

**System Requirements Specification**

**Hospital Compare Downloadable Database Data Dictionary**

**Centers for Medicare & Medicaid Services**

[**https://data.medicare.gov/data/hospital-compare**](https://data.medicare.gov/data/hospital-compare)

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# Introduction

Hospital Compare is a consumer-oriented website that provides information on the quality of care hospitals are providing to their patients. This information can help consumers make informed decisions about health care. Hospital Compare allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery, and other conditions. The Centers for Medicare & Medicaid Services (CMS) created the Hospital Compare website to better inform health care consumers about a hospital’s quality of care. Hospital Compare provides data on over 4,000 Medicare-certified hospitals, including acute care hospitals, critical access hospitals (CAHs), children’s hospitals, VA Medical Centers, and hospital outpatient departments. Hospital Compare is part of an Administration-wide effort to increase the availability and accessibility of information on quality, utilization and costs for effective, informed decision-making. More information about Hospital Compare can be found by visiting the [CMS.gov](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html) website and performing a search for Hospital Compare. To access the Hospital Compare website, please visit [www.medicare.gov/hospitalcompare.](http://www.medicare.gov/hospitalcompare)

Hospital Compare is typically updated, or refreshed, each quarter in April, July, October, and December, however, the refresh schedule is subject to change and not all measures will update during each quarterly release. See the [Measure Descriptions and](#_bookmark3) [Reporting Cycles](#_bookmark3) section of this Data Dictionary for additional information. Hospital Compare data are reported in median time only, however, the median time is often referred to as the “average time” to allow for ease of understanding across a wider audience.

Links to download the data from the Downloadable Databases in Microsoft Access and zipped comma-separated value (CSV) flat file formats can be found toward the top of the [Official Hospital Compare Data](https://data.medicare.gov/data/hospital-compare) website. A catalogue of datasets is also available toward the bottom of the website where files can be viewed and exported within a web browser. Datasets can be exported in a variety of formats and a [Data.Medicare.gov: Getting Started Training](https://data.medicare.gov/help-contents/get-started) video tutorial is available to assist with exporting the data. Embedded datasets for certain measures can also be found within the Hospital Compare website. Archived data from 2005 - 2014 is available in the [Official Hospital Compare Data Archive.](https://data.medicare.gov/data/archives/hospital-compare)

All Hospital Compare websites are publically accessible. As works of the U.S. government, Hospital Compare data are in the public domain and permission is not required to reuse them. An attribution to the agency as the source is appreciated. Your materials, however, should not give the false impression of government endorsement of your commercial products or services.

# Document Purpose

The purpose of this document is to provide a directory of material for use in the navigation of information contained within the Hospital Compare downloadable databases. [Appendix A](#_bookmark26) of this data dictionary provides a full list of Hospital Compare measures contained in the downloadable databases and the [Measure Dates and Collection Periods](#_bookmark4) section of this data dictionary provides additional information about measure dates and quarters. This information can also be found on the Hospital Compare website under [Measures Displayed on Hospital Compare](http://medicare.gov/hospitalcompare/Data/Measures-Displayed.html) and is organized as follows:

* General information (structural and health information technology [IT])
* Survey of patients’ experiences (HCAHPS Survey)
* Timely and effective care (process of care)
* Complications (surgical complications, Agency for Healthcare Research and Quality [AHRQ] Patient Safety Indicators [PSIs], and healthcare-associated infections [HAIs])
* Readmissions and deaths (30-day readmission and mortality )
* Use of medical imaging (outpatient imaging efficiency)
* Payment and value of care (Medicare spending per beneficiary [MSPB], payment for heart attack, heart failure, and pneumonia patients, and value of care for heart attack, heart failure, and pneumonia patients)

The [Spotlight](http://medicare.gov/hospitalcompare/search.html) section of Hospital Compare provides links to data for the following quality reporting programs:

* PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
* Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
* American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP®)

The [Additional Information](http://medicare.gov/hospitalcompare/search.html) section of Hospital Compare provides links to data for the following payment programs:

* Hospital Value-Based Purchasing Program( HVBP)
  + HVBP Program Data and Scoring (Efficiency)
  + HVBP Program Incentive Payment Adjustments
* Hospital-Acquired Conditions Reduction Program (HACRP)
* Hospital Readmissions Reduction Program (HRRP)

# Acronym Index

The following acronyms are used within this data dictionary and in the corresponding downloadable databases (Access and CSV flat files – Revised):

|  |  |
| --- | --- |
| **Acronym** | **Meaning** |
| AMI | Acute Myocardial Infarction |
| AVG | Average |
| CABG | Coronary Artery Bypass Graft |
| CAC | Children’s Asthma Care |
| COMP | Complications |
| COPD | Chronic Obstructive Pulmonary Disease |
| ED | Emergency Department |
| FTNT | Footnote |
| HACRP | Hospital-Acquired Conditions Reduction Program |
| HAI | Healthcare-Associated Infections |
| HBIPS | Hospital-Based Inpatient Psychiatric Services |
| HCAHPS | Hospital Consumer Assessment of Healthcare Providers and Systems |
| HF | Heart Failure |
| HIP-KNEE | Total Hip/Knee Arthoplasty |
| HIT | Health Information Technology |
| HRRP | Hospital Readmissions Reduction Program |
| HVBP | Hospital Value-Based Purchasing |
| IMG | Imaging |
| IMM | Immunization |
| IPFQR | Inpatient Psychiatric Facility Quality Reporting |
| IQR | Inpatient Quality Reporting |
| MORT | Mortality |
| MSPB | Medicare Spending per Beneficiary (also referred to as SPP for Spending Per Patient) |
| MSR | Measure |
| MPV | Medicare Payment and Volume |
| NQF | National Quality Forum |
| OIE | Outpatient Imaging Efficiency |
| OP | Outpatient |
| OQR | Outpatient Quality Reporting |
| PCHQR | PPS-Exempt Cancer Hospital Quality Reporting |
| PN | Pneumonia |
| PSI | Patient Safety Indicators |
| READM | Readmissions |
| SCIP | Surgical Care Improvement Project |
| SM | Structural Measures |
| SPP | Spending per Patient (also referred to as MSPB for Medicare Spending per Beneficiary) |
| STK | Stroke |
| TPS | Total Performance Score |
| VTE | Venous Thromboembolism |

