (the 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 Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under the Inpatient Prospective Payment System (IPPS). Under 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).

Preview Period

Prior to the release of data on Hospital Compare, hospitals are given the opportunity to review data during a 30-day preview period via the QualityNet Secure Portal, the only CMS-approved website for secure healthcare quality data exchange at https://www.qualitynet.org.
Section 2: Preview Report Access

NOTE: Users must be enrolled and proofed in the QualityNet Secure Portal in order to access the Preview Report.

The Preview Report is accessed via the QualityNet Secure Portal. To access a Preview Report, the user must be:

1. **Registered as a QualityNet user**
   a. Registration Instructions are available on the QualityNet homepage by selecting the [Hospitals-Inpatient] link under the QualityNet Registration header in the first navigation box on the left-hand side of the page at direct link: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1205442058760.

2. **Enrolled for access to the QualityNet Secure Portal**

3. **Assigned the “Hospital Reporting Feedback - Inpatient” role**
   a. This role must be assigned by a hospital’s QualityNet Security Administrator (SA).
Access Preview Report

Follow the instructions below to access the preview report:

2. Select [Login] under the Log in to QualityNet Secure Portal header.
4. Read the Terms and Conditions statement and select [I Accept] to proceed. Note: If [I Decline] is selected, the program closes.

Run Preview Report

1. Select [Run Reports] from the My Reports drop-down.


![Image of Report Category drop-down]

4. Select [View Reports]. The selected report will display under Report Name.

![Image of View Reports option]


6. Select [Run Reports].

**View Preview Report**

Select the [Search Reports] tab. The report requested will display, as well as the report status. A green check mark will display in the Status column when the report is complete. Once complete, the report can be viewed or downloaded.
Section 3: Preview Report Details

The Preview Report displays your hospital characteristics information at the top of each section. Your hospital CMS Certification Number (CCN) and name display above the hospital characteristics information. Hospital characteristics include your hospital’s Address, City, State, ZIP Code, Telephone Number, County Name, Type of Facility, Type of Ownership, and Emergency Service Provided status.

Type of Ownership is not publicly reported; however, this is available in the downloadable database on Hospital Compare.

If the hospital characteristics displayed are incorrect, your hospital should contact your state Certification and Survey Provider Enhanced Reporting (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. Once the screen refreshes, select the [CASPER/ASPEN] (Automated Survey Processing Environment) contacts link from the left-side navigation pane (direct link):


When your hospital’s state CASPER agency is unable to make the needed change, your hospital should contact its CMS regional office.

Preview Report Star Ratings and Measures

Overall Hospital Quality Star Ratings

The Overall Hospital Quality Star Rating summarizes information from the existing quality information across seven groups (Outcomes – Mortality; Outcomes – Safety; Outcomes – Readmissions; Patient Experience; Process – Effectiveness of Care; Process – Timeliness of Care; and Efficiency – Imaging) in a statistically sound way that is useful and interpretable for patients and consumers. These star ratings are intended to supplement, not replace, the information on the Hospital Compare website.

The Overall Hospital Quality Star Rating is based on a hospital’s available Inpatient and Outpatient Quality Reporting (IQR and OQR) data that will be posted to Hospital Compare in April 2016. Hospitals will receive an overall star rating (1, 2, 3, 4, or 5 stars) and categorical ratings for each of the measure groups (Above the National Average; No Different than the
National Average; or Below the National Average). The Preview Report also contains supplemental information for the hospital to understand the calculation of the overall star ratings, which includes an overall summary score (the weighted average of each hospital’s available group scores); the hospital’s group scores; the national average group score for each of the seven groups; the number of measures included in the hospital’s calculation of the group scores; and the weighting of each group used to calculate the overall summary score.

Please refer to the Overall Hospital Quality Star Ratings methodology resources on QualityNet (www.qualitynet.org > Hospitals-Inpatient > Hospital Star Ratings > Methodology Resources or www.qualitynet.org > Hospitals-Outpatient > Hospital Star Ratings > Methodology Resources) for a detailed discussion of the ratings’ calculation.

The Hospital Compare Preview Report has two Star Rating sections:

- Overall Hospital Star Rating
- Overall Hospital Star Rating Group Scores

Overall Hospital Star Rating section:

- Your Hospital’s Overall Star Rating – 1, 2, 3, 4 or 5. A hospital will only receive a star rating if they have at least three group scores (of which one must be an outcome group) with at least three measures in each group.
- Your Overall Summary Score – the weighted average of the hospital’s latent variable group scores.

