
OREGON OFFICE
ORH
of RURAL HEALTH
CRITICAL ACCESS HOSPITAL
QUALITY REPORTING OVERVIEW GUIDE
OCTOBER | 2021

National quality improvement reporting has traditionally been difficult for Critical Access Hospitals (CAHs) due to the challenges that arise from attempting to measure improvement in "low-volume" settings, which often have limited resources. In fact, CAHs have been exempt from reporting programs at the national level for these very reasons. Recent work has shown that it is possible for CAHs to not only participate in national quality improvement reporting programs, but to excel in areas that are relevant to their rural locations and hospital size. One example of such success is small rural hospitals that participate in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) assessments. These hospitals often outperform prospective payment system (PPS) hospitals on the same survey.

With the prospect of a health care system that pays for value of care over volume of care, it is vital for CAHs to demonstrate their ability to provide quality care by participating in federal public quality reporting. The concerns of the past about low-volume are no longer a good reason for CAHs to refrain from monitoring or reporting quality data. Instead, it is important to provide evidence-based care for every patient, 100 percent of the time. This can be achieved through monitoring, reporting and continuous quality improvement efforts.

About this Guide:

This guide explains the various quality reporting programs in which CAHs may participate. The programs are outlined via the areas the hospital covers (i.e., outpatient, inpatient, etc.) and the type of program the hospital is associated with (i.e., HCAHPS, Medicare Beneficiary Quality Improvement Project, etc.). Participation in these programs varies depending on the needs and desire for quality monitoring by the CAH.

Purpose of this Guide:

This guide was written by CAH Quality Improvement Directors for other CAH Quality Improvement Directors and staff. The purpose of this guide is to help Quality Improvement Directors structure and support quality improvement (QI) efforts as well as make informed decisions about the quality reporting for their facilities.

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CONTENTS

I. REGULATORY PROGRAM OVERVIEW

PROGRAM AND DESCRIPTION	VOLUNTARY or REQUIRED	IMPACTS	LEAD ORGANIZATION
Medicare Beneficiary Quality Improvement Project (MBQIP) This is a federal grant program administered by The Oregon Office of Rural Health to support CAHs to report common, rural-relevant quality measures that are appropriate to low-volume hospitals.	Voluntary (*Required to receive support from the Rural Hospital Flexibility Grant)	CAHs only	Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP) Oregon Office of Rural Health (ORH)
Hospital Inpatient Quality Reporting Program (HIQRP or IQR) Includes inpatient measures collected and submitted by acute care hospitals paid under Prospective Payment System (PPS) and claims-based inpatient measures calculated by CMS.	Voluntary	CAHs (reporting MBQIP) PPS hospitals	CMS
Hospital Outpatient Quality Reporting (HOQRP or OQR) Includes outpatient measures collected and submitted by acute care hospitals paid under PPS and claims-based outpatient measures calculated by CMS.	Voluntary	CAHs (reporting MBQIP) PPS hospitals	CMS
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey program that collects patients' evaluations of health care experiences for the purposes of comparison, value-based purchasing and consumer education for health care decisions.	Voluntary	CAHs (reporting MBQIP) PPS hospitals	CMS
Medicare Access and CHIP Reauthorization ACT, Merit-Based Incentive Payment System (MACRA-MIPS) Uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. Program of initial payment incentives and future payment penalties for physician practices to submit quality data.	Required if using Method 2 billing and have eligible providers	Eligible professionals and practices	CMS
Electronically-Specified Clinical Quality Measures (eCQMs) Meaningful Use Reporting clinical quality measures (CQMs) is a requirement for hospitals under the Promoting Interoperability Program (PIP) (formerly the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs or Meaningful Use (MU)). For the FY20/21 payment determination for the Promoting Interoperability Program, hospitals are required to report on at least four of the eight available measures using the 2015 Edition of Certified EHR Technology.	Required (if participating)	CAHs PPS hospitals	CMS Office of the National Coordinator for Health Information Technology (ONC)
The Hospital Quality Improvement Contractor (HQIC) Initiative Provides targeted QI assistance to rural and critical access hospitals, as well as hospitals serving vulnerable and underserved populations to achieve measurable outcomes with a focus on patient safety, care transitions and opioids.	Voluntary Recommended	CAHs Rural hospitals	CMS HQIC Contractors

II. PROGRAM DETAILS

Medical Beneficiary Quality Improvement Project (MBQIP)

Program Overview:

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity through the Federal Office of Rural Health Policy's (FORHP) Rural Hospital Flexibility (Flex) grant program and is specific to CAHs. This voluntary program, implemented in 2011, focuses on reporting quality measures that are relevant to rural, low-volume hospitals. The program encourages CAHs to measure outcomes, demonstrate improvements and share best practices with data that is aggregated and shared as state and national benchmarks. MBQIP provides an opportunity for individual hospitals to look at their own data, compare their results against other CAHs and partner with other hospitals around quality improvement initiatives.

Why Report?

As the U.S. moves rapidly toward a health care system that pays for value over volume of care provided, it is extremely important for CAHs to participate in federal, public quality reporting programs to demonstrate the quality of care they are providing. MBQIP takes a proactive approach to ensure CAHs are well-prepared to meet future quality requirements.

Reporting Method: See Table 2.

Every year, FORHP will increase the minimum requirements for CAHs to be eligible to participate in Flex funded activities or receive Flex funds. See Table 1 for an example of opportunities available to your CAH under the Flex grant.

Table 1. Flex Opportunities in Oregon:

SUPPORT FOR QUALITY IMPROVEMENT:

- Antimicrobial Stewardship Program (ASP) support
- Quality improvement and MBQIP training including peer-to-peer sharing opportunities
- Scholarships for CAH quality staff to attend local and national conferences
- Memberships to NAQH with support for CAH quality professionals to obtain their CPHQ
- Grants and collaborative programs to support quality improvement projects
- Support to improve the patient experience and HCAHPS scores
- MBQIP Top Performer Program
- MBQIP and HCAHPS technical assistance

SUPPORT FOR OPERATIONAL IMPROVEMENTS AND COMMUNITY ENGAGEMENT:

- Scholarships for NRHA Rural Hospital CEO, CFO and CNO Certifications
- Support for Community Health Needs Assessments (CHNAs)
- IT training support
- Grants for Board of Trustee training and education
- Scholarships for leadership to attend national conferences

SUPPORT FOR EMERGENCY MEDICAL SERVICES (EMS):

- Sponsorship for Oregon EMS forums
- Scholarships for EMS personnel to attend national conferences
- Research and assistance on EMS service implementation in rural and frontier Oregon
- Support for CAH participation in simulation-based team training for trauma and medical emergency scenarios
- Grants to support CAH-EMS innovation efforts
- EMS billing training

SUPPORT FOR PROVIDER BASED RURAL HEALTH CLINICS (PBRHC):

- Scholarships for leadership to attend state and regional conferences
- Grants to support practice innovation efforts
- Peer-to-peer learning and compliance cohort
- RHC specific training opportunities on emergency preparedness standards
- Support and training for filing state wrap-around payment
- Mock site surveys and on-site technical assistance
- Quality improvement collaborative
- Annual RHC Workshop

Table 2. Core MBQIP Measures 2021

In addition to the core improvement activities below, there are additional activities that Flex participants may work on with any cohort of CAHs based on need and relevance. The additional improvement activities information can be found in Appendix A.

Measure	Description	Reporting Method
Patient Safety/Inpatient		
HCP/IMM-3	Influenza Vaccination Coverage Among Healthcare Personnel (HCP) (formerly OP-27)	National Healthcare Safety Network (NHSN)
Antibiotic Stewardship	Antibiotic Stewardship Program (ASP) via the CDC Annual Facility Survey	National Healthcare Safety Network (NHSN)
Patient Engagement: **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. The survey is 29 questions.*		
	– 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	QualityNet via HCAHPS vendor or self-administered if in compliance with program requirements.
Care Transitions: **Emergency Department Transfer Communication (EDTC)** *8 data elements; 1 composite*		
EDTC-1	Home Medications	Oregon Office of Rural Health
EDTC-2	Allergies and/or Reactions	
EDTC-3	Medication Administered in ED	
EDTC-4	ED Provider Note	
EDTC-5	Mental Status/Orientation Assessment	
EDTC-6	Reason for Transfer and/or Plan of Care	
EDTC-7	Tests and/or Procedures Performed	
EDTC-8	Tests and/or Procedure Results	
ALL EDTC	Composite of all data elements	
Outpatient		
OP-2	Fibrinolytic Therapy Received within 30 minutes	QualityNet Via Outpatient CART/Vendor
OP-3	Median Time to Transfer to another Facility for Acute Coronary Intervention	
OP-18	Median Time from Arrival to Departure for Discharged ED Patients	
OP-22	Patient Left Without Being Seen	QualityNet as a web-based measure

Newer MBQIP Measures:

The Federal Office of Rural Health Policy (FORHP) announced the addition of the following Core Measures under the Patient Safety category for the Flex project period of 2018-2021. CAHs should continue building capacity and submitting data on these measures as indicated below:

Antibiotic Stewardship: Improving antibiotic use in hospitals is vital to improving patient outcomes, decreasing antibiotic resistance and reducing overall healthcare costs. Overexposure to antibiotics contributes to antibiotic resistance, making antibiotics less effective. FORHP is working closely with the CDC to help educate and assist hospitals and nursing homes to align locally or regionally to fight resistance.

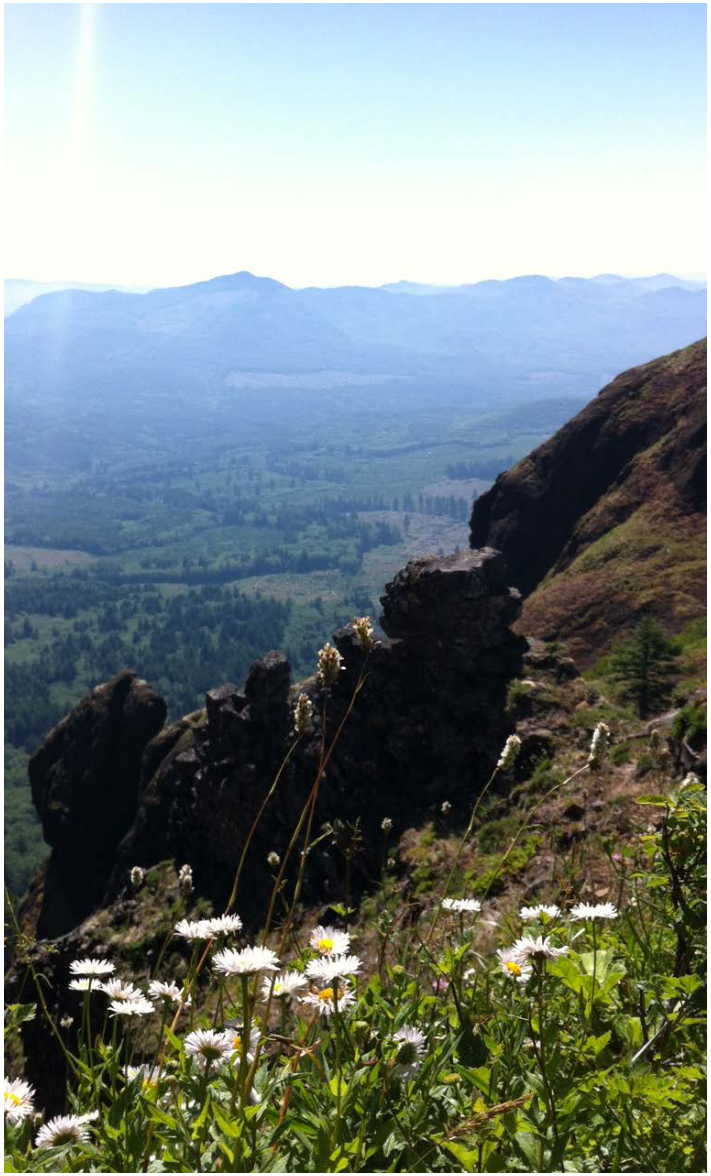
Effective March 30, 2020, CMS made Antimicrobial Stewardship Programs (ASPs) a required Condition of Participation (CoP) under the CAH program. CAHs are required to meet core elements of the CDC's Annual Facility Survey to demonstrate compliance with the CDC's 7 Core Elements:

- **Leadership Commitment:** Dedicate human, financial and IT resources
- **Accountability:** Leader responsible for outcomes (physician recommended)
- **Drug Expertise:** Pharmacist leader
- **Action:** Implement recommended action(s) such as "antibiotic time-out"
- **Tracking:** Monitor prescribing and resistance patterns
- **Reporting:** Regular information to doctors, nurses, and relevant staff
- **Education:** Focus on resistance and optimal prescribing with clinicians

Retiring Measures:

CMS regularly evaluates and removes measures from both Hospital Inpatient and Outpatient quality reporting (IQR and OQR) through their annual rule making process. Once removed, measures are no longer reportable and it is not possible to submit data through QualityNet. FORHP works to align MBQIP reporting measures with other federal reporting programs, thus these measures are typically removed from MBQIP when removed by CMS.

