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MBQIP 2025 Measure Core Set Information Guide

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Version History		
Date	**Version Number**	**Update History**
September 2023	Version 1.0	• Initial release
December 2023	Version 2.0	• Updated the MBQIP reporting timeline for the new measures • Details added for the CAH Quality Infrastructure measure • Clarifying details added for OP-18 measure set ID#s • Details added to the Hybrid Hospital-Wide Readmission data elements • Added details for encounter periods and reporting deadlines • Document name change • Other non-substantive changes

Introduction

The MBQIP 2025 Core Measures is a list of quality measures the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) is adopting for use in the Medicare Beneficiary Quality Improvement Project (MBQIP) within the Medicare Rural Hospital Flexibility Program.

Starting in calendar year 2025, hospitals will collect data to report on the updated MBQIP core measures set as part of the Flex Program. Details on the new MBQIP core measure set along with those measures continuing from the current MBQIP measure set are depicted in the following tables.

During calendar years 2023 and 2024, hospitals should continue reporting the existing MBQIP core measure set. In addition, hospitals are encouraged to start reporting on the measures that will be new in MBQIP 2025 as soon as they are able. At a minimum, hospitals need to put processes in place so they can collect and report data from the 2025 calendar year. During this time, State Flex Programs and the RQITA team are available to assist hospitals and health systems with the transition.

This 2025 Core Measure Set has been adopted after a process involving State Flex Programs, Critical Access Hospitals, FORHP staff, and the general public via a public comment process. It has been finalized but is subject to change as necessary to respond to changes in federal and state health care quality programs as well as to the needs of rural hospitals and the communities they serve.
Please share questions, comments, and feedback with your Flex Project Officer.

This resource is intended to be used by critical access hospital personnel involved in MBQIP quality improvement and reporting and State Flex Program coordinators. This guide is based on currently available information. Information provided and submissions dates are subject to change.

The MBQIP 2025 Core Measure Set is detailed in this guide.

Measures in gold denote **new measures added for MBQIP reporting within the Flex Program** and are to be added to reporting data by calendar year 2025.

Measures in *blue denote **existing measures within the MBQIP Flex Program.**

MBQIP 2025 Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
+CAH Quality Infrastructure *(annual submission)* **Hospital Commitment to Health Equity** *(annual submission)*	***HCP/IMM-3:** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(annual submission)* ***Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey *(annual submission)* **Safe Use of Opioids (eCQM)** *(annual submission)*	***Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *(quarterly submission)*	**Hybrid Hospital-Wide Readmission** *(annual submission)* **Social Determinants of Health Screening** *(annual submission)* **Social Determinants of Health Screening Positive** *(annual submission)*	***Emergency Department Transfer Communication (EDTC)** *(quarterly submission)*: ***OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients *(quarterly submission)* ***OP-22:** Patient Left Without Being Seen *(annual submission)*

*Measures in the current MBQIP core measure set
+Data collection began in 2023 to inform state Flex quality programs. Data will continue to be collected going forward.

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New Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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
Measure Rationale	This measure will provide state and national comparison information to assess your CAH infrastructure, QI processes, and areas of improvement for each facility. Using this measure, SFPs can plan quality activities to improve CAH quality infrastructure. Data will provide timely, accurate, and useful CAH quality-related information to help inform state-level technical assistance for CAH improvement activities. This measure will provide hospital and state-specific information to help inform the future of MBQIP and national technical assistance and data analytic needs.
Calculations	Hospital score can be a total of zero to nine points (one point for each element, must meet each of element's criteria to receive credit).
Measure Submission and Reporting Channel	Annual submission through National CAH Quality Inventory and Assessment via FMT-administered Qualtrics platform
Measure Resources	**Specifications for CAH Quality Infrastructure Measure will be released in 2024 and are dependent on data collection via the National CAH Quality Inventory and Assessment. More information about the Core Elements of Quality Infrastructure and the Assessment can be found below:** Building Sustainable Capacity for Quality and Organizational Excellence | National Rural Health Resource Center (ruralcenter.org)

