MBQIP Core Measures

GETTING TO 100% REPORTING ON ALL MEASURES

New Rules for MBQIP Reporting

- 12 core measures
  - Reporting required on ALL core measures
  - Most are annual submissions
- Required reporting begins September 1, 2025
- SORH required to report all non-reporting hospitals to the federal level
- Technical assistance will be arranged for hospitals not meeting reporting requirements
- We have 91 CAHs in Texas to get reporting all measures!!!

Current Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

MBQIP measures are divided into two categories:

- **Core MBQIP Measures** are those that all state Flex Programs are expected to support. Reporting on these measures contributes towards a CAH's Flex eligibility requirements.
- **Additional MBQIP Measures** are those that state Flex Programs can elect to support in addition to the Core measures, particularly in alignment with other partners or initiatives. While these measures are also rural relevant, they may not be as widely applicable across all CAHs. The MBQIP Measures resource includes a list of potential additional measures, but that list is not meant to be exhaustive. Flex programs can propose to work on other quality improvement topics within the four MBQIP domains. If there is not a nationally standardized or standardly reported measure currently available, Flex programs can propose a data collection mechanism.

Core MBQIP Measures			
Patient Safety/Inpatient	***Patient Engagement***	***Care Transitions***	***Outpatient***
HCP/IMM-3 (formerly OP-27): Influenza Vaccination Coverage Among Healthcare Personnel (HCP) **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass eight key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes screener questions and demographic items. The survey is 29 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *1 composite; 8 elements* • **All EDTC Composite** • Home Medications • Allergies and/or Reactions • Medications Administered in ED • ED provider Note • Mental Status/Orientation Assessment • Reason for Transfer and/or Plan of Care • Tests and/or Procedures Performed • Test and/or Procedure Results	**AMI:** • **OP-2:** Fibrinolytic Therapy Received within 30 minutes • **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **ED Throughput** • **OP-18:** Median Time from ED Arrival to ED Departure for *Discharged* ED Patients • **OP-22:** Patient Left Without Being Seen

retired

Retired

New Core Measure Set

Removed

Proposed New MBQIP Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
▪ CAH Quality Infrastructure Implementation *(annual submission)* ▪ Hospital Commitment to Health Equity (required CY 2025) *(annual submission)*	▪ Healthcare Personnel Influenza Immunization *(annual submission)* ▪ Antibiotic Stewardship Implementation *(annual submission)* ▪ Safe Use of Opioids (eCQM) *(annual submission)*	▪ Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) *(quarterly submission)*	▪ Hybrid All-Cause Readmissions (required starting in 2025) *(annual submission)* ▪ SDOH Screening (required CY 2025) *(annual submission)* ▪ SDOH Screening Positive (required CY 2025) *(annual submission)*	▪ Emergency Department Transfer Communication (EDTC) *(quarterly submission)* ▪ OP-18 Time from Arrival to Departure *(quarterly submission)* ▪ OP-22 Left without Being Seen *(annual submission)*

eCQM

Critical Access Hospital Electronic Clinical Quality Measure (eCQM) Resource List

August 2023

eCQM Reporting requirements are aligned between two CMS programs:

Promoting Interoperability (PI) Program	Inpatient Quality Reporting (IQR)
• CAHs must participate in the Medicare PI Program to avoid a downward payment adjustment. • Hospitals are required to submit eCQM data from certified electronic health record technology (CEHRT) • eCQMs submission is one component of the Medicare PI Program • For a complete summary of PI requirements, see 2023 Promoting Interoperability Program Requirements | CMS	• Critical access hospitals (CAHs) are not held to the IQR program requirements but meeting the Hospital IQR Program eCQM requirement also satisfies the eCQM electronic reporting requirement for the Medicare PI Program. • CAHs are not included in the CMS eCQM data validation process.

Calendar Year (CY) 2023 eCQM Reporting Requirements:

- All four quarters of CY 2023
- Four measures:
  - Safe Use of Opioids – Concurrent Prescribing (mandatory)
  - Self-select Three (3) of the thirteen available eCQMs for each quarter
- Submission period deadline: **February 29, 2024**

eCQM Measure Options

Available eCQMs:

Short Name	Available Measures by Reporting Year	CY 2023	CY 2024
ED-2	Median Admit Decision Time to ED Departure Time for Admitted Patients	X	
VTE-1	Venous Thromboembolism Prophylaxis	X	X
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	X	X
PC-05	Exclusive Breast Milk Feeding	X	
STK-2	Discharged on Antithrombotic Therapy	X	X
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	X	X
STK-5	Antithrombotic Therapy By End of Hospital Day 2	X	X
STK-6	Discharged on Statin Medication	X	
ePC-02	Cesarean Birth*	X	Required
ePC-07	Severe Obstetric Complications*	X	Required
HH-01	Hospital Harm—Severe Hypoglycemia	X	X
HH-02	Hospital Harm—Severe Hyperglycemia	X	X
HH-ORAE	Hospital Harm – Opioid-Related Adverse Events		X
GCMS	Global Malnutrition Composite Score		X
Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing	Required	Required

*All hospitals, except those that do not have OB or do not perform deliveries, are required to report ePC-02 and ePC-07 starting with the CY 2024 reporting period.

Timeline

- **September 2024**
  - **Prepare to begin collecting new measures**
- **September 2025**
  - **SORH/THA/RCHI begin tracking non-reporting CAHs**
  - **Report to FORHP**
- **September 2026**
  - **Continue tracking non-reporting CAHs**
- **November 2026**
  - **Report to FORHP list of non-reporting CAHs for CY2025**

Measures

Emergency Department Transfer Communication
Data Source: Chart Abstraction / EHR

Measure Name – Emergency Department Transfer Communication (EDTC)	
MBQIP Domain	Emergency Department
Encounter Periods	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1- December 31)
Submission Deadlines	Q1 encounters (January 1 – March 31) DUE April 30 Q2 encounters (April 1 – June 30) DUE July 31 Q3 encounters (July 1 – September 30) DUE October 31 Q4 encounters (October 1- December 31) DUE January 31 Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Percent of Patients who are transferred from an ED to another healthcare facility that have all necessary communication made available to the receiving facility in a timely manner.