Hospital Inpatient Quality Reporting Program (Hospital IQR)



Program Overview:

The Hospital Inpatient Quality Reporting Program (Hospital IQR) was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This section authorized CMS to pay hospitals that successfully report designated quality measures a higher annual increase to their payment rates.

Why Report?

CAHs are not required to report on the measures listed in Table 3.

> *This is voluntary; however, it is important to note that some of these measures comply with reporting requirements of more than one program such as MBQIP and the Promoting Interoperability Program (Appendix C).*

Typically, CAHs do not have many patients that qualify for these measures and hence the measures show up as N/A on Care Compare (CC) (www.medicare.gov/care-compare), although MBQIP reports do capture low-volume numbers reported. Collecting data on these measures can help with internal tracking for the hospital on the patient safety measures and the quality of care.

Reporting Methods:

Option 1: Contract and authorize a vendor for data extraction and submission.

Option 2: Extract data from your Electronic Health Record (EHR) and use The CMS Abstraction & Reporting Tool (CART) for upload and submission of data to CMS via Hospital Quality Reporting Application on the QualityNet website. (Review steps 2, 3 and 5 in the Reporting Method Checklist on Page 25).

Table 3. Hospital IQR Measures (Updated for FY20/21)

Measure	Description	Programs	Method
Chart-Abstracted Clinical Process of Care			
PC-01	Elective delivery	CC	Chart abstracted
Sepsis	Severe sepsis and septic shock: Management bundle (Composite Measure)	CC	Chart abstracted
EHR-Based Clinical Process of Care (eCQMs)			
ED-2	Admit decision time to ED departure time for admitted patients	CC, PIP	eCQM
PC-05	Exclusive breast milk feeding	CC, PIP	eCQM
STK-2	Ischemic stroke patients discharged on antithrombotic therapy	CC, PIP	eCQM
STK-3	Anticoagulation therapy for arterial fibrillation/flutter	CC, PIP	eCQM
STK-5	Antithrombotic therapy by the end of hospital day two	CC, PIP	eCQM
STK-6	Discharged on statin medication	CC, PIP	eCQM
VTE-1	Venous thromboembolism prophylaxis	CC, PIP	eCQM
VTE-2	Intensive care unit venous thromboembolism prophylaxis	CC, PIP	eCQM
Safe Use of Opioids	Safe use of opioids – Current prescribing	CC, PIP	eCQM
VTE-2	Intensive care unit venous thromboembolism prophylaxis	CC, PIP	eCQM
Healthcare-Associated Infection			
HCP/IMM-3	Influenza Vaccination Coverage Among Healthcare Personnel	CC	NHSN
Patient Experience of Care Survey			
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey	CC	Patient Surveys
Claims-Based Patient Safety			
CMS PSI 04	CMS Death Rate Among Surgical Inpatients with Serious Treatable Complications		Claims-based
Claims-Based Mortality Outcome			
Mort-30-STK	Hospital 30 Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke		Claims-based
Claims-Based Coordination of Care			
READM-30-HWR	Hospital-Wide All-Cause Unplanned Readmission Measure		Claims-based
AMI Excess Days	Excess Days in Acute Care after Hospitalization for AMI		Claims-based
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure		Claims-based
PN Excess Days	Acute Care after Hospitalization for Pneumonia		Claims-based

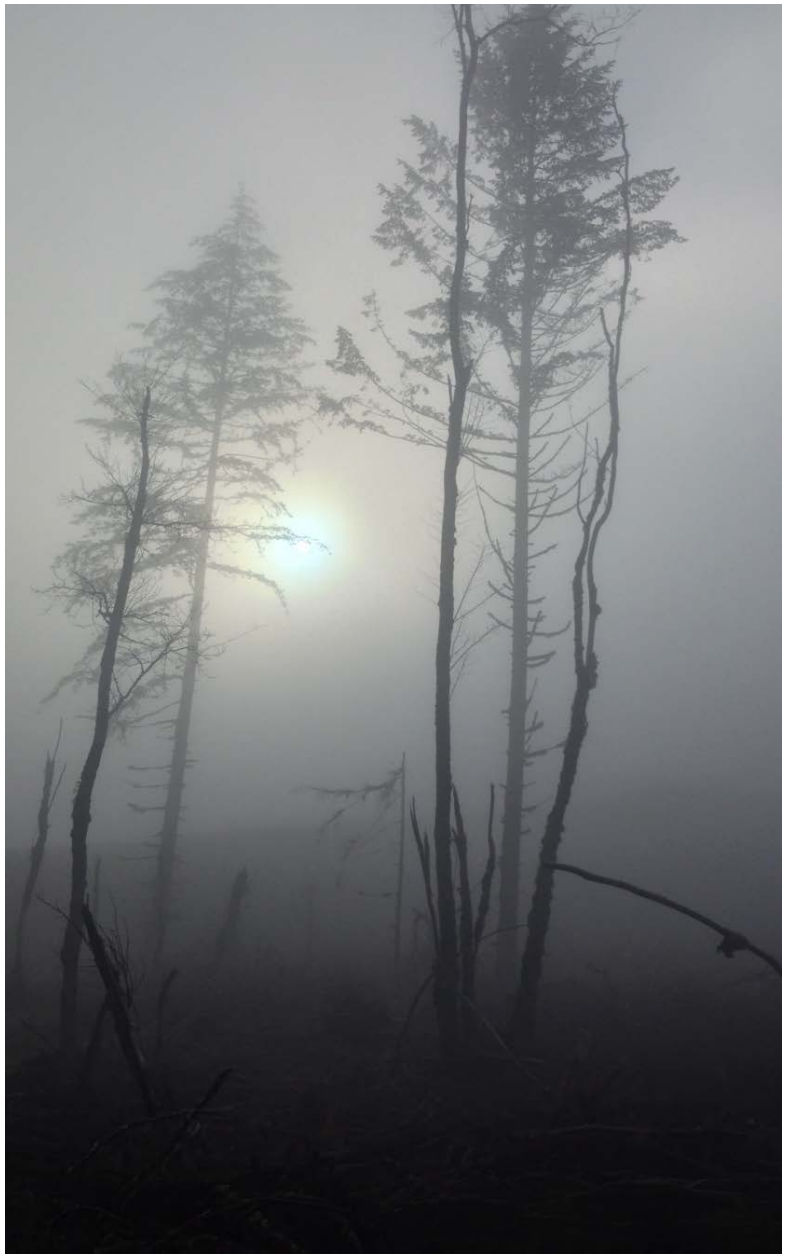
–

Table 3 continued:

Claims-Based Payment			
AMI Payment	Hospital-Level Risk Standardization Payment Associated w/30 day EOC for AMI		Claims-based
HF Payment	Hospital-Level Risk Standardization Payment Associated w/30 day EOC for HF		Claims-based
PN Payment	Hospital-Level Risk Standardization Payment Associated w/30 day EOC for PN		Claims-based
THA/TKA Payment	Hospital-Level Risk Standardization Payment Associated w/30 day EOC for Primary Elective TKA/TKH		Claims-based

Acronyms			
AMI	Acute Myocardial Infarction	HWR	Hospital-Wide Readmission
APU	Annual Payment Update	IQR	Inpatient Quality Reporting
CC	Care Compare	MORT	Mortality
CMS	Centers for Medicare & Medicaid Services	NHSN	National Healthcare Safety Network
Comp	Complication	PC	Perinatal Care
eCQM	Electronic Clinical Quality Measure	PIP	Promoting Interoperability Program
ED	Emergency Department	PN	Pneumonia
EHR	Electronic Health Record	PSI	Patient Safety Indicator
EOC	Episode of Care	READM	Readmission
FY	Fiscal Year	STK	Stroke
HCAHPS	Hospital Consumer Assessment of Healthcare Providers & Systems	THA	Total Hip Arthroplasty
HCP	Healthcare Personnel	TKA	Total Knee Arthroplasty
HF	Heart Failure	VTE	Venous Thromboembolism

Hospital Outpatient Quality Reporting Program (Hospital OQR)



Program Overview:

The Hospital Outpatient Quality Reporting Program (Hospital OQR) is a pay-for-quality data reporting program implemented by CMS for outpatient hospital services. The Hospital OQR Program was mandated by the Tax Relief and Health Care Act of 2006, which requires subsection (d) (general acute care) hospitals to submit data on measures on the quality of care furnished by hospitals in outpatient settings. Measures of quality may be of various types, including those of process, structure, outcome and efficiency.

In addition to providing hospitals with a financial incentive to report their data, the Hospital OQR Program provides CMS with data to help Medicare beneficiaries make more informed decisions about their health care. Hospital quality of care information gathered through the Hospital OQR Program is available on the Care Compare (CC) website.

Why Report?

CAHs are not required to report on the measures listed in Table 4.

This is voluntary; however, it is important to note that some of these measures also comply with reporting requirements of more than one program such as MBQIP. (Appendix C).

Typically, CAHs do not have many patients that qualify for these measures and hence they show as N/A on Care Compare (CC), although MBQIP reports do capture low-volume numbers reported. Collecting data on these measures can help the hospital track the quality of care and identify trends for continuous quality improvement.

Reporting Method for Non-Claims-Based Measures:

a) Contract and authorize a vendor for data extraction and submission.

b) Extract data from your EHR system and use CART to upload and submit data to CMS via Hospital Quality Reporting Application on the QualityNet website (Review steps 2, 3 and 5 in the Reporting Method Checklist on Page 25).