Overall Hospital Star Rating Group Scores section:

- Group — Hospital quality is represented by several dimensions, ranging from clinical care processes to initiatives focused on care transitions to patients’ experiences. Overall Hospital Star Ratings include seven measure groups:
  - Outcome: Mortality
  - Outcome: Safety of Care
  - Outcome: Readmission
  - Patient Experience
  - Process: Effectiveness of Care
  - Process: Timeliness of Care
  - Efficiency: Imaging Use
- Number of Measures — the number of measures used to calculate the hospital’s group scores. This is based on the data reported by the hospital.
  - Star Ratings aims to be inclusive of measures on Hospital Compare. However, the following types of measures will not be incorporated into hospitals’ star ratings: (1) measures that have been suspended, retired, or delayed from Hospital Compare; (2) duplicative measures already captured in a composite measure; (3) measures that are not required under IQR or OQR; (4) measures with fewer than
100 hospitals reporting on that measure; (5) structural measures without evidence of association with improved outcomes; and (6) non-directional measures (for which it is not clear if higher or lower score is better).

- The table below includes a full list of the measures included in each group that may be used in calculating the overall star rating.

<table>
<thead>
<tr>
<th>Measure Group</th>
<th>Possible Measures Included*</th>
</tr>
</thead>
</table>
| **Outcome:** Mortality | • 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: Stroke 30-day mortality rate  
• PSI-4-SURG-COMP: Death among surgical patients with serious, treatable complications |
| Outcome: Safety of Care | • HAI-1: Central-Line Associated Bloodstream Infection (CLABSI) – ICU and Ward Specific  
• HAI-2: Catheter-Associated Urinary Tract Infections (CAUTI) – ICU and Ward Specific  
• HAI-3: Surgical Site Infection from colon surgery (SSI: Colon)  
• HAI-4: Surgical Site Infection from abdominal hysterectomy (SSI: abdominal hysterectomy)  
• HAI-5: 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 Total Knee Arthroplasty (TKA)  
• PSI-90-Safety: Complication/Patient Safety for Selected Indicators (PSI) |
| Outcome: Readmission | • READM-30-AMI: Acute Myocardial Infarction (AMI) 30-day Readmission Rate  
• 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-HF: Heart Failure (HF) 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-PN: Pneumonia (PN) 30-Day Readmission Rate  
• READM-30-STK: Stroke (STK) 30-Day Readmission Rate  
• READM-30-HOSP-WIDE: HWR Hospital-Wide All-Cause Unplanned Readmission |
| Patient Experience | • H-CLEAN-HSP: Cleanliness of Hospital Environment (Q8)  
• H-COMP-1: Nurse Communication (Q1, Q2, Q3) |
<table>
<thead>
<tr>
<th>Measure Group</th>
<th>Possible Measures Included*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• H-COMP-2: Doctor Communication (Q5, Q6, Q7)</td>
</tr>
<tr>
<td></td>
<td>• H-COMP-3: Responsiveness of Hospital Staff (Q4, Q11)</td>
</tr>
<tr>
<td></td>
<td>• H-COMP-4: Pain Management (Q13, Q14)</td>
</tr>
<tr>
<td></td>
<td>• H-COMP-5: Communication About Medicines (Q16, Q17)</td>
</tr>
<tr>
<td></td>
<td>• H-COMP-6: Discharge Information (Q19, Q20)</td>
</tr>
<tr>
<td></td>
<td>• H-HSP-RATING: Overall Rating of Hospital (Q21)</td>
</tr>
<tr>
<td></td>
<td>• H-QUIET-HSP: Quietness of Hospital Environment (Q9)</td>
</tr>
<tr>
<td></td>
<td>• H-RECMND: Willingness to Recommend Hospital (Q22)</td>
</tr>
<tr>
<td></td>
<td>• H-COMP-7: HCAHPS 3 Item Care Transition Measure (CTM-3)</td>
</tr>
<tr>
<td>Process: Effectiveness of Care</td>
<td>• AMI-7a: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival</td>
</tr>
<tr>
<td></td>
<td>• CAC-3: Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver</td>
</tr>
<tr>
<td></td>
<td>• IMM-2: Influenza Immunization</td>
</tr>
<tr>
<td></td>
<td>• OP-2: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival</td>
</tr>
<tr>
<td></td>
<td>• OP-4: Aspirin at Arrival</td>
</tr>
<tr>
<td></td>
<td>• OP-22: Patient left without being seen</td>
</tr>
<tr>
<td></td>
<td>• OP-23: Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival</td>
</tr>
<tr>
<td></td>
<td>• PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation</td>
</tr>
<tr>
<td></td>
<td>• STK-1: Venous Thromboembolism (VTE) Prophylaxis</td>
</tr>
<tr>
<td></td>
<td>• STK-4: Thrombolytic Therapy</td>
</tr>
<tr>
<td></td>
<td>• STK-6: Discharged on Statin Medication</td>
</tr>
<tr>
<td></td>
<td>• STK-8: Stroke Education</td>
</tr>
<tr>
<td></td>
<td>• VTE-1: Venous Thromboembolism Prophylaxis</td>
</tr>
<tr>
<td></td>
<td>• VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis</td>
</tr>
<tr>
<td></td>
<td>• VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy</td>
</tr>
<tr>
<td></td>
<td>• VTE-5: Venous Thromboembolism Warfarin Therapy Discharge Instructions</td>
</tr>
<tr>
<td></td>
<td>• VTE-6: Hospital Acquired Potentially-Preventable Venous Thromboembolism</td>
</tr>
<tr>
<td>Process: Timeliness of Care</td>
<td>• ED-1b: Median Time from ED Arrival to ED Departure for Admitted ED Patients</td>
</tr>
<tr>
<td></td>
<td>• ED-2b: Admit Decision Time to ED Departure Time for Admitted Patients</td>
</tr>
<tr>
<td></td>
<td>• OP-1: Median Time to Fibrinolysis</td>
</tr>
<tr>
<td></td>
<td>• OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention</td>
</tr>
<tr>
<td></td>
<td>• OP-5: Median Time to ECG</td>
</tr>
</tbody>
</table>
|               | • OP-18b/ED-3: Median Time from ED Arrival to ED Departure for...
<table>
<thead>
<tr>
<th>Measure Group</th>
<th>Possible Measures Included*</th>
</tr>
</thead>
</table>
| 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 |
| Efficiency: Imaging Use | • OP-8: MRI Lumbar Spine for Low Back Pain  
• OP-10: Abdomen 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 CT |