Where we are at as a state

Emergency Department – Emergency Department Transfer Communication (EDTC)

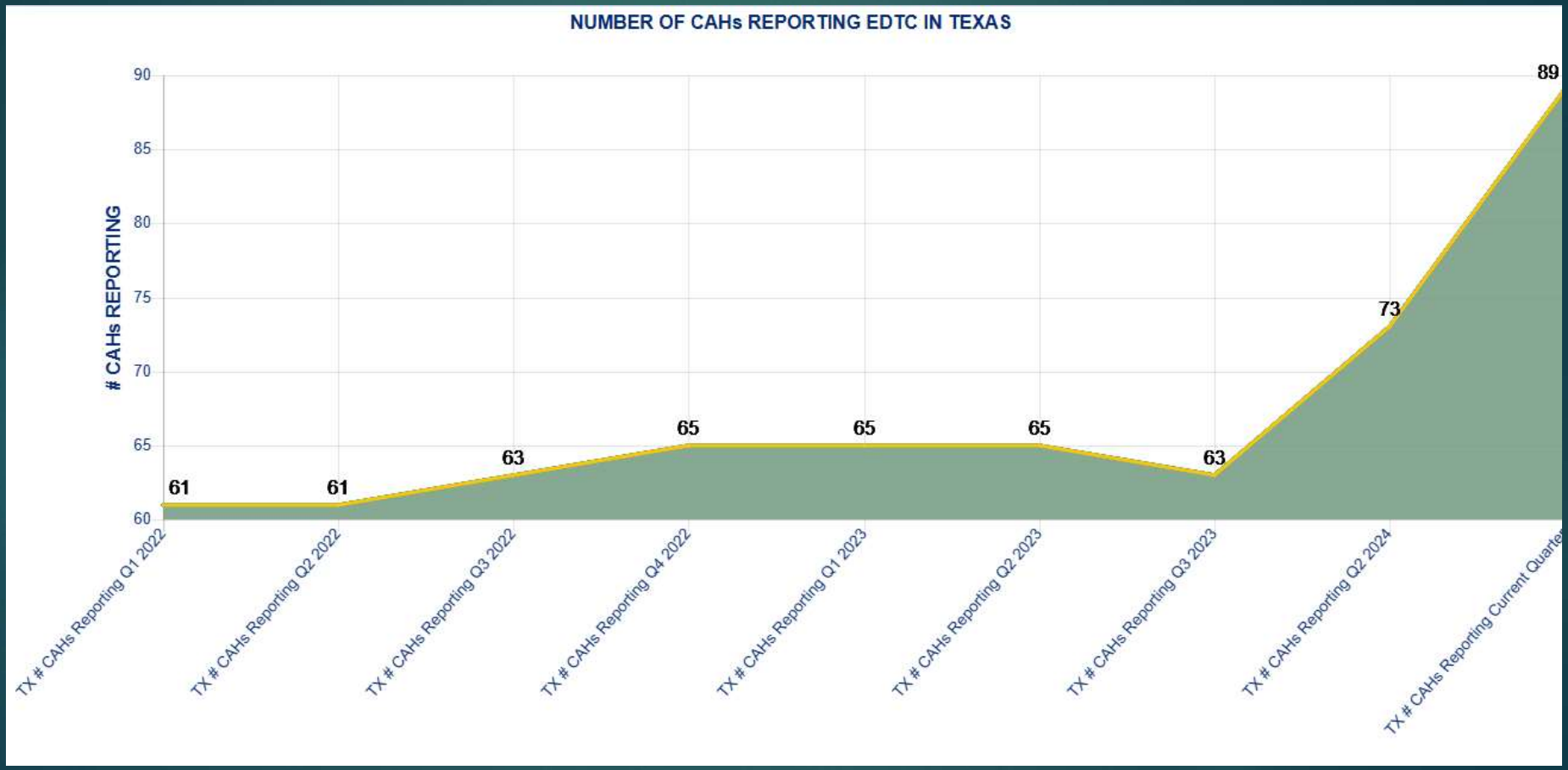
Table 1: EDTC Performance in Texas

		Your State's Performance by Quarter					State Current Quarter			National Current Quarter		Bench-mark
	MBQIP Quality Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Aggregate for All Four Quarters	# CAHs Reporting	Average Current Quarter	90th Percentile	# CAHs Reporting	Average Current Quarter	Composite Percentage
EDTC-All	Composite	93%	93%	92%	91%	92%	89	91%	100%	1,228	92%	100%
	Home Medications	96%	95%	96%	94%	95%	89	94%	100%	1,228	95%	
	Allergies and/or Reactions	98%	98%	98%	97%	98%	89	97%	100%	1,228	96%	
	Medications Administered in ED	99%	98%	98%	98%	98%	89	98%	100%	1,228	97%	
	ED Provider Note	98%	98%	97%	98%	98%	89	98%	100%	1,228	96%	
	Mental Status/Orientation Assessment	99%	98%	98%	99%	98%	89	99%	100%	1,228	96%	
	Reason for Transfer and/or Plan of Care	99%	99%	99%	99%	99%	89	99%	100%	1,228	97%	
	Tests and/or Procedures Performed	99%	99%	99%	99%	99%	89	99%	100%	1,228	97%	
	Tests and/or Procedures Results	99%	99%	99%	99%	99%	89	99%	100%	1,228	96%	
	Total Medical Records Reviewed (N)	N=2,559	N=2,533	N=2,885	N=3,024	N=11,001	N=3,024			N=55,013		

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

89 of 91 CAHs reporting on this measure

CAH Reporting Q1 2022 to Q3 2024



Quality Infrastructure
Data Source: Annual submission National CAH Quality Inventory

Measure Name – CAH Quality Infrastructure	
MBQIP Domain	Global Measures
Measure Description	**Specification for CAH Quality Infrastructure Measure will be released in 2024 and are dependent on data collection via the National CAH Quality Inventory and Assessment.** Structural measure to assess CAH quality infrastructure based on the nine core elements of CAH quality infrastructure: 1. Leadership Responsibility & Accountability 2. Quality Embedded within the Organization's Strategic Plan 3. Workforce Engagement & Ownership 4. Culture of Continuous Improvement through Behavior 5. Culture of Continuous Improvement through Systems 6. Integrating Equity into Quality Practices 7. Engagement of Patients, Partners, and Community 8. Collecting Meaningful and Accurate Data 9. Using Data to Improve Quality

Where we are at

- 91 CAHs total in Texas
- 89 CAHs completed the Quality Infrastructure Survey at end of 2024
- 9 hospitals met all 9 elements
- 21 hospitals met less than 5 elements

CAH Facility Data Summary - Infrastructure										
Total State CAHs	91	Leadership Responsibility and Accountability	Quality Embedded within the Organization's Strategic Plan	Workforce Engagement and Ownership	Culture of Continuous Improvement Through Systems	Culture of Continuous Improvement Through Behavior	Integrating Equity into Quality Practices	Engagement of Patients, Partners, and Community	Collecting Meaningful and Accurate Data	Using Data to Improve Quality
State CAHs Meeting Element: Count		81	45	55	82	79	20	44	75	44
State CAHs Meeting Element: Percentage		89%	49%	60%	90%	87%	22%	48%	82%	48%
National CAHs Meeting Element: Percentage		91%	57%	67%	88%	83%	29%	56%	81%	65%