Table 4. Hospital OQR Measures (Updated for CY21/22)

Measure	Measure Description	Programs
Cardiac Care (AMI and CP) Measures		
OP-2	Fibrinolytic therapy received within 30 minutes of ED arrival	CC, MBQIP
OP-3	Median time to transfer to another facility for acute coronary intervention	CC, MBQIP
ED Throughput		
OP-18	Median time from ED arrival to ED departure for discharged ED patients	CC, MBQIP
Stroke		
OP-23	ED head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke who received head CT or MRI scan	CC, *MBQIP**
Imaging Efficiency Measures		
OP-8	MRI lumbar spine for low back pain	CC
OP-10	Abdomen CT use of contrast material	CC
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	CC
Chart-Abstracted Measures - Data Submission by Web-Based Tool (QualityNet)		
OP-22	ED patient left without being seen	CC, MBQIP
OP-29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients	CC
OP-31	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery*	CC
Claims-Based Measures		
OP-32	Facility 7-day risk standardized hospital visit rate after outpatient colonoscopy	
OP-35	Admissions and emergency department visits for patients receiving outpatient chemotherapy	
OP-36	Hospital visits after hospital outpatient surgery	

**OP-23 is currently an Additional, not Core MBQIP Measure*

Population and Sampling:

"Population and Sampling" refers to recording the number of cases the hospital submits to the QualityNet Warehouse. This is done directly through the QualityNet Secure Portal. Hospitals have the option to sample from their population or submit their entire population. Hospitals that choose to sample must ensure that the sampled data represent their outpatient population by using either the simple random sampling or systematic random sampling method and that the sampling techniques are applied consistently within a quarter.

CAHs are strongly encouraged to submit their population and sample size counts each quarter, but reporting of population and sampling data is not required for data to be submitted to CMS.

Sample Size Requirements for OP-2, OP-3, OP-5, OP-23

Population Per Quarter	Sample Size
≤ 80	Use all cases
81-100	80
101-125	95
126-150	109
151-175	121
176-200	132
201-225	143
226-250	152
251-275	161
276-300	169
301-325	177
326-350	184
351-375	191
376-400	197

Population Per Quarter	Sample Size
401-425	203
426-450	208
451-500	218
501-600	235
601-700	249
701-800	260
801-900	270
901-1000	278
1001-2000	323
2001-3000	341
3001-4000	351
4001-5000	357
5001-10000	370
>10000	377

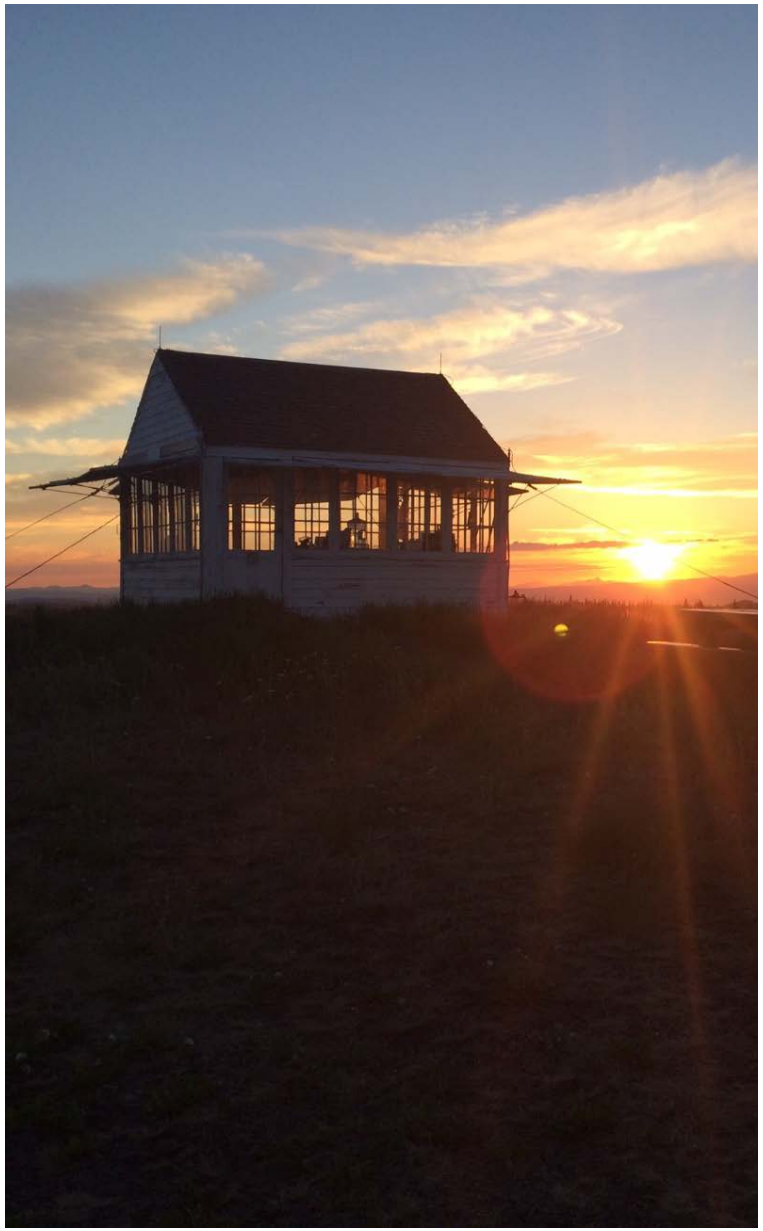
Sample Size Requirements for OP-18

Population per Quarter	Sample Size
0-900	63
≥ 901	96

Sample Size Requirements for OP-29, OP-30, OP-31

Population per Year	Sample Size
0-900	63
≥ 901	96

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)



Program Overview:

The HCAHPS survey was created by CMS as a standardized assessment of the patient experience. It was designed to allow for comparison of patient perspectives across hospitals and public reporting instated as an incentive for improving quality of care in addition to allowing for transparency for the public.

Since 2006, the survey has been administered to a random sample of inpatients. The official survey comprises 29 questions about the patient's hospital stay; 19 meaningful questions about hospital experiences, three screening questions to skip to appropriate areas and five to adjust for the mix of patient plus two to assist with congressionally mandated reports. The 19 meaningful questions about the hospital experience cover areas including cleanliness, noise levels, nurse and provider communication and likelihood of recommendation. The results are publicly reported on Care Compare and are also made available to CAHs via the MBQIP Reports.

Why Report?

All 25 of Oregon's Critical Access Hospitals Report on HCAHPS

HCAHPS provides information about patient satisfaction to the hospital, helping to identify opportunities for quality improvement activities that could improve the overall patient experience and care.

Furthermore, the HCAHPS score feeds into Care Compare and therefore contributes to the star rating received by a facility.

Reporting Method:

Option 1: Contract and authorize (via the Secure Portal at QualityNet) an approved HCAHPS vendor to administer and submit the survey data to the QualityNet Clinical Data Warehouse.

Option 2: Self-administer the survey and submit the data to the QualityNet Clinical Data Warehouse.

More information can be found on page 29.

Medicare Access and CHIP Reauthorization Act (MACRA)

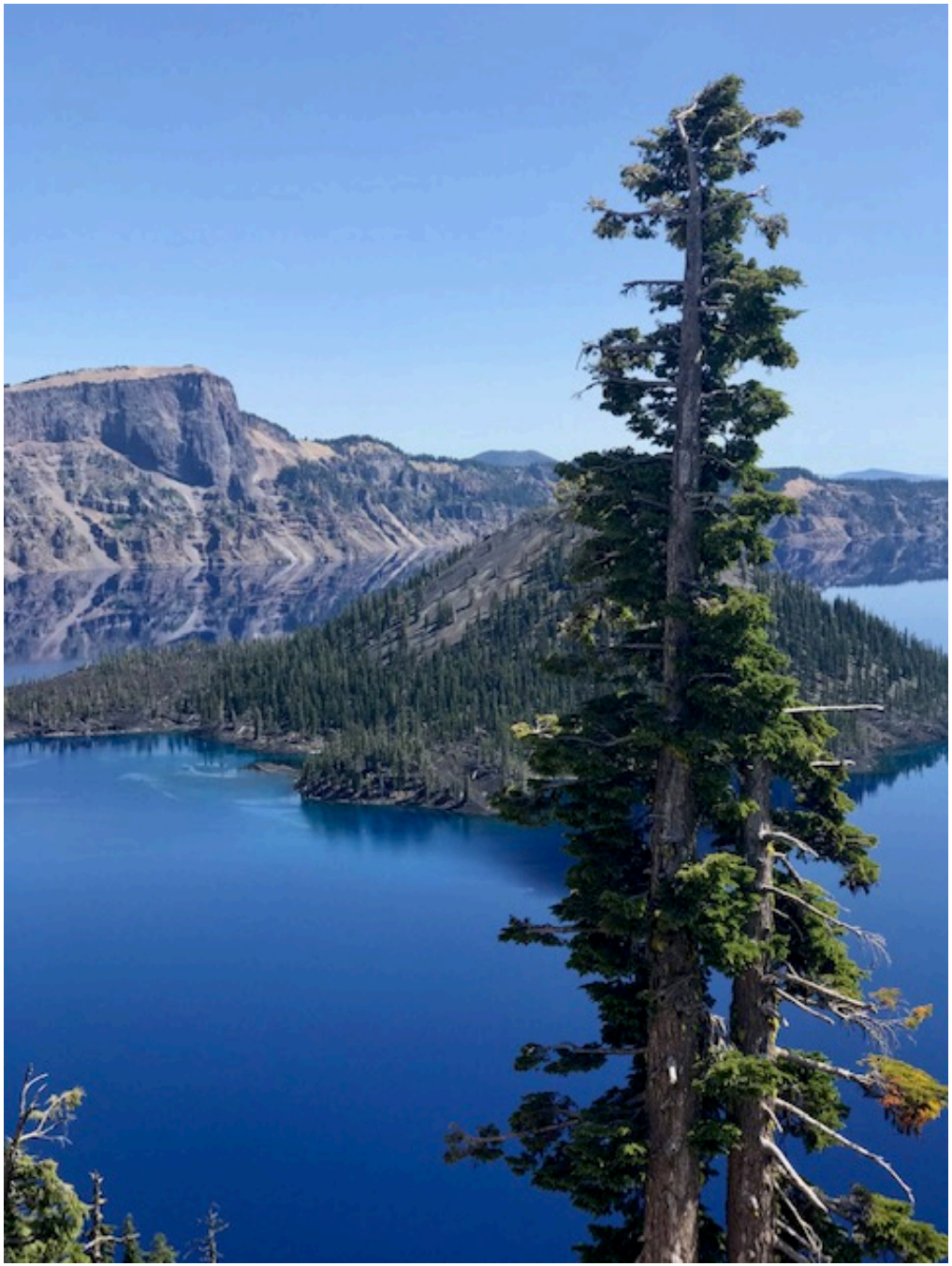
Program Overview:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. If a clinician participates in Medicare Part B, they can participate in the Quality Payment Program (QPP) by choosing one of the following two tracks:

- Advanced Alternative Payment Models (APMs), which includes certain Medicare Shared Savings Programs (the most common APM are known as Accountable Care Organizations, or ACOs); or
- The Merit-based Incentive Payment System (MIPS).

The Merit-based Incentive Payment System (MIPS) combined legacy CMS programs such as Meaningful Use (MU) and the Physician Quality Reporting System (PQRS) into one. The program changes how CMS reimburses MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and health outcomes. Under MIPS, CMS evaluates your performance across multiple performance categories that lead to improved quality and value in health care systems. If you're eligible for MIPS in 2021:

- Individual providers or clinics (groups) generally have to submit data in three areas: The Quality, Improvement Activities, and Promoting Interoperability performance categories. The fourth category, Cost, is calculated by CMS as they have your claims.
- The provider or clinic performance across the MIPS performance categories, each with a specific weight, will result in a MIPS Final Score of 0 to 100 points.
- The MIPS Final Score will determine whether a negative, neutral, or positive MIPS payment adjustment is received.
- For the 2021 performance period (2023 payment year): The performance threshold to avoid a penalty is set at **60 points** and the additional performance threshold for exceptional performance remains at **85 points**.
- To check if a provider is eligible to participate in MIPS in 2021, enter the 10-digit National Provider Identifier in the Quality Payment Program Participation Status Tool on the Quality Payment Program website: https://qpp.cms.gov/participation-lookup.



