Inpatient *Hospital Compare*
Preview Report 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 Preview Report prior to publication of data on *Hospital Compare*.

*July 2017 Preview/October 2017 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](http://www.medicare.gov/hospitalcompare).

*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 otherwise meet all of the requirements of the Hospital Inpatient Quality Reporting (IQR) Program. The Hospital IQR Program was initially established by Section 501(b) of the Medicare Modernization Act (MMA) of 2003, which was 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 hospital inpatient stays under the Inpatient Prospective Payment System (IPPS). Under the IPPS, Medicare payment for hospital inpatient operating and capital-related costs are 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 if Hospital IQR Program requirements are not met for each 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 release of data on *Hospital Compare*, hospitals are given the opportunity to review data during a 30-day preview period. Reports can be accessed via the *QualityNet Secure Portal*, the only CMS-approved website for secure healthcare quality data exchange, at [https://www.qualitynet.org](https://www.qualitynet.org).
Section 2: Preview Report Access

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**

   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=1138115987954.

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

   Detailed enrollment and login instructions can be found on the QualityNet homepage under the Log in to QualityNet Secure Portal header in the first sidebar on the right-hand side of the page and selecting Portal Resources at direct link: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228773343598.

3. **Assigned the “Hospital Reporting Feedback - Inpatient” role**

   The hospital’s QualityNet Security Administrator (SA) must assign this role.
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.

2. Select IQR from the Report Program drop-down.
3. Select **Public Reporting–Preview Reports** from the list in the *Report Category* drop-down.

![Image of Public Reporting–Preview Reports selection]

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

![Image of View Reports selection]

5. Select **Public Reporting–Preview Reports** under *Report Name*.

6. Select **Run Reports**.

![Image of Run Reports button]

**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.

![Image of View Preview Report]
Section 3: Preview Report Details

The Preview Report displays your hospital CMS Certification Number (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 not publicly reported; however, this is publicly available 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. Once the screen refreshes, select the CASPER/ASPEN (Automated Survey Processing Environment) contacts link from the left-side navigation pane (direct link): 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.

Preview Report Overall Hospital Quality Star Rating and Measures

Overall Hospital Quality Star Rating

The Overall Hospital Quality Star Rating provides a summary of hospital quality data reported on the Hospital Compare website. These ratings reflect up to 57 measures across seven aspects of quality currently captured by existing measures on Hospital Compare: mortality, safety of care, readmission, excess days in acute care, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging. The methodology used to calculate the Star Rating is scientifically rigorous and a valid way to summarize the quality information available on Hospital Compare. The Star Rating is intended to supplement, rather than replace, the information on Hospital Compare.

Star Ratings are generally updated on a bi-annual schedule and are anticipated to be updated with the July and December Hospital Compare releases using the data reported for that release. The Star Ratings for April and October Hospital Compare releases will generally maintain the same rating reported from the previous quarter’s release, unless otherwise noted.
NOTE: Star Ratings were not updated for the July 2017 Hospital Compare release. The October 2017 Star Rating includes the FY 2018 Patient Safety Indicator (PSI) measure results and the corrected Central Line-associated Bloodstream Infection (CLABSI), *Clostridium Difficile* (CDI) and Catheter-associated Urinary Tract Infection (CAUTI) Standardized Infection Ratios (SIRs). We anticipate that the Star Rating will return to the bi-annual release schedule beginning with the December 2017 update.

Hospitals will receive a Star Rating (1, 2, 3, 4, or 5 stars) and a performance category for each of the measure groups (above the national average, same as the national average, or below the national average). The Preview Report also contains supplemental information for hospitals to help them understand the calculation of the Star Rating. Calculations for the ratings include a summary score (the weighted average of a hospital’s available group scores), the hospital’s group scores, the national 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 summary score.

Please refer to the Hospital Compare Star Rating methodology resources on QualityNet.org. Visit Hospitals-Inpatient or Hospitals-Outpatient in the Questions & Answers box on the right side of the page. Select Star Ratings. Then, select Methodology for a detailed discussion of the rating calculations.