Safe Use of Opioids
Data Source: EHR

Measure Name – Safe Use of Opioids – Concurrent Prescribing	
MBQIP Domain	Patient Safety
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	February 28, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on two or more opioids, or an opioid and benzodiazepine concurrently at discharge.
Measure Rationale	Unintentional opioid overdose fatalities have become an epidemic and major public health concern in the United States. Concurrent prescriptions of opioids, or opioids and benzodiazepines, places patients at a greater risk of unintentional overdose due to increased risk of respiratory depression. Patients who have multiple opioid prescriptions have an increased risk for overdose, and rates of fatal overdose are ten (10) times higher in patients who are co-dispensed opioid analgesics and benzodiazepines than opioids alone. A measure that calculates the proportion of patients with two or more opioids or opioids and benzodiazepines concurrently has the potential to reduce preventable mortality and reduce costs associated with adverse events related to opioids.

Where we are as a state

Patient Safety – Safe Use of Opioids

Table 8: Safe Use of Opioids Performance in Texas

	Your State's Performance by Calendar Year	State Current Year		National Current Year		Benchmark
	CY 2023	# CAHs Reporting	Current Year %	# CAHs Reporting	Current Year %	
Safe Use of Opioids Number of Patients	13% N=3,907	48 N=3,907	13%	1,030 N=112,128	17%	N/A

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

Only 48 of 91 CAHs reporting on this measure

Hybrid All Cause Hospital Wide Readmission
Data Source: Chart abstraction of clinical data and administrative claims data

Measure Name – Hybrid Hospital-Wide Readmission	
MBQIP Domain	Care Coordination
Encounter Period	July 1st, 20XX - June 30th, 20XX
Submission Deadline	September 30, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Hospital-level, all-cause, risk-standardized readmission measure that focuses on unplanned readmissions 30 days of discharge from an acute hospitalization. Hybrid measures differ from the claims-only measures in that they merge electronic health record (EHR) data elements with claims-data to calculate the risk-standardized readmission rate. The Hybrid HWR was developed to address complex and critical aspects of care that cannot be derived through claims data alone. The Hybrid HWR uses EHR data including clinical variables and linking elements for each patient: • Clinical variables (13): Heart Rate, Systolic Blood Pressure, Respiratory Rate, Temperature, Oxygen Saturation, Weight, Hematocrit, White Blood Cell Count, Potassium, Sodium, Bicarbonate, Creatinine, Glucose • Linking elements (6): CMS Certification Number (CCN), Health Insurance Claims Number or Medicare Beneficiary Identifier, Date of birth, Sex, Admission date, Discharge date

Where we are as a state

Hybrid HWR – Hybrid Hospital-Wide Readmission

Table 11: Hybrid HWR Performance in Texas

	State Performance by Reporting Period	State Current Reporting Period		National Current Reporting Period		Benchmark
	Q3 2022-Q2 2023	# CAHs Reporting	Current Year %	# CAHs Reporting	Current Year %	
Hybrid Hospital-Wide Readmissions	7%	5	7%	176	12%	N/A
Number of Patients	N=531	N=531		N=19,285		

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

Only 5 of 91 CAHs reporting on this measure

Screening for Social Determinants of Health

Data Source: Chart Abstraction

Measure Name – Screening for Social Drivers of Health (SDOH Screening)	
MBQIP Domain	Care Coordination
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	May 15, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. To report on this measure, hospitals will provide: (1) The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; **and** (2) the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted. A specific screening tool is not required to be used, but all areas of health-related social needs must be included.

- Looking at 5 health related social needs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety

Where we are as a state

SDOH-1: Screening for Social Drivers of Health

Table 9: SDOH-1 Performance in Texas

	State Performance by Calendar Year	State Current Year		National Current Year		Benchmark
	CY 2023	# CAHs Reporting	Current Year %	# CAHs Reporting	Current Year %	
Patients Screened for Social Drivers of Health	19%	5	19%	133	25%	N/A
Number of Patients	N=786	N=786		N=47,464		

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

Only 5 of 91 CAHs reporting on this measure

Patients Screening Positive for Social Drivers of Health
Data Source: Chart Abstraction

Measure Name – Screen Positive for Social Drivers of Health (SDOH Screening Positive)	
MBQIP Domain	Care Coordination
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	May 15, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HSRN, and who screen positive for one or more of the following five health-related social needs (HSRNs): Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Where we are as a state

SDOH-2: Screen Positive Rate for Social Drivers of Health

Table 10. SDOH-2 Performance in Texas

	State Performance by Calendar Year	State Current Year		National Current Year		Bench-mark
	CY 2023	# CAHs Reporting	Current Year %	# CAHs Reporting	Current Year %	
Patients Screening Positive for Food Insecurity	3%	5	3%	133	5%	N/A
Patients Screening Positive for Housing Instability	4%	5	4%	133	5%	N/A
Patients Screening Positive for Interpersonal Safety	0%	5	0%	133	2%	N/A
Patients Screening Positive for Transportation Needs	3%	5	3%	133	5%	N/A
Patients Screening Positive for Utility Difficulties	2%	5	2%	133	5%	N/A
Number of Patients	N=146	N=146		N=11,634		

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.
"ZD" indicates a zero denominator. While no value is available for this measure, CAHs in this state reported the measure, but did not screen any patients.

Only 5 of 91 CAHs reporting on this measure

Healthcare Personnel Influenza Immunization
Data Source: Administrative data

Measure Name – Healthcare Personnel Influenza Immunization	
MBQIP Domain	Patient Safety
Encounter Period	October 1, 20XX – March 31, 20XX (Aligns with flu season, for example: October 1, 2023 – March 31, 2024)
Submission Deadline	May 15, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Influenza Vaccination Coverage among Healthcare Personnel

Where we are as a state

Patient Safety – HCP/IMM-3

Table 6: HCP/IMM-3 Performance in Texas

		State Reported Adherence Percentage				State Current Flu Season			National Current Flu Season		Bench-mark
	NHSN Immunization Measure	Q4 2020 - Q1 2021	Q4 2021 - Q1 2022	Q4 2022 - Q1 2023	Q4 2023 - Q1 2024	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	CAH Overall Rate
HCP/IMM-3	Healthcare Provider Influenza Vaccination	83%	73%	79%	77%	59	77%	93%	1,207	79%	100%

