Hospital Report Card Reporting Manual for the Community Hospitals

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VERMONT
Department of Health
Agency of Human Services

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INTRODUCTION

This Manual was developed to provide the necessary information for Vermont hospitals to follow the Vermont Statute[1] and regulation[2] for reporting related to:

- State Comparative Hospital Report Card published on Vermont Department of Health's website – including the quality of care measures, healthcare-associated infection measures, patient safety, nurse staffing, pricing information on common services, and a link to the Green Mountain Care Board's website for related Act 53 financial data;

- Community-specific information to be published at individual hospital's website – including public participation and strategic planning; community health needs assessment, implementation plan, annual progress report; complaint process information; and financial assistance policy.

The Manual sets the expected measures, timelines, and processes for the annual reporting by hospitals for: 1. Hospital Quality Measures, 2. Financial Data, and 3. Public Participation and Strategic Planning.

The Department will notify all hospitals if there are any changes made to the required measures or reporting processes during the year. New measures may be added as follows:

- For measures requiring new data collection by the hospitals, the Department will notify hospitals 180 days prior to the inception date for data collection of new measures.
- For measures included in existing federal or state reporting, the Department will notify hospitals by December 1 of the year prior to the scheduled June 1 publication date.

It is the hospital's responsibility to inform the Department of any staffing change in order to receive up-to-date information related to Act 53/Hospital Report Card. This includes, but not limited to, the following: CEO, CFO, Infection Preventionist, Quality Director, Communications Officer, Chief Nursing Officer, and IT/Web staff.

[1] . Vermont Statute, 18 V.S.A. § 9405a applies to the public participation and strategic planning, and Vermont Statute, 18 V.S.A. § 9405b addresses hospital community reports.

[2] 2018 Hospital Reporting Rule, Section 9

SECTION ONE: HOSPITAL QUALITY MEASURES

The measures below will be published in the 2024 Hospital Report Card (the comparative statewide report card posted on the health department website).

In addition to measures listed under the Quality of Care, Patient Safety, and Healthcare-associated Infections below, starting with the April 2023 refresh data, VDH may publish other data available in Care Compare for all Vermont hospitals. VDH will evaluate these measures with sufficient data to publish in the Report Card. Please see Appendix E for a complete list of measures in Care Compare (as of December 2023).

To avoid any misunderstandings and/or confusions from the public, VDH will provide a note on the Report Card website that explains why some data are not available for CAHs. Also included will be an explanation of why some data are not shown due to small numbers.

1. Quality of Care Measures

There are two data sources for the quality of care measures: CMS Care Compare and Agency for Healthcare Research and Quality (AHRQ). Please note that the Hospital Report Card is updated quarterly as CMS updates Care Compare (formerly Hospital Compare) data. Measures that appear on the Report Card will reflect any changes made in Care Compare.

CMS measures that are required to report under Acute Care Inpatient Prospective Payment System (IPPS) (CMS Acute Inpatient PPS).

- MORT-30-AMI: Acute myocardial infarction 30-day mortality rate
- READM-30-AMI: Acute myocardial infarction 30-day readmission rate
- MORT-30-HF: Heart failure 30-day mortality rate
- READM-30-HF: Heart failure 30-day readmission rate
- MORT-30-PN: Pneumonia 30-day mortality rate
- READM-3-PN: Pneumonia 30-day readmission rate
- READM-30-HOSP-WIDE (HWR): 30-day overall hospital-wide readmission rate

VDH will download the above data quarterly directly from the CMS website. Hospitals will adhere to CMS data submission guidelines, specifications, and deadlines.

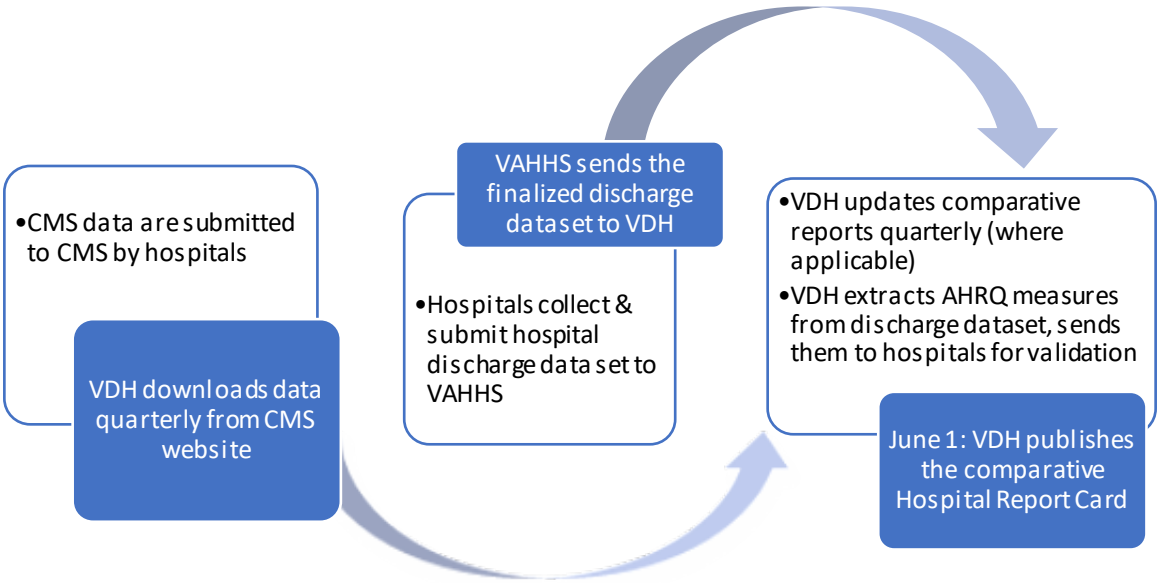
The Agency for Healthcare Research and Quality (AHRQ) Measures (Individual Measure Technical Specifications).

- Volume and mortality rate of esophageal resections (IQI 8)
- Volume and mortality rate of pancreatic resections (IQI 9)
- Volume and mortality rate of abdominal aortic aneurysm repairs (IQI 11)

VDH will extract the above data directly from the Vermont Uniform Discharge Data Set. Hospitals will adhere to Vermont Association of Hospitals and Health Systems (VAHHS) data submission guidelines, specifications, and deadlines.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (HCAHPS Overview). VDH downloads the dataset quarterly directly from the CMS website.

Data flow (see Appendix A).