The Hospital Compare Preview Report has two overall rating sections (separate from the HCAHPS Star Rating):

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

**Hospital Compare Overall Hospital Quality Star Rating section:**

- **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 (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 recalculated for the July and December releases only. It is not recalculated for the April and October releases.
NOTE: The score was not calculated for July 2017. Instead, the score will be recalculated for October 2017 to include the corrected CLABSI, CDI, and CAUTI SIRs and the updated PSI measure rates.

**Hospital Compare Star Rating Group Scores section:**

- **Group** – Hospital quality is represented by several dimensions, including clinical care processes, initiatives focused on care transitions, and patient experiences. The Hospital Compare 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 reported by the hospital.

  The Star Rating aims to be as inclusive as possible of measures on Hospital Compare. However, the following types of measures will not be incorporated into the hospital Star Rating: (1) measures suspended, retired, or delayed from public reporting on Hospital Compare; (2) measures with no more than 100 hospitals reporting performance publicly; (3) structural measures; (4) measures for which it is unclear whether a higher or lower score is better (non-directional); (5) measures no longer required for the IQR Program or OQR Program; and (6) 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 table below includes a full list the measures included in each group that, if reported by the hospital, are used in calculating the Star Rating.

**Mortality (N=7)**

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

**Safety of Care (N=8)**

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

**Readmission (N=8)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>READM-30-CABG</td>
<td>Coronary Artery Bypass Graft (CABG) 30-Day Readmission Rate</td>
</tr>
<tr>
<td>READM-30-COPD</td>
<td>Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate</td>
</tr>
<tr>
<td>READM-30-Hip-Knee</td>
<td>Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)</td>
</tr>
<tr>
<td>READM-30-PN</td>
<td>Pneumonia (PN) 30-Day Readmission Rate</td>
</tr>
<tr>
<td>READM-30-STK</td>
<td>Stroke (STK) 30-Day Readmission Rate</td>
</tr>
<tr>
<td>READM-30-HOSP-WIDE</td>
<td>Hospital-Wide All-Cause Unplanned Readmission (HWR)</td>
</tr>
<tr>
<td>EDAC-30-AMI</td>
<td>Excess Days in Acute Care (EDAC) after hospitalization for Acute Myocardial Infarction (AMI)</td>
</tr>
<tr>
<td>EDAC-30-HF</td>
<td>Excess Days in Acute Care (EDAC) after hospitalization for Heart Failure (HF)</td>
</tr>
</tbody>
</table>

**Patient Experience (N=11)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-CLEAN-HSP</td>
<td>Cleanliness of Hospital Environment (Q8)</td>
</tr>
<tr>
<td>H-COMP-1</td>
<td>Nurse Communication (Q1, Q2, Q3)</td>
</tr>
<tr>
<td>H-COMP-2</td>
<td>Doctor Communication (Q5, Q6, Q7)</td>
</tr>
<tr>
<td>H-COMP-3</td>
<td>Responsiveness of Hospital Staff (Q4, Q11)</td>
</tr>
<tr>
<td>H-COMP-4</td>
<td>Pain management (Q13, Q14)</td>
</tr>
<tr>
<td>H-COMP-5</td>
<td>Communication About Medicines (Q16, Q17)</td>
</tr>
<tr>
<td>H-COMP-6</td>
<td>Discharge Information (Q19, Q20)</td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>H-HSP-RATING</td>
<td>Overall Rating of Hospital (Q21)</td>
</tr>
<tr>
<td>H-QUIET-HSP</td>
<td>Quietness of Hospital Environment (Q9)</td>
</tr>
<tr>
<td>H-RECMND</td>
<td>Willingness to Recommend Hospital (Q22)</td>
</tr>
<tr>
<td>H-COMP-7</td>
<td>HCAHPS 3 Item Care Transition Measure (CTM-3)</td>
</tr>
</tbody>
</table>

**Effectiveness of Care (N=11)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMM-2</td>
<td>Influenza Immunization</td>
</tr>
<tr>
<td>IMM-3/OP-27</td>
<td>Healthcare Personnel (HCP) Influenza Vaccination</td>
</tr>
<tr>
<td>OP-4</td>
<td>Aspirin at Arrival</td>
</tr>
<tr>
<td>OP-22</td>
<td>ED-Patient Left Without Being Seen</td>
</tr>
<tr>
<td>OP-23</td>
<td>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</td>
</tr>
<tr>
<td>OP-29</td>
<td>Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients</td>
</tr>
<tr>
<td>OP-30</td>
<td>Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use</td>
</tr>
<tr>
<td>PC-01</td>
<td>Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation</td>
</tr>
<tr>
<td>STK-4</td>
<td>Thrombolytic Therapy</td>
</tr>
<tr>
<td>VTE-5</td>
<td>Venous Thromboembolism Warfarin Therapy Discharge Instructions</td>
</tr>
<tr>
<td>VTE-6</td>
<td>Hospital Acquired Potentially-Preventable Venous Thromboembolism</td>
</tr>
</tbody>
</table>