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

Only 59 of 91 CAHs reporting on this measure

Antibiotic Stewardship Data Source: NHSN Annual Survey

Measure Name – Antibiotic Stewardship Implementation	
MBQIP Domain	Patient Safety
Encounter Period	Calendar Year (January 1, 20XX– December 31, 20XX)
Submission Deadline	March 1, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Annual Survey

Where we are as a state

Table 7: Antibiotic Stewardship Performance in Texas

Antibiotic Stewardship Measure – CDC Core Elements	State Percentage by Survey Year				State Percentage for Current Survey Year		National Percentage for Current Survey Year		Bench-mark
	Survey Year 2020	Survey Year 2021	Survey Year 2022	Survey Year 2023	# CAHs Reporting	% of CAHs Meeting Element	# CAHs Reporting	% of CAHs Meeting Element	% of Elements Met
All Elements Met	75%	83%	84%	85%	80	85%	1,271	92%	100%
Element 1: Leadership	94%	97%	92%	96%	80	96%	1,271	98%	
Element 2: Accountability	92%	93%	94%	95%	80	95%	1,271	97%	
Element 3: Drug Expertise	89%	94%	91%	95%	80	95%	1,271	96%	
Element 4: Action	94%	90%	94%	95%	80	95%	1,271	99%	
Element 5: Tracking	89%	93%	95%	91%	80	91%	1,271	96%	
Element 6: Reporting	86%	93%	96%	96%	80	96%	1,271	98%	
Element 7: Education	85%	99%	99%	99%	80	99%	1,271	99%	

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

80 of 91 CAHs completing this survey in NHSN
** This is a CoP by CMS

OP – 18 Time from ED Arrival to ED Discharge
Data Source: Chart Abstration

Measure Name – OP-18 Time from ED Arrival to ED Departure	
MBQIP Domain	Emergency Department
Encounter Periods	Q1 (January 1 – March 31) Q2 (April 1 – June 30) Q3 (July 1 – September 30) Q4 (October 1- December 31)
Submission Deadlines	Q1 encounters (January 1 – March 31) DUE August 1 Q2 encounters (April 1 – June 30) DUE November 1 Q3 encounters (July 1 – September 30) DUE February 1 Q4 encounters (October 1- December 31) DUE May 1 Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Median time from Emergency Department (ED) arrival to time of departure from the emergency room for patients discharged from the ED.

Where we are at as a state

Emergency Department – OP-18b

Table 2: OP-18b Performance in Texas

		State Performance by Quarter				State Current Quarter			National Current Quarter		Bench-mark
	Emergency Department – Quarterly Measure	Q3 2023	Q4 2023	Q1 2024	Q2 2024	# CAHs Report-ing	Median Time	90th Per-centile	# CAHs Report-ing	Median Time	Median Time
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	111 min	106 min	110 min	112 min	60	112 min	81 min	1,116	114 min	85 min
	Number of Patients (N)	N=5,078	N=5,888	N=7,456	N=8,538	N=8,538			N=148,218		

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

60 of 91 CAHs reporting on this measure

OP – 22 Left Without Being Seen
Data Source: Hospital Tracking

Measure Name – OP-22 Left Without Being Seen	
MBQIP Domain	Emergency Department
Encounter Periods	Encounter Period - Calendar Year (January 1 – December 31)
Submission Deadlines	May 15, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Percent of patients who leave the Emergency Department (ED) without being evaluated by a physician/advanced practice nurse/physician's assistant (physician/APN/PA.

Where we are at as a state

Emergency Department – OP-22

Table 3: OP-22 Performance Texas

		State Performance by Calendar Year				State Current Year			National Current Year		Bench-mark
	Emergency Department – Annual Measure	CY 2020	CY 2021	CY 2022	CY 2023	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	CAH Overall Rate
OP-22	Patient Left Without Being Seen	1%	2%	1%	1%	37	1%	0%	1,027	1%	0%
	Number of Patients (N)	N=153,491	N=175,102	N=194,642	N=225,155	N=225,155			N=7,159,942		

"DNR" indicates that CAHs in the state did not submit any measure or submitted data was rejected/not accepted.

37 of 91 CAHs reporting on this annual measure

HCAHPS
Data Source: Certified Vendor

Existing Measure for MBQIP Reporting Within the Flex Program
MBQIP 2025 Core Measure Set

- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Communication about medications
- Cleanliness of hospital environment
- Quietness of hospital environment
- Discharge Information
- Care Transitions
- Overall Rating of Hospital

FORHP will be identifying HCAHPS low volume threshold option that applies to SHIP and Flex