2. Patient Safety

Each Vermont hospital must report to the *Vermont Patient Safety Surveillance and Improvement System (VPSSIS)* any incidence of any of the National Quality Forum's serious reportable events. The complete list can be found on the National Quality Forum's website (NQF Serious Reportable Events).

Reports are submitted to VPSSIS by downloading and filling out the appropriate form(s) found here: Patient Safety Surveillance and Improvement. Scroll down to "HOSPITAL REPORTING", then go to "Reporting a NFQ event or Intentional Unsafe Act". Following forms are available: Causal Analysis and Corrective Action Plan", "Intentional Unsafe Act", and "Reportable Adverse Event". Hospitals may submit the form(s) by mail, e-mail, or fax to the Patient Safety Program.

E-mail to: sre@vpqhc.org

Fax form(s) to: Vermont Program for Quality in Health Care, Inc.
802-262-1307
Attention: Patient Safety Program

Mail form(s) to: Vermont Program for Quality in Health Care, Inc.
Attention: Patient Safety Program
132 Main Street #1 Montpelier, VT 05602

Hospitals must report the event to the VPSSIS within **seven days** of incidence.

In addition, **all Designated Hospitals[3] are also required to report** critical incidents to the Vermont Department of Mental Health. Please note that the reporting requirements for the Department of Mental Health are different from VPSSIS. *The Manual for Critical Incident Reporting Requirements for Designated Hospitals* can be found here: [The Manual for Critical Incident Reporting Requirements for Designated Hospitals.]

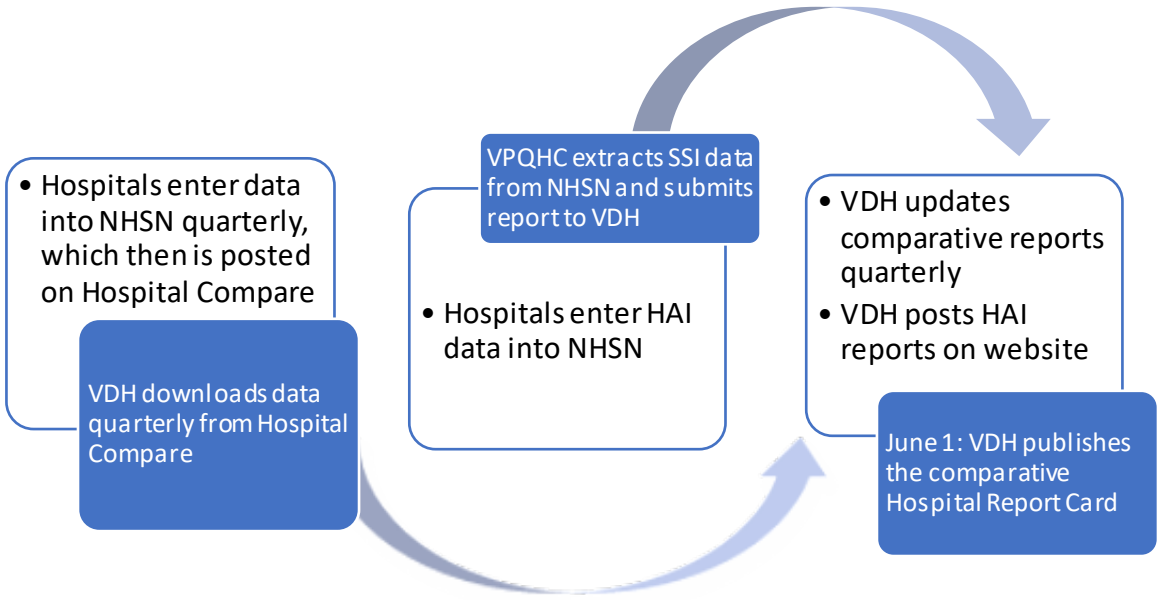
3. Healthcare-Associated Infection Measures

CMS IPPS required National Healthcare Safety Network (NHSN) Measures.

- Central Line-Associated Bloodstream Infection (CLABSI) Ratios (HAI-1)
- *Clostridioides difficile* (C. diff) Infection Ratios (HAI-6)
- Surgical Site Infection Ratios – Abdominal Hysterectomy (HAI-4)
- Surgical Site Infection Ratios – Hip Replacement*
- Surgical Site Infection Ratios – Knee Replacement*

VDH will download the first three measures directly from CMS Hospital Compare. VPQHC will extract the last two Surgical Site Infection (SSI) data from NHSN annually. Hospitals will adhere to CMS/NHSN measure specifications, data submission guidance and deadlines.

Data flow



[3] Brattleboro Retreat, Central Vermont Medical Center, The University of Vermont Medical Center, Vermont Psychiatric Care Hospital, Rutland Regional Medical Center, and Springfield Hospital (Windham Center) refers to the inpatient psychiatry unit of each hospital respectively.

* Applies to all Vermont hospitals per Act 53 although not IPPS-required.

4. Nurse Staffing (Appendix B)

Hospitals will use the template provided by the Department to submit data. Templates are found on the Report Card webpage under "Resources for Vermont Hospitals".

Two types of templates are available: Full-Time Equivalent (FTE) based, and hour based. Hospitals will use the appropriate template that aligns with hospital's data collection method.

- Data entry is limited to the highlighted area of the spreadsheet: by shift, RN, LPN, UAP hours or FTEs; and patient census.

Completed templates will be emailed to the general Hospital Report Card inbox: AHS.VDHHospitalReportCard@vermont.gov. at least every three months.

SECTION TWO: FINANCIAL REPORTING

Per 18 VSA §9405b, a statewide comparative report must include measures indicative of the hospital's financial health and a summary of the hospital's budget, as more fully described below, and it will be posted on the Green Mountain Care Board's (GMCB) website. Hospitals will have an option to review the report before it is published on GMCB's website. Measures relating to the hospital's financial health will include comparisons to appropriate nation and/or other benchmarks for efficient operation and fiscal health and will be derived from the hospital budget and budget-to-actual information submitted annually to the GMCB pursuant to Rule 7.000 (Unified Health Care Budget).

5. Hospital's Financial Assistance Policies

Hospital will post on its website **Financial Assistance Policies (FAP)** and its related contents consistent with IRS requirements, including but not limited to the following:

- The list of providers, other than hospital facility itself, delivering emergency or other care in the hospital and to specify which providers are covered by the hospital's FAP and which are not.
- The eligibility criteria for financial assistance, whether such assistance includes free or discounted care, and the basis for calculating amounts charged to patients.
- Description of how an individual applies for financial assistance under the FAP and either the hospital's FAP or FAP application form must describe the information or documentation the hospital may require an individual to submit as part of FAP application.
- A plain language summary of the FAP.
- Action that may be taken in the event of nonpayment.