**Timeliness of Care (N=7)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-1b</td>
<td>Median Time from Emergency Department (ED) Arrival to ED Departure for Admitted ED Patients</td>
</tr>
<tr>
<td>ED-2b</td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients</td>
</tr>
<tr>
<td>OP-3</td>
<td>Median Time to Transfer to Another Facility for Acute Coronary Intervention</td>
</tr>
<tr>
<td>OP-5</td>
<td>Median Time to electrocardiogram (ECG)</td>
</tr>
<tr>
<td>OP-18b/ED-3</td>
<td>Median Time from ED Arrival to ED Departure for Discharged ED Patients</td>
</tr>
<tr>
<td>OP-20</td>
<td>Door to Diagnostic Evaluation by a Qualified Medical Professional</td>
</tr>
<tr>
<td>OP-21</td>
<td>ED-Median Time to Pain Management for Long Bone Fracture</td>
</tr>
</tbody>
</table>

**Efficient Use of Medical Imaging (N=5)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-8</td>
<td>MRI Lumbar Spine for Low Back Pain</td>
</tr>
<tr>
<td>OP-10</td>
<td>Abdomen Computed Tomography (CT) Use of Contrast Material</td>
</tr>
<tr>
<td>OP-11</td>
<td>Thorax CT Use of Contrast Material</td>
</tr>
<tr>
<td>OP-13</td>
<td>Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery</td>
</tr>
<tr>
<td>OP-14</td>
<td>Simultaneous Use of Brain CT and Sinus CT</td>
</tr>
</tbody>
</table>
Measures with less than 100 hospitals reporting are not included in the Hospital Compare Star Rating calculation. A complete list of the measures that will be individually reported, including the measures excluded from the Hospital Compare Star Rating, is available on QualityNet.

NOTE: For hospitals participating in both the IQR and the OQR Programs and reporting the Healthcare Personnel Influenza Vaccination measure (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 group to calculate the hospital’s summary score, which is then translated into the hospital’s 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 CMS Quality Strategy
  - Stakeholder input, including the prioritization of measure groups by the Technical Expert Panel (TEP), 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** – The estimate of the latent variable model used to produce a group score for each group.

- **National Average Group Score** – The national average group score for each group based on the distribution of group scores across all hospitals.

- **Category** – The group performance category provides a hospital with a national comparison across a three-point scale for each of the hospital’s available group scores. These performance categories are: above the national average, same as the national average, and below the national average.
**Hospital Compare Star Rating Hospital-Specific Reports (HSRs)**

HSRs have historically been provided to support the bi-annual (July and December) Star Rating updates. After the release of the July 2017 Star Rating on the Preview Report, it was determined that, due to the FY 2018 PSI software issue and an error in the CLABSI, CDI, and CAUTI data, the Star Rating would not be updated on Hospital Compare for the July release. Instead, the previous data will continue to display; therefore, the July 2017 Star Rating HSR was not distributed. For the October release, the FY 2018 PSI measure data and the corrected CLABSI, CDI, and CAUTI SIRs will be used to calculate the Star Rating and an additional Star Rating HSR will be provided for the October 2017 release.

The 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 Hospital Compare Star Rating HSRs along with the Hospital Inpatient and Outpatient Quality Reporting Preview Reports.

**Hospital Compare Star Rating 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 use</td>
</tr>
</tbody>
</table>
| 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. |

**Questions Regarding the Hospital Compare Star Rating**

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

**Structural Measures**

<table>
<thead>
<tr>
<th>Structural Measures (SM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SM-3</td>
</tr>
<tr>
<td>SM-4</td>
</tr>
<tr>
<td>SM-5</td>
</tr>
</tbody>
</table>
The Structural Measures section follows the Star Rating Section in the Preview Report. 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.