Where we are as a state

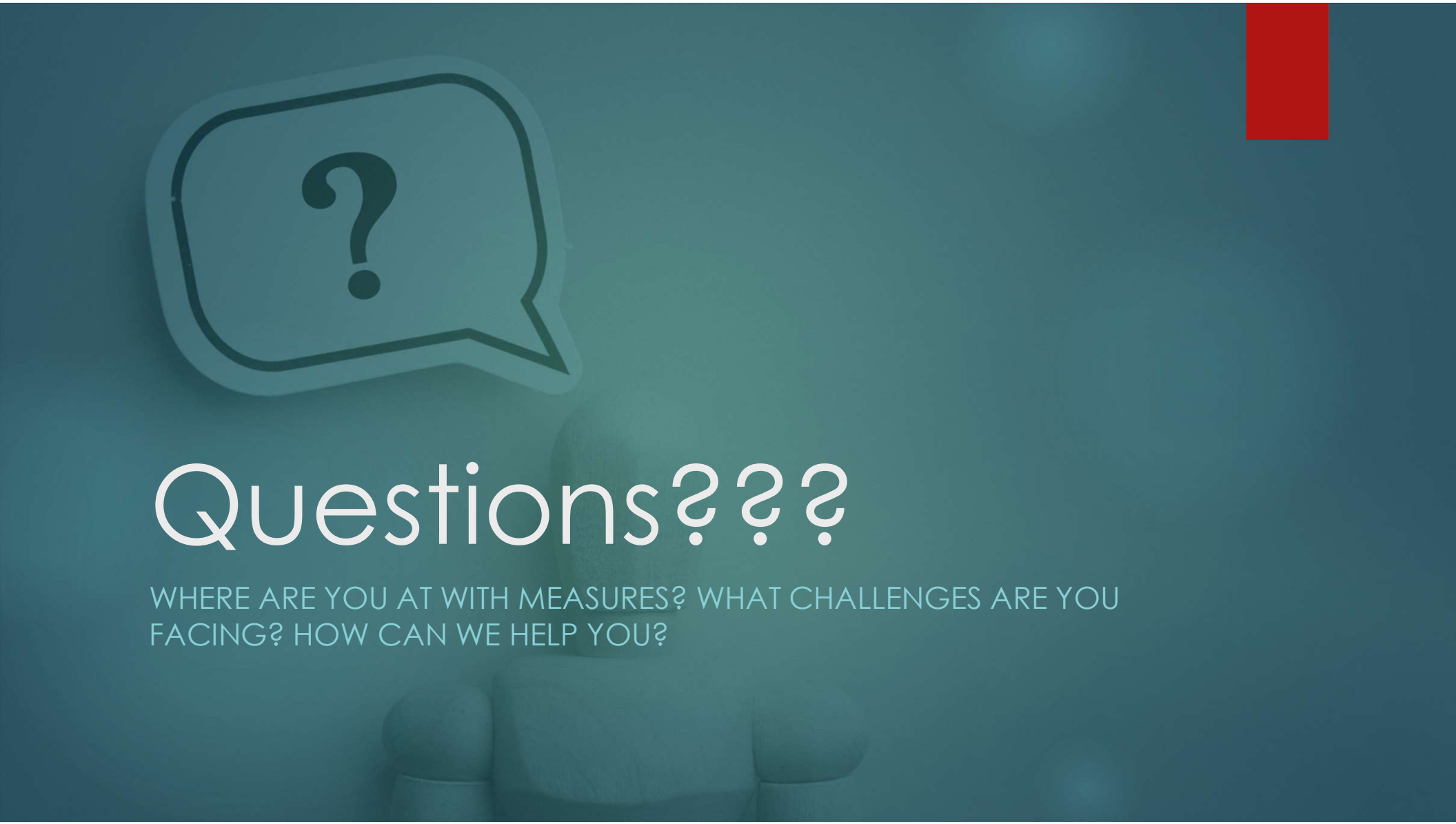
Texas

State-Level HCAHPS Report
Current Reporting Period: Q2 2023 - Q1 2024

Generated on 02/21/25

State Number of Completed Surveys: 2,610
State Response Rate: 18%

National Number of Completed Surveys: 94,696
National Response Rate: 26%



Questions???

WHERE ARE YOU AT WITH MEASURES? WHAT CHALLENGES ARE YOU FACING? HOW CAN WE HELP YOU?

What you can expect from us….