Data flow (see below).

6. Hospital's Financial Health and Budget Information

GMCB will post a **statewide comparative report** summarizing the hospitals' financial health and budget Minimum content and presentation requirements for hospital's financial health and summary hospital budget information will be based on the hospitals' financial performance, as reported in the annual hospital budget submissions to the GMCB for the current and past fiscal years, and will be presented as follows:

- Finances: Summaries of the hospitals' finances, including but not limited to ratios, statistics and indicators relating to liquidity, cash flow, productivity, surplus, charges and payer mix. Such ratios, statistics and indicators will represent both actual results and projections for subsequent budget years and will be presented against at least one national peer, regional peer or Vermont peer group data, or against one bond rating agency's comparable rating.
- Budgets: Summaries of the hospitals' budgets which represent two years of actual results and current budget year. Data will be presented against at least one national peer, regional peer or Vermont peer group data, or against one bond rating agency's comparable rating.

- Cost Shift: Quantification of cost shifting from public payers to private payers for one year of actual results and current budget year.
- Key Performance Indicators: Summaries of the hospitals' capital key performance indicators for two years of actual results and current budget year.
- Capital Investments: Summaries of capital expenditures and plans for one to four years.

Data flow (see below).

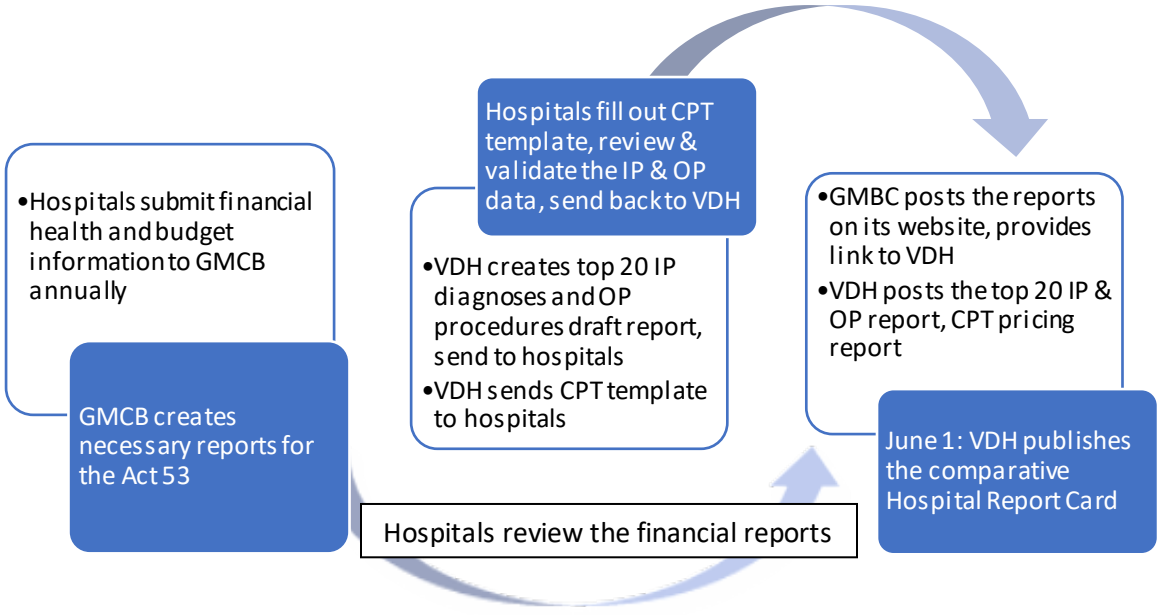
7. Charges for Higher Volume Health Care Services and Common Procedures

For Higher Volume Health Care Services, the Department will identify the top 20 inpatient diagnoses, outpatient procedures, and their counts and charges, and produce a draft report for each hospital for their review and validation prior to publication of the report.

For Common Procedure Pricing, hospitals will fill out the CPT pricing template provided by the Department with the most recent charge listed in the hospital's chargemaster.

Hospitals will follow the timelines specified in Appendix A.

Data flow.



SECTION THREE: PUBLIC PARTICIPATION AND STRATEGIC PLANNING

Each hospital must have a protocol for meaningful public participation in its strategic planning process for identifying and addressing health care needs that the hospital provides or could provide in its service area. Needs identified through the process will be integrated with the hospital's long-term planning.

Staff at the District Offices of the Department of Health (Appendix D) are available to partner with hospitals in conducting the community health needs assessment (CHNA) and in developing the required Implementation Plan in the following ways:

- Compilation of health outcome data to develop a Community Health Profile,
- Developing community survey and/or other engagement methods,
- Providing evidence-based strategies that have proven impact in improving health outcomes to consider when developing the Implementation Plan, and
- Collaborating in monitoring of the Implementation Plan to evaluate its success in improving health outcomes.

The following information will be posted on **each hospital's website**.

8. Community Health Needs Assessment

Each hospital will post on its website a community health needs assessment (CHNA) in accordance with IRS[4] and alignment with the GMCB guidance for budget submission reporting requirements, which includes at minimum the following:

- Definition of the community it serves;
- Assessment of the health needs of the community that can include access to care and other needs to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community[5];
- Identification of the significant health needs;
- Prioritization of the health needs, including the description of the process and criteria used in prioritization and description of how public input was solicited/considered in prioritizing the health needs;
- Description of resources available to address the significant health needs;
- Report on *the evaluation* of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s)[6];

[4] *See* Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirements of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule, 79 Fed. Reg. 78954, 78956 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, and 602), *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf [hereinafter Final Rule].

[5] Final Rule at 78963; 26 C.F.R. § 1.501(r)-3(b)(4).

[6] *See id.,* at 78969.

- Contact information including but not limited to: the telephone numbers, e-mail addresses, fax numbers and postal addresses of the person in charge of the CHNA at the hospital;
- Contact information including but not limited to: the department(s), telephone numbers, e-mail addresses, fax numbers and postal addresses at the hospital for consumers to use if interested in learning about public participation events[4]; website references may also be included, and;
- Description of where and how consumers can obtain detailed information about, or a copy, of the hospital's CHNA and strategic plan.