New measure for MBQIP reporting within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – Hospital Commitment to Health Equity	
MBQIP Domain	Global Measures
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	This structural measure assesses hospital commitment to health equity. Hospitals will receive points for responding to questions in five (5) different domains of commitment to advancing health equity: • Domain 1 – Equity is a Strategic Priority • Domain 2 – Data Collection • Domain 3 – Data Analysis • Domain 4 – Quality Improvement • Domain 5 – Leadership Engagement Hospital score can be a total of zero (0) to five (5) points (one point for each domain, must attest "yes" to all sub-questions in each domain, no partial credit).
Measure Rationale	The recognition of health disparities and inequities has been heightened in recent years and it is particularly relevant in rural areas. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists and subspecialists, and limited job opportunities. Rural residents are also less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid. The intent of this measure is to help ensure hospitals are considering and addressing equity in the care they provide to their community.
Improvement Noted As	Increase in the total score (up to 5 points).
Data Elements	**Domain 1 – Equity is a Strategic Priority** Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all of the following elements (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital strategic plan identifies priority populations who currently experience health disparities. B. Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals. C. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals. D. Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

Measure Name – Hospital Commitment to Health Equity	
Data Elements	**Domain 2 – Data Collection** Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital collects demographic information, including self-reported race and ethnicity, and/or social determinant of health information on the majority of our patients. B. Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. C. Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using certified EHR technology. **Domain 3 – Data Analysis** Please attest that your hospital engages in the following activities (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital strategies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards. **Domain 4 – Quality Improvement** Select all that apply (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities. **Domain 5 – Leadership Engagement** Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the numerator): A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.
Measure Population	N/A – This measure assesses hospital and leadership commitment.
Sample Size	No sampling
Calculations	Hospital score can be a total of zero to five points (one point for each domain, must attest “yes” to all sub-questions in each domain, no partial credit)
Data Collection	Attestation
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) secure portal – annually
Measure Resources	Measure Specification Attestation Guidance Rural Health Disparities Overview – Rural Health Information Hub

New Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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.
Measure Program Alignment	Safe Use of Opioids is a current measure of the Medicare Promoting Interoperability (PI) Program. Critical access hospitals must meet PI Program requirements on an annual basis to avoid a downward payment. One of the program requirements is submission of electronic clinical quality measures (eCQM)data from certified electronic health record technology (CEHRT). Calendar year (CY) 2023 eCQM reporting requirements for PI include data reflecting all four quarters of CY 2023 for: • Three self-selected measures of the thirteen available eCQMs for each quarter • One required measure: Safe Use of Opioid Measure
Improvement Noted As	Decrease in the rate
Numerator	Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge.
Denominator	Inpatient hospitalizations (inpatient stay less than or equal to 120 days) that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge.

Measure Name – Safe Use of Opioids – Concurrent Prescribing	
Exclusions	Exclusions include patients with cancer that begin prior to or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay.
Measure Population (Determines the cases to abstract/submit)	Inpatient hospitalizations (inpatient stay less than or equal to 120 days) that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge.
Sample Size Requirements	No sampling – report all patients that meet data elements
Calculations	Numerator divided by Denominator
Data Source	Certified electronic health record technology (CEHRT)
Data Collection Approach	Chart Abstracted via QRDA Category I file
Measure Submission and Reporting Channel	Annually, QRDA Category I File via Hospital Quality Reporting (HQR) platform.
Data Available On	CMS Care Compare CMS Provider Data Catalog
Measure Resources	NQF: Quality Positioning System Safe Use of Opioids – Concurrent Prescribing | eCQI Resource Center (healthit.gov) Critical Access Hospital eCQM Resource List | National Rural Health Resource Center (ruralcenter.org)

New Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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
Measure Rationale	Returning to the hospital for unplanned care disrupts patients' lives, increases risk of harmful events like healthcare-associated infections, and results in higher costs absorbed by the health care system. High readmission rates of patients with clinically manageable conditions in primary care settings, such as diabetes and bronchial asthma, may identify quality-of-care problems in hospital settings. A measure of readmissions encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions and costs.
Measure Program Alignment	CMS Inpatient Quality Reporting (IQR) program measure. Currently available for reporting.
Improvement Noted As	Decrease in the rate.
Numerator	If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.