# Measure Descriptions and Reporting Cycles

Data for each measure set is collected in differing timeframes from various quality measurement contractors. Additional information about the data collection periods can be found in the [Current Data Collection Periods](http://medicare.gov/hospitalcompare/Data/Data-Updated.html) section of the Hospital Compare website and the update frequency/refresh schedule is provided in [Measures Displayed on Hospital Compare.](http://medicare.gov/hospitalcompare/Data/Measures-Displayed.html) Below is a brief description of the collection process and reporting cycles for each measure set included on Hospital Compare:

|  |  |
| --- | --- |
| **Name** | **General Information: Structural Measures** |
| Description/  Background | As part of the general information available through CMS, structural measures reflect the environment in which  providers care for patients. Examples of structural measures can be inpatient (participation in general surgery registry) or outpatient (tracking clinical results between visits). Hospitals submit structural measure data using an online data entry tool made available to hospitals and their vendors. Structural measures include information provided by the American College of Surgeons (ACS), the Society of Thoracic Surgeons (STS), the Joint Commission (TJC), and CMS. |
| Reporting Cycle | Collection period: 12 months. Refreshed annually, except the ACS Registry which is refreshed semi-anually. |

|  |  |
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| **Name** | **General Information: Health Information Technology (HIT) Measures** |
| Description/  Background | As part of the general information available through CMS, hospitals submit HIT measure data which is part of  the Electronic Health Record (EHR) Incentive Program. The HIT measures include hospitals’ ability to receive lab results electronically and track patients’ health information, including lab results, tests , and referrals electronically between visits. |
| Reporting Cycle | Collection period: 12 months. Refreshed annually. |

|  |  |
| --- | --- |
| **Name** | **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Patient Survey** |
| Description/  Background | The HCAHPS Patient Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS, is a survey  instrument and data collection methodology for measuring patients’ perceptions of their hospital experience. The survey is administered to a random sample of adult inpatients after discharge. The HCAHPS survey contains patient perspectives on care and patient rating items that encompass key topics: communication with hospital staff, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of hospital environment, quietness of hospital environment, and transition of care. The survey also includes screening questions and demographic items, which are used for adjusting the mix of patients  across hospitals and for analytic purposes. See [Appendix B](#_bookmark27) for a full list of current HCAHPS Survey items  included in the Hospital Compare downloadable databases. More information about the HCAHPS Survey, including a complete list of survey questions, can be found on the official [HCAHPS website.](http://www.hcahpsonline.org/) |
| Reporting Cycle | Collection period: 12 months. Refreshed quarterly. |

|  |  |
| --- | --- |
| **Name** | **Timely and Effective Care: Process of Care Measures** |
| Description/  Background | The measures of timely and effective care report the percentage of hospital patients who receive the treatments  that are known to get the best results for certain common, serious medical conditions or surgical procedures; how quickly hospitals treat patients who come to the hospital with certain medical emergencies; and how well hospitals provide preventive services. These measures only apply to patients for whom the recommended treatment would be appropriate. The measures of timely and effective care apply to adults and children treated at hospitals paid under the Inpatient Prospective Payment System (IPPS) or the Outpatient Prospective Payment System (OPPS), as well as those that voluntarily report data on measures for whom the recommended treatments would be appropriate including: Medicare patients, Medicare managed care patients, and non-Medicare patients. Timely and effective care measures are also referred to as process of care measures and include acute myocardial infarction, heart failure, pneumonia, Surgical Care Improvement Project (SCIP), emergency department, preventive care, children’s asthma care, stroke care, blood clot prevention and treatment, and pregnancy and delivery care measures. |
| Reporting Cycle | Collection period: Approximately 12 months. Refreshed quarterly, except OP-22, IMM-2, and IMM-3 which are  refreshed anually. |

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| **Name** | **Complications: Surgical Complication Measure** |
| Description/  Background | The hip/knee complication measure is an estimate of complications within an applicable time period for  Medicare beneficiaries who were electively admitted for primary total hip and/or knee replacement. Complications included in this measure are: infection, heart attack, pneumonia, wounds that split open or bleed after surgery, serious blood clots, replacement hip/knee joints that do not work, and death. Hospitals’ rates of hip/knee complications are compared to the national rate to determine if hospitals’ performance on this measure is better than the national rate (lower), no different than the national rate, or worse than the national rate (higher). Rates are provided in the downloadable databases as decimals and typically indicate information that is  presented on the Hospital Compare website as percentages. Lower rates for surgical complications are better. |
| Reporting Cycle | Collection period: 36 months. Refreshed annually. |

|  |  |
| --- | --- |
| **Name** | **Complications: AHRQ Patient Safety Indicators (PSIs)** |
| Description/  Background | The Agency for Healthcare Research and Quality (AHRQ) PSIs reflect quality of care for hospitalized adults and  focus on potentially avoidable complications and iatrogenic events. AHRQ PSIs only apply to Medicare beneficiaries who were discharged from a hospital paid through the IPPS. These indicators are risk adjusted to account for differences in hospital patients’ characteristics. CMS calculates rates for AHRQ PSIs using Medicare claims data and a statitistical model that determines the interval estimates for the PSIs. CMS publicly reports data on two PSIs—PSI-4 (death rate among surgical patients with serious treatable complications) and the composite measure PSI-90. PSI-90 is composed of 11 NQF-endorsed measures, including PSI-3 (pressure ulcer rate), PSI-6 (iatrogenic pneumothorax rate), PSI-7 (central venous catheter-related blood stream infection rate), PSI-8 (postoperative hip fracture rate), PSI-9 (postoperative hemorrhage or hematoma rate), PSI-10 (postoperative physiologic and metabolic derangement rate), PSI-11 (postoperative respiratory failure rate), PSI- 12 (postoperative pulmonary embolism or deep vein thrombosis rate), PSI-13 (postoperative sepsis rate), PSI-14 (postoperative wound dehiscence rate), and PSI-15 (accidental puncture or laceration rate). PSI-90’s composite rate is the weighted average of its component indicators. Hospitals’ PSI rates are compared to the national rate to determine if hospitals’ performance on PSIs is better than the national rate (lower), no different than the national rate, or worse than the national rate (higher). |
| Reporting Cycle | Collection period: 24 months. Refreshed annually. |

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| **Name** | **Complications: Healthcare-Associated Infections (HAI) Measures** |
| Description/  Background | To receive payment from CMS, hospitals are required to report data about some infections to the Centers for  Disease Control and Prevention’s (CDC’s) National Healthcare Safety Network (NHSN). HAI measures provide information on infections that occur while the patient is in the hospital and include: central line-associated bloodstream infections (CLABSI), **c**atheter-associated urinary tract infections (CAUTI), surgical site infection (SSI) from colon surgery or abdominal hysterectomy, methicillin-resistant *Staphylococcus Aureus* (MRSA) blood laboratory-identified events (bloodstream infections), and *Clostridium difficile* (*C.diff*.) laboratory- identified events (intestinal infections). The HAI measures show how often patients in a particular hospital contract certain infections during the couse of their medical treatment, when compared to like hospitals. The CDC calculates a Standardized Infection Ratio (SIR) which may take into account the type of patient care location, number of patients with an existing infection, laboratory methods, hospital affiliation with a medical school, bed size of the hospital, patient age, and classification of patient health. SIRs are calculated for the hospital, the state, and the nation. Hospitals’ SIRs are compared to the national benchmark to determine if hospitals’ performance on these measures is better than the national benchmark (lower), no different than the national benchmark, or worse than the national benchmark (higher). The HAI measures apply to all patients treated in acute care hospitals, including adult, pediatric, neonatal, Medicare, and non-Medicare patients. |
| Reporting Cycle | Collection period: 12 months. Refreshed quarterly. |