**Clinical Process Measures**

These measures are listed as Clinical Process Measures on the Preview Report and can be found in the Timely and Effective Care tab on Hospital Compare. The Clinical Process Measure sets include:

- Stroke (STK)
- Venous Thromboembolism (VTE)
- Emergency Department (ED)
- Emergency Department Volume (EDV)
- Influenza Immunization (IMM)
- 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)
- State Performance
- National Performance

**Clinical Process Measure Details**

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

_Denominators greater than zero and less than 11 will display on the Preview Report but will not be reported on Hospital Compare._

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 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
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, quarter four through quarter two, and will refresh with each December Hospital Compare 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>Number</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 zero and less than eleven. 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 CMS Clinical Data Warehouse was sampled for a reported quarter for a topic; Applied at the topic level (e.g., VTE)</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 CMS Clinical Data 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 use.</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 CMS Clinical Data 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 all hospitals in 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 all hospitals in 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:

- If above X.5, round up to the nearest whole number.
- If below X.5, round down to the nearest whole number.
- If 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.)
- If 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/](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
- 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
  - Composite 6 – Discharge Information (Q19, Q20)

- Care Transition Composite
  - Composite 7 – Care Transition (Q23, Q24, Q25)

HCAHPS Global Items section includes:

- Hospital Rating (Q21)
- Willingness to Recommend this Hospital (Q22)
**HCAHPS Star Rating 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.
- Whole stars (1, 2, 3, 4, or 5) are assigned to each of the 11 HCAHPS measures, plus the HCAHPS Summary Star Rating.

**Linear Mean Scores:** HCAHPS Linear Mean Scores are provided for each of the seven composite measures, two environment items, and two global items, and are available in the downloadable database on *Hospital Compare*.

**HCAHPS Measure Details**

All IPPS hospitals must continuously collect and submit HCAHPS data in order to qualify for the full annual payment update. All participating hospitals receive a Preview Report, 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 Measures Footnote Table**

<table>
<thead>
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<tbody>
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<td>The number of cases/patients is too few to report</td>
<td>Applied in the following situations:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Applied when a hospital has zero cases, or five or fewer eligible HCAHPS patient discharges.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- HCAHPS scores based on fewer than 25 completed surveys will display on the Preview Report.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Data will not display on <em>Hospital Compare</em>.</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 use.</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>Number</td>
<td>Description</td>
<td>Application</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Fewer than 100 patients completed the HCAHPS survey</td>
<td>Applied when the number of completed HCAHPS surveys is 50–99.</td>
</tr>
<tr>
<td></td>
<td>(Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>• Very few patients were eligible for the HCAHPS survey&lt;br&gt;• The scores shown reflect fewer than 50 completed surveys</td>
<td>Applied when the number of completed HCAHPS surveys is fewer than 50.</td>
</tr>
<tr>
<td></td>
<td>(Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.)</td>
<td></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 Measures
Risk-Standardized Surgical Complication Measures
Medicare 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 the following:

- 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 Discharges 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
• Total Hip Arthroplasty/Total Knee Arthroplasty (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), 95% Interval Estimates, and Number of Eligible Medicare Discharges will display on the Preview Report.

### Risk-Standardized Surgical Complications

The Surgical Complication portion of the Preview Report displays the Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA and/or 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 Discharges will display on the Preview Report. The performance period for the THA/TKA Complication Measure starts and ends one quarter before the THA/TKA Readmission Measure.

### Outcome Measures Details

The Outcome Measures data for 30-Day Risk-Standardized Mortality, 30-Day Risk-Standardized 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.

### Outcome Measures Footnotes

**Mortality, Readmission, Surgical Complication Measures Footnote Table**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Application</th>
</tr>
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<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 zero) to reliably tell how well a hospital is performing.</td>
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<td>4</td>
<td>Data suppressed by CMS for one or more quarters</td>
<td>Reserved for CMS use.</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>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>
</tbody>
</table>
| 13     | Results cannot be calculated for this reporting period | Applied in the following situations:  
- 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. |

### 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 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.

The Hospital Specific Reports (HSRs) that are distributed to hospitals via the QualityNet Secure Portal do provide the average state risk-standardized outcome rates, 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 cmsmortalitymeasures@yale.edu.
Questions regarding Readmission Measures may be directed to the Outcome Measures Implementation Team by email at cmsreadmissionmeasures@yale.edu.