Hospital will post the above information on their website by **June 1**. IRS requires the hospitals make the CHNA report available until two subsequent assessments are made available. Therefore, hospitals must have links to at least the two most recent reports.

9. CHNA Implementation Plan, Strategic Initiatives, Annual Progress Report

The Implementation Plan/strategic initiatives will be written in accordance with the IRS[7] and alignment with the GMCB guidance for budget submission reporting requirements.

The Implementation Plan/Strategic Initiatives will describe how the hospital plans to address the identified health needs, including:

- Actions the hospital intends to take to address the health needs, which may include interventions designed to prevent illness or address social, behavioral, and environmental factors within an implementation strategy[8];
- Anticipated impact of these actions;
- Resources the hospital plans to commit to address the health needs, and
- Any planned collaboration between the hospital and other facilities or organizations;
- Identifies the health needs the hospital does not intend to address and explain why the hospital does not intend to address them and will **provide** a brief explanation of its reasons, including resource constraints, other facilities or organizations addressing the need, lack of experience or competency, relatively low priority for community, or lack of identified effective interventions.

Each hospital will post on its website an **Annual Progress Report.**[9] Annual Progress Report will include at minimum the following:

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[7] *See* Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirements of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule, 79 Fed. Reg. 78954, 78956 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, and 602), *available at* http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf [hereinafter Final Rule].

[8] *See id.,* at 78970.

[9] Annual Progress Reports can be submitted as part of CHNA to comply with the IRS Rule "CHNA report include an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its

- Health needs identified in CHNA, and actions hospitals plan to take to address each health needs;
- Health needs identified in CHNA for which no action is planned with an explanation of why;
- Current initiatives, activities, action items for each health need being worked on. Include items such as list of partners, resources, funding sources, supports received; program description (or link to the program webpage). And;
- Any of the following: progress made, outcome for each initiative, activity, action item, lessons learned, or any barriers encountered.

Hospitals will post the above information on their website **by June 1**.

10. Description of Hospital Complaint Process

Each hospital will describe its **consumer complaint resolution** process including but not limited to:

- A description of the complaint process including how to register a complaint;
- Contact information, including but not limited to: telephone numbers, e-mail addresses, fax numbers, and postal addresses
  - for the hospital employee(s) responsible for implementation of the complaint resolution process; and
  - for Department of Disability, Aging, and Independent Living, Division of Licensing and Protection in order to register a complaint against the hospital;
- Contact information or website URL for all of the organizations listed in the Office of the Health Care Advocate website who provide assistance with filing complaints, or the Office of the health Care Advocate website URL itself (https://vtlawhelp.org/complaints#) to direct consumers to a resource website which provides information on how to file complaints outside of hospital.

Hospitals will post the above information on their website by **June 1**.

11. Hospital Governance

Each hospital will provide the **hospital's governance**, including but not limited to:

- Information on membership and governing body qualifications;
- A listing of the current governing body members, including each member's name, town of residence, occupation, employer, and job title, and the amount of compensation, if any, for serving on the governing body;
- Means of obtaining a schedule of meeting of the hospital's governing body, including times scheduled for public participation;
- Contact information including, but not limited to, the telephone numbers, e-mail addresses, fax numbers and postal addresses of the person responsible for public participation at the hospital, and;

immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s)."

- The hospital's affiliation and membership with other hospitals, Accountable Care Organizations (ACOs), and/or other managing entities.

Hospitals will post the above information on their website by **June 1**.

12. Link to the Health Department's Statewide Comparative Hospital Report Card

Hospitals will display this link: VT Department of Health Hospital Report Card Webpage (http://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/hospital-report-cards) on hospital's website.

Hospitals will post the above information on their website by **June 1.**

Hospitals will promptly notify the Department (contact information in Appendix D) of all the links of information, measures, documents per requirement of Act 53 that are posted on the hospital's website by **May 24, 2024, Friday.**

Appendix A: Hospital Report Card Timelines

Community Hospitals

Timeline/ Deadline	Hospitals	Department (VDH)
ONGOING	• Submit nurse staffing data to VDH at least every three months using the nurse staffing template available from the VDH website.	• Makes nurse staffing templates available on VDH website.
January		• Updates the Report Card with refreshed CMC Hospital Compare data.
Before or on Wednesday, March 13		• Releases the 2024 Hospital Report Card Reporting Manual. • Sends the CPT pricing template to hospitals. • Produces a draft inpatient & outpatient pricing report and send to hospitals.
Friday, March 22	• Send VDH completed CPT template.	
April		• Updates the Report Card with refreshed CMS Care Compare data.
Friday, April 5	• Send comments to VDH on inpatient and outpatient pricing.	• Sends AHRQ's volume and mortality data to hospitals (if any).
Friday, April 19	• Validation due on AHRQ's volume and mortality data.	• Sends formatted nurse staffing data to hospitals for review. • Sends inpatient & outpatient pricing report to hospitals for final review.
Friday, April 26	• Send the nurse staffing data back to VDH with final comment. • Send inpatient & outpatient pricing with final comments back to VDH.	
Monday, May 20		• Publishes the 2024 Hospital Report Card on its website. During this time, it will be used to make sure all contents and links are correct. Hospitals are strongly encouraged to visit the site for quality checking.
Friday, May 24	• Send links of all the reports and information posted on hospital website to VDH.	
Friday, May 30	• Publishes all reports and information on all hospital websites.	• Publishes Comparative report on VDH's website.
July, October		• Updates the Report Card with refreshed CMS Care Compare data.

Appendix B: Nurse Staffing Information

1. Required Units for Reporting:

- Neonatal In-Patient
  - Level III/IV Critical Care
  - Level II Intermediate Care
  - Level I Continuing Care
  - Well Baby Nursery
- Pediatric In-Patient
  - Critical Care-Pediatric
  - Bone Marrow Transplant
  - Step Down
  - Medical
  - Surgical
  - Med-Surg Combined
  - Burn
  - High Acuity
  - Moderate Acuity
  - Blended Acuity
- Adult In-Patient
  - Critical Care-Adult
  - Step Down
  - Medical
  - Surgical
- Med-Surg Combined
  - Bone Marrow Transplant
  - Burn
  - Critical Access Unit
  - Long-term Acute Care
  - High Acuity
  - Moderate Acuity
  - Blended Acuity
  - Universal Bed
- Psychiatric
  - Adult
  - Adolescent
  - Child/adolescent
  - Child
  - Geripsych
  - Behavioral health
  - Specialty
  - Multiple unit types
- Rehab In-Patient
  - Adult
  - Pediatric

For other unit not listed, reporting is optional.