Measure Name – Hybrid Hospital-Wide Readmission	
Denominator	1.Enrolled in Medicare FFS Part A for the 12 months prior to the date of admission and during the index admission; 2. Aged 65 or over; 3. Discharged alive from a non-federal short-term acute care hospital; 4. Not transferred to another acute care facility
Exclusions	The measure excludes index admissions for patients: 1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals; 2. Without at least 30 days post-discharge enrollment in Medicare FFS; 3. Discharged against medical advice (AMA); 4. Admitted for primary psychiatric diagnoses; 5. Admitted for rehabilitation; or 6. Admitted for medical treatment of cancer
Measure Population (Determines the cases to abstract/submit)	1.Enrolled in Medicare FFS Part A for the 12 months prior to the date of admission and during the index admission; 2. Aged 65 or over; 3. Discharged alive from a non-federal short-term acute care hospital; 4. Not transferred to another acute care facility
Sample Size Requirements	No sampling – report on all information requested in denominator and numerator.
Data Collection Approach	Hybrid – chart extraction of electronic clinical data and administrative claims data.
Data Elements	**Core Clinical Data Elements (13)** Heart Rate Systolic Blood Pressure Respiratory Rate Temperature Oxygen Saturation Weight Hematocrit White Blood Cell Count Potassium Sodium Bicarbonate Creatinine Glucose **For each encounter, please also submit the following Linking Variable:** • CMS Certification Number • Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) • Date of Birth • Sex • Inpatient Admission Date • Discharge Date
Measure Submission and Reporting Channel	Annual-Hospital Quality Reporting (HQR) via patient-level file in QRDA I format
Data Available On	CMS Care Compare – starting in July 2025
Measure Resources	Hybrid Hospital-Wide Readmission Measure Specification | eCQI Resource Center (healthit.gov) Reporting the Hybrid Hospital-Wide Readmission Measure to the Hospital IQR Program (qualityreportingcenter.com) Hybrid Measure Overview (cms.gov)

New Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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.
Measure Rationale	The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.
Measure Program Alignment	This is a new CMS Inpatient Quality Reporting (IQR) program measure. The first available reporting period is May 15, 2024, for calendar year (CY) 2023 data.
Improvement Noted As	Increase in the rate.
Numerator	The number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay
Denominator	The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.
Exclusions	(1) Patients who opt- out of screening; and (2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay.

Measure Name – Screening for Social Drivers of Health (SDOH Screening)	
Measure Population (Determines the cases to abstract/submit)	The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.
Sample Size Requirements	No sampling – report on all information requested in denominator and numerator.
Calculations	The Screening for Social Drivers of Health measure is calculated by dividing the total number of hospital inpatients who are 18 and older and screened for all five health HRSNs by the total number of patients admitted to a hospital inpatient stay who are 18 or older at the time of admission.
Data Source	Chart abstraction
Measure Submission and Reporting Channel	Annual numerator and denominator submission through Hospital Quality Reporting (HQR) system
Measure Resources	Screening for Social Drivers of Health Measure Specification Frequently Asked Questions: SDOH Measures (August 2023) Listing of Various Screening Tools Guide to social needs screening (aafp.org) Rural Health Disparities Overview - Rural Health Information Hub

New Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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.
Measure Rationale	The recognition of health disparities and impact of health-related social needs (HRSN) has been heightened in recent years. Economic and social factors, known as drivers of health, are known to affect health outcomes and costs, and exacerbate health inequities. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.
Measure Program Alignment	This is a new CMS Inpatient Quality Reporting (IQR) program measure. The first available reporting period is May 15, 2024, for calendar year (CY) 2023 data.
Improvement Noted As	This measure is not an indication of performance.
Numerator	The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety.
Denominator	The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.
Exclusions	The following patients would be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

Measure Name – Screen Positive for Social Drivers of Health (SDOH Screening Positive)	
Measure Population (Determines the cases to abstract/submit)	The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.
Sample Size Requirements	No sampling – report on all information requested in denominator and numerator.
Calculations	The result of this measure would be calculated as **five separate rates.** Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.
Data Source	Chart abstraction
Measure Submission and Reporting Channel	Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.
Data Elements	CMS is not recommending specific value sets currently.
Measure Resources	Screen Positive Rate for Social Drivers of Health Measure Specification Frequently Asked Questions: SDOH Measures (August 2023) Listing of Various Screening Tools Guide to social needs screening (aafp.org) Rural Health Disparities Overview - Rural Health Information Hub