* Measures with less than 100 hospitals reporting are not included in the star rating calculations. A complete list of measures with a list of excluded measures will be available January 25, 2016 on QualityNet.

- For hospitals participating in both IQR and OQR and reporting IMM-3 and OP-27, only one score will be used. For hospitals participating in IQR only, the IMM-3 score will be used. For hospitals participating in OQR only, the OP-27 score will be used.
- Weight – The weight used for the specified measure 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 in order to calculate a hospital summary score. The weighting scheme, based on the CMS Quality Strategy, is consistent with the weights used for the Hospital VBP program. If a hospital does not report on all seven measure groups, the missing percentage of weight is redistributed among the reported measure groups proportionally.
- Group Score – The latent variable score calculated for each measure group.
- National Group Score – National average group score for each group based on data available across all hospitals.
- Category – This provides the hospital with a national comparison across a three-point scale for each of the hospital’s available group scores: Above the National Average, No Different than the National Average, or Below the National Average.

**Overall Hospital Quality Star Ratings Footnotes**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS.</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
<td>Application</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 16     | The hospital did not have enough measures or measure groups to receive a measure group score or a star rating. | This footnote is applied when a hospital:  
- Reported data for fewer than three measures in any measure group used to calculate star ratings; or  
- Reported data for fewer than three of the measure groups used to calculate star ratings; or  
- Did not report data for at least one outcomes measure group. |
| 17     | The hospital’s star rating is calculated with IQR data only. | This footnote is applied when a hospital only reports data for inpatient hospital services. |

**Questions Regarding the Overall Hospital Quality Star Rating**

Questions regarding the Overall Hospital Quality Star Rating may be directed to the Star Rating Implementation Team by email at: cmsstarratings@lantanagroup.com.

**Structural Measures**

The Structural Measures section follows the hospital characteristics section. Data are entered in the *QualityNet Secure Portal* web-based data collection tool from April 1 through May 15 annually and updated with the December *Hospital Compare* release.

<table>
<thead>
<tr>
<th>Structural Measures (SM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SM-1</td>
</tr>
<tr>
<td>SM-3</td>
</tr>
<tr>
<td>SM-4</td>
</tr>
<tr>
<td>SM-5</td>
</tr>
</tbody>
</table>

**Clinical Process Measures**

The Clinical Process Measure sets include: Acute Myocardial Infarction (AMI); Heart Failure (HF); Pneumonia (PN); Surgical Care Improvement Project (SCIP); Emergency Department (ED); Emergency Department Volume (EDV); Immunization Measures (IMM); Stroke (STK); Venous Thromboembolism (VTE); and Perinatal Care (PC). The measure sets contain up to four quarters of data and display as an aggregate rate.

Each measure displays:
- Your Hospital Performance for All Quarters (when submitted)
- 10% of All Hospitals Submitting Data Performed Equal to or Better Than (i.e., 90th percentile)
Clinical Process Measure Details

The Preview Report displays an aggregate of four rolling quarters of data (a new quarter of data is added and the oldest quarter removed). The Clinical Process measures data are updated quarterly.

The EDV measure displays based on the volume of patients submitted by a hospital as the denominator used for the OQR measure OP-22, Patient Left Without Being Seen. Category assignments are:

- Very High – values greater than 60,000 patients 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 below 19,999 patients per year

Measures No Longer Required for IQR APU

- The Preview Report displays measures no longer required to meet annual payment update (APU) requirements.
- AMI-8a, HF-2, PN-6, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2, STK-2, STK-3, STK-5, STK-10, and VTE-4 display data submitted voluntarily by the hospital. These measures may be suppressed from Public Reporting by completing the Request for Withholding Data From Public Reporting Form and submitting the form to the Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Support Contractor no later than close of business on the last day of Preview. When less than the full four quarters of data are displayed in the aggregate, Footnote 3 is applied.