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| **Name** | **Readmissions and Deaths: 30-Day Readmission and Death Measures** |
| Description/  Background | The 30-day unplanned readmission measures are estimates of unplanned readmission to any acute care hospital  within 30 days of discharge from a hospitalization for any cause related to medical conditions, including heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), and stroke; and surgical procedures, including hip/knee replacement and cornary artery bypass graft (CABG). The 30-day unplanned hospital-wide readmission measure focuses on whether patients who were discharged from a hospitalization were hospitalized again within 30 days. The hospital-wide readmission measure includes all medical, surgical and gynecological, neurological, cardiovascular, and cardiorespiratory patients. The 30-day death measures are  estimates of deaths within 30-days of a hospital admission from any cause related to medical conditions,  including heart attack, heart failure, pneumonia, COPD, and stroke; and surgical procedures, including CABG. Hospitals’ rates are compared to the national rate to determine if hospitals’ performance on these measures is better than the national rate (lower), no different than the national rate, or worse than the national rate (higher). For some hospitals, the number of cases is too small to reliably compare their results to the national average rate. Rates are provided in the downloadable databases as decimals and typically indicate information that is presented on the Hospital Compare website as percentages. Lower percentages for readmission and mortality are better. |
| Reporting Cycle | Collection period: Approximately 36 months. Refreshed annually. |

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| **Name** | **Use of Medical Imaging: Outpatient Imaging Efficiency (OIE)** |
| Description/  Background | CMS has adopted six measures which capture the quality of outpatient care in the area of imaging. CMS notes  that the purpose of these measures is to promote high-quality efficient care. Each of the measures currently utilize both the Hospital OPPS claims and Physician Part B claims in the calculations. These calculations are based on the administrative claims of the Medicare fee-for-service population. Hospitals do not submit additional data for these measures. The measures on the use of medical imaging show how often a hospital provides specific imaging tests for Medicare beneficiaries under circumstances where they may not be medically appropriate. Lower percentages suggest more efficient use of medical imaging. The purpose of reporting these measures is to reduce unnecessary exposure to contrast materials and/or radiation, to ensure adherence to evidence-based medicine and practice guidelines, and to prevent wasteful use of Medicare resources. The measures only apply to Medicare patients treated in hospital outpatient departments. |
| Reporting Cycle | Collection period: 12 months. Refreshed annually. |

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| --- | --- |
| **Name** | **Payment and Value of Care Measures** |
| Description/  Background | The Medicare Spending Per Beneficiary (MSPB-1) Measure assesses Medicare Part A and Part B payments for  services provided to a Medicare beneficiary during a spending-per-beneficiary episode that spans from three days prior to an inpatient hospital admission through 30 days after discharge. The payments included in this measure are price-standardized and risk-adjusted.  The payment measures for heart attack, heart failure, and pneumonia include the payments made for Medicare beneficiaries who are 65 years and older. The measures add up payments made for care and supplies starting the day the patient enters the hospital and for the next 30 days. The measures are meant to reflect differences in the services and supplies provided to patients.  Hospital results are provided in the downloadable databases for the heart attack, heart failure, and pneumonia payment measures. You can see whether the payments made for patients treated at a particular hospital is less than, no different than, or greater than the national average payment. For some hospitals, the number of cases is too small to reliably compare their results to the national average payment. |
| Reporting Cycle | Collection Period: 12 months for MSPB-1 and 36 months for the payment for heart attack (PAYM-30-AMI),  heart failure (PAYM-30-HF), and pneumonia (PAYM-30-PN) measures. All measures refreshed annually. |

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| **Name** | **Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program** |
| Description/  Background | The IPFQR Program is a pay-for-reporting program intended to provide consumers with quality of care  information to make more informed decisions about health care options. To meet the IPFQR Program requirements, Inpatient Psychiatric Facilities (IPFs) are required to submit all quality measures to CMS. The IPFQR Program measures allow consumers to find and compare the quality of care given at psychiatric facilities where patients are admitted as inpatients. Inpatient psychiatric facilities are required to report data on these measures. Facilities that are eligible for this program may have their Medicare payments reduced if they do not  report. |
| Reporting Cycle | Collection period: 9 months. Refreshed annually. |

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| **Name** | **Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program** |
| Description/  Background | The PPS-Exempt Cancer Hospital Quality Reporting Program measures allow consumers to find and compare the  quality of care provided at the eleven PPS-exempt cancer hospitals participating in the program. Under the PCHQR Program, cancer hospitals submit data to CMS regarding the Adjuvant Chemotherapy Colon Cancer (PCH-1) and Combination Chemotherapy Breast Cancer (PCH-2) measures. |
| Reporting Cycle | Collection period: 12 months. Refreshed quarterly. |

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| --- | --- |
| **Name** | **Linking Quality to Payment: Hospital-Acquired Conditions Reduction Program (HACRP)** |
| Description/  Background | The Hospital-Acquired Condition Reduction Program (HACRP) was established in 2010 to provide an incentive  for hospitals to reduce HACs. CMS adopted the AHRQ PSI-90 composite measure, the CDC NHSN central line- associated blood stream infection (CLABSI) measure, and the CDC NHSN catheter-associated urinary tract infection (CAUTI) measure as part of HACRP. The overall score for serious complication is based on how adult patients who had certain serious, but potentially preventable, complications related to medical or surgical inpatient hospital care scored on the individual measures. |
| Reporting Cycle | Collection Period: 24 months. Refreshed Annually. |

|  |  |
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| **Name** | **Linking Quality to Payment: Hospital Readmissions Reduction Program (HRRP)** |
| Description/  Background | In October 2012, CMS began reducing Medicare payments for IPPS hospitals with excess readmissions. Excess  readmissions are measured using a ratio, by dividing a hospital’s number of “predicted” 30-day readmissions for AMI, HF, and PN by the number that would be “expected,” based on an average hospital with similar patients. A ratio greater than one indicates excess readmissions. The calculations include only acute care hospitals paid under IPPS and Maryland hospitals. |
| Reporting Cycle | Collection period: 36 months. Refreshed annually. |

|  |  |
| --- | --- |
| **Name** | **Linking Quality to Payment: Hospital Value-Based Purchasing (HVBP) Program** |
| Description/  Background | The HVBP program is part of CMS’ long-standing effort to link Medicare’s payment system to quality. The  program implements value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country. Hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide. The Fiscal Year 2015 HVBP adjusts hospitals’ payments based on their performance on four domains that reflect hospital quality: the Clinical Process of Care Domain, the Patient Experience of Care domain, the Outcome  domain, and the Efficiency domain. The Total Performance Score (TPS) is comprised of the Clinical Process of  Care domain score (weighted as 20% of the TPS), the Patient Experience of Care domain score (weighted as 30% of the TPS), the Outcome domain score (weighted as 30% of the TPS), and the Efficiency domain score (weighted as 20% of the TPS). |
| Reporting Cycle | Collection period: Approximately 12 months. Refreshed annually. |

|  |  |
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| **Name** | **Linking Quality to Payment: HVBP Payment Adjustments** |
| Description/  Background | The Inpatient HVBP Program adjusts Medicare’s payments to reward hospitals based on the quality of care that  they provide to patients. The program operates by 1) reducing participating hospitals’ Medicare payments by a specified percentage, then 2) using the estimated total amount of those payment reductions to fund value-based incentive payments to hospitals based on their performance under the program. |
| Reporting Cycle | Collection period: Approximately 12 months. Refreshed annually. |