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

**Medicare Payment Measures**

The 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, the Risk-Standardized Payment Associated with 30-Day Episode-of-Care for Pneumonia, and the Risk-Standardized Payment Associated with 90-Day Episode-of-Care for THA/TKA 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 either 30 days or 90 days post-admission, depending on the measure.

The 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 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 AMI, HF, and Pneumonia. The THA/TKA payment measure aligns with the corresponding 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 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.

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 Discharges will be displayed in the Preview Report. A column has been added to the Medicare Payment Measures Table to provide the Value of Care category, which displays the mortality/complication and payment values for each hospital.
The results for the Medicare Payment Measures will be updated 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).” Those hospitals are included in the measure calculation but will not be reported on Hospital Compare.

### Medicare Payment Measures Footnotes

<table>
<thead>
<tr>
<th>Number</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 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.</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>7</td>
<td>No cases met the criteria for this measure</td>
<td>Applied when a hospital did not have any cases meet the inclusion criteria for a measure.</td>
</tr>
<tr>
<td>13</td>
<td>Results cannot be calculated for this reporting period</td>
<td>Applied in the following situations:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Applied when the provider was excluded from the measure calculation as a non-IPPS hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Applied to the value of care display if one of the two measures that assess value of care is unavailable.</td>
</tr>
</tbody>
</table>
State and National Average Payment

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

Excess Days in Acute Care (EDAC) Measures

The Excess Days in Acute Care section displays the EDAC measures:

- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
- Excess Days in Acute Care after Hospitalization for Heart Failure

The measures incorporate the time spent in acute care (emergency department visits, observation stays, and unplanned readmissions) after discharge from the hospital.

In addition to the performance category (Fewer Days than Average, Average Days, More Days than Average, or Number of Cases Too Small), Your Hospital’s Measure Days, 95% Interval Estimates, and Number of Eligible Medicare Discharges will display on the Preview Report.

<table>
<thead>
<tr>
<th>Excess Days in Acute Care Measures</th>
<th>Hospital Quality Measures</th>
<th>Your Hospital’s Performance</th>
<th>Your Hospital’s Number of Eligible Medicare Discharges</th>
<th>Your Hospital’s Measure Days (Lower Bound, Upper Bound of 95% Interval Estimate)</th>
<th>Number of Hospitals...</th>
<th>Fewer Days than Average</th>
<th>Average Days</th>
<th>More Days than Average</th>
<th>Number of Cases Too Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDAC-30-AMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>242</td>
<td>1436</td>
<td>463</td>
<td>1893</td>
</tr>
<tr>
<td>EDAC-30-HF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21</td>
<td>46</td>
<td>13</td>
<td>49</td>
</tr>
</tbody>
</table>

EDAC Measures Details

The results for EDAC Measures will be updated annually during the July Hospital Compare release. Hospitals are not required to submit data for the EDAC Measures because CMS calculates the measures from claims and enrollment data.

- Measure results are calculated using three years of data.
- Hospital Compare will report as “Hospital Return Days” measure.
• 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 estimate the hospital’s average Measure Days.” Those hospitals are included in the measure calculation but will not be reported on Hospital Compare.

EDAC Measures Footnotes

<table>
<thead>
<tr>
<th>Number</th>
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<tr>
<td>1</td>
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<td>Applied when a hospital did not have any cases meet the inclusion criteria for a measure.</td>
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</tbody>
</table>

National and State Average EDAC Measures

The Preview Report does not display the state rates for the EDAC Measures. However, for each of the EDAC Measures, it does provide a hospital’s national and state observed percentile rank, and the number of hospitals in the state and the nation whose performance was categorized as Fewer Days than Average, Average Days, More Days than Average or Number of Cases Too Small.

Questions Regarding EDAC Measures

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

Agency for Healthcare Research and Quality (AHRQ) Indicators

The Fiscal Year (FY) 2018 Hospital IQR Patient Safety Indicator (PSI) results are included, beginning with the October 2017 Hospital Compare Preview Report.