Measures Removed From Hospital Compare

Beginning with the December 2015 Hospital Compare release, the chart-abstracted measures, AMI-2, AMI-10, HF-1, HF-3, and SCIP-Inf-10 are not displayed on the Preview Report or on Hospital Compare.

Influenza Immunization (IMM-2)

The aggregate rate for IMM-2 includes data collected only during the influenza season quarters. Data displayed is for a full influenza season, 4Q–1Q, and will refresh with each December release.

Perinatal Care (PC-01): Elective Delivery

The aggregate rate is generated from count data reported as a percentage of patients with elective deliveries. Data are entered using the QualityNet Secure Portal web-based data collection tool.
Clinical Process Measures Footnotes

Clinical Process Measures Footnote Table

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The number of cases/patients is too few to report.</td>
<td>Applied to any measure rate where the denominators are greater than 0 and less than 11. Data will not display on Hospital Compare.</td>
</tr>
<tr>
<td>2</td>
<td>Data submitted were based on a sample of cases/patients.</td>
<td>Applied when any case submitted to the Warehouse was sampled for a reported quarter for a topic. Applied at the topic level, e.g., AMI.</td>
</tr>
<tr>
<td>3</td>
<td>Results are based on a shorter time period than required.</td>
<td>Applied when a hospital elected not to submit data, had no data to submit, or did not successfully submit data to the Warehouse for a measure for one or more, but not all possible quarters.</td>
</tr>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS.</td>
</tr>
<tr>
<td>5</td>
<td>Results are not available for this reporting period.</td>
<td>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.</td>
</tr>
<tr>
<td>7</td>
<td>No cases met the criteria for this measure.</td>
<td>Applied when a hospital treated patients for a particular topic, but no patients met the criteria for inclusion in the measure calculation.</td>
</tr>
</tbody>
</table>

State and National Performance Rates

The state and national performance rates for the Clinical Process measures are calculated based on the data in the Warehouse, regardless of whether or not your hospital elected to opt-out of publicly reporting data on Hospital Compare.

State Performance: 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-1b and 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 the state.

**National Performance:** 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.

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.

• ED-1b and 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 the nation.

**Rounding Rules**

All rates (provider, state, and national) are rounded to the nearest whole number (i.e., no use of fractions) 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.)

**Questions Regarding Clinical Process Measures**

Questions regarding the Hospital IQR Program may be directed to the Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Support Contractor (SC) through the Inpatient Questions and Answers tool at: https://cms-ip.custhelp.com/, or by calling, toll-free, 844.472.4477 or 866.800.8765 weekdays from 8 a.m. to 8 p.m. ET.

**HCAHPS Survey Data**

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data section of the report contains 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 Report contains 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 Report. Hospitals will receive an HCAHPS Star Rating (1, 2, 3, 4, or 5 stars) for each of the 11 HCAHPS measures plus the HCAHPS Summary Star Rating, which is a single summary of all the HCAHPS Star Ratings. The Preview Report also contains 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.

The HCAHPS Survey Results have four sections:

- HCAHPS Survey Completion, Response Rate, and Summary Star Rating
- HCAHPS Star Ratings and HCAHPS Linear Mean Scores
- HCAHPS Composites and Individual Items
- HCAHPS Global Items

HCAHPS Survey Completion, Response Rate, and Summary Star Rating section includes:

- Number of Completed Surveys
  - Please note that, beginning October 2015, Hospital Compare switched from displaying the number of completed surveys in ranges such as “300 or more,” to displaying the exact number of completed surveys, such as “403.” However, if the number of completed surveys is between 1 and 49, then Fewer than 50 will be displayed along with Footnote 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.

- Survey Response Rate
- HCAHPS Summary Star Rating

HCAHPS Composites and Individual Items section includes:

- **HCAHPS Composites**
  - Composite 1–Communication with Nurses (Q1, Q2, Q3)
  - Composite 2–Communication with Doctors (Q5, Q6, Q7)
  - Composite 3–Responsiveness of Hospital Staff (Q4, Q11)
  - Composite 4–Pain Management (Q13, Q14)
  - Composite 5–Communication about Medicines (Q16, Q17)

- **Hospital Environment Items**
  - Cleanliness of Hospital Environment (Q8)
  - Quietness of Hospital Environment (Q9)
• Discharge Information Composite  
  o Composite 6–Discharge Information (Q19, Q20)

• Care Transition Composite  
  o Composite 7–Care Transition (Q23, Q24, Q25)

HCAHPS Global Items section includes:  
  o Overall Rating of Hospital (Q21)  
  o Willingness to Recommend this Hospital (Q22)

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

• HCAHPS Star Ratings are provided for each of the seven composite measures, two environment items, and two global items.
• 1, 2, 3, 4, or 5 whole stars are assigned to each of the 11 HCAHPS measures plus the HCAHPS Summary Star Rating.