CHECKING IN VIA PHONE CALL

SCHEDULING SITE VISITS

MONITORING DATA REPORTS FOR HOSPITALS

REPORTING TO FORH

MBQIP Data Portal

HOW TO GET YOUR REPORTS

MBQIP Portal HOME MEASURES RESOURCES DEADLINES NEWS DICTIONARY

Welcome to the MBQIP Portal

All the MBQIP Information You Need

in One Location

QNet

QualityNet

LOGIN

Established by the Centers for Medicare & Medicaid Services

NHSN

National Hea Safety Network

LOGIN

MBQIP-DB

MBQIP Datab

LOGIN

ARCHI is working in collaboration with the State Office of Rural Health

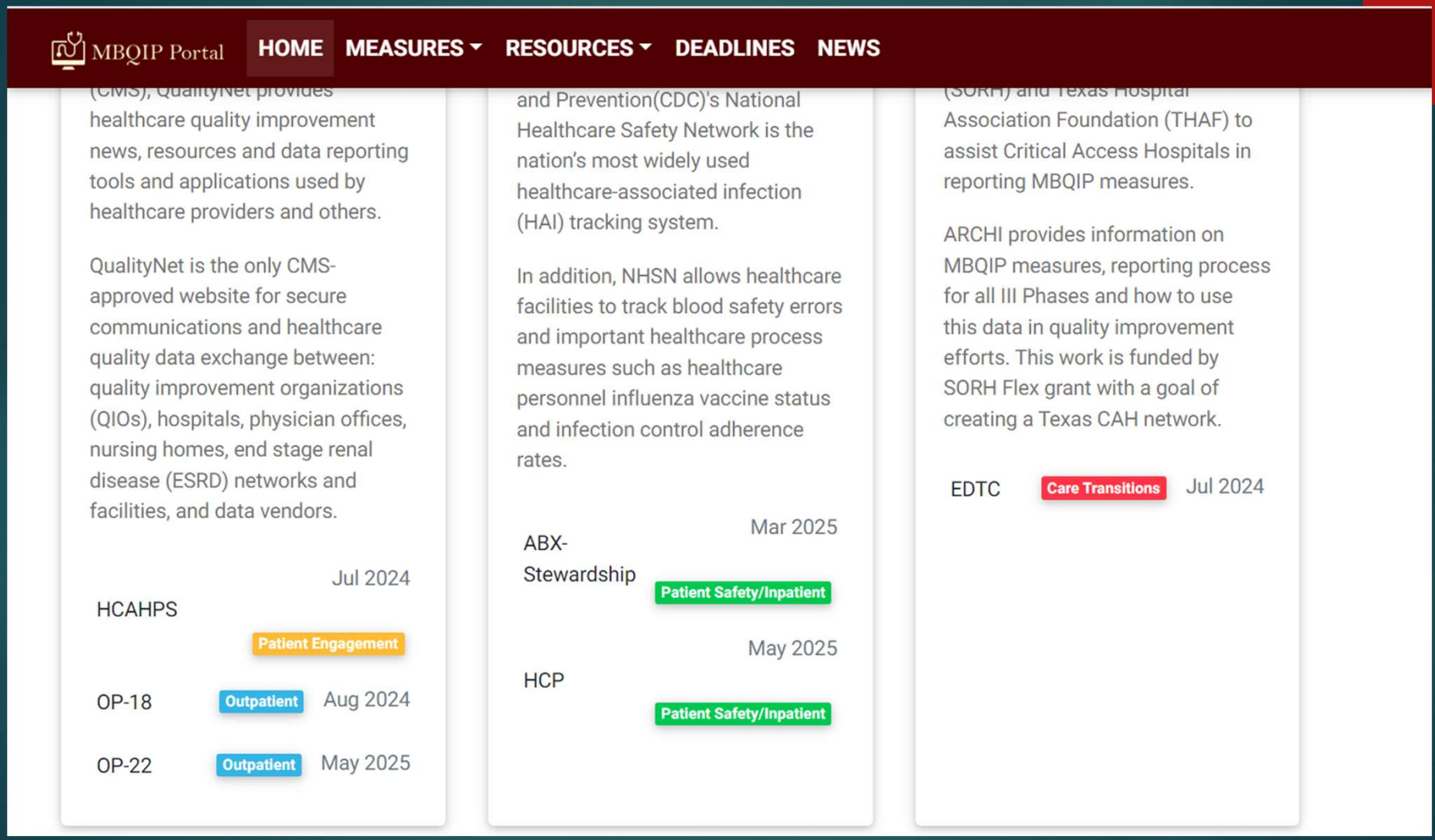
Upcoming Deadlines

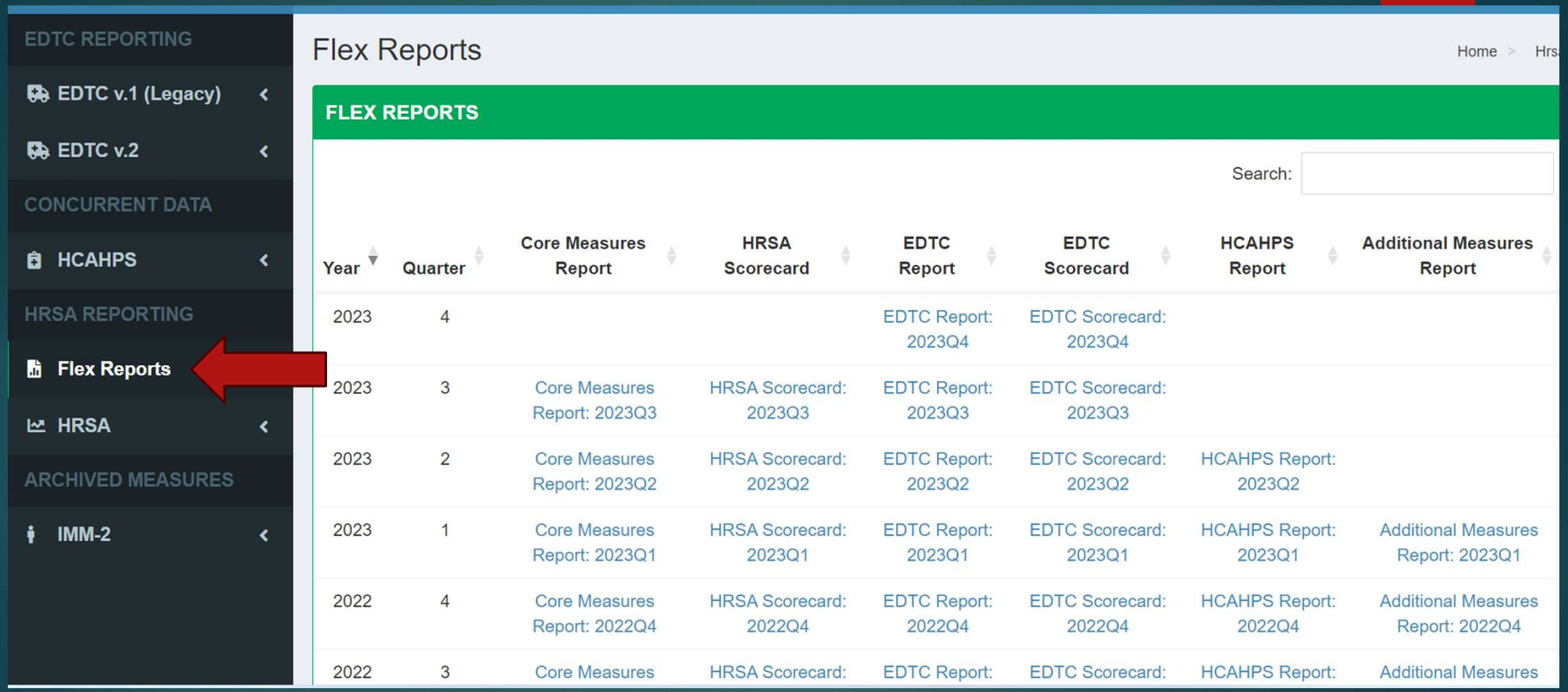
HCAHPS »
Apr 3rd

EDTC »
Apr 15th

OP-18 »
May 1st

OP-22 »
May 15th


MBQIP Portal
HOME
MEASURES
RESOURCES
DEADLINES
NEWS
(CMS), QualityNet provides healthcare quality improvement news, resources and data reporting tools and applications used by healthcare providers and others.
QualityNet is the only CMS-approved website for secure communications and healthcare quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end stage renal disease (ESRD) networks and facilities, and data vendors.
HCAHPS
Patient Engagement
Jul 2024
OP-18
Outpatient
Aug 2024
OP-22
Outpatient
May 2025
and Prevention(CDC)'s National Healthcare Safety Network is the nation's most widely used healthcare-associated infection (HAI) tracking system.
In addition, NHSN allows healthcare facilities to track blood safety errors and important healthcare process measures such as healthcare personnel influenza vaccine status and infection control adherence rates.
ABX-Stewardship
Patient Safety/Inpatient
Mar 2025
HCP
Patient Safety/Inpatient
May 2025
(SORH) and Texas Hospital Association Foundation (THAF) to assist Critical Access Hospitals in reporting MBQIP measures.
ARCHI provides information on MBQIP measures, reporting process for all III Phases and how to use this data in quality improvement efforts. This work is funded by SORH Flex grant with a goal of creating a Texas CAH network.
EDTC
Care Transitions
Jul 2024



Year	Quarter	Core Measures Report	HRSA Scorecard	EDTC Report	EDTC Scorecard	HCAHPS Report	Additional Measures Report
2023	4			EDTC Report: 2023Q4	EDTC Scorecard: 2023Q4		
2023	3	Core Measures Report: 2023Q3	HRSA Scorecard: 2023Q3	EDTC Report: 2023Q3	EDTC Scorecard: 2023Q3		
2023	2	Core Measures Report: 2023Q2	HRSA Scorecard: 2023Q2	EDTC Report: 2023Q2	EDTC Scorecard: 2023Q2	HCAHPS Report: 2023Q2	
2023	1	Core Measures Report: 2023Q1	HRSA Scorecard: 2023Q1	EDTC Report: 2023Q1	EDTC Scorecard: 2023Q1	HCAHPS Report: 2023Q1	Additional Measures Report: 2023Q1
2022	4	Core Measures Report: 2022Q4	HRSA Scorecard: 2022Q4	EDTC Report: 2022Q4	EDTC Scorecard: 2022Q4	HCAHPS Report: 2022Q4	Additional Measures Report: 2022Q4
2022	3	Core Measures	HRSA Scorecard:	EDTC Report:	EDTC Scorecard:	HCAHPS Report:	Additional Measures

Core Measure Report

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Core Measures Report
Quarter 3 - 2023

Generated on 03/06/24

		Your Hospital's Performance by Quarter				State Current Quarter			National Current Quarter		Bench-mark
	Emergency Department – Quarterly Measure	Q4 2022	Q1 2023	Q2 2023	Q3 2023	# CAHs Reporting	Median Time	90th Percentile	# CAHs Reporting	Median Time	Median Time
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	90	92	122	N/A	53	111	79	1,004	114	85
	Number of Patients (N)	N=94	N=99	N=96	N/A						