Why Report?

CAHs that bill under Method II and have eligible providers who fail to satisfactorily report for the QPP program are subject to a negative payment adjustment.

Here is additional information to determine your reporting category and payment adjustment:

For eligible clinicians practicing in Method I:

- The MIPS payment adjustment would apply to payments made for items and services that are Medicare Part B charges billed by MIPS eligible clinicians.
- The payment adjustment would not apply to the facility payment to the CAH itself.

For eligible clinicians practicing in Method II who have assigned their billing rights to the CAH:

- The MIPS payment adjustment would apply to Method II CAH payments.

For eligible clinicians practicing in Method II who have not assigned their billing rights to CAH:

- The MIPS payment adjustment would apply the same way as for Method I CAHs.

You may be excluded from MIPS if you are a part of an RHC or FQHC. If you bill for Medicare Part B services exclusively through the RHC or FQHC payment methods, then you are not eligible for payment adjustments under MIPS. This is because MIPS does not apply to these facility payments. However, if you are a part of an RHC or FQHC and bill for Medicare Part B services under the Physician Fee Schedule (PFS), then payment for such other services would be subject to the MIPS payment adjustments unless your billings are below the low-volume threshold or you meet another exclusion.

Who Can Participate in the QPP Program?

Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, occupational therapists, clinical psychologists, qualified speech-language pathologists, qualified audiologists and registered dietitians or nutrition professionals.

Providers are part of the MIPS Program if they:

Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) and furnish covered professional services to more than 200 Medicare beneficiaries a year and provide more than 200 covered professional services under the PFS.

If they do not exceed all three of the above criteria for the 2021 performance year, they are excluded from MIPS. However, they have the opportunity to opt-in to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criteria.

Reporting Method: Clinicians Can Report as Individuals or with a Group

Report as an individual	Report with a group
An individual is defined as a single clinician, identified by a single National Provider Identifier (NPI) number tied to a single Tax Identification Number (TIN). For 2021, individuals can choose from a list of ways to submit (some options vary based on performance category), including: • Electronic Clinical Quality Measures (eCQMs) • MIPS Clinical Quality Measures (MIPS CQMs) (formerly referred to as "Registry measures") • Qualified Clinical Data Registry (QCDR) Measures • Medicare Part B claims can only be submitted by clinicians in a small practice (16 or fewer eligible clinicians)	A group is defined as a single Taxpayer Identification Number (TIN) with two or more eligible clinicians, as identified by their National Provider Identifiers (NPI), who have reassigned their Medicare billing rights to the TIN. For 2021, groups can choose from a list of available data submission mechanisms (some options vary based on performance category) including: • Electronic Clinical Quality Measures (eCQMs) • MIPS Clinical Quality Measures (MIPS CQMs) (formerly referred to as "Registry measures") • Qualified Clinical Data Registry (QCDR) Measures • Medicare Part B claims can only be submitted by groups (Small practices (fewer than 16 clinicians) only) • CMS web Interface (only available to groups with 25 or more eligible clinicians). Web interface will sunset in 2021 • Two administrative claims measures

What to Report:

The MIPS score is a composite of performance in all four reporting categories (see https://qpp.cms.gov/ for details).

Quality	Cost	Promoting Interoperability	Improvement Activities
40% of MIPS final score **Performance period:** 2021 calendar year **Scoring:** • A total of 209 quality measures • Substantive changes to 113 existing quality measures • Report on at least six quality measures, including one outcome or high priority measure. Measure or report on a defined specialty measure • Quality measures submitted for the 2021 performance period will receive between one and 10 points as measure achievement points • Quality measures will be scored against a benchmark if a benchmark is available, the provider submits at least 20 cases, and the data meet the data completion requirement standard (70%)	**20% of MIPS final score** **Performance period:** 2021 calendar year **Scoring:** A total score will comprise these measures: • Medicare Spending per Beneficiary (MSPB) • Total per capita cost measures • 18 new episode-based measures to the cost performance category	**25% of MIPS final score** **Performance period:** minimum 90 days **Scoring:** • Performance-based methodology • Four "Objectives and Measures": e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange • A new optional Health Information Exchange (HIE) bi-directional exchange measure existing measures under the HIE objective • Must complete risk analysis. Submit a "yes" to the Prevention of Information Blocking Attestations and to the ONC Direct Review Attestation • EHR technology must be certified to the 2015 Edition certification criteria, 2015 Edition Cures Update	**15% of MIPS final score** **Performance period:** minimum of 90 days **Scoring:** • Groups with fewer than 15 participants or if in a rural or health professional shortage area, attest that you completed one high-weighted activity or two medium-weighted activities • Group or virtual group, at least 50% of the eligible clinicians in the group must implement the same activity during any continuous 90-day period • Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model automatically earn full credit, but 50% of sites must have recognition

		certification criteria or combination of both *Practitioners who qualify as non-patient-facing physicians have the option to not report ACI and have the 25% performance score weighted under quality category*	• Modification of two existing improvement activities. • Continuation of the COVID-19 clinical data reporting improvement activity with modification as outlined in the September Interim Final Rule with Comment (IFC) • Removal of one improvement activity that is obsolete: o CC_5 CMS

If a practice is identified as facility-based and is attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score, the practice will not be required to submit data for the Quality performance category. Instead, the Hospital VBP score will be used for the Quality and Cost performance categories as long as the practice submits group-level data for the Improvement Activities and/or Promoting Interoperability performance categories. A facility-based practice could also submit Quality data via another collection type and CMS will use whichever data set results in a higher combined Quality and Cost score for the practice.

Fact Sheet Information:

- APM Performance Pathway (APP) – CMS finalized a new reporting framework, the APP, to begin in 2021. The APP is only available to MIPS eligible clinicians participating in MIPS APMs and it is required for Medicare Shared Savings Program ACOs. The APP may be reported by the individual eligible clinician, group, or APM entity. The APP is comprised of a fixed set of measures for each performance category.

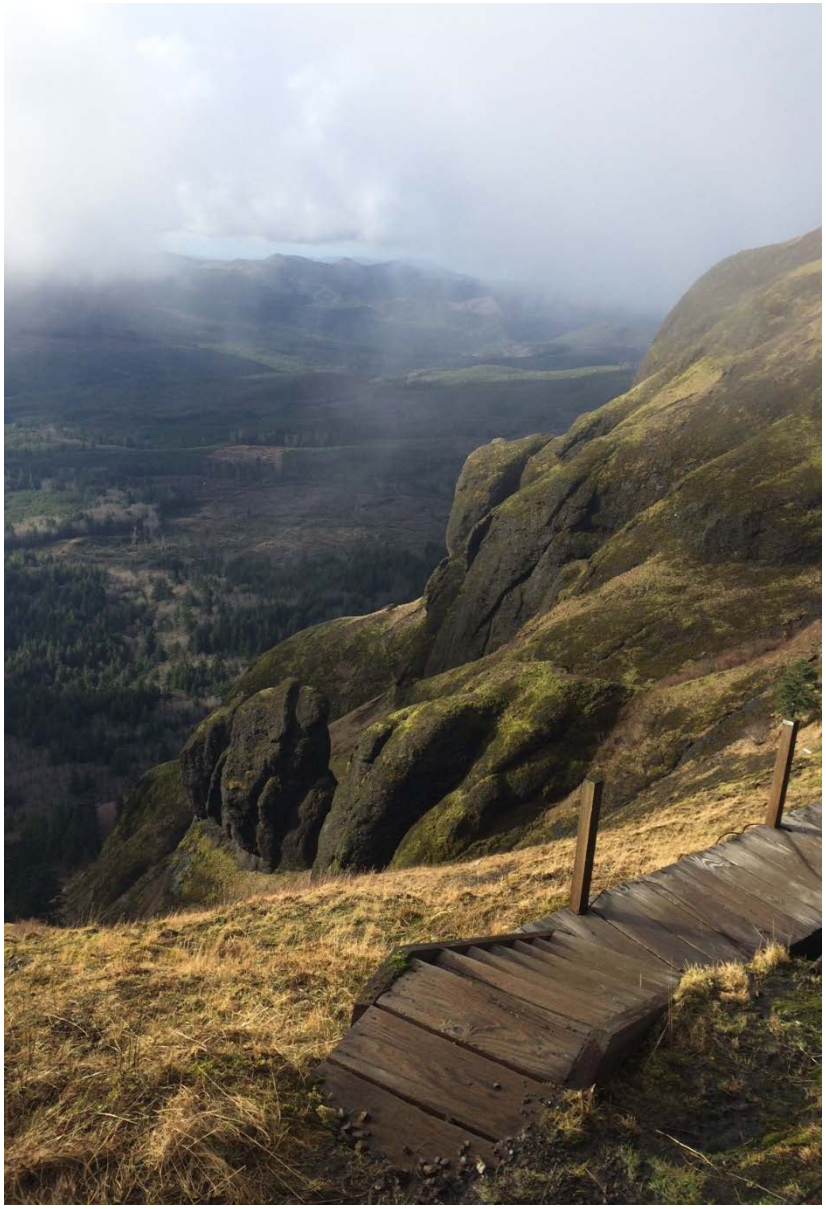
- MIPS Value Pathways (MVPs) are a subset of measures and activities, established through rulemaking that can be used to meet MIPS reporting requirements. The MVPs framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. MVPs won't be available for MIPS reporting until 2023.

- There are two exception applications available to clinicians in Program Year 2021:
  - The Extreme and Uncontrollable Circumstances Exception application allows you to request reweighting for any or all performance categories if you encounter an extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of your control.
  - The MIPS Promoting Interoperability Performance Category Hardship Exception application allows you to request reweighting specifically for the Promoting Interoperability performance category if you qualify.

- Clinicians, groups, virtual groups and APM Entities will be able **to earn up to 10 bonus points** (instead of five bonus points) to account for the additional complexity of treating their patient population due to COVID-19.

- Extra bonus points for end-to-end electronic reporting bonus, additional outcome/high priority measures, complex patients, and improvement in the quality performance category from the previous performance year.

Electronic Clinical Quality Measures (eCQMs)



Program Overview

Electronic Clinical Quality Measures (eCQMs) are a part of the Promoting Interoperability Program, (formerly the Medicare and Medicaid EHR IncentivePrograms). Under the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act), incentive payments or payment adjustments are applied to eligible professionals (EPs), CAHs, and eligible hospitals that successfully demonstrate meaningful use of certified EHRtechnology.

Why Report?

Reporting on the following measures fulfills a portion of both the Medicare EHR incentive program clinical program submission requirements and a portion of the IQR program reporting requirements with a single data submission.

CAHs (as defined for the Medicare Promoting Interoperability Program (PIP)) are required to demonstrate meaningful use of their CEHRT each year to avoid a downward payment adjustment.

Table 5 shows the eCQM measure sets that are applicable to both IQR and PIP.

Reporting Method:

Contact your EHR vendor for information on the eCQMs. They should provide support and instruction on submission of the eCQMs to CMS. Submission of your eCQMs can also be done through the Hospital Quality Reporting System located within the QualityNet Secure Portal after data on the measures is obtained.