Linear Mean Scores:
• Are provided for each of the seven composite measures, two environment items, and two global items; and
• Will be available in the downloadable database on Hospital Compare beginning in October 2015.

HCAHPS Measure Details

All IPPS hospitals must continuously collect and submit HCAHPS data in order to qualify for the full APU. All participating hospitals receive a Preview Report, 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 suppress HCAHPS data.*
## HCAHPS Measures Footnotes

### HCAHPS Measure Footnote Table

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The number of cases/patients is too few to report.</td>
<td>Applied when a hospital has zero cases, or five or fewer eligible HCAHPS patient discharges</td>
</tr>
<tr>
<td>3</td>
<td>Results are based on a shorter time period than required.</td>
<td>Applied when CMS has opted to display HCAHPS results on fewer than the required months of survey data.</td>
</tr>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS</td>
</tr>
<tr>
<td>5</td>
<td>Results are not available for this reporting period.</td>
<td>Applied in the following situations:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• When a hospital did not participate in HCAHPS during the period covered by the preview report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• When a hospital participated in HCAHPS but only for a portion of the period covered by the preview report</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• When a hospital has HCAHPS results but chose to suppress the public reporting of its results. In this situation, a hospital will see its HCAHPS results on its Preview Report, but results will be suppressed on <em>Hospital Compare</em></td>
</tr>
<tr>
<td>6</td>
<td>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.</td>
<td>Applied when the number of completed HCAHPS surveys is 50–99</td>
</tr>
<tr>
<td>10</td>
<td>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.</td>
<td>Applied when the number of completed HCAHPS surveys is 1–49</td>
</tr>
<tr>
<td>11</td>
<td>There were discrepancies in the data collection process.</td>
<td>Applied when there have been deviations from HCAHPS data collection protocols</td>
</tr>
<tr>
<td>15</td>
<td>The number of cases/patients is too few to report a Star Rating.</td>
<td>Applied when CMS has determined there are too few cases or patients to report a Star Rating</td>
</tr>
</tbody>
</table>
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.

Questions Regarding HCAHPS Measures

Questions regarding HCAHPS may be directed to the HCAHPS Project Team by email at: hcahps@hcqis.org.

Outcome and Payment Measures

The Outcome and Payment Measures section of the Preview Report includes:

- 30-Day Risk-Standardized Condition-Specific Mortality Measures
- 30-Day Risk-Standardized Procedure-Specific Mortality Measures
- 30-Day Risk-Standardized Condition-Specific Readmission Measures
- 30-Day Risk-Standardized Procedure-Specific Readmission Measures
- 30-Day Risk-Standardized Hospital-Wide Readmission Measure
- Risk-Standardized Surgical Complication Measure
- 30-Day Risk-Standardized Condition-Specific Payment Measures

30-Day Risk-Standardized Mortality Measures

The Mortality Measures portion of the Outcome Measures section displays the 30-Day Risk-Standardized Mortality Measures for:

- Acute Myocardial Infarction (AMI)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure (HF)
- Pneumonia
- Stroke
- Coronary Artery Bypass Graft (CABG)

In addition to the performance category (Better, No Different, or Worse than the National Rate), your hospital’s Risk-Standardized Mortality Rate (RSMR), 95% interval Estimates, and Number of Eligible Medicare Admissions will display on the Preview Report.
30-Day Risk-Standardized Readmission Measures

The Readmission Measures portion of the Outcome Measures section displays the 30-Day Risk-Standardized Readmission Measures for:

- AMI
- COPD
- HF
- Pneumonia
- Stroke
- Hospital-wide
- Hip/Knee (THA/TKA)
- CABG

In addition to the performance category (Better, No Different, or Worse than the National Rate), your hospital’s Risk-Standardized Readmission Rate (RSRR), Interval Estimates, and Number of Eligible Medicare Discharges will display on the Preview Report.

<table>
<thead>
<tr>
<th>30-Day Risk-Standardized Condition-Specific Readmission Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Quality Measures</strong></td>
</tr>
<tr>
<td>READM-30-AMI</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Risk-Standardized Surgical Complications

The Surgical Complication portion of the Preview Report displays the Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure. This measure is also referred to as the THA/TKA Complication Measure. In addition to the performance category (Better, No Different, or Worse than the National Rate), your hospital’s RSCR, 95% Interval Estimates, and Number of Eligible Medicare Admissions will display on the Preview Report. Beginning with the 2014 reporting, CMS expanded the performance period for the THA/TKA Complication measure from 33 to 36 months. This increased the number of eligible discharges used to calculate the measure, thus improving the precision of your hospital’s complication estimates while capturing eligible complications for up to 90 days after the end of the performance period. CMS also shifted the performance period for the THA/TKA Complication Measure to start one quarter before that of the THA/TKA Readmission Measure.
Outcome Measures Details

The Outcome Measures data for 30-Day Risk-Standardized Mortality, 30-Day Risk-Standardized Readmission, Hospital-Wide Readmission, and Risk-Standardized Complication Measures are typically updated annually during the July Hospital Compare release.