		Your Hospital's Performance by Calendar Year			State Current Year			National Current Year		Bench-mark
	Emergency Department – Annual Measure	CY 2020	CY 2021	CY 2022	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	CAH Overall Rate
OP-22	Patient Left Without Being Seen	N/A	N/A	N/A	29	1%	0%	963	1%	0%
	Number of Patients (N)	N/A	N/A	N/A						

		Your Hospital's Reported Adherence Percentage			State Current Flu Season			National Current Flu Season		Bench-mark
	NHSN Immunization Measure	4Q20 - 1Q21	4Q21 - 1Q22	4Q22 - 1Q23	# CAHs Reporting	CAH Overall Rate	90th Percentile	# CAHs Reporting	CAH Overall Rate	CAH Overall Rate
HCP/IMM-3	Healthcare Provider Influenza Vaccination	94%	N/A	88%	32	79%	91%	1,063	79%	100%

"N/A" indicates that a CAH either:

- Did not submit any measure data, or
- Submitted data that was rejected/not accepted into the CMS Clinical Warehouse.

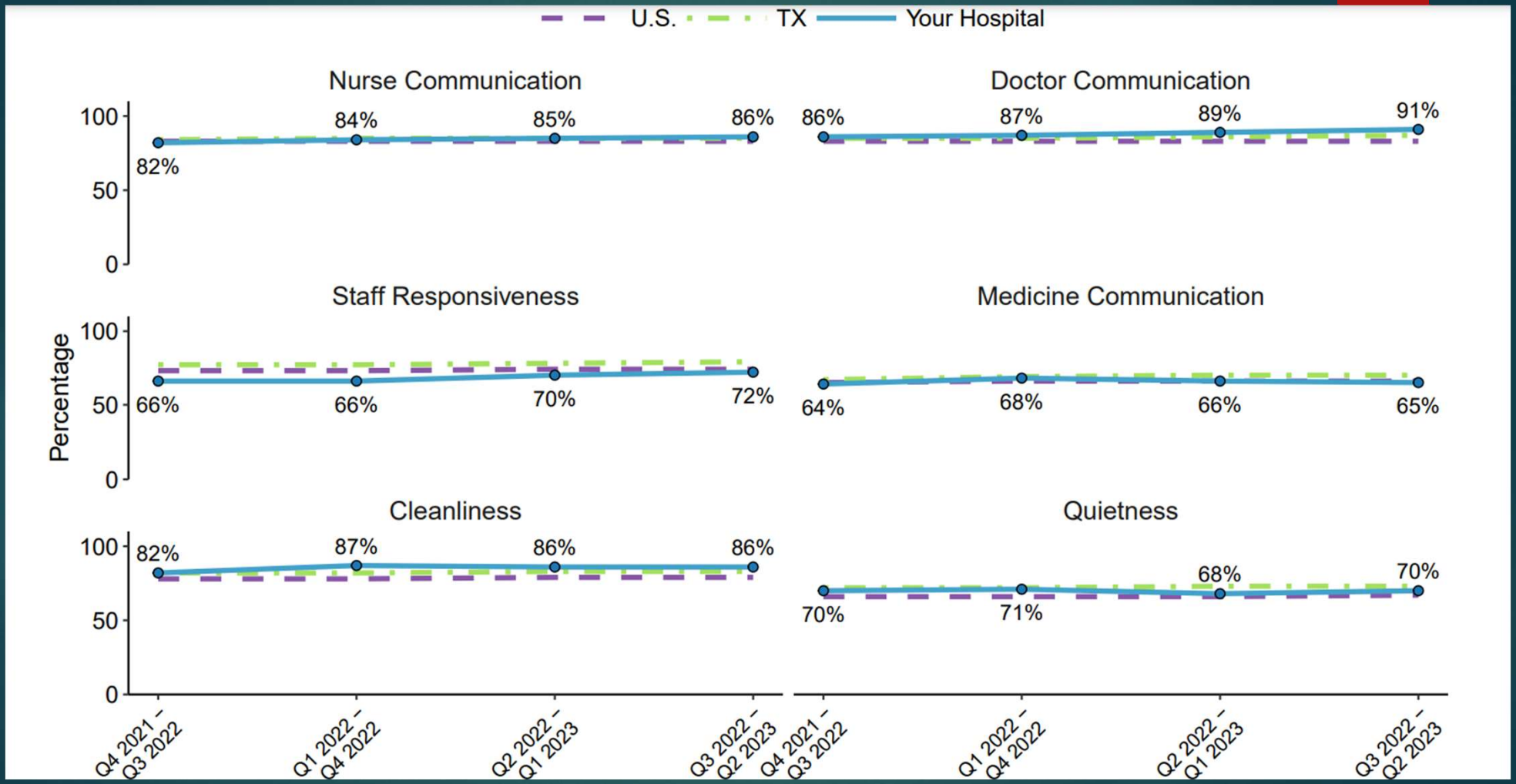
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this time period.

	HCAHPS Star Rating	Your Hospital's Adjusted Score		Your State's CAH Data		National CAH Data		Benchmark
Discharge Information Composite	Star Rating (0-5)	No	Yes	No	Yes	No	Yes	Yes
Composite 6 (Q16 & Q17) Discharge Information	N/C	14%	86%	12%	88%	12%	88%	92%

	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data			Benchmark
Care Transition Composite	Star Rating (0-5)	Disagree to Strongly Disagree	Agree	Strongly Agree	Disagree to Strongly Disagree	Agree	Strongly Agree	Disagree to Strongly Disagree	Agree	Strongly Agree	Strongly Agree
Composite 7 (Q20 to Q22) Care Transition	N/C	6%	45%	49%	4%	38%	58%	4%	41%	55%	64%

	HCAHPS Star Rating	Your Hospital's Adjusted Score			Your State's CAH Data			National CAH Data			Benchmark
HCAHPS Global Items	Star Rating (0-5)	0-6 rating	7-8 rating	9-10 rating	0-6 rating	7-8 rating	9-10 rating	0-6 rating	7-8 rating	9-10 rating	9-10 rating
Q18 Overall Rating of Hospital (0 = worst hospital, 10 = best hospital)	N/C	4%	12%	84%	6%	15%	80%	5%	18%	77%	86%
	Star Rating (0-5)	Definitely Not or Probably Not	Probably	Definitely	Definitely Not or Probably Not	Probably	Definitely	Definitely Not or Probably Not	Probably	Definitely	No Benchmark
Q19 Willingness to Recommend This Hospital	N/C	2%	25%	73%	3%	20%	77%	4%	22%	74%	

"N/A" indicates that a CAH did not report data in at least 10 of the 12 months for the current reporting period.