The AHRQ Measures – Patient Safety 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 and Adverse Events (Composite Score)

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

• PSI-3 Pressure Ulcer Rate
• PSI-6 Iatrogenic Pneumothorax Rate
• PSI-8 In-Hospital Fall with Hip Fracture Rate
• PSI-9 Postoperative Hemorrhage or Hematoma Rate
• PSI-10 Postoperative Acute Kidney Injury 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

In addition to the hospital’s performance category (Better, No 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

<table>
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<td>4</td>
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</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>

Questions Regarding AHRQ Measures

For technical support regarding the AHRQ QI measure specifications, visit the AHRQ FAQ and Support website. Support is also available via e-mail at QIsupport@ahrq.hhs.gov.
For questions regarding the AHRQ Patient Safety Indicators (PSIs) refer to Hospital Inpatient Quality Reporting (IQR) Program Frequently Asked Questions (on the AHRQ Resources page on QualityNet)

**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, neonatal intensive care unit (ICU) and selected ward patients for events identified within the displayed time frame.

**NEW:** CLABSIs identified in patients with mucosal-barrier injury (MBI) are excluded.

**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.

**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.

**NEW:** SSIs that were present at time of surgery (PATOS) are excluded.

**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.

**NEW:** SSIs that were present at time of surgery (PATOS) are excluded.

**Methicillin-Resistant Staphylococcus aureus (MRSA) 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.
**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.

**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).

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

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**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 procedure count field on this preview report 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 Standardized Infection Ratio (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 here: [https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf](https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf)

**SSI-Abdominal Hysterectomy:** The procedure count field on this Preview Report 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 Standardized Infection Ratio (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 here: [https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf](https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf)

**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 calculated using national aggregate NHSN data from 2015 (resulting in the updated 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.

### 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). The following link provides more information regarding SIR calculations: [https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf](https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf)

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

### 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 eight 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 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.

**Healthcare Personnel (HCP) Influenza Vaccination**

The HCP Influenza Vaccination Measure includes the number of healthcare workers 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 healthcare workers 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 (also designated as IMM-3) displays on the Inpatient Preview Report and displays the same data as 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 2016/2017 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**

<table>
<thead>
<tr>
<th>Number</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 use.</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>8</td>
<td>The lower limit of the confidence interval cannot be calculated if the number</td>
<td>Applied when the lower limit of the confidence interval cannot be calculated.</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
<td>Application</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>of observed infections equals zero</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.  
- *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. |

**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 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.
Section 4: 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.

Suppression Overview

To suppress 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 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 to publicly report data for the preview report period.”

If a provider determines they received this message in error, contact the Hospital Inpatient VIQR Support Contractor prior to the last day of the Preview Period.

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. Click on the Hospitals - Inpatient tab.
3. Select the **Public Reporting** link.

4. Select the **Optional Public Reporting** link from the left-side navigation panel.

5. Select the **Hospital Compare Request for Withholding Data from Public Reporting** link. Your hospital must complete the form and fax or email to the Hospital Inpatient VIQR SC prior to the last day of the preview period at secure fax 1 (877) 789-4443 or email QRSsupport@HCQIS.org.

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*Any forms received after the preview period will not have the requested measures suppressed for that Hospital Compare release.*
Section 5: Question Resources

Overall Hospital Quality Star Rating

Hospital Compare Star Rating Team by email at cmsstarratings@lantanagroup.com.

Clinical Process Measures, HAI and HCP Influenza Vaccination, PSI-90 Measures

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

HCAHPS Measures

HCAHPS Project Team by email at hcahps@hcqis.org

Outcome Measures

Mortality Measures to the Outcome Measures Implementation Team by email at cmsmortalitymeasures@yale.edu

Readmission Measures to the Outcome Measures Implementation Team by email at cmsreadmissionmeasures@yale.edu

THA/TKA Complication Measure to the Measures Implementation Team by email at cmscomplicationmeasures@yale.edu

Payment Measures

Payment Measure Implementation Team by email at cmsepisodepaymentmeasures@yale.edu

EDAC Measures

EDAC Measure Implementation Team by email at cmsedacmeasures@yale.edu

AHRQ Measures

- Technical support available via e-mail at QIsupport@ahrq.hhs.gov.
- AHRQ Patient Safety Indicators (PSIs) questions refer to Hospital Inpatient Quality Reporting (IQR) Program Frequently Asked Questions (on the AHRQ Resources page on QualityNet)