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

- With the exception of the Hospital-Wide Readmission Measure that is calculated using one year of data, the Outcome Measures are all calculated using three years of data.
- Hospitals with fewer than 25 eligible cases for the Mortality, Readmission, and Complication 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.
- Hospitals participating in the Hospital IQR Program may not suppress the Outcome Measures.

Outcome Measures Footnotes

### Mortality, Readmission, and Surgical Complication Measures Footnote Table

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The number of cases/patients is too few to report.</td>
<td>Applied to any hospital where the number of cases reported is too small (less than 25 and greater than 0) to reliably tell how well a hospital is performing</td>
</tr>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS</td>
</tr>
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<td>5</td>
<td>Results are not available for this reporting period.</td>
<td>Applied when no data are available</td>
</tr>
<tr>
<td>7</td>
<td>No cases met the criteria for this measure.</td>
<td>Applied when a hospital did not have any cases meeting the inclusion criteria for a measure</td>
</tr>
<tr>
<td>13</td>
<td>Results cannot be calculated for this reporting period.</td>
<td>Applied when the provider was excluded from the measure calculation as a non-IPPS hospital</td>
</tr>
</tbody>
</table>
State and National Rates

The Preview Report does not display the state rates for the Mortality, Readmission, and THA/TKA Complication Measures. However, for each of the outcome measures, it does provide the national observed (unadjusted) rate 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.

The Hospital Specific Reports (HSRs) that are distributed to hospitals via the QualityNet Secure Portal do provide the average state risk-standardized outcome rates, as well as national observed (unadjusted) rates for all of the Outcomes Measures.

Questions Regarding Outcome Measures

Questions regarding the Mortality Measures may be directed to the Outcome Measures Implementation Team by email at: cmsgmortalitymeasures@yale.edu.

Questions regarding Readmission Measures may be directed to the Outcome Measures Implementation Team by email at: cmsgreadmissionmeasures@yale.edu.

Questions regarding the THA/TKA Complication Measure may be directed to the Measures Implementation Team by email at: cmscomplicationmeasures@yale.edu.

Risk-Standardized Payment Measures

The 30-Day Condition-Specific Payment Measures portion of the Preview Report displays the Risk-Standardized Payment Associated with 30-Day Episode-of-Care for Acute Myocardial Infarction, the Risk-Standardized Payment Associated with 30-Day Episode-of-Care for Heart Failure, and the Risk-Standardized Payment Associated with 30-Day Episode-of-Care for Pneumonia Measures. These measures are hospital-level measures of payments for an episode of care that begins with an inpatient admission for the condition of interest and ends 30 days post-admission.

The Payment Measures calculate Risk-Standardized Payments (RSPs) which add up payments for patients across multiple care settings, services, and supplies (Inpatient, Outpatient, Skilled Nursing Facility, Home Health Agency, Hospice, Physician/Clinical Laboratory/Ambulance Services, Durable Medical Equipment, Prosthetics/Orthotics, and Supplies) during the 30-day episode of care.

While the 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 the Payment Measures were closely aligned with the specifications of the corresponding mortality measures for the same condition. 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 RSP does not, by itself, imply that a hospital is providing better care. An RSP should be considered along with hospital performance on other
patient outcomes, such as the corresponding 30-day Mortality Measures (AMI, HF, and pneumonia). CMS presents the Payment Measures in two discrete locations in the [Payment and Value of Care] tab on Hospital Compare:

- Under Payment, (beneath the Medicare Spending Per Beneficiary measure)
- Under Value of Care, along with the corresponding 30-Day Risk-Standardized Mortality Measures

In addition to the payment category (Greater, No Different, or Less than the National Average Payment), your hospital’s RSPs, 95% Interval Estimates, and Number of Eligible Medicare Admissions will be displayed in the Preview Report.

Payment Measure Details

The results for 30-Day Condition-Specific Payment Measures will be updated annually with the Outcome Measure results during the July Hospital Compare release. Hospitals are not required to submit Outcome and Payment Measures data because CMS calculates the measures 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),” and are included in the measure calculation but will not be reported on Hospital Compare.
- Hospitals participating in the Hospital IQR Program may not suppress the Payment Measures.

Payment Measures Footnotes

<table>
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<tr>
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</tr>
</tbody>
</table>
State and National Average Payment

The Preview Report does not display the State Average RSP for the Payment Measures. However, it does provide the National Average Payment and the number of hospitals in the state and the nation whose performance was categorized as Greater, No Different, or Lower than the National Average Payment.

The State Average RSP and National Average Payment are both included in the HSRs distributed to hospitals via the QualityNet Secure Portal.

Questions Regarding Payment Measures

Questions regarding the Payment Measures may be directed to the Payment Measure Implementation Team by email at: cmsepisodepaymentmeasures@yale.edu.