# Measure Dates and Collection Periods



The downloadable databases are refreshed within 24 hours of the Hospital Compare data update and this update will be indicated in the [Additional Information](http://www.medicare.gov/hospitalcompare/search.html) section of the Hospital Compare home page. The Measure Dates file located within the downloadable databases contains a comprehensive listing of all measures displayed on Hospital Compare, their start quarters and dates, and their end quarters and dates. A sample of the collection periods from the July 2015 Measure Dates file is shown below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Measure\_ID | Measure\_Start\_Quarter | Measure\_Start\_Date | Measure\_End\_Quarter | Measure\_End\_Date |
| ACS\_REGISTRY | 3Q2013 | 01-Jul-13 | 2Q2014 | 30-Jun-14 |
| AMI\_10 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| AMI\_2 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| AMI\_7a | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| AMI\_8a | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| CAC\_1 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| CAC\_2 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| CAC\_3 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| COMP\_HIP\_KNEE | 2Q2011 | 01-Apr-11 | 1Q2014 | 31-Mar-14 |
| ED\_1b | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| ED\_2b | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| EDV | 1Q2013 | 01-Jan-13 | 4Q2013 | 31-Dec-13 |
| HAI\_1 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| HAI\_2 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| HAI\_3 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| HAI\_4 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| HAI\_5 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |
| HAI\_6 | 4Q2013 | 01-Oct-13 | 3Q2014 | 30-Sep-14 |

# File Summary

The table below shows the titles of all MS Access tables and CSV Revised file names included in the downloadable database. A Hospital.pdf (data dictionary) file and corresponding readme.txt file are included in both downloadable databases formats.

|  |  |
| --- | --- |
| MS Access Downloadable Database:  **Hospital.zip** | CSV Revised Downloadable Database:  **Hospital\_revised\_flatfiles.zip** |
| **MS Access tables** | **CSV Revised (.csv) file names** |
| Measure\_Dates | Measure Dates |
| HQI\_FTNT | Footnote Crosswalk |
| HQI\_HOSP | Hospital General Information |
| HQI\_HOSP\_STRUCTURAL | Structural Measures – Hospital |
| HQI\_HOSP\_HCAHPS | HCAHPS – Hospital |
| HQI\_NATIONAL\_HCAHPS | HCAHPS – National |
| HQI\_STATE\_HCAHPS | HCAHPS – State |
| HQI\_HOSP\_TimelyEffectiveCare | Timely and Effective Care – Hospital |
| HQI\_NATIONAL\_TimelyEffectiveCare | Timely and Effective Care – National |
| HQI\_STATE\_TimelyEffectiveCare | Timely and Effective Care – State |
| HQI\_HOSP\_Comp | Complications – Hospital |
| HQI\_NATIONAL\_Comp | Complications – National |
| HQI\_STATE\_Comp | Complications - State |
| HQI\_HOSP\_ReadmDeath | Readmissions and Deaths – Hospital |
| HQI\_NATIONAL\_ReadmDeath | Readmissions and Deaths – National |
| HQI\_STATE\_ReadmDeath | Readmissions and Deaths – State |
| HQI\_HOSP\_HAI | Healthcare Associated Infections – Hospital |
| HQI\_NATIONAL\_HAI | Healthcare Associated Infections – National |
| HQI\_STATE\_HAI | Healthcare Associated Infections – State |
| HQI\_HOSP\_ Payment | Payment - Hospital |
| HQI\_NATIONAL\_ Payment | Payment - National |
| HQI\_STATE\_ Payment | Payment - State |
| HQI\_HOSP\_IMG | Outpatient Imaging Efficiency – Hospital |
| HQI\_NATIONAL\_IMG\_AVG | Outpatient Imaging Efficiency – National |
| HQI\_STATE\_IMG\_AVG | Outpatient Imaging Efficiency – State |
| HQI\_HOSP\_MSPB | Medicare Hospital Spending per Patient – Hospital |

|  |  |
| --- | --- |
| MS Access Downloadable Database:  **Hospital.zip** | CSV Revised Downloadable Database:  **Hospital\_revised\_flatfiles.zip** |
| **MS Access tables** | **CSV Revised (.csv) file names** |
| HQI\_NATIONAL\_MSPB | Medicare Hospital Spending per Patient – National |
| HQI\_STATE\_MSPB | Medicare Hospital Spending per Patient – State |
| Medicare Hospital Spending by Claim | Medicare Hospital Spending by Claim |
| HQI\_OP\_Procedure\_Volume | Outpatient Procedures – Volume |
| HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_IPFQR\_  HOSPITAL | HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_IPFQR\_  HOSPITAL |
| HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_IPFQR\_  NATIONAL | HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_IPFQR\_  NATIONAL |
| HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_IPFQR\_  STATE | HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_IPFQR\_  STATE |
| PCH\_CANCERSPECIFICMEASURES\_HOSPITAL | HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_PCH\_  HOSPITAL |
| HOSPITAL\_QUARTERLY\_HAC\_DOMAIN\_HOSPITAL | HOSPITAL\_QUARTERLY\_HAC\_DOMAIN\_HOSPITAL |
| vwHQI\_READM\_REDUCTION | READMISSION REDUCTION |
| Hvbp\_ami\_05\_28\_2015 | hvbp\_ami\_05\_28\_2015 |
| Hvbp\_Efficiency\_05\_20\_2015 | hvbp\_Efficiency\_05\_20\_2015 |
| Hvbp\_hai\_05\_28\_2015 | hvbp\_hai\_05\_28\_2015 |
| Hvbp\_hcahps\_05\_28\_2015 | hvbp\_hcahps\_05\_28\_2015 |
| Hvbp\_hf\_05\_28\_2015 | hvbp\_hf\_05\_28\_2015 |
| Hvbp\_outcome\_05\_28\_2015 | hvbp\_outcome\_05\_18\_2015 |
| Hvbp\_pn\_05\_28\_2015 | hvbp\_pn\_05\_28\_2015 |
| Hvbp\_quarters | hvbp\_quarters |
| Hvbp\_scip\_05\_28\_2015 | hvbp\_scip\_05\_28\_2015 |
| Hvbp\_tps\_05\_28\_2015 | hvbp\_tps\_05\_28\_2015 |
| FY2013\_Distribution\_of\_Net\_Change\_in\_Base\_Op\_DRG\_Paym  ent\_Amt | FY2013\_Distribution\_of\_Net\_Change\_in\_Base\_Op\_DRG\_Paym  ent\_Amt |
| FY2013\_Value\_Based\_Incentive\_Payment\_Amount | FY2013\_Value\_Based\_Incentive\_Payment\_Amount |
| FY2013\_Net\_Change\_in\_Base\_Op\_DRG\_Payment\_Amt | FY2013\_Net\_Change\_in\_Base\_Op\_DRG\_Payment\_Amt |
| FY2013\_Percent\_Change\_in\_Base\_Operating\_DRG\_Payment\_A  mount | FY2013\_Percent\_Change\_in\_Medicare\_Payments |