Table 5. eCQM Measure Sets for both IQR and PIP

Measure	Description
EHR-Based Clinical Process of Care (eCQMs)	
ED-2	Admit decision time to ED departure time for admitted patients
PC-05	Exclusive breast milk feeding
STK-02	Ischemic stroke patients discharged on antithrombotic therapy
STK-03	Anticoagulation therapy for arterial fibrillation/flutter
STK-05	Antithrombotic therapy by the end of hospital day two
STK-06	Discharged on statin medication
VTE-1	Venous thromboembolism prophylaxis
VTE-2	Intensive care unit venous thromboembolism prophylaxis
Safe Use of Opioids	Safe use of opioids – Current prescribing

III. REPORTING

Reporting Method Checklist

To view the crosswalk of the reporting tools for each measure review Appendix C. Once a CAH completes all of the following steps, they are ready to report for MBQIP, IQR, OQR, HCAHPS, and NHSN measures.

Step 1: Create HARP Accounts for all Security Administrators at: https://harp.cms.gov/register/profile-info

Step 2: Register Security Administrator/Officer in QualityNet:

Step 3: Enroll in the Hospital Quality Reporting System located within the QualityNet Secure Portal

Step 4: Complete the Optional Public Reporting Notice of Participation

Step 5: Install CMS Abstraction & Reporting Tool (CART) software on your computer from CMS Abstraction & Reporting Tool or contract with an approved measure reporting vendor. CART is free for the inpatient and outpatient reporting programs.

Step 6: Enroll in CDC/NHSN to report Health Care Acquired Infections at: https://www.cdc.gov/nhsn/

Step 7: To submit HCAHPS data either:

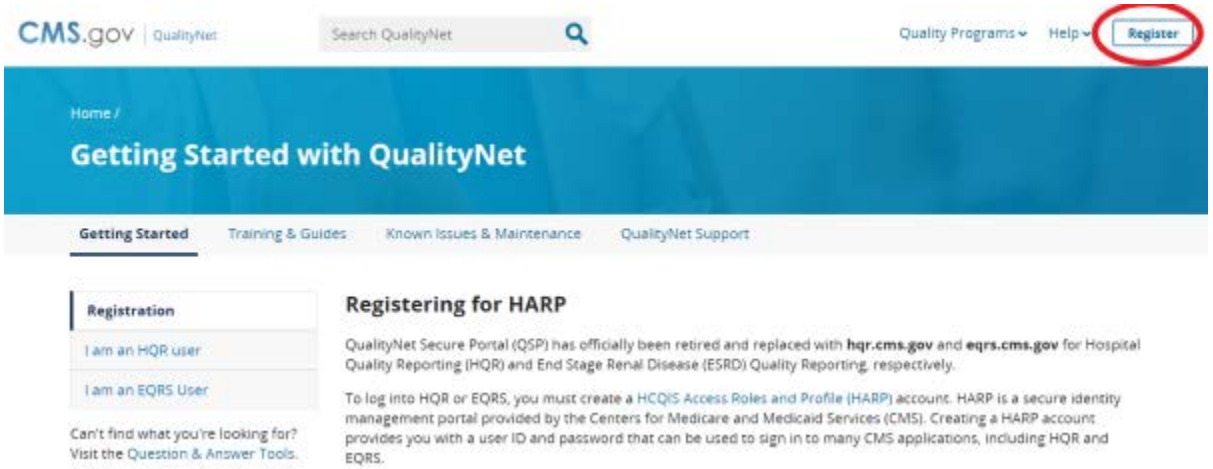
a) Contract and authorize (via the Administration section in the HQR) an approved HCHAPS vendor to submit data; or
b) Become authorized by CMS to administer the survey yourself and submit the data to the HQR website.

Step 8: To submit Emergency Department Transfer Communication (EDTC) measures: Use the online tool available on the Stratis Health website at: https://stratishealth.org/toolkit/emergency-department-transfer-communication/ to record data and send to your Flex Coordinator at the Oregon Office of Rural Health at rothwels@ohsu.edu.

Step 1: Create HARP accounts for all new Security Administrators at https://harp.cms.gov/register/profile-info

Step 2: Register Security Administrator with QualityNet

If a hospital has another Security Administrator (SA) active in QualityNet, they may add anyone with a HARP ID into this facility's QualityNet account. The SA logs in, selects *Administration* and then *Access Management*. Select *Add User* and then enter the HARP ID of the new SA.



If a hospital does not have another Security Administrator active in QualityNet, the new SA will call HQR program support at 866-288-8912.

Step 3: Enroll in the Hospital Quality Reporting System located within the QualityNet Secure Portal

> ***Training Materials:*** A set of instructional support videos are now available to help you navigate through HQR. You may access these videos from the HQR playlist at: https://www.youtube.com/playlist?list=PLaV7m2-zFKpjctAKzszs_jNbXmhvADgcy.

Step 4: Complete Inpatient Notice of Participation (NoP)

For a hospital to have their data publicly reported, a Notice of Participation (NoP) must be completed. A NoP must be completed for inpatient and outpatient reporting. NoPs are required for participation in the Medicare Beneficiary Quality Improvement Program (MBQIP) to verify if your hospital has completed a NoP, or needs to complete a NoP for the first time:

a) Log into the QualityNet Secure Portal.
b) From the dashboard, under *Administration*, select *Notice of Participation*.
c) Next, you will see the available programs to confirm for NoP selection.
d) Select the program to review the pledge on file or follow the confirmation steps, if needed.

Hospitals are required to maintain an active QualityNet Security Administrator. To maintain an active account, it is recommended that QualityNet SAs log into their account at least once per month. If an account is not logged into for 120 days, it will be disabled. Once an account is disabled, the user will need to contact the QualityNet Help Desk to have their account reset.

Step 5: Install CART on your computer or contract with an approved measures reporting vendor

CART is free CMS Abstraction & Reporting Tool software for the inpatient and outpatient reporting programs and can be downloaded from QualityNet: https://qualitynet.cms.gov/outpatient/data-management/cart.

a) Follow the instructions on the page to install or update CART as needed.
b) CMS releases new versions of CART when changes are made in the Core Measures – you will not be able to report if you are not using the correct version of CART.
c) Follow the same steps to install or update CART – Outpatient.

Important: *CART – Inpatient and CART – Outpatient are two separate software packages and need to be installed individually. The login for each of the accounts will also be individual.*

Training videos for CART set-up and initial login: View the following training videos (also posted on QualityNet) to understand the basics and as well as the patient set up and abstraction:

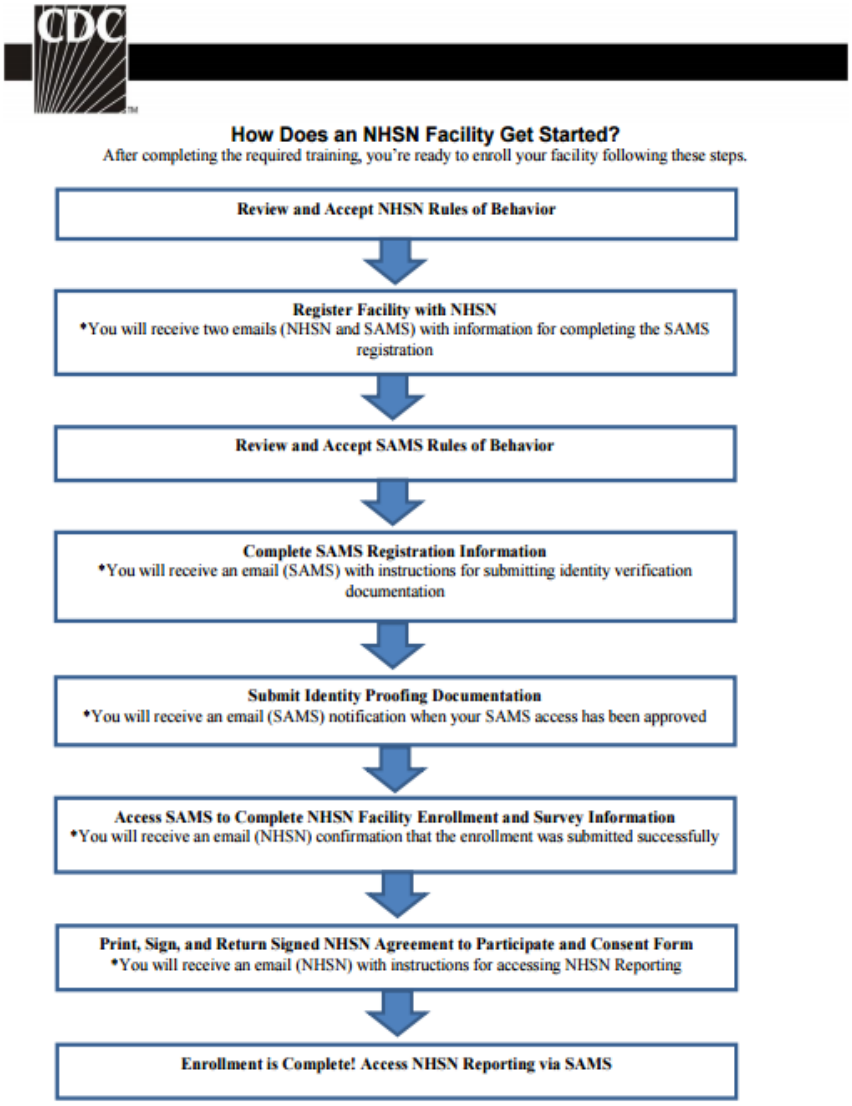
- CART Basics (32-minute video)
- CART Patient Set-up/Abstraction and Import/Export (28-minute video)

Contact QualityNet Help Desk at 866-288-8912 for any questions about CART or QualityNet.

Step 6: Enroll in Centers for Disease Control (CDC)/National Healthcare Safety Network (NHSN) to report Health Care Acquired Infections (HAI)

a) To enroll your facility with CDC to report HAI visit: http://www.cdc.gov/nhsn/enrollment/index.html
b) Choose your facility type to enroll in the program and follow the steps on the webpage.
c) Once all the steps in the picture to the right are complete, you will need to wait to receive a SAMS grid card credential in the mail from CDC. *This can take up to a few weeks.*
d) Using the SAMS grid credential, login to NHSN at: http://www.cdc.gov/nhsn/enrollment/index.html.
e) After logging into SAMS using the SAMS grid card, click *NHSN Enrollment*. Then click *Access and print required enrollment forms.*
f) Print the required forms listed under the component you are enrolling in, which will be submitted electronically in the next step. CAHs should enroll under the *Healthcare Personnel Safety* component.
g) After accessing, printing and completing required enrollment forms, select *Enroll facility*.
h) Complete the enrollment.
i) You will immediately receive an "NHSN Facility Enrollment Submitted" email with a link to your consent form.
j) Consent forms are facility specific – print the forms within 30 days of receiving the email.
k) Forms must be signed by:
    I. A contact person for each component being followed; and
    II. The leadership/administrator.

    Signature pages must be faxed to 404-929-0131 (do not mail)
l) Within 3 -5 business days you will receive an email notification from NHSN notifying you of facility activation.



Copied from NHSN Facility Administrator Enrollment

Contact the NHSN Help desk at nhsn@cdc.gov if you have any questions.

Step 7: HCAHPS Survey administration and reporting

Determine the process for the HCAHPS survey implementation. The survey can be implemented by either the hospital or a vendor contracted by the hospital. It should be noted that the requirements for implementing the survey are stringent so most hospitals choose to have their survey process completed by a vendor. As with any service provided by a vendor it is recommended that CAHs work closely with their chosen vendor to ensure that their survey data is submitted and will contribute to their HCAHPS measure score.

An updated list of approved vendors can be found at on the HCAHPS Online website https://hcahpsonline.org/en/approved-vendor-list/.