Agency for Healthcare Research and Quality (AHRQ) Indicators

The AHRQ Indicators section displays the AHRQ Patient Safety Indicators (PSIs):

- PSI-4 – Rate of Death among Surgical Inpatients with Serious Treatable Complications
- PSI-90 – Patient Safety for Selected Indicators (Composite Score)

While the following indicators display on the Preview Report, the indicators will only display in the downloadable file on Hospital Compare:

- PSI-6 Iatrogenic Pneumothorax
- PSI-12 Postoperative Pulmonary Embolism or Deep Vein Thrombosis
- PSI-14 Postoperative Wound Dehiscence
- PSI-15 Accidental Puncture or Laceration

Note: Case numbers greater than 0 and less than 11 will display on the Preview Report but will not be reported on Hospital Compare.

In addition to the hospital’s performance category (Better, Different, or No Worse Than the National Rate), the hospital’s PSI Rate (reported per 1,000 discharges), Confidence Interval, and Number of Eligible Medicare Discharges display on the Preview Report.
AHRQ PSI Footnotes

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<thead>
<tr>
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<td></td>
<td></td>
<td>for a measure</td>
</tr>
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<td>13</td>
<td>Results cannot be calculated for this reporting</td>
<td>Applied when the provider was excluded from the measure calculation as a non-IPPS hospital</td>
</tr>
<tr>
<td></td>
<td>period.</td>
<td></td>
</tr>
</tbody>
</table>

Healthcare-Associated Infection (HAI)

Hospitals submit HAI data to the Centers for Disease Control and Prevention’s (CDC’s) National Healthcare Safety Network (NHSN) system. CDC provides the HAI data to CMS for display on Hospital Compare.

HAI Hospital Quality Measures

Central Line-Associated Bloodstream Infection (CLABSI)

The CLABSI measure includes the number of laboratory-confirmed cases of CLABSI among Adult, Pediatric, and Neonatal Intensive Care Unit (ICU) and selected Ward patients for events identified within the displayed time frame. Please note that there are two separate rows of CLABSI data: one for ICU locations only, and one for both ICU and select Ward locations combined. Refer to the Quick Reference Guide for information about the different time periods of data collection used for these CLABSI data.

*Note: The Preview Report header reflects the collection dates for the ICU locations only and is not reflecting the ICU and select Ward locations data collection time period.*
Catheter-Associated Urinary Tract Infection (CAUTI)

The CAUTI measure includes the number of laboratory-confirmed cases of CAUTI among Adult and Pediatric Intensive Care Unit (ICU) and selected Ward patients for events identified within the displayed time frame. Please note that there are two separate rows of CAUTI data: one for ICU locations only, and one for both ICU and select Ward locations combined. Refer to the Quick Reference Guide for information about the different time periods of data collection used for these CAUTI data.

**Note:** The Preview Report header reflects the collection dates for the ICU locations only and is not reflecting the ICU and select Ward locations data collection time period.

**Surgical Site Infections (SSIs) 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.

**Surgical Site Infections (SSIs) 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.

**Methicillin-Resistant Staphylococcus aureus (MRSA) Blood Infections**

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

**Clostridium difficile (C. difficile) Infections**

The *C. difficile* measure includes the number of *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.

**Preview Report**

**Your Hospital’s Reported Number of Infections**

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 Standardized Infection Ratio (SIR).
Data submitted to NHSN after the submission deadline will display in NHSN reports; however, data submitted after the submission deadline will not be included in the data reported in the Preview Report or on Hospital Compare.

**Device or Patient Days/Procedures**

**CLABSI:** The number of central line days in hospital locations in scope (Adult, Pediatric, and Neonatal ICUs and selected wards) for quality reporting.

**CAUTI:** The number of urinary catheter days in hospital locations in scope (Adult and Pediatric ICUs and selected wards) for quality reporting.

**SSI-Colon:** The number of criteria-specific colon surgeries performed within the facility.

**SSI-Abdominal Hysterectomy:** The number of criteria-specific abdominal hysterectomy surgeries performed within the facility.

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

**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.

**Your Hospital’s Predicted Number of Infections**

Your Hospital’s Predicted Number of Infections is the predicted number of infections in scope for quality reporting. The predicted number of infections is used by NHSN as the denominator to calculate your hospital’s SIR.

**Ratio of Reported to Predicted Infections (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).

> When a hospital’s SIR cannot be calculated because there are too few predicted events, or because the hospital’s MRSA or 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.

**Your Hospital’s Performance**

Your hospital’s performance phrase is determined by comparing the actual number of HAIs in your facility to a national benchmark based on previous years of reported data and adjusts the data based on several factors. A Confidence Interval with a lower and upper limit is displayed around each SIR to indicate a high degree of confidence that the true value of the SIR lies within that interval.
Performance phrases displayed in the *Your Hospital’s Performance* column are:

- **Better than the National Benchmark**
  - Displays if your hospital’s SIR has an upper limit that is less than the National Benchmark of one

- **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 than the National Benchmark**
  - Displays if your hospital’s SIR has a lower limit that is greater than the National Benchmark of one

**Confidence Interval**

The Confidence Interval column lists your hospital’s lower-bound limit and upper-bound limit of the hospital’s Confidence Interval. 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 will be applied.