# Appendix A – Hospital Compare Measures

The following crosswalk contains a listing of all measures located at the hospital-level files of the Downloadable Databases (Access and CSV Flat Files – Revised). The tables below display the locations of each measure within the corressponding Access tables and CSV files, including an HVBP file directory:

|  |  |
| --- | --- |
| **Access** | **HQI\_HOSP\_STRUCTURAL** |
| **CSV** | **Structural Measures – Hospital.csv** |
| **Measure ID** | **Measure Name** |
| SM\_PART\_CARD | Cardiac surgery registry (alternate Measure ID: SM-1) |
| SM\_PART\_STROKE | Stroke care registry (alternate Measure ID: SM-2) |
| SM\_PART\_NURSE | Nursing care registry (alternate Measure ID: SM-3) |
| SM\_PART\_GEN\_SU  RG | General Surgery Registry (alternate Measure ID: SM-4) |
| ACS\_REGISTRY | Multispecialty Surgical Registry |
| OP-12 | Able to receive lab results electronically (HIT measure) |
| OP-17 | Able to track patients’ lab results, tests, and referrals electronically between visits (HIT measure) |
| OP-25 | Safe Surgery Checklist Use |

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| **Access** | **HQI\_HOSP\_HCAHPS** |
| **CSV** | **HCAHPS –Hospital.csv** |
| **Measure ID** | **Measure Name** |
| H-CLEAN-HSP-A-P | Patients who reported that their room and bathroom were "Always" clean |
| H-CLEAN-HSP-SN-P | Patients who reported that their room and bathroom were "Sometimes" or "Never" clean |
| H-CLEAN-HSP-U-P | Patients who reported that their room and bathroom were "Usually" clean |
| H-CLEAN-HSP-  STAR-RATING | Cleanliness - star rating |
| H-COMP-1-A-P | Patients who reported that their nurses "Always" communicated well |
| H-COMP-1-SN-P | Patients who reported that their nurses "Sometimes" or "Never" communicated well |
| H-COMP-1-U-P | Patients who reported that their nurses "Usually" communicated well |
| H-COMP-1-STAR-  RATING | Nurse communication - star rating |
| H-COMP-2-A-P | Patients who reported that their doctors "Always" communicated well |
| H-COMP-2-SN-P | Patients who reported that their doctors "Sometimes" or "Never" communicated well |
| H-COMP-2-U-P | Patients who reported that their doctors "Usually" communicated well |
| H-COMP-2-STAR-  RATING | Doctor communication - star rating |
| H-COMP-3-A-P | Patients who reported that they "Always" received help as soon as they wanted |
| H-COMP-3-SN-P | Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted |
| H-COMP-3-U-P | Patients who reported that they "Usually" received help as soon as they wanted |
| H-COMP-3-STAR-  RATING | Staff responsiveness - star rating |
| H-COMP-4-A-P | Patients who reported that their pain was "Always" well controlled |
| H-COMP-4-SN-P | Patients who reported that their pain was "Sometimes" or "Never" well controlled |
| H-COMP-4-U-P | Patients who reported that their pain was "Usually" well controlled |
| H-COMP-4-STAR-  RATING | Pain management - star rating |
| H-COMP-5-A-P | Patients who reported that staff "Always" explained about medicines before giving it to them |
| H-COMP-5-SN-P | Patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them |
| H-COMP-5-U-P | Patients who reported that staff "Usually" explained about medicines before giving it to them |
| H-COMP-5-STAR-  RATING | Communication about medicine- star rating |
| H-COMP-6-N-P | Patients who reported that NO, they were not given information about what to do during their recovery at |

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|  | home |
| H-COMP-6-Y-P | Patients who reported that YES, they were given information about what to do during their recovery at  home |
| H-COMP-6-STAR-  RATING | Discharge information - star rating |
| H-COMP-7-A | Patients who “Agree” they understood their care when they left the hospital |
| H-COMP-7-D-SD | Patients who “Disagree” or “Strongly Disagree” that they understood their care when they left the hospital |
| H-COMP-7-SA | Patients who “Strongly Agree” that they understood their care when they left the hospital |
| H-COMP-7-STAR-  RATING | Care transition - star rating |
| H-HSP-RATING-0-6 | Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest) |
| H-HSP-RATING-7-8 | Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest) |
| H-HSP-RATING-9-10 | Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) |
| H-HSP-RATING-  STAR-RATING | Overall rating of hospital - star rating |
| H-QUIET-HSP-A-P | Patients who reported that the area around their room was "Always" quiet at night |
| H-QUIET-HSP-SN-P | Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night |
| H-QUIET-HSP-U-P | Patients who reported that the area around their room was "Usually" quiet at night |
| H-QUIET-HSP-  STAR-RATING | Quietness - star rating |
| H-RECMND-DN | Patients who reported NO, they would probably not or definitely not recommend the hospital |
| H-RECMND-DY | Patients who reported YES, they would definitely recommend the hospital |
| H-RECMND-PY | Patients who reported YES, they would probably recommend the hospital |
| H-RECMND-STAR-  RATING | Recommend hospital - star rating |
| H-STAR-RATING | Summary star rating |