2. Category of Nursing Staff

- Registered Nurse (RN) includes Advanced Practice Registered Nurse (APRN)
- Licensed Practical Nurses (LPN) includes Licensed Vocational Nurses (LVN)
- Unlicensed Assistive Personnel (UAP) includes the following:
  - Nurse assistants
  - Orderlies
  - Paramedics
  - Patient care technicians
  - Mental health technicians
  - Licensed Nurse Assistants (LNA)
  - Emergency medical technicians (EMS)

3. Direct patient care means patient centered nursing activities in the presence of the patient and activities that occur away from the patient that are patient related such as:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening

Appendix C: Where Information Is Published

VDH (Hospital Report Card)	Hospitals	GMCB
Quality of care measures	Financial Assistance Policy	Financial health report
Healthcare-Associated Infection measures	CHNA report	Budget information
Patient safety	Implementation Plan	
Nurse staffing report	Annual Progress Report	
Charge/pricing information	Hospital complaint process	
	Hospital governance	
	Link to VDH's website	

Appendix D: Contact Information and Resources

Any questions regarding the Hospital Report Card, please contact
Hospital Report Card General Inbox
AHS.VDHHospitalReportCard@vermont.gov
Vermont Department of Health
108 Cherry St. Burlington VT 05401
802-863-7300 (general)

Or

Hillary Wolfley
Vermont Program for Quality in Health Care (VPQHC)
132 Main St #1 Montpelier VT 05602
HillaryW@vpqhc.org
802-262-1304

Any questions regarding the financial/budget reporting, please contact
Green Mountain Care Board
144 State Street
Montpelier, VT 05602
phone: 802 828-6971; cell: 802 622-4675
E-mail: GMCB Health Systems Finances GMCB.HealthSystemsFinances@vermont.gov

Community Health Needs Assessment (CHNA) and Implementation Plan
Staff at the District Offices of the State Health Department are available to partner with hospitals. Contact information for each District Office is listed here below or on the website: http://www.healthvermont.gov/local

District Office	Toll Free Number	Local Phone Number	Email
Barre	(888) 253-8786	(802) 479-4200	AHS.VDHOLHBarre@vermont.gov
Bennington	(800) 637-7347	(802) 447-3531	AHS.VDHOLHBennington@vermont.gov
Brattleboro	(888) 253-8805	(802) 257-2880	AHS.VDHOLHBrattleboro@vermont.gov
Burlington	(888) 253-8803	(802) 863-7323	AHS.VDHOLHBurlington@vermont.gov
Middlebury	(888) 253-8804	(802) 388-4644	AHS.VDHOLHMiddlebury@vermont.gov
Morrisville	(888) 253-8798	(802) 888-7447	AHS.VDHOLHMorrisville@vermont.gov
Newport	(800) 952-2945	(802) 334-6707	AHS.VDHOLHNewport@vermont.gov
Rutland	(888) 253-8802	(802) 786-5811	AHS.VDHOLHRutland@vermont.gov
St. Albans	(888) 253-8801	(802) 524-7970	AHS.VDHOLHStAlbans@vermont.gov
St. Johnsbury	(800) 952-2936	(802) 748-5151	AHS.VDHOLHStJohnsbury@vermont.gov
Springfield	(888) 296-8151	(802) 289-0600	AHS.VDHOLHSpringfield@vermont.gov
White River Junction	(888) 253-8799	(802) 295-8820	AHS.VDHOLHWhiteRiverJunction@vermont.gov

Local Resources:

Vermont Department of Health	http://www.healthvermont.gov/
VT Hospital Report Card	http://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/hospital-report-cards
VDH Patient Safety Surveillance and Improvement	http://www.healthvermont.gov/health-professionals-systems/hospitals-health-systems/patient-safety
VPQHC	https://www.vpqhc.org/
Vermont Association of Hospitals and Health Systems	http://vahhs.org/
Vermont Department of Mental Health (DMH)	http://mentalhealth.vermont.gov
DMH Designated Hospital: Manual and Standards	http://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/DH_Manual_Standards_2017-05.pdf
DMH Critical Incident Reporting Requirements of Designated Hospitals	http://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/Critical_Incidents_Req%27s_DH_2016-02.pdf
Vermont Statute, 18 V.S.A. § 9405a (public participation and strategic planning)	https://legislature.vermont.gov/statutes/section/18/221/09405a

Vermont Statute, 18 V.S.A. § 9405b (Hospital Community Reports)	https://legislature.vermont.gov/statutes/section/18/221/09405b
Vermont Department of Health Hospital Reporting Rule	http://www.healthvermont.gov/sites/default/files/documents/pdf/7.%202018%20Hospital%20Report%20Rule%20Clean%20Copy.pdf

National Resources:

Care Compare (formerly Hospital Compare)	https://www.medicare.gov/care-compare/
CDC/NHSN	https://www.cdc.gov/nhsn/index.html
IRS Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return	https://www.federalregister.gov/documents/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable#h-17
National Quality Forum Serious Reportable Events	http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx
Specifications Manual for Joint Commission National Quality Core Measures	https://manual.jointcommission.org/releases/TJC2013A/index.html

Appendix E: List of CMS Care Compare Measures (as of December, 2023)

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
Patient survey- Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)			
H-COMP-1-A-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Always" communicated well	Quarterly (January, April, July, October)
H-COMP-1-U-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Usually" communicated well	Quarterly (January, April, July, October)
H-COMP-1-SN-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Sometimes" or "Never" communicated well	Quarterly (January, April, July, October)
H-COMP-2-A-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Always" communicated well	Quarterly (January, April, July, October)
H-COMP-2-U-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Usually" communicated well	Quarterly (January, April, July, October)
H-COMP-2-SN-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Sometimes" or "Never" communicated well	Quarterly (January, April, July, October)
H-COMP-3-A-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Always" received help as soon as they wanted	Quarterly (January, April, July, October)
H-COMP-3-U-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Usually" received help as soon as they wanted	Quarterly (January, April, July, October)
H-COMP-3-SN-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted	Quarterly (January, April, July, October)
H-COMP-5-A-P	Communication about medicines (composite measure)	Patients who reported that staff "Always" explained about medicines before giving it to them	Quarterly (January, April, July, October)