For more information about approved vendors, including those that work specifically with small rural hospitals, see the HCAHPS Vendor Directory at https://www.ruralcenter.org/tasc/resources/hospital-consumer-assessment-healthcare-providers-and-systems-overview-vendor from the National Rural Health Resource Center.

Training materials for hospitals that plan to self-administer the survey can be found at: https://hcahpsonline.org/en/training-materials/.

Step 8: Use the online tool available on the Stratis Health website to record data on the Emergency Department Transfer Communication (EDTC)

a) The data specifications manual can be found at http://www.stratishealth.org/documents/ED-Transfer-Data-Specifications-Manual.pdf.
b) Download and save the Excel data collection tool ("ED_Transfer_Tool_Data_Collection_Tool.xls") by clicking https://stratishealth.org/toolkit/emergency-department-transfer-communication/.
c) Instructions on using the EDTC Data Collection Tool and abstraction of data can be found at: https://stratishealth.org/wp-content/uploads/2020/07/EDTC-Data-Collection-Tool-Manual-v4.1.pdf.

Training Video: The EDTC Data Collection training video is a 25-minute video that serves as a step-by-step guide on how to download the Excel-based data collection tool, enter data, and run reports to calculate your measures.

Exporting Data from CART

a) Open CART and choose inpatient or outpatient.

b) Click on *Abstraction* → *Search* (Figure 1).

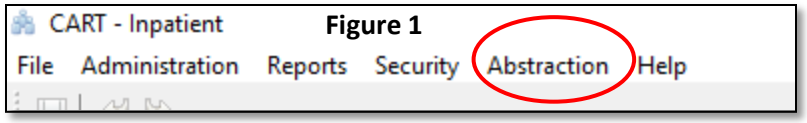


Figure 1

c) Search by discharge date to reflect the quarter dates (Figure 2):
   a. Make sure to use "-" as separators for the date.
   b. Click *Search* on the page.

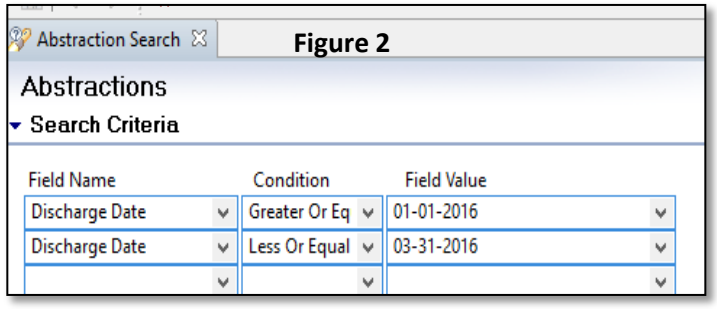


Figure 2

d) Pull down all the records to one page by using the down arrow (Figure 3).

e) Sort by abstraction status to check if there are any pending files or errors.

f) Select all the files on the page once all the files show abstraction status of "complete."

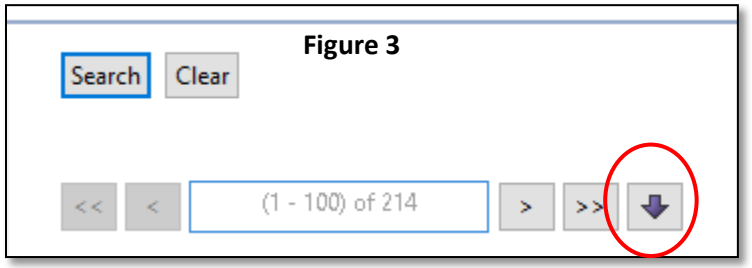
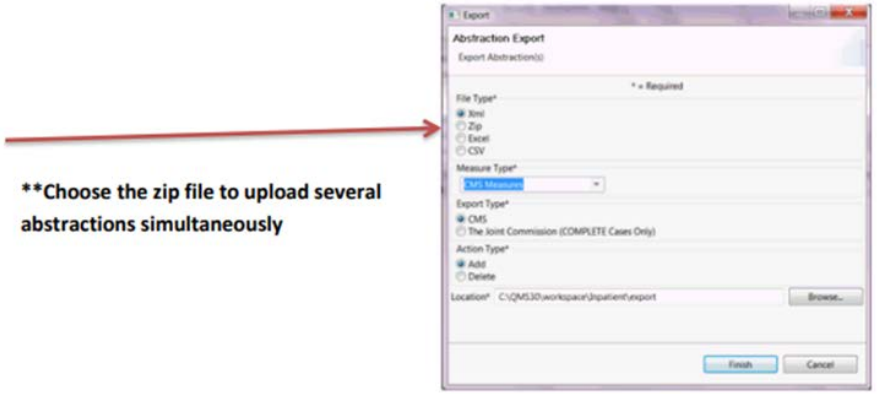


Figure 3

g) Click on *Export* at the bottom of the page:
   a. File type: Zip
   b. Measure type and export type: CMS
   c. Action type: Add
   d. Location: Make sure to create a new folder and choose that folder as your location. XML files are individual files, so it is much easier to have all files in one zip file. Otherwise, if you have 250 files, you will have 250 individual files.

h) Once the export is complete, confirm that the number of files exported is same as the number of files in CART.

Abstraction Export Screen



Uploading IQR and OQR files

a) Log in to Hospital Quality Reporting (HQR) at https://hqr.cms.gov/hqrng/login.
b) Under the *Dashboard*, select *Data Submissions,*
c) Choose *Chart Abstracted* from the tabs at the top of the screen.
d) Make sure to select *Production* as the submission type.
e) Click *Select Files*. A browsing window will open. Then navigate to the folder where you have saved your CART xml files.
f) You can select all the xml files and click open or save the CART folder as a zip folder and choose to upload the files as a zip folder (zip folder uploading leads to less chance of upload failure as well as fewer confirmation emails).
g) You will receive an email from qnetsupport@sdps.org if and when your files are processed. If you upload the files as a zip folder, you will receive one email with the information about number of files accepted vs. rejected.

To verify that cases have been accepted:

a) Log in to Hospital Quality Reporting (HQR) at https://hqr.cms.gov/hqrng/login.
b) Under the *Dashboard*, select *Data Results*.
c) Select *Chart Abstracted* under *Data Results.*
d) Select the relevant program from the drop-down menu, *IQR* or *OQR.*
e) From the *Report* drop-down menu, select *Case Statue Summary.*
f) Select the appropriate *Encounter Quarter* from the drop-down menu.
g) Select *Export CSV*.
h) The report requested will pop up in an Excel spreadsheet. Open the spreadsheet to view the report.

Web-Based/Structural Measures Reporting

For each of the below:

- Log in to Hospital Quality Reporting (HQR) at https://hqr.cms.gov/hqrng/login.
- Under the *Dashboard*, select *Data Submissions*.
- Choose *Web-based Measures* from the tabs at the top of the screen.
- Select the way you would like to submit your data – either with a file upload or via data form. The most common way to submit data for a CAH is via data form.

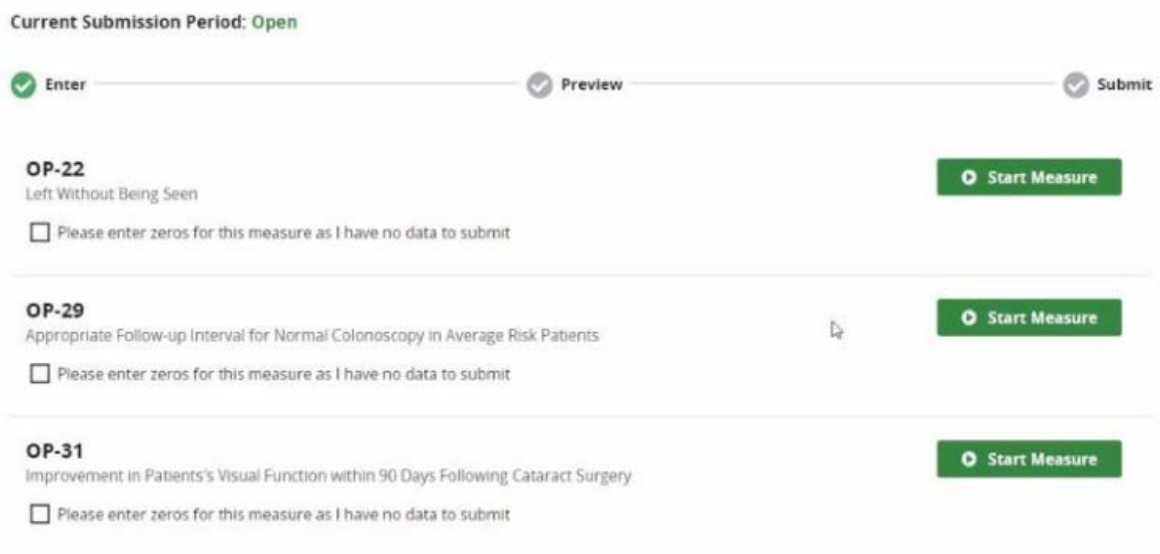
PC-01: Quarterly Reporting

a) Select *IQR Launch Data Form*.
b) Select the most recent year from drop-down of *Payment Year*.
c) After selecting the quarter, click on "PC-01."
d) Select *Start Measure* to enter all the questions.
e) Select *Submit the Data* when you are finished.

Outpatient Web-based Measures (OP-22, OP-29, OP-31): Annual Reporting

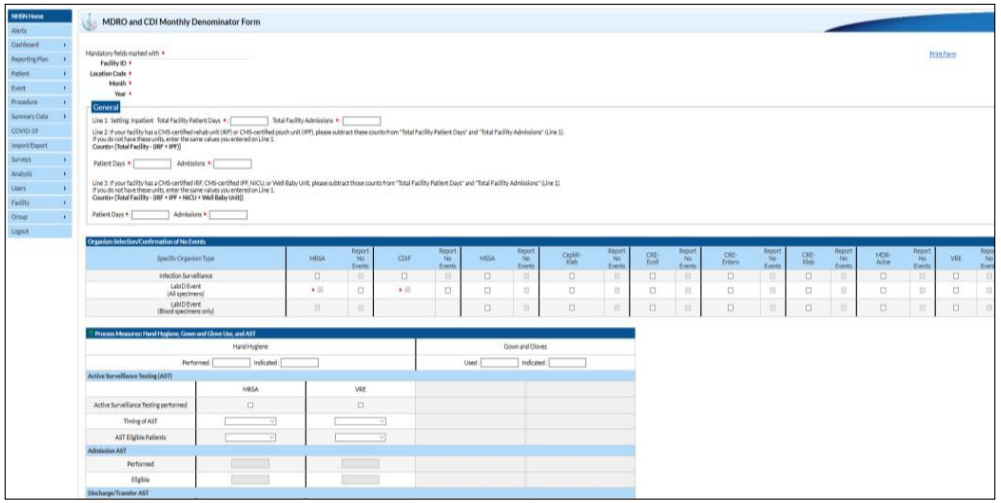
a) Select *OQR Launch Data Form*.
b) Select the most recent year from drop-down of *Payment Year*.
c) Select *Start Measure* to complete all the data for each measure.
d) If you are not submitting data (for OP-29 or OP-31), you must select, *Please enter zeros for this measure as I have no data to submit*.

Once all three measures are complete, you may select, *I am ready to submit*.