---

**State Standardized Infection Ratio (SIR)**

The state-level 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 Standardized Infection Ratio (SIR)**

The National Standardized Infection Ratio (SIR) shown in this column 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 between the National SIR Benchmark used to compare hospital performance.
Healthcare Personnel (HCP) Influenza Vaccination

The **HCP Influenza Vaccination Measure** includes the number of HCP contributing towards successful influenza vaccination adherence within the displayed time frame, regardless of clinical responsibility or patient contact.

Your hospital’s quality measures will include the total number of HCP in your hospital who are eligible for vaccination, your hospital’s reported adherence percentage, the state reported adherence percentage, and the national reported adherence percentage.

**Note:** The HCP measure, IMM-3, displays on the Inpatient Preview Report and displays the same data as is displayed for the outpatient measure, OP-27. To avoid duplication of the measure data in the downloadable files on *Hospital Compare*, the Measure ID IMM-3_OP-27 will be used to represent IMM-3 and OP-27 rather than listing the data separately.

**Total Number of Healthcare Personnel Eligible for Vaccination** represents the total number of healthcare workers in your hospital who are eligible to receive the Influenza vaccine for the 2014/2015 flu season, per NHSN protocol.

**Influenza Vaccination Adherence Percentage**

The Influenza Vaccination Adherence Percentage is calculated as the total number of healthcare workers contributing to successful vaccination adherence divided by the total number of healthcare workers eligible to receive the Influenza vaccine per NHSN protocol.

**State Reported Adherence Percentage** 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 eligible to receive the Influenza vaccine per NHSN protocol.

**National Reported Adherence Percentage** 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 eligible to receive the Influenza vaccine per NHSN protocol.

### HAI and HCP Influenza Vaccination Measures Footnotes

#### HAI and HCP Influenza Vaccination Measures Footnote Table

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Results are based on a shorter time period than required.</td>
<td>Applied when a hospital has less than the maximum number of quarters of data (one or more but not all possible quarters)</td>
</tr>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS</td>
</tr>
<tr>
<td>5</td>
<td>Results are not available for this reporting period.</td>
<td>Applied when no data are available</td>
</tr>
<tr>
<td></td>
<td>The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.</td>
<td>Applied when the lower limit of the confidence interval cannot be calculated</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 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 |
| 13 | Results cannot be calculated for this reporting period. | Applied when the hospital’s SIR cannot be calculated because:  
  - The number of predicted infections is less than one  
  - MRSA or *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 MRSA or *C. difficile* prevalence rate. |

**Questions Regarding HAI and HCP Influenza Vaccination Measures**

Questions regarding the HAI and HCP Influenza Vaccination measures may be directed to the Hospital Inpatient VIQR Support Contractor through the Inpatient Questions and Answers tool at: [https://cms-ip.custhelp.com](https://cms-ip.custhelp.com), or by calling, toll-free, 844.472.4477 or 866.800.8765 weekdays from 8 a.m. to 8 p.m. ET.
Section 4: Withholding Data from Hospital Compare

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

Hospitals not participating in the Hospital IQR Program have an option to withhold data from public reporting on Hospital Compare. The option to request suppression (withholding) of data from Hospital Compare is only available to hospitals during the 30-day Preview Period.

Suppression Overview

To withhold (suppress) publication of data, your hospital must complete and fax an Inpatient Hospital Compare Request for Withholding Data from Public Reporting form on or before the last day of the preview period to the Hospital Inpatient VIQR SC.

Hospitals that do not have an appropriate notice of participation, or pledge, display only the CCN and hospital name along with the following message:

“You do not have an Inpatient Notice of Participation (pledge) to publicly report data for the preview report period. If you think this is an error, contact the Hospital Inpatient VIQR Program Support Contractor prior to the Preview Period closing.”

Questions regarding the Hospital IQR Program may be directed to the Hospital Inpatient VIQR SC through the Inpatient Questions and Answers tool at: https://cms-ip.custhelp.com, or by calling, toll-free, 844.472.4477 or 866.800.8765 weekdays from 8 a.m. to 8 p.m. ET.

Procedure to Suppress Data

2. Place the cursor over the [Hospitals - Inpatient] tab.
3. Select the [Optional Public Reporting (formerly HQA)] link.

4. Select the [How to Participate] link from the left-side navigation pane.

5. Select the [Hospital Compare Request for Withholding Data from Public Reporting] link. Your hospital must complete the form and fax to the Hospital Inpatient VIQR SC.

   Secure fax: 1.877.789.4443

   Any forms completed after the preview period will not be in effect for that preview period.