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
H-COMP-5-U-P	Communication about medicines (composite measure)	Patients who reported that staff "Usually" explained about medicines before giving it to them	Quarterly (January, April, July, October)
H-COMP-5-SN-P	Communication about medicines (composite measure)	Patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them	Quarterly (January, April, July, October)
H-CLEAN-HSP-A-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Always" clean	Quarterly (January, April, July, October)
H-CLEAN-HSP-U-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Usually" clean	Quarterly (January, April, July, October)
H-CLEAN-HSP-SN-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Sometimes" or "Never" clean	Quarterly (January, April, July, October)
H-QUIET-HSP-A-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was "Always" quiet at night	Quarterly (January, April, July, October)
H-QUIET-HSP-U-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was "Usually" quiet at night	Quarterly (January, April, July, October)
H-QUIET-HSP-SN-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night	Quarterly (January, April, July, October)
H-COMP-6-Y-P	Discharge information (composite measure)	Patients who reported that YES, they were given information about what to do during their recovery at home	Quarterly (January, April, July, October)
H-COMP-6-N-P	Discharge information (composite measure)	Patients who reported that NO, they weren't given information about	Quarterly (January, April, July, October)

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
		what to do during their recovery at home	
H-COMP-7-SA	Care transition (composite measure)	Patients who "Strongly Agree" they understood their care when they left the hospital	Quarterly (January, April, July, October)
H-COMP-7-A	Care transition (composite measure)	Patients who “Agree” they understood their care when they left the hospital	Quarterly (January, April, July, October)
H-COMP-7-D-SD	Care transition (composite measure)	Patients who “Disagree” or “Strongly Disagree” they understood their care when they left the hospital	Quarterly (January, April, July, October)
H-HSP-RATING-9-10	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	Quarterly (January, April, July, October)
H-HSP-RATING-7-8	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	Quarterly (January, April, July, October)
H-HSP-RATING-0-6	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)	Quarterly (January, April, July, October)
H-RECMND-DY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would definitely recommend the hospital	Quarterly (January, April, July, October)
H-RECMND-PY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would probably recommend the hospital	Quarterly (January, April, July, October)
H-RECMND-DN	Willingness to recommend the hospital (global measure)	Patients who reported NO, they would probably not or definitely not recommend the hospital	Quarterly (January, April, July, October)
Maternal Health			
SM-7	Maternal Morbidity Structural Measure	Whether a hospital participated in a state or national program aimed	Annually, October

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
		at improving maternal and child health	
PC-01	Elective delivery	Percentage of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary	Quarterly (January, April, July, October)
Timely & effective care			
SEP-1	Early management bundle, severe sepsis/septic shock	Percentage of patients who received appropriate care for severe sepsis and septic shock	Quarterly (January, April, July, October)
OP-31	Improvement in patient's visual function within 90 days following cataract surgery	Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery	Annually, January
OP-29	Appropriate follow-up interval for normal colonoscopy in average risk patients	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy	Annually, January
OP-3b	Median time to transfer to another facility for acute coronary intervention	Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital	Quarterly (January, April, July, October)
OP-2	Fibrinolytic therapy received within 30 minutes of emergency department arrival	Percentage of outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival	Quarterly (January, April, July, October)
Timely & effective care- Emergency department (ED) throughput			
EDV	Emergency department volume	Emergency department volume	Annually, January

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
OP-18b	Median time from emergency department arrival to emergency department departure for discharged patients	Average (median) time patients spent in the emergency department before leaving from the visit	Quarterly (January, April, July, October)
OP-18c	Median time from emergency department arrival to emergency department departure for discharged patients – Psychiatric/ mental health Patients	Average (median) time psychiatric or other mental health patients spent in the emergency department before leaving from the visit	Quarterly (January, April, July, October)
OP-22	Left without being seen	Percentage of patients who left the emergency department before being seen	Annually, January
OP-23	Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival	Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival	Quarterly (January, April, July, October)
Timely & effective care- Preventive care			
HCP COVID-19	COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)	The percent of healthcare personnel who completed COVID-19 primary vaccination series	Quarterly (January, April, July, October)
IMM-3- FAC-ADHPCT	Influenza vaccination coverage among healthcare personnel	Percentage of healthcare workers given influenza vaccination	Annually, October
Timely & effective care- Pregnancy & delivery care			
PC-01	Elective delivery prior to 39 completed weeks of gestation	Percentage of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary	Quarterly (January, April, July, October)
Timely & Effective Care- Use of medical imaging			

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
OP-8	MRI lumbar spine for low back pain	Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments (like physical therapy) first	Annually, July
OP-10	Abdomen CT - use of contrast material	Percentage of outpatient CT scans of the abdomen that were "combination" (double) scans	Annually, July
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery	Annually, July
OP-39	Breast Cancer Screening Recall Rates	Percentage of patients who had an advanced breast screening on the same day or within 45 days of their initial mammogram or digital breast tomosynthesis (DBT) study	Annually, July
Complications & deaths- Complications			
COMP-HIP-KNEE	Hospital level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	Rate of complications for hip/knee replacement patients	Annually, July
PSI-90-SAFETY	CMS Medicare PSI 90: Patient safety and adverse events composite	Serious complications	Annually, July
PSI-03-ULCER	Pressure ulcer rate	Pressure injury	Annually, July
PSI-04-SURG-COMP	Death rate among surgical inpatients with serious treatable complications	Deaths among patients with serious treatable complications after surgery	Annually, July
PSI-06-IAT-PTX	Iatrogenic pneumothorax rate	Collapsed lung that results from medical treatment	Annually, July