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| **Access** | **HQI\_HOSP\_TimelyEffectiveCare** |
| **CSV** | **Timely and Effective Care – Hospital.csv** |
| **Measure ID** | **Measure Name** |
| AMI-2 | Heart attack patients given aspirin at discharge |
| AMI-7a | Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival \*This measure is displayed on  Hospital Compare as “Heart attack patients given drugs to break up blood clots within 30 minutes of arrival” |
| AMI-8a | Heart attack patients given PCI within 90 minutes of arrival |
| AMI-10 | Heart attack patients given a prescription for a statin at discharge |
| CAC-1 | Children who received reliever medication while hospitalized for asthma |
| CAC-2 | Children who received systemic corticosteroid medication (oral and IV medication that reduces  inflammation and controls symptoms) while hospitalized for asthma |
| CAC-3 | Children and their caregivers who received a home management plan of care document while hospitalized  for asthma |
| ED-1b | Average time patients spent in the emergency department, before they were admitted to the hospital as an  inpatient (alternate Measure ID: ED-1) |
| ED-2b | Average time patients spent in the emergency department, after the doctor decided to admit them as an  inpatient before leaving the emergency department for their inpatient room (alternate Measure ID: ED-2) |
| EDV | Emergency department volume |
| HF-1 | Heart failure patients given discharge instructions |
| HF-2 | Heart failure patients given an evaluation of Left Ventricular Systolic (LVS) function |
| HF-3 | Heart failure patients given ACE inhibitor or ARB for left ventricular systolic dysfunction (LVSD) |
| IMM-2 | Patients assessed and given influenza vaccination |
| IMM-3 | Healthcare workers given influenza vaccination (alternate Measure ID: IMM-3-FAC-ADHPCT) |
| OP-1 | Median time to fibrinolysis. \*This measure is only found in the downloadable database, it is not displayed  on Hospital Compare |
| OP-2 | Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes  of arrival |
| OP-3b | Average number of minutes before outpatients with chest pain or possible heart attack who needed |

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| **Access** | **HQI\_HOSP\_TimelyEffectiveCare** |
| **CSV** | **Timely and Effective Care – Hospital.csv** |
|  | specialized care were transferred to another hospital |
| OP-4 | Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival |
| OP-5 | Average number of minutes before outpatients with chest pain or possible heart attack got an ECG |
| OP-6 | Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery |
| OP-7 | Outpatients having surgery who got the right kind of antibiotic |
| OP-18b | Average time patients spent in the emergency department before being sent home (alternate Measure ID:  OP-18) |
| OP-20 | Average time patients spent in the emergency department before they were seen by a healthcare professional |
| OP-21 | Average time patients who came to the emergency department with broken bones had to wait before  receiving pain medication. |
| OP-22 | Percentage of patients who left the emergency department before being seen |
| OP-23 | Percentage of patients who came to the emergency department with stroke symptoms who received brain  scan results within 45 minutes of arrival |
| PC-01 | Percent of newborns whose deliveries were scheduled too early (1-3 weeks early), when a scheduled  delivery was not medically necessary |
| PN-6 | Pneumonia patients given the most appropriate initial antibiotic(s) |
| SCIP-CARD-2 | Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were  kept on the beta blockers during the period just before and after their surgery |
| SCIP-Inf-1 | Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help  prevent infection |
| SCIP-Inf-2 | Surgery patients who were given the right kind of antibiotic to help prevent infection |
| SCIP-Inf-3 | Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) |
| SCIP-Inf-4 | Heart surgery patients whose blood sugar (blood glucose) is kept under good control 18-24 hours after  surgery |
| SCIP-Inf-9 | Surgery patients whose urinary catheters were removed on the first or second day after surgery |
| SCIP-Inf-10 | Patients having surgery who were actively warmed in the operating room or whose body temperature was  near normal by the end of surgery |
| SCIP-VTE-2 | Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent  blood clots after certain types of surgery |
| STK-1 | Ischemic or hemorrhagic stroke patients who received treatment to keep blood clots from forming anywhere  in the body within 2 days of arriving at the hospital |
| STK-2 | Ischemic stroke patients who received a prescription for medicine known to prevent complications caused  by blood clots before discharge |
| STK-3 | Ischemic stroke patients with a type of irregular heartbeat who were given a prescription for a blood thinner  at discharge |
| STK-4 | Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started |
| STK-5 | Ischemic stroke patients who received medicine known to prevent complications caused by blood clots  within 2 days of arriving at the hospital |
| STK-6 | Ischemic stroke patients needing medicine to lower cholesterol, who were given a prescription for this  medicine before discharge |
| STK-8 | Ischemic or hemorrhagic stroke patients or caregivers who received written educational materials about  stroke care and prevention during the hospital stay |
| STK-10 | Ischemic or hemorrhagic stroke patients who were evaluated for rehabilitation services |
| VTE-1 | Patients who got treatment to prevent blood clots on the day of or day after hospital admission or surgery |
| VTE-2 | Patients who got treatment to prevent blood clots on the day of or day after being admitted to the intensive  care unit (ICU) |
| VTE-3 | Patients with blood clots who got the recommended treatment, which includes using two different blood  thinner medicines at the same time |
| VTE-4 | Patients with blood clots who were treated with an intravenous blood thinner, and then were checked to  determine if the blood thinner was putting the patient at an increased risk of bleeding |
| VTE-5 | Patients with blood clots who were discharged on a blood thinner medicine and received written instructions  about that medicine |

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| **Access** | **HQI\_HOSP\_TimelyEffectiveCare** |
| **CSV** | **Timely and Effective Care – Hospital.csv** |
| VTE-6 | Patients who developed a blood clot while in the hospital who did not get treatment that could have  prevented it |

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| **Access** | **HQI\_HOSP\_Comp** |
| **CSV** | **Complications – Hospital.csv** |
| **Measure ID** | **Measure Name** |
| COMP-HIP-KNEE | Rate of complications for hip/knee replacement patients |
| PSI-90 | Serious complications (this is a composite or summary measure; alternate Measure ID: PSI-90-SAFETY) |
| PSI-4 | Deaths among patients with serious treatable complications after surgery (alternate Measure ID: PSI-4-  SURG-COMP) |
| PSI-6 | Collapsed lung due to medical treatment (alternate Measure ID: PSI-6-IAT-PTX) |
| PSI-12 | Serious blood clots after surgery (alternate Measure ID: PSI-12-POSTOP-PULMEMB-DVT) |
| PSI-14 | A wound that splits open after surgery on the abdomen or pelvis (alternate Measure ID: PSI-14-POSTOP-  DEHIS) |
| PSI-15 | Accidental cuts and tears from medical treatment (alternate Measure ID: PSI-15-ACC-LAC) |

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| **Access** | **HQI\_HOSP\_HAI** |
| **CSV** | **Healthcare Associated Infections – Hospital.csv** |
| **Measure ID** | **Measure Name** |
| HAI-1 | Central line-associated Bloodstream Infection (CLABSI) |
| HAI-2 | Catheter-associated urinary tract infections (CAUTI) |
| HAI-3 | Surgical Site Infection from colon surgery (SSI: Colon) |
| HAI-4 | Surgical Site Infection from abdominal hysterectomy (SSI: Hysterectomy) |
| HAI-5 | Methicillin-resistant staphylococcus aureus (or MRSA) blood laboratory-identified events (bloodstream  infections) |
| HAI-6 | Clostridium difficile (C.diff.) laboratory identified events (intestinal infections) |