U.S.
TX
Your Hospital
Nurse Communication
82%
84%
85%
86%
Doctor Communication
86%
87%
89%
91%
Staff Responsiveness
66%
66%
70%
72%
Medicine Communication
64%
68%
66%
65%
Cleanliness
82%
87%
86%
86%
Quietness
70%
71%
68%
70%
Percentage
100
50
0
Q4 2021 – Q3 2022
Q1 2022 – Q4 2022
Q2 2022 – Q1 2023
Q3 2022 – Q2 2023

Hospital-Level Patient Safety/Inpatient and Outpatient MBQIP Additional Measures Report

Quarter 1 - 2023

Generated on 09/13/23

		Your Hospital's Performance by Quarter								State Current Quarter			National Current Quarter		
		Q2 2022		Q3 2022		Q4 2022		Q1 2023							
	Healthcare-Associated Infection	# Cases	SIR	# Cases	SIR	# Cases	SIR	# Cases	SIR	# CAHs Report-ing	Total # Cases	Overall SIR	# CAHs Report-ing	Total # Cases	Overall SIR
CAUTI	Catheter-associated urinary tract infections	0	N/C	0	N/C	0	N/C	0	N/C	56	0	0.0	1,160	53	0.6
CDI	Clostridium difficile (C.diff) intestinal infections	0	N/C	N/A	N/A	1	N/C	0	N/C	53	8	0.9	951	151	0.8
CLABSI	Central-line associated bloodstream infections	0	N/C	0	N/C	0	N/C	0	N/C	55	0	N/C	1,122	7	0.6
MRSA	Methicillin-resistant Staphylococcus aureus blood infections	1	N/C	N/A	N/A	0	N/C	0	N/C	53	0	N/C	929	9	0.6
SSI:C	Surgical site infections from colon surgery	0	N/C	0	N/C	0	N/C	0	N/C	15	0	N/C	460	17	1.1
SSI:H	Surgical site infections from abdominal hysterectomy	0	N/C	0	N/C	0	N/C	0	N/C	14	1	N/C	420	8	2.3

"N/A" indicates that the CAH did not submit data for this measure.
"#" indicates that the CAH did not have a signed MOU at the time of reporting for this period.
"N/C" indicates that a SIR was not able to be calculated.

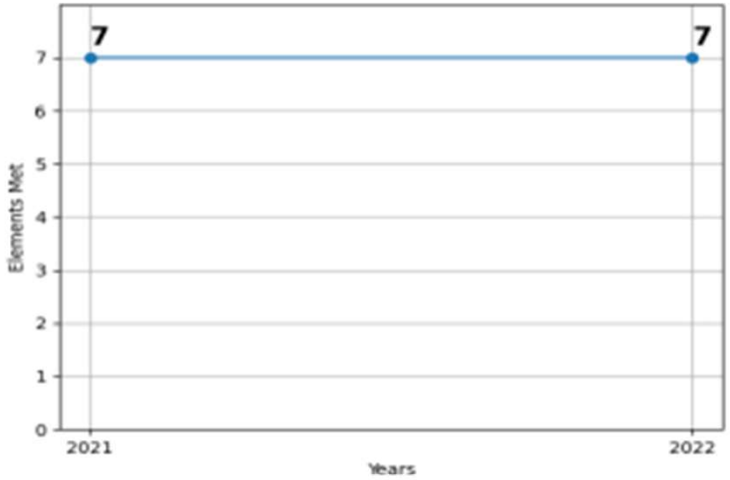
Trending Scorecard

Antibiotic Stewardship

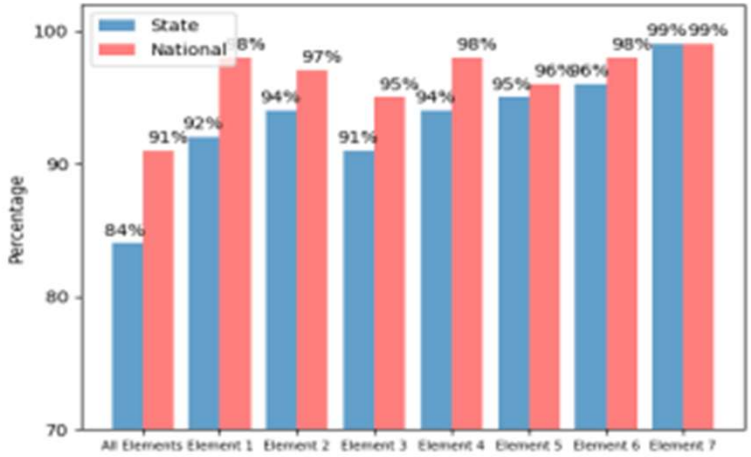
Positive Outcome: High Core Elements Met

(Reported Annually)
2021 through 2022

Your Hospital's Performance



Current Survey Year



CDC Core Elements Across Time	2021	2022
Elements Met	7	7
Element 1: Leadership	Y	Y
Element 2: Accountability	Y	Y
Element 3: Drug Expertise	Y	Y
Element 4: Action	Y	Y

Percentage of CAHs Meeting Elements	Facility	State	National
All Elements Met	Y	84%	91%
Element 1: Leadership	Y	92%	98%
Element 2: Accountability	Y	94%	97%
Element 3: Drug Expertise	Y	91%	95%
Element 4: Action	Y	94%	98%

Going Forward

- Start evaluating your data
  - What measures you currently collect
  - What measures you need to start collecting
- Discuss with organizational leadership
  - Must have engagement from top down
- Discuss with your QI Committee
  - Don't try to do all the work alone – It Takes Everyone!!!
  - Develop plan of action
- We are here to help you!!!!
  - Technical assistance
  - Site Visits


Questions???

Upcoming Events

- CNO Bootcamp
  - July 31-Aug 1, 2025 – Austin, Tx
- Frontline webinar series on Quality Improvement
  - Basics of Quality Improvement
  - Patient Centered Care
  - Ownership On the Frontline and Moving Toward High Reliability
  - AI in Healthcare

Who To Contact

- **Regional Coordinator with SORH**
- **Need access or have issues with MBQIP Portal?**
  - **Diana Miller, MSN, RN** | Director Quality Texas A&M Rural and Community Health Institute | Texas A&M Health
  - dgmiller@tamu.edu
- **Need quality improvement technical assistance or want to schedule a site visit?**
  - **Sheila Dolbow, MSN, RN, CFN, CPHQ /** Quality Improvement Manager
  - Texas Hospital Association Foundation
  - sdolbow@tha.org