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
PSI-08-POST-HIP	In-hospital fall with hip fracture rate	Broken hip from a fall in the hospital	Annually, July
PSI-09-POST-HEM	Perioperative hemorrhage or hematoma rate	Bleeding or blood clots requiring a procedure after surgery	Annually, July
PSI-10-POST-KIDNEY	Postoperative acute kidney injury requiring dialysis rate	Kidney failure requiring dialysis after surgery	Annually, July
PSI-11-POST-RESP	Postoperative respiratory failure rate	Respiratory failure after surgery	Annually, July
PSI-12-POSTOP-PULMEMB-DVT	Perioperative pulmonary embolism or deep vein thrombosis rate	Blood clots in the lung or a large leg vein after surgery	Annually, July
PSI-13-POST-SEPSIS	Postoperative sepsis rate	Blood stream infection after surgery	Annually, July
PSI-14-POSTOP-DEHIS	Postoperative wound dehiscence rate	A wound that splits open after surgery on the abdomen or pelvis	Annually, July
PSI-15-ACC-LAC	Abdominopelvic accidental puncture or laceration rate	Accidental cuts and tears requiring a corrective procedure after abdominal or pelvic surgery	Annually, July
Complications & deaths- Infections			
HAI-1	Central line-associated bloodstream infections (CLABSI) in ICUs and select wards	Central line-associated bloodstream infections (CLABSI) in ICUs and select wards	Quarterly (January, April, July, October)
HAI-2	Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards	Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards	Quarterly (January, April, July, October)
HAI-3	Surgical site infections from colon surgery (SSI: Colon)	Surgical site infections (SSI) from colon surgery	Quarterly (January, April, July, October)
HAI-4	Surgical site infections from abdominal hysterectomy (SSI: Hysterectomy)	Surgical site infections (SSI) from abdominal hysterectomy	Quarterly (January, April, July, October)

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
HAI-5	Methicillin-resistant Staphylococcus aureus (MRSA) Blood Laboratory-identified Events (Bloodstream infections)	Methicillin-resistant Staphylococcus aureus (MRSA) blood infections	Quarterly (January, April, July, October)
HAI-6	Clostridium difficile (C. diff) Laboratory-identified Events (Intestinal infections)	Clostridium difficile (C. diff) intestinal infections	Quarterly (January, April, July, October)
Complications & deaths- 30-day death rates			
MORT-30-COPD	Chronic obstructive pulmonary disease (COPD) 30-day mortality rate	Death rate for COPD patients	Annually, July
MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	Death rate for heart attack patients	Annually, July
MORT-30-HF	Heart failure (HF) 30-day mortality rate	Death rate for heart failure patients	Annually, July
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	Death rate for pneumonia patients	Annually, July
MORT-30-STK	Stroke 30-day mortality rate	Death rate for stroke patients	Annually, July
MORT-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day mortality rate	Death rate for CABG surgery patients	Annually, July
Unplanned hospital visits			
OP-32	Facility 7-day risk standardized hospital visit rate after outpatient colonoscopy	Rate of unplanned hospital visits after an outpatient colonoscopy	Annually, January
OP-35 ADM	Admissions and emergency department visits for patients receiving outpatient chemotherapy	Rate of unplanned hospital visits for patients receiving outpatient chemotherapy	Annually, January

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
OP-35 ED	Admissions and emergency department visits for patients receiving outpatient chemotherapy	Rate of emergency department visits for patients receiving outpatient chemotherapy	Annually, January
OP-36	Hospital visits after hospital outpatient surgery	Ratio of unplanned hospital visits after hospital outpatient surgery	Annually, January
EDAC-30-AMI	Acute myocardial infarction (AMI) excess days in acute care (EDAC)	Hospital return days for heart attack patients	Annually, July
EDAC-30-HF	Heart failure (HF) excess days in acute care (EDAC)	Hospital return days for heart failure patients	Annually, July
EDAC-30-PN	Pneumonia (PN) excess days in acute care (EDAC)	Hospital return days for pneumonia patients	Annually, July
READM-30-COPD	Chronic obstructive pulmonary disease (COPD) 30-day readmission rate	Rate of readmission for chronic obstructive pulmonary disease (COPD) patients	Annually, July
READM-30-AMI	Acute myocardial infarction (AMI) 30-day readmission rate	Rate of readmission for heart attack patients	Annually, July
READM-30-HF	Heart failure (HF) 30-day readmission rate	Rate of readmission for heart failure patients	Annually, July
READM-30-PN	Pneumonia (PN) 30-day readmission rate	Rate of readmission for pneumonia patients	Annually, July
READM-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day readmission rate	Rate of readmission for coronary artery bypass graft (CABG) surgery patients	Annually, July
READM-30-HIP-KNEE	30-day readmission rate following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Rate of readmission after hip/knee replacement	Annually, July

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
READM-30-HOSP-WIDE	30-day hospital-wide all- cause unplanned readmission (HWR)	Rate of readmission after discharge from hospital (hospital-wide)	Annually, July
Psychiatric unit services- Healthcare personnel vaccination			
IPFQR-HCP COVID-19	COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)	The percent of healthcare personnel who completed COVID-19 primary vaccination series Higher percentages are better.	Quarterly (January, April, July, October)
Psychiatric unit services- Preventive care and screening			
SMD	Screening for metabolic disorders	Patients discharged on antipsychotic medications who had body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year. Higher percentages are better.	Annually, January
IPFQR IMM-2	Influenza immunization	Patients assessed and given influenza vaccination. Higher percentages are better.	Annually, January
Psychiatric unit services- Substance use treatment			
SUB-2	Alcohol use brief intervention provided or offered	Patients with alcohol abuse who received or refused a brief intervention during their inpatient stay. Higher percentages are better.	Annually, January
SUB-2a	Alcohol use brief intervention	Patients with alcohol abuse who received a brief intervention during their inpatient stay. Higher percentages are better.	Annually, January
SUB-3	Alcohol and other drug use disorder treatment provided or offered at discharge	Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received or refused a prescription for	Annually, January

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
		medications to treat their alcohol or drug use disorder OR (2) received or refused a referral for addiction treatment. Higher percentages are better.	
SUB-3a	Alcohol and other drug use disorder treatment at discharge	Patients who screened positive for an alcohol or drug use disorder during their inpatient stay who, at discharge, either: (1) received a prescription for medications to treat their alcohol or drug use disorder OR (2) received a referral for addiction treatment. Higher percentages are better.	Annually, January
TOB-2	Tobacco use treatment provided or offered	Patients who use tobacco and who received or refused counseling to quit AND received or refused medications to help them quit tobacco or had a reason for not receiving medication during their hospital stay	Annually, January
TOB-2a	Tobacco use treatment (during the hospital stay)	Patients who use tobacco and who received counseling to quit AND received medications to help them quit tobacco or had a reason for not receiving medication during their hospital stay. Higher percentages are better.	Annually, January