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| **Access** | **HQI\_HOSP\_ReadmDeath** |
| **CSV** | **Readmissions and Deaths – Hospital.csv** |
| **Measure ID** | **Measure Name** |
| MORT-30-COPD | Death rate for chronic obstructive pulmonary disease (COPD) patients |
| MORT-30-CABG | Death rate following Coronary Artery Bypass Graft (CABG) surgery |
| MORT-30-AMI | Death rate for heart attack patients |
| MORT-30-HF | Death rate for heart failure patients |
| MORT-30-PN | Death rate for pneumonia patients |
| MORT-30-STK | Death rate for stroke patients |
| READM-30-AMI | Rate of unplanned readmission for heart attack patients |
| READM-30-COPD | Rate of unplanned readmission for chronic obstructive pulmonary disease (COPD) patients |
| READM-30-CABG | Rate of unplanned readmission following Coronary Artery Bypass Graft (CABG) surgery |
| READM-30-HF | Rate of unplanned readmission for heart failure patients |
| READM-30-PN | Rate of unplanned readmission for pneumonia patients |
| READM-30-HIP-  KNEE | Rate of unplanned readmission after hip/knee surgery |
| READM-30-HOSP-  WIDE | Rate of readmission after discharge from hospital (hospital-wide) |
| READM-30-STK | Rate of unplanned readmission for stroke patients |

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| **Access** | **HQI\_HOSP\_IMG** |
| **CSV** | **Outpatient Imaging Efficiency – Hospital.csv** |
| **Measure ID** | **Measure Name** |
| OP-8 | Outpatients with low back pain who had an MRI without trying recommended treatments first, such as  physical therapy (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain) |
| OP-9 | Outpatients who had a follow-up mammogram, ultrasound, or MRI of the breast within 45 days after a  screening mammogram (A follow-up rate near zero may indicate missed cancer; a rate higher than 14% may mean there is unnecessary follow up) |
| OP-10 | Outpatient CT scans of the abdomen that were “combination” (double) scans (If a number is high, it may  mean that too many patients are being given a double scan when a single scan is all they need) |
| OP-11 | Outpatient CT scans of the chest that were “combination” (double) scans (If a number is high, it may mean  that too many patients are being given a double scan when a single scan is all they need) |
| OP-13 | Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery (If a number is high, it  may mean that too many cardiac scans were done prior to low-risk surgeries) |
| OP-14 | Outpatients with brain CT scans who got a sinus CT scan at the same time (If a number is high, it may mean  that too many patients are being given both a brain scan and sinus scan, when a single scan is all they need) |

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| **Access** | **HQI\_HOSP\_MSPB** |
| **CSV** | **Medicare Hospital Spending per Patient – Hospital.csv** |
| **Measure ID** | **Measure Name** |
| MSPB-1 | Spending per Hospital Patient with Medicare (Medicare Spending per Beneficiary) |

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| **Access** | **HQI\_OP\_Procedure\_Volume** |
| **CSV** | **Outpatient Procedures –Volume.csv** |
| **Measure ID** | **Measure Name** |
| OP-26 | Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures \*This measure is only found  in the downloadable database, it is not displayed on Hospital Compare |

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| **Access** | **HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_IPFQR\_HOSPITAL** |
| **CSV** | **HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_IPFQR\_HOSPITAL.csv** |
| **Measure ID** | **Measure Name** |
| HBIPS-2 | Hours of Physical Restraint Use \*This measure is only found in the downloadable database, it is not  displayed on Hospital Compare |
| HBIPS-3 | Hours of Seclusion Use \*This measure is only found in the downloadable database, it is not displayed  on Hospital Compare |
| HBIPS-4 | Patients Discharged on Multiple Antipsychotic Medications \*This measure is only found in the  downloadable database, it is not displayed on Hospital Compare |
| HBIPS-5 | Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification \*This  measure is only found in the downloadable database, it is not displayed on Hospital Compare |
| HBIPS-6 | Post Discharge Continuing Care Plan Created \*This measure is only found in the downloadable  database, it is not displayed on Hospital Compare |
| HBIPS-7 | Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge  \*This measure is only found in the downloadable database, it is not displayed on Hospital Compare |

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| **Access** | **HOSPITAL\_QUARTERLY\_HAC\_DOMAIN\_HOSPITAL** |
| **CSV** | **HOSPITAL\_QUARTERLY\_HAC\_DOMAIN\_HOSPITAL.csv** |
| **Measure** | |
| Domain 1 Score | |
| PSI-90 Score (see [Appendix C](#_bookmark28) – Footnote Crosswalk for \* definition) | |
| Domain 2 Score | |
| CLABSI Score (see [Appendix C](#_bookmark28) – Footnote Crosswalk for \*\* definition) | |
| CAUTI Score | |
| Total HAC Score (see [Appendix C](#_bookmark28) – Footnote Crosswalk for \*definition) | |

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| **Access** | **vwHQI\_READM\_REDUCTION** |
| **CSV** | **READMISSION REDUCTION.csv** |
| **Measure ID** | **Measure Name** |
| READM-30-AMI-HRRP | Excess readmission ratio for heart attack patients |
| READM-30-HF-HRRP | Excess readmission ratio for heart failure patients |
| READM-30-PN-HRRP | Excess readmission ratio for pneumonia patients |
| READM-30-COPD-HRRP | Excess readmission ratio for chronic obstructive pulmonary disease (COPD) patients |
| READM-30-HIP-KNEE-  HRRP | Excess readmission ratio for hip/knee replacement patients |

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| **Access** | **PCH\_CANCERSPECIFICMEASURES\_HOSPITAL** |
| **CSV** | **HOSPITAL\_QUARTERLY\_QUALITYMEASURE\_PCH\_HOSPITAL.csv** |
| **Measure ID** | **Measure Name** |
| PCH-1 | Adjuvant Chemotherapy Colon Cancer |
| PCH-2 | Combination Chemotherapy Breast Cancer |

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| **Access** | **HQI\_HOSP\_ Payment** |
| **CSV** | **Payment – Hospital.csv** |
| **Measure ID** | **Measure Name** |
| PAYM-30-AMI | Payment for heart attack patients |
| PAYM-30-HF | Payment for heart failure patients |
| PAYM-30-PN | Payment for pneumonia patients |

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| **Access / CSV** | **HVBP Measures Directory** |
| **File Name** | **Measure**  (Performance Rate, Achievement Points, Improvement Points, and Measure Score) |
| Hvbp\_ami\_05\_28\_2015 | AMI-7a; AMI-8a |
| Hvbp\_Efficiency\_05\_20\_2015 | MSPB-1 |
| Hvbp\_hai\_05\_28\_2015 | SCIP-Inf-1; SCIP-Inf-2; SCIP-Inf-3; SCIP-Inf-4; SCIP-Inf-9 |
| Hvbp\_hcahps\_05\_28\_2015 | H-COMP-1-A-P; H-COMP-2-A-P; H-COMP-3-A-P; H-COMP-4-A-P; H-COMP-5-A-P; H-CLEAN-  HSP-A-P; H-QUIET-A-P; H-COMP-6-Y-P |
| Hvbp\_hf\_05\_28\_2015 | HF-1 |
| Hvbp\_outcome\_05\_28\_2015/  Hvbp\_outcome\_05\_18\_2015 | MORT-30-AMI; MORT-30-HF; MORT-30-PN; PSI-90; HAI-1 |
| Hvbp\_pn\_05\_28\_2015 | PN-3b; PN-6 |
| Hvbp\_quarters | AMI-7a; AMI-8a; HF-1; PN-3b; PN-6; SCIP-Inf-1; SCIP-Inf-2; SCIP-Inf-3; SCIP-Inf-4; SCIP-Inf-9;  SCIP-VTE-2; SCIP-CARD-2; HCAHPS; MORT-30-AMI; MORT-30-HF; MORT-30-PN; PSI-90; MSPB-1; CLABSI |
| Hvbp\_scip\_05\_28\_2015 | SCIP-Card-2; SCIP-VTE-2 |
| Hvbp\_tps\_05\_28\_2015 | TPS Scores (Weighted and Unweighted) for Clinical Process of Care, Patient Experience of Care,  Outcome, and Efficiency Domains |