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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
Measure Rationale	1 in 5 people in the U.S. get influenza each season. Combined in pneumonia, influenza is the 8th leading cause of death, with two-thirds of those attributed to patients hospitalized during the flu season.
Improvement Noted As	Increase in the rate (percent)
Numerator	All HCP personnel who: • Received vaccination at the facility • Received vaccination outside of the facility • Did not receive vaccination due to contraindication Did not receive vaccination due to declination
Denominator	All HCP* that worked in the facility (part-time or full-time) for at least one day during the encounter period of October 1 – March 31. **Please see definition for HCP in MBQIP measure specification manual**
Measure Population	All HCP* that worked in the facility (part-time or full-time) for at least one day during the encounter period of October 1 – March 31. **Please see definition for HCP in MBQIP measure specification manual**
Sample Size Requirements	No sampling - report all cases
Calculations	All data reporting is aggregate (whether monthly, once a season, or at a different interval)
Data Source	Administrative Data
Data Collection Approach	Hospital Tracking

Measure Name – Healthcare Personnel Influenza Immunization	
Data Elements	Three categories (all with separate denominators) of HCP working in the facility at least one day b/w 10/1-3/31: • Employees on payroll • Licensed independent practitioners • Students, trainees, and volunteers 18yo+ A fourth optional category is available for reporting other contract personnel HCP workers who: • Received vaccination at the facility • Received vaccination outside of the facility • Did not receive vaccination due to contraindication Did not receive vaccination due to declination
Measure Submission and Reporting Channel	This data is reported annually through the Healthcare Personnel Safety Component of National Healthcare Safety Network (NHSN) website.
Data Available On	MBQIP Data Reports
Other Notes	Each facility in a system needs to be registered separately and HCPs should be counted in the sample population for every facility at which they work. Facilities must complete a monthly reporting plan for each year or data reporting period. All data reporting is aggregated (whether monthly, once a season, or at a different interval).

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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
Measure Rationale	Improving antibiotic use in hospitals is imperative to improving patient outcomes, decreasing antibiotic resistance, and reducing healthcare costs. According to the Centers for Disease Control and Prevention (CDC), 20-50 percent of all antibiotics prescribed in U.S. acute care hospital are either unnecessary or inappropriate, which leads to serious side effects such as adverse drug reactions and Clostridium difficile infection. Overexposure to antibiotics also contributes to antibiotic resistance, making antibiotics less effective. In 2014, CDC released the "Core Elements of Hospital Antibiotic Stewardship Programs" that identifies key structural and functional aspects of effective programs and elements designed to be flexible enough to be feasible in hospitals of any size.
Improvement Noted As	Increase in the number of core elements met
Measure Population	NA – This measure uses administrative data and not claims to determine the measure's denominator population.
Sample Size Requirements	No sampling – report all information as requested
Data Collection Approach	Hospital tracking
Data Elements	Questions as answered on the Patient Safety Component Annual Hospital Survey inform whether the hospitals have successfully implemented the following core elements of antibiotic stewardship: • Leadership • Accountability • Drug Expertise • Action • Tracking • Reporting • Education
Measure Submission and Reporting Channel	National Healthcare Safety Network (NHSN) website

Measure Name – Antibiotic Stewardship Implementation	
Data Available On	MBQIP Data Reports
Measure Resources	Patient Safety/Inpatient | National Rural Health Resource Center (ruralcenter.org)

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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.
Measure Rationale	Timely, accurate, and direct communication facilitates the handoff to the receiving facility, provides continuity of care and avoids medical errors and redundant tests.
Numerator	Number of patients discharged, transferred, or returned to another healthcare facility whose medical record documentation indicated that ALL 8 data elements were documented and communicated to the receiving hospital in a timely manner.
Denominator	ED patients who are discharged, transferred, or returned to another healthcare facility