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
TOB-3	Tobacco use treatment provided or offered at discharge	Patients who use tobacco and at discharge (1) received or refused a referral for outpatient counseling AND (2) received or refused a prescription for medications to help them quit or had a reason for not receiving medication. Higher percentages are better.	Annually, January
TOB-3a	Tobacco use treatment at discharge	Patients who use tobacco and at discharge (1) received a referral for outpatient counseling AND (2) received a prescription for medications to help them quit or had a reason for not receiving medication. Higher percentages are better.	Annually, January
Psychiatric unit services- Patient safety			
HBIPS-2	Hours of physical restraint use	Hours that patients spent in physical restraints for every 1,000 hours of patient care. Lower rates are better.	Annually, January
HBIPS-3	Hours of seclusion use	Hours that patients spent in seclusion for every 1,000 hours of patient care. Lower rates are better.	Annually, January
Psychiatric unit services- Follow-up care			
TR-1	Transition record with specified elements received by discharged patients	Patients discharged from an inpatient psychiatric facility who received (or whose caregiver received) a complete record of inpatient psychiatric care and plans for follow-up. Higher percentages are better.	Annually, January

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
TR-2	Timely transmission of transition record	Patients whose follow-up care provider received a complete record of their inpatient psychiatric care and plans for follow-up within 24 hours of discharge. Higher percentages are better.	Annually, January
HBIPS-5	Patients discharged on multiple antipsychotic medications with appropriate justification	Patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications (medications to prevent individuals from experiencing hallucinations, delusions, extreme mood swings, or other issues), and whose multiple prescriptions were clinically appropriate. Higher percentages are better.	Annually, January
FUH-30	Follow-up after hospitalization for mental illness	Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 30 days of discharge. Higher percentages are better.	Annually, January
FUH-7	Follow-up after hospitalization for mental illness	Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 7 days of discharge. Higher percentages are better.	Annually, January

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
MedCont	Medication continuation following inpatient psychiatric discharge	Patients admitted to an inpatient psychiatric facility for major depressive disorder (MDD), schizophrenia, or bipolar disorder who filled at least one prescription between the 2 days before they were discharged and 30 days after they were discharged from the facility. Higher percentages are better.	Annually, January
Psychiatric unit services- Unplanned readmissions			
READM-30-IPF	30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility. Lower percentages are better.	Annually, January
Payment & value of care- Medicare Spending Per Beneficiary			
MSPB-1	Medicare hospital spending per patient	Medicare Spending Per Beneficiary	Annually, January
Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)			
Staff care and cleanliness - Definitely	Patients who reported that staff definitely gave care in a professional way and the facility was clean	Patients who reported that staff definitely gave care in a professional way and the facility was clean	Quarterly
Staff care and cleanliness - Somewhat	Patients who reported that staff somewhat gave care in a professional way and the facility was clean	Patients who reported that staff somewhat gave care in a professional way and the facility was clean	Quarterly
Staff care and cleanliness – Did not	Patients who reported that staff did not give care in a professional way and the facility was clean	Patients who reported that staff did not give care in a professional way and the facility was clean	Quarterly

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
Staff communication - Definitely	Patients who reported that staff definitely communicated about what to expect during and after the procedure	Patients who reported that staff definitely communicated about what to expect during and after the procedure	Quarterly
Staff communication - Somewhat	Patients who reported that staff somewhat communicated about what to expect during and after the procedure	Patients who reported that staff somewhat communicated about what to expect during and after the procedure	Quarterly
Staff communication – Did not	Patients who reported that staff did not communicate about what to expect during and after the procedure	Patients who reported that staff did not communicate about what to expect during and after the procedure	Quarterly
Facility rating – 9-10	Patients who gave the facility a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	Patients who gave the facility a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	Quarterly
Facility rating – 7-8	Patients who gave the facility a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	Patients who gave the facility a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	Quarterly
Facility rating –0-6	Patients who gave the facility a rating of 0 to 6 on a scale from 0 (lowest) to 10 (highest)	Patients who gave the facility a rating of 0 to 6 on a scale from 0 (lowest) to 10 (highest)	Quarterly
Recommend facility - Yes	Patients who reported YES they would DEFINITELY recommend the facility to family or friends	Patients who reported YES they would DEFINITELY recommend the facility to family or friends	Quarterly
Recommend facility - Probably	Patients who reported PROBABLY YES they would recommend the facility to family or friends	Patients who reported PROBABLY YES they would recommend the facility to family or friends	Quarterly

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
Recommend facility - No	Patients who reported NO, they would not recommend the facility to family or friends	Patients who reported NO, they would not recommend the facility to family or friends	Quarterly
Ambulatory surgical center (ASC) quality measures			
ASC-9	Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients	Annually, October
ASC-11	Cataracts: Improvement in patient's visual function within 90 days following cataract surgery	Cataracts: Improvement in patient's visual function within 90 days following cataract surgery	Annually, October
ASC-12	Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy	Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy	Annually, January
ASC-13	Normothermia	Normothermia	Annually, October
ASC-14	Unplanned anterior vitrectomy	Unplanned anterior vitrectomy	Annually, October
ASC-17	Hospital visits after orthopedic ambulatory surgical center procedures	Hospital visits after orthopedic ambulatory surgical center procedures	Annually, January
ASC-18	Hospital visits after urology ambulatory surgical center procedures	Hospital visits after urology ambulatory surgical center procedures	Annually, January
*Omitting all PPS-Exempt Cancer Hospital Measures			
Payment & value of care- Payment measures			
PAYM-30-AMI	Acute myocardial infarction (AMI) payment	Payment for heart attack patients	Annually, July
PAYM-30-HF	Heart failure (HF) payment	Payment for heart failure patients	Annually, July
PAYM-30-PN	Pneumonia (PN) payment	Payment for pneumonia patients	Annually, July

Measure identifier	Technical measure title	Measure as posted on Medicare.gov	Update frequency
PAYM-90-HIP-KNEE	Elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)replacement payment	Payment for hip/knee replacement patients	Annually, July
Comprehensive Care for Joint Replacement (CJR)			
HLMR	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey	HCAHPS Linear mean roll-up score	Annually, July
CJR-COMP-HIP-KNEE	Rate of complications for hip and knee replacement patients	Total hip/knee arthroplasty 30-day complication rate	Annually, July
CJR-PRO	Patient-reported outcomes (PRO)	Patient-reported outcomes (PRO)	Annually, July
Promoting Interoperability			
Promoting Interoperability	Meets criteria for promoting interoperability of EHRs	Meets criteria for promoting interoperability of EHRs	Annually, July
Overall Hospital Quality Star Rating			
Overall Star Rating	Overall Hospital Star Rating	Overall Star Rating	Annually