# Appendix B – HCAHPS Survey Questions Listing

The HCAHPS survey is 32 questions in length and contains 21 substantive items that encompass critical aspects of the hospital experience, 4 screening items to skip patients to appropriate questions, and 7 demographic items that are used for adjusting the mix of patients across hospitals for analytical purposes. An overview of HCAHPS topics (7 composite topics, 2 individual topics, and 2 global topics) can be found on the [Survey of Patients' Experiences](http://medicare.gov/hospitalcompare/Data/Overview.html) webpage in the About the Data section of Hospital Compare.

|  |  |
| --- | --- |
| **#** | **Question** |
| **Q1** | During this hospital stay, how often did nurses treat you with courtesy and respect? |
| **Q2** | During this hospital stay, how often did nurses listen carefully to you? |
| **Q3** | During this hospital stay, how often did nurses explain things in a way you could understand? |
| **Q4** | During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? |
| **Q5** | During this hospital stay, how often did doctors treat you with courtesy and respect? |
| **Q6** | During this hospital stay, how often did doctors listen carefully to you? |
| **Q7** | During this hospital stay, how often did doctors explain things in a way you could understand? |
| **Q8** | During this hospital stay, how often were your room and bathroom kept clean? |
| **Q9** | During this hospital stay, how often was the area around your room quiet at night? |
| **Q11** | How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted? |
| **Q13** | During this hospital stay, how often was your pain well controlled? |
| **Q14** | During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? |
| **Q16** | Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? |
| **Q17** | Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? |
| **Q19** | 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? |
| **Q20** | 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? |
| **Q21** | 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? |
| **Q22** | Would you recommend this hospital to your friends and family? |
| **Q23** | 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. |
| **Q24** | When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. |
| **Q25** | When I left the hospital, I clearly understood the purpose for taking each of my medications. |

HCAHPS Star Ratings provide a quick summary of each HCAHPS measure in a format that allows consumers to more easily compare hospitals. The HCAHPS Summary Star Rating is a roll-up of all the HCAHPS Star Ratings.

Additional information about [HCAHPS Star Ratings,](http://www.hcahpsonline.org/StarRatings.aspx) includiong technical notes and frequently asked questions, can be found on the HCAHPS website ([www.HCAHPSonline.org](http://www.hcahpsonline.org/)).

# Appendix C – Footnote Crosswalk

The footnote numbers below are associated with the Hospital Compare quality measures:

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| --- | --- | --- |
| **Hospital Compare Footnote Values** | | |
| **#** | **Text** | **Definition** |
| 1 | The number of cases/patients is too few to report. | This footnote is applied:   * When the number of cases/patients does not meet the required minimum amount for public reporting; * When the number of cases/patients is too small to reliably tell how well a hospital is performing; and/or * To protect personal health information. |
| 2 | Data submitted were based on a sample of cases/patients. | This footnote indicates that a hospital chose to submit data for a random sample of its cases/patients while following specific rules for how to select the patients. |
| 3 | Results are based on a shorter time period than required. | This footnote indicates that the hospital’s results were based on data from less than the maximum possible time period generally used to collect data for a measure. View the [Hospital Compare Data Collection](http://www.medicare.gov/hospitalcompare/Data/Data-Updated.html) [Periods](http://www.medicare.gov/hospitalcompare/Data/Data-Updated.html) for more information. |
| 4 | Data suppressed by CMS for one or more quarters. | The results for these measures were excluded for various reasons, such as data inaccuracies. |
| 5 | Results are not available for this reporting period. | This footnote is applied when the hospital does not have data to report or has chosen not to submit data. |
| 6 | Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance. | This footnote is applied when the number of completed surveys the hospital or its vendor provided to CMS is less than 100. |
| 7 | No cases met the criteria for this measure. | This footnote is applied when a hospital did not have any cases meet the inclusion criteria for a measure. |
| 8 | The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero. | None |
| 9 | No data are available from the state/territory for this reporting period. | This footnote is applied when:   * Too few hospitals in a state/territory had data available or * No data was reported for this state/territory. |
| 10 | Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance. | This footnote is applied when the number of completed surveys the hospital or its vendor provided to CMS is less than 50. |
| 11 | There were discrepancies in the data collection process. | This footnote is applied when there have been deviations from data collection protocols. CMS is working to correct this situation. |
| 12 | This measure does not apply to this hospital for this reporting period. | This footnote is applied when:   * There were zero device days or procedures, * The hospital does not have ICU locations, * The hospital is a new member of the registry and didn’t have an opportunity to submit any cases or * The hospital does not report this voluntary measure |

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| **Hospital Compare Footnote Values** | | |
| **#** | **Text** | **Definition** |
| 13 | Results cannot be calculated for this reporting period. | This footnote is applied when:   * The number of predicted infections is less than 1. * The number of observed MRSA or Clostridium difficile infections present on admission (community-onset prevalence) was above a pre-determined cut-point. |
| 14 | The results for this state are combined with nearby states to protect confidentiality. | This footnote is applied when a state has fewer than 10 hospitals in order to protect confidentiality. Results are combined as follows: (1) the District of Columbia and Delaware are combined; (2) Alaska and Washington are combined; (3) North Dakota and South Dakota are combined; and (4) New Hampshire and Vermont are combined. Hospitals located in Maryland and U.S. territories are excluded from the measure calculation. |
| 15 | The number of cases/patients is too few to report a star rating. | This footnote is applied when the number of completed surveys the hospital or its vendor provided to CMS is less than 100. In order to receive HCAHPS Star Ratings, hospitals must have at least 100 completed HCAHPS Surveys over a four quarter period. |
| \* | For Maryland hospitals, no data are available to calculate a PSI 90 measure result; therefore, no performance decile or points are assigned for Domain 1 and the Total HAC score is dependent on the Domain 2 score. | None |
| \*\* | This value was calculated using data reported by the hospital in compliance with the requirements outlined for this program and does not take into account information that became available at a later date. | None |