Measure Name – Emergency Department Transfer Communication (EDTC)	
Exclusions	ED patients AMA (left against medical advice) Expired Discharged to Home includes: Assisted Living Facilities, Board and care, foster or residential care, group or personal care homes, and homeless shelters Discharged to Court/Law Enforcement – includes detention facilities, jails, and prison Discharged Home with Home Health Services Discharged to Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs, and Partial Hospitalization Discharged to Hospice-at home Not Documented/Unable to determine discharge location Discharged to Observation Status
Improvement Noted As	Increase in the rate
Measure Population (Determines the cases to abstract/submit)	Patients admitted to the emergency department who were then discharged, transferred, or returned to any type of acute care facility, or other care facility
Sample Size Requirements	Quarterly 0-44 - submit all cases > 45 - submit 45 cases Monthly 0-15 - submit all cases > 15 - submit 15 cases The following measure specific sampling requirements exist: Hospitals need to submit a minimum of 45 cases per quarter from the required population. A hospital may choose to sample and submit more than 45 cases. Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. Hospitals whose initial patient population size is less than the minimum number of 45 cases per quarter for the measure cannot sample and should submit all cases for the quarter
Calculations	This measure is calculated using an all or none approach. The overall EDTC Measure can be calculated as the percent of patients that met all the eight data elements divided by all transfers from ED to another healthcare facility.
Data Source	Manual Chart Abstraction Retrospective data sources for required data elements include administrative data and medical records.
Data Collection Approach	Chart Abstracted, composite of EDTC data elements 1-8, using an all or none approach

Measure Name – Emergency Department Transfer Communication (EDTC)	
Data Elements	1. Home Medications 2. Allergies and/or Reactions 3. Medications Administered in ED 4. ED Provider Note 5. Mental Status/Orientation Assessment 6. Reason for Transfer and/or Plan of Care 7. Tests and/or Procedures Performed 8. Tests and/or Procedures Results
Measure Submission and Reporting Channel	Submission process directed by state Flex Program
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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.
Measure Rationale	Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care, potentially improves access to care specific to the patient condition, and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.
Exclusions	Patients who expired in the emergency department
Improvement Noted As	Decrease in median value (time)

<table>
<tr><th colspan="2">Measure Name – OP-18 Time from ED Arrival to ED Departure</th></tr>
<tr><td>Measure Population (Determines the cases to abstract/submit)</td><td>Patients seen in a Hospital Emergency Department that have an E/M code in Appendix A, OP Table 1.0 of the CMS Hospital OQR Specifications Manual.</td></tr>
<tr><td>Set Measure ID # and Measure Category Assignment</td><td>Measure ID# OP-18 has 4 Set Measure ID numbers:
<table>
<tr><th>OP-18 Set Measure ID#s</th><th>Performance Measure Name</th><th>Measure Category Assignment</th><th>OP-18 Algorithm Stratification Table**</th></tr>
<tr><td>OP-18</td><td>Median Time from ED Arrival to ED Departure for Discharged ED Patients</td><td></td><td></td></tr>
<tr><td>• OP-18a</td><td>Median Time from ED Arrival to ED Departure for Discharged ED Patients – Overall Rate</td><td>Rate used to identify stratified populations of specific measures.</td><td>(D1) Overall Measure</td></tr>
<tr><td>• OP-18b</td><td>Median Time from ED Arrival to ED Departure for Discharged ED Patients – Reporting Measure</td><td>The measure population for MBQIP abstraction.*</td><td>(D) Reporting Measure</td></tr>
<tr><td>• OP-18c</td><td>Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients</td><td>In the measure population but only the Psychiatric/Mental Health Patients.</td><td>(D2) Psych/Mental Health Measure</td></tr>
<tr><td>• OP-18d</td><td>Median Time from ED Arrival to ED Departure for Discharged ED Patients – Transfer Patients</td><td>In the measure population but only the Transfer Patients.</td><td>(D3) Transfer Measure</td></tr>
</table>
*For MBQIP abstracting purposes, the ED-Throughput Abstraction Tools automatically calculate the measure algorithm and measure categories for the abstractor.
**The OP-18 Measure Algorithms and Stratification Tables can be found in the QualityNet CMS Hospital Outpatient Specifications Manuals</td></tr>
</table>