Completing Monthly HAI Reporting

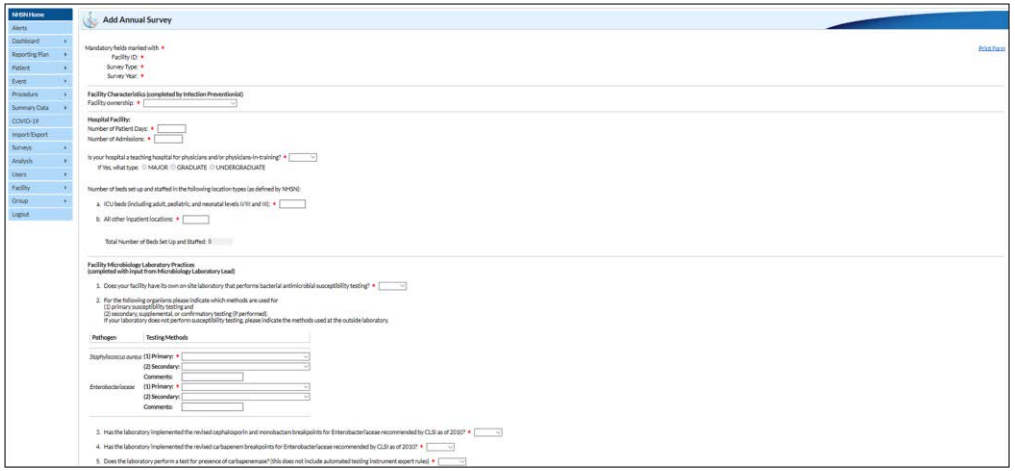
a) Log in to the NHSN site at https://www.cdc.gov/nhsn/index.html and select *NHSN Member Login*, using SAMS grid card.
b) Navigate to *Summary Data > Add.*
c) Select *MDRO and CDI Monthly Denominator Form – All Locations*.
d) Complete the required fields.
e) If there have been any infections, then you will complete a separate module.



Training Video: MDRO and CDI Monthly Denominator Training. This video is a step-by-step guide to completing the form.

Completing Annual HAI Survey

a) Log in to the NHSN site at https://www.cdc.gov/nhsn/index.html and select *NHSN Member Login*, using SAMS grid card.
b) Navigate to *Summary Data > Add.*
c) Select *Annual Survey*.
d) Complete the required fields.



RESOURCES FOR QUALITY DIRECTORS AND STAFF

National Organizations:

National Rural Health Resource Center (https://www.ruralcenter.org/)
Provides technical assistance, information, tools and resources for the improvement of rural health care. It serves as a national rural health knowledge center to build state and local capacity. It supports various programs including:

- Small Rural Hospital Improvement Grant Program (SHIP)
- Health Education and Learning Program Webinars
- Performance Management Group (PMG) calls
- Technical Assistance and Services Center (TASC)
- Rural Health Performance Improvement (RHPI)
- Rural HIT Network Development (RHITND)
- Population Health Portal
- Key Health Alliance

Quality Reporting Center (http://www.qualityreportingcenter.com/)
This website provides outreach and education support programs. Here you will find resources to assist hospitals, inpatient psychiatric facilities, PPS-exempt cancer hospitals, and ambulatory surgical centers with quality data reporting. Through these sites, you can access:

- Reference and training materials
- Educational presentations
- Timelines and calendars
- Data collection tools
- Contact information
- Helpful links to resources
- Question and answer tools

Quality Net (https://qualitynet.cms.gov/)
Established by the Centers for Medicare & Medicaid Services (CMS), QualityNet provides health care quality improvement news, resources and data reporting tools and applications used by health care providers and others. It supports information for CART, HIQR, HOQR, ASCs, ESRD facilities, and Inpatient Psychiatry facilities. QualityNet is the only CMS-approved website for secure communications and health care quality data exchange between: quality improvement organizations (QIOs), hospitals, physician offices, nursing homes, end stage renal disease (ESRD) networks and facilities, and data vendors.

Institute of Healthcare Improvement (http://www.ihi.org/Pages/default.aspx)
IHI is a not-for-profit organization, which is a leading innovator, partner and driver of the results in health and health care improvement worldwide. IHI provides various forms of education including virtual training, conferences, IHI open school and in-person training. IHI focus areas include:

- Improvement capability
- Person and family-centered care
- Patient safety
- Quality, cost and value
- Triple Aim for populations

Quality Payment Program (https://qpp.cms.gov/)
The Quality Payment Program makes Medicare better by helping you focus on care quality and the one thing that matters most – making patients healthier. The Quality Payment Program ends the sustainable growth rate formula and gives you new tools, models, and resources to help you give your patients the best possible care. You can choose how you want to take part based on your practice size, specialty, location, or patient population. The QPP website has step-by-step instructions to meet MACRA/MIPS requirement and is governed by CMS.

Stratis Health Quality Improvement Basics Course, Concepts and Tools (https://stratishealth.org/quality-improvement-basics/)
This QI Basics course is designed to equip professionals with the knowledge and tools to start quality improvement projects at their facilities. The course may be completed in sequence, or individual modules and tools may be used for stand-alone training and review.

Other National Quality Sites:

- National Association for Healthcare Quality (http://www.nahq.org/)
- Agency for Healthcare Research and Quality (http://www.ahrq.gov/)
- Centers for Medicare and Medicaid Services, Quality Initiatives (https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/index.html)

State Organizations:

Oregon Office of Rural Health (ORH) (https://www.ohsu.edu/oregon-office-of-rural-health)
The mission of ORH is to improve the quality, availability, and accessibility of health care for rural Oregonians. The office engages in four principal activities:

- Planning, policy development and advocacy
- Information clearinghouse
- Provider recruitment and retention
- Technical assistance to communities

ORH administers the HRSA Rural Hospital Flexibility Grant Program (Flex). See Table 1 for a list of the quality improvement support ORH offers under the grant.

Comagine Health (https://comagine.org/)
Comagine Health serves as Oregon's Medicare Quality Improvement Organization (QIO) and leads QI initiatives in Oregon as a QIN-QIO subcontractor. They are a nonprofit consulting organization that works directly with practitioners across care settings, and with purchasers, community-based organizations, professional associations, policymakers, and consumers, to ensure that every patient gets the right care every time.

Oregon Patient Safety Commission (http://oregonpatientsafety.org/)
The Oregon Patient Safety Commission is a semi-independent state agency charged by the Oregon Legislature with reducing the risk of serious adverse events occurring in Oregon's health care system and encouraging a culture of patient safety. They support following programs:

- Patient Safety Reporting Program (PSRP)
- Early Discussion and Resolution (EDR)
- Improvement initiatives

Oregon Health Authority HAI Reporting
(https://www.oregon.gov/oha/ph/diseasesconditions/communicabledisease/hai/reporting/Pages/index.aspx)
The Oregon Health Authority HAI Division provides support for all HAI activities including full technical assistance for the use of the National Healthcare Safety Network (NHSN) such as user set up and data entry. The OHA HAI Division is a valuable resource for infection control staff at Oregon's CAHs.

IV. ANALYZING AND SHARING DATA WITHIN THE HOSPITAL

It is important for staff, managers, leadership and board members to regularly receive information about the hospital's performance on quality metrics and patient safety measures and for the hospital to use this information to identify ways it can improve. Strong Quality Committee participation and engagement help to ensure compliance with CAH standards.

Sharing MBQIP and HCAHPS Data

The Oregon Office of Rural Health provides quarterly MBQIP reports to each CAH, which compares an individual hospital's MBQIP and HCAHPS performance to the state and national average. These reports are good indicators of your hospital's current performance in these measures.

MBQIP data is released with a lag time of about two quarters. The EDTC reporting tool, however, can help identify your facility's performance for the current quarter. The figure below shows an example EDTC tool report that can be run once the data are entered in the EDTC Excel tool.

Data Elements	Q1 2020 # of Records Reviewed (N): 45		Q2 2020 # of Records Reviewed (N): 0		Q3 2020 # of Records Reviewed (N): 0		Q4 2020 # of Records Reviewed (N): 0	
	Number (n) and percent (%) of patients discharged/transferred to another healthcare facility whose medical record documentation indicated that the following relevant elements were documented and communicated to the receiving hospital in a timely manner:							
	n	%	n	%	n	%	n	%
1. Home Medications	44	97.78%	N/A	N/A	N/A	N/A	N/A	N/A
2. Allergies and/or Reactions	42	93.33%	N/A	N/A	N/A	N/A	N/A	N/A
3. Medications Administered in ED	45	100.00%	N/A	N/A	N/A	N/A	N/A	N/A
4. ED Provider Note	45	100.00%	N/A	N/A	N/A	N/A	N/A	N/A
5. Mental Status/Orientation Assessment	45	100.00%	N/A	N/A	N/A	N/A	N/A	N/A
6. Reason for Transfer and/or Plan of Care	45	100.00%	N/A	N/A	N/A	N/A	N/A	N/A
7. Tests and/or Procedures Performed	45	100.00%	N/A	N/A	N/A	N/A	N/A	N/A
8. Tests and/or Procedures Results	45	100.00%	N/A	N/A	N/A	N/A	N/A	N/A
Overall EDTC Measure (All eight data elements were documented and communicated in a timely manner)	**41**	**91.11%**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

If CAHs are using a vendor to conduct the HCAHPS survey, the vendor can provide a monthly report to share the hospital's scores. Please contact your vendor for more information.

Sharing IQR and OQR Data

The CART "Measure Summary" and "Measure Failure" are two important reports that will help the hospitals measure their performance.

Measure Summary Report: This report shows the hospital's performance rate for all the measures. The hospitals performance score shows the number of failed cases

- Choose *Measure Summary"* → *Provider – Your facility*.
- Choose the *Measure Set*.
- Choose *Discharge Date* for the quarter or the month.

Measure Failure Report: This report will help identify individual cases that failed the measure. Follow-up on these patient charts can help identify the reason for failure.

- Choose the provider, measure set and discharge date for the report.

Other Examples of How to Share Data

One way-to share data is to create and share a stop light report outlining quality measures and your hospital's progress.

Visual indicators that provide a snapshot of information are often meaningful ways of promoting a culture of providing high quality of care with frontline staff.

A quality and patient safety bulletin board can showcase information about patient safety measures; Patient Falls, Adverse Drug Events, CLABSI, CAUTI, SSI, and Immunization measures in addition to other quality measures.

Note that it is important to be sure that this information is shared and located in a highly visible location for staff. If the whole board is too much to concentrate on at one time, highlight certain key measures to work on and show what is being done to address those measures. This is ideally done in the same location to better communicate process and outcome results.