Measure Name – OP-18 Time from ED Arrival to ED Departure	
Sample Size Requirements	Quarterly 0-900 Submit 63 cases > 900 - Submit 96 cases Monthly Note: Monthly sample size requirements for this measure are based on the quarterly patient population. 0-900 - submit 21 cases > 900 - submit 32 cases
Data Source	Hospital tracking
Data Collection Approach	Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10-CM diagnosis and procedure codes, which require retrospective data entry.
Data Elements	Arrival Time Discharge Code E/M Code ED Departure Date ED Departure Time ICD-10-CM Principal Diagnosis Code Outpatient Encounter Date
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via Outpatient CART/Vendor
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
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.
Measure Rationale	Reducing patient wait time in the ED helps improve access to care, increase capability to provide treatment, reduce ambulance refusals/diversions, reduce rushed treatment environments, reduce delays in medication administration, and reduce patient suffering.
Numerator	The total number of patients who left without being evaluated by a physician/APN/PA
Denominator	The total number of patients who presented to the ED
Improvement Noted As	Decrease in rate (percent)
Sample Size Requirements	No sampling - report all cases
Data Collection Approach	Hospital Tracking
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via Online Tool (HARP)
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) – Composite 1: Communication with Nurses	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who reported that their nurses "Always" communicated well.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, how often did nurses treat you with courtesy and respect? • During this hospital stay, how often did nurses listen carefully to you? During this hospital stay, how often did nurses explain things in a way you could understand?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Composite 2: Communication with Doctors	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who reported that their doctors "Always" communicated well.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, how often did doctors treat you with courtesy and respect? • During this hospital stay, how often did doctors listen carefully to you? During this hospital stay, how often did doctors explain things in a way you could understand?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Composite 3: Responsiveness of Hospital Staff	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who reported that they "Always" received help as soon as they wanted.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Composite 5: Communications About Medicines	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who reported that staff "Always" explained about medicines before giving them.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Question 8: Cleanliness of Hospital Environment	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who reported that their room and bathroom were "Always" clean.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: During this hospital stay, how often were your room and bathroom kept clean?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Question 9: Quietness of Hospital Environment	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who reported that the area around their room was “Always” quiet at night.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: During this hospital stay, how often was the area around your room quiet at night?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Composite 6: Discharge Information	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who reported that "Yes" they were given information about what to do during their recovery at home.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Composite 7: Care Transitions	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Set	HCAHPS
Measure Description	Percentage of patients surveyed who "Strongly Agree" they understood their care when they left the hospital.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Questions: • During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. • When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. When I left the hospital, I clearly understood the purpose for taking each of my medications.
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Question 21: Overall Rating of Hospital	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports

Existing Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – HCAHPS – Question 22: Willingness to Recommend	
MBQIP Domain	Patient Experience
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 first Wednesday in July Q2 encounters (April 1 – June 30) due first Wednesday in October Q3 encounters (July 1 – September 30) due first Wednesday in January Q4 encounters (October 1- December 31) due first Wednesday in April 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. See MBQIP Data Submission Deadlines
Measure Description	Percentage of patients surveyed who reported "Yes" they would definitely recommend the hospital.
Measure Rationale	Growing research shows positive associations between patient experience and health outcomes, adherence to recommended medication and treatments, preventive care, health-care resource use and quality and safety of care.
Measure Population (Determines the cases to abstract/submit)	Patients discharged from the hospital following at least one overnight stay sometime between 48 hours and 6 weeks ago who are over the age of 18 and did not have a psychiatric principal diagnosis at discharge.
Sample Size Requirements	Sampling determined by HCAHPS vendor or self-administered if in compliance with program requirements. **FORHP will be identifying an HCAHPS low volume threshold option that applies to SHIP and Flex – threshold and timeline for implementation is forthcoming.**
Data Collection Approach	Survey (typically conducted by a certified vendor)
Data Elements	Question: Would you recommend this hospital to your friends and family?
Measure Submission and Reporting Channel	Hospital Quality Reporting (HQR) via HCAHPS vendor or self-administered if in compliance with program requirements.
Data Available On	MBQIP Data Reports