	Meets the goal / Does not meet the goal	Goal (1,313 CAH)	4th qtr. 2014	1st qtr. 2015	2nd qtr. 2015	3rd qtr. 2015
3	Median time to fibrinolysis	≤31 minutes	34 minutes	Excluded	Excluded	Excluded
4	Fibrinolytic therapy received within 30 min. of hosp. arrival	23%	0% (0/1)	Excluded	Excluded	Excluded
	Inpt. ED					
5	Median time ED arrival to departure for admitted patients	≤198 minutes	157 minutes	150 minutes	154 minutes	150 minutes
6	Median time from Decision to admit to ED departure time	≤61 minutes	40 minutes	30 minutes	31 minutes	45 minutes
	Inpt. HF					
7	Evaluation of LVS function	≥88%	50% (2/4)	100% (2/2)	100% (2/2)	80% (4/5)
	Inpt. Immunization					
8	Pneumococcal Vaccination	≥90%	91%	86%(45/52)	91%(52/57)	94%(45/48)
9	Influenza Vaccination	≥87%	90%	88%(76/86)	Excluded	80% (4/5)
	Inpt. VTE					
17	VTE prophylaxis	≥85%	40%	43% (25/58)	47% (27/57)	48% (24/50)
	Inpt. Stroke					
18	VTE prophylaxis	≥84%	Not reported	100%	100%	Not reported
19	Discharge on antithrombotic therapy	≥93%	Not reported	100%	Excluded	Not reported
	Oupt. AMI					
26	Median time to transfer to another facility	≤120 min. (National Avg: 75 min.)	Excluded	174 minutes	162 Minutes	Excluded
27	Aspirin at arrival	≥96%	100%	100%	100%	100%
28	Median time to ECG	≤8 minutes	20 minutes	6 minutes	4 minutes	14 minutes
	Outpt. Chest Pain					
29	Aspirin at arrival	≥96%	100%	100%	100%	100%
30	Median time to ECG	≤8 minutes	1 minute	4 minutes	5 minutes	5 minutes
	Outpt. ED throughput					
31	Median time from ED arrival to ED departure for discharged pts.	≤103 minutes	126 minutes	109 minutes	117 minutes	127 minutes
32	Door to diagnostic evaluation by a Qualified medical personnel	≤21 minutes	23 minutes	29 minutes	38.5 minutes	28 minutes
	Outpt. Pain Management					
33	Median time to pain management	38 minutes	35 minutes	96 minutes	30 minutes	26 minutes
	Outpt. Stroke					
34	Head CT or MRI results for Stroke patients with interpretation of results within 45 minutes	≥68%	Not Reported	0% (0/1)	Excluded	0% (0/2)
	MBQIP - ED transfer measures					
35	Administrative Communication (Nurse - Nurse & physician-physician)	100%	100%	100%	100%	100%
36	Patient Information (Pt. demographic)	100%	100%	100%	100%	100%
37	Vital Signs Pulse, RR, HR, O_2, Temp, Neuro Ass.)	100%	92%	100%	100%	96% (n=22)
38	Medication information	100%	100%	100%	91%	35% (n=8)
39	Physician generated (H&P, reason for transfer)	100%	100%	100%	100%	96% (n=22)
40	Nurse generated (Nursing notes, catheters/IV, immobilizations, sensory status, NPO)	100%	100%	88%	100%	83% (n=19)

V. APPENDICES

See appendices A through D on the following pages.

Appendix A: Additional Improvement Activities/MBQIP Measures

Patient Safety/Inpatient		
CLABSI	Central Line-Associated Bloodstream Infection	National Healthcare Safety Network (NHSN)
CAUTI	Cather Associated Urinary Tract Infection	
CDI	Clostridium Difficile Infection	
MRSA	Methicillin Resistance Staphylococcus Aureus	
SSIs	Surgical Site Infections Colon or Hysterectomy	
Perinatal Care	PC-01: Elective Delivery	Internal Tracking
Falls	Potential measurement around: • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk	Internal Tracking
Adverse Drug Events (ADE)	Potential measurement around: • Falls with Injury • Opioids • Glycemic Control • Anticoagulant Therapy	Internal Tracking
Patient Safety Culture	Patient Safety Culture Survey	AHRQ Surveys on Patient Safety Culture (SOPS)
Influenza Vaccination	Inpatient Influenza Vaccination (formerly IMM-2)	Internal Tracking
Patient Engagement		
ED Patient Experience	Emergency Department Patient Experience Survey	Internal Tracking
Care Transitions		
Discharge Planning	Potential measurement	Internal Tracking
Medication Reconciliation	Potential measurement	Internal Tracking
Swing Bed Care	Potential measurement	Internal Tracking
Claims-Based Measures	These measures are automatically calculated for hospitals using Medicare Administrative Claims Data including: • Reducing Readmissions • Complications • Hospital Return Days	Medicare Administrative Claims Data Reports (PPS hospitals only)
Outpatient		
Chest Pain/AMI	Potential measurement around: Aspirin at Arrival (formerly OP-4) Median Time to ECG (formerly OP-5)	Internal Tracking
ED Throughput	Potential measurement: Door to Diagnostic Evaluation by a Qualified Medical Professional (formerly OP-20)	Internal Tracking

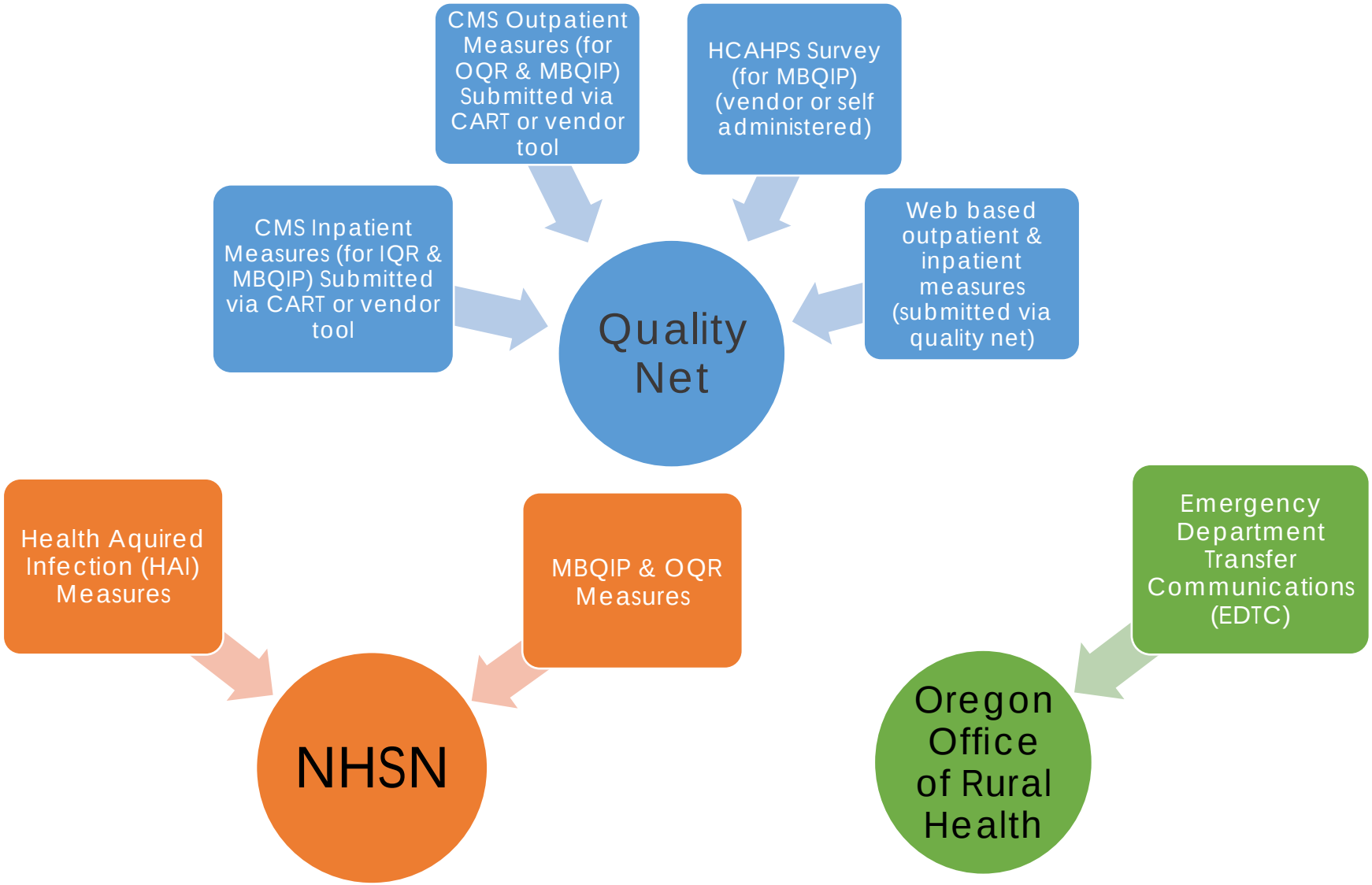
Appendix B: Tools Used for Reporting

Program	Tool
HAI	NHSN
HCAHPS	QualityNet through registered vendor or self-administered
IQR	QualityNet via CART or data vendor
MBQIP	EDTC Reporting tool via ORH, Quality Net & NHSN
OQR	QualityNet via CART or data vendor
MIPS	Registry or EHR

Appendix C: Quality Crosswalk for CAHs

Measure	Measure Name	MBQIP	IQR	eCQM	OQR	HQIC	PIP
OP-2	Fibrinolytic therapy received within 30 minutes	✓			✓		
OP-3	Median time to transfer to another facility for acute coronary intervention	✓			✓		
OP-8	MRI lumbar spine for low back pain				✓		
OP-10	Abdomen CT use of contrast material				✓		
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery				✓		
OP-18	Median time from ED arrival to ED departure for dischargedED patients	✓			✓		
OP-22	Patient left without being seen	✓			✓		
OP-23	ED head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke who received head CT or MRI scan interpretation within 45 minutes of arrival	✓			✓		
HCP/IMM-3	Influenza vaccination coverage among health care personnel (formerly OP-27)	✓			✓		
OP-29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients				✓		
OP-31	Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery				✓		
EDTC	Emergency department transfer communication	✓					
ED-2	Admit decision time to ED departure time for admitted patients		✓	✓			✓
Sepsis	Severe sepsis and septic shock: Management bundle (Composite Measure)		✓				
STK-2	Ischemic stroke patients discharged on antithrombotic therapy		✓	✓			✓
STK-3	Anticoagulation therapy for arterial fibrillation/flutter		✓	✓			✓
STK-5	Antithrombotic therapy by the end of hospital day two		✓	✓			✓
STK-6	Discharged on statin medication		✓	✓			✓
STK-8	Stroke education		✓				
STK-10	Assessed for rehabilitation services		✓				
VTE-1	Venous thromboembolism prophylaxis		✓				✓
VTE-2	Intensive care unit venous thromboembolism prophylaxis		✓				✓
PC-01	Elective delivery prior to 39 completed weeks of gestation	✓	✓				✓
PC-05	Exclusive breast milk feeding		✓	✓			✓
CLABSI	Central line-associated bloodstream infection, expand to include some non-ICU wards	✓				✓	
SSI	Surgical site infection	✓				✓	
CAUTI	Catheter-associated urinary tract infection, expand to include some non- ICU wards	✓				✓	
MRSA	MRSA bacteremia	✓					
CDIFF	Clostridium difficile (C. Diff)	✓				✓	

Appendix D: Quality Data Reporting Channels



REFERENCES

1. MBQIP Quality Reporting Guide 2020. Downloaded at following address: https://www.ruralcenter.org/resource-library/mbqip-quality-reporting-guide
2. EDTC Reporting Tool manual gives detailed instructions on how to download and use the tool. It can be viewed at: https://stratishealth.org/wp-content/uploads/2020/07/EDTC-Data-Collection-Tool-Manual-v4.1.pdf
3. National Rural Health Resource Center MBQIP Measures: https://www.ruralcenter.org/tasc/resources/mbqip-measures
4. Quality Improvement Implementation Guide and Toolkit for Critical Access Hospitals: https://www.ruralcenter.org/tasc/resources/quality-improvement-implementation-guide-and-toolkit-critical-access-hospitals
5. Rural Emergency Department Transfer Communication Resources (Stratis Health): http://www.stratishealth.org/providers/ED_Transfer_Resources.html
6. Quality Payment Program: https://qpp.cms.gov/
7. Payment Adjustment Cycle information and graphic: https://nrdrsupport.acr.org/support/solutions/articles/11000028996-merit-based-incentive-payment-system-mips-
8. Hospital Inpatient Quality Reporting (IQR) Program Measures: https://www.qualitynet.org/inpatient/iqr/measures
9. Hospital Outpatient Quality Reporting (OQR) Program Measures: https://qualitynet.cms.gov/outpatient/oqr/measures
10. Hospital Consumer Assessment of Healthcare Providers and Systems: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html