



MBQIP Quality Measures Annual Report

Iowa - 2022

Key Findings

- **Patient Safety/Inpatient Measures:** The Patient Safety/Inpatient reporting rate of 97.6% for Iowa in 2022 was higher than the national reporting rate of 97.1%. Compared with all CAHs nationally, CAHs in Iowa scored significantly better on 1 measure, significantly worse on 0 measures, and did not have significantly different performance on 1 measure.
- **Outpatient Measures:** The Outpatient reporting rate of 92.7% for Iowa in 2022 was higher than the national reporting rate of 89.0%. Compared with all CAHs nationally, CAHs in Iowa scored significantly better on 2 measures, significantly worse on 1 measure, and did not have significantly different performance on 1 measure.
- **Patient Engagement Measures:** The HCAHPS reporting rate of 98.8% for Iowa in 2022 was higher than the national reporting rate of 94.6%. Compared with all CAHs nationally, CAHs in Iowa scored significantly better on 6 measures, significantly worse on 0 measures, and did not have significantly different performance on 4 measures.
- **Care Transitions Measures:** The EDTC reporting rate of 90.2% for Iowa in 2022 was lower than the national reporting rate of 92.4%. Compared with all CAHs nationally, CAHs in Iowa scored significantly better on 3 measures, significantly worse on 2 measures, and did not have significantly different performance on 4 measures.

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Background

The Medicare Beneficiary Quality Improvement Program (MBQIP) focuses on quality improvement efforts in the 45 states that participate in the Medicare Rural Hospital Flexibility (Flex) Program. Through Flex, MBQIP supports more than 1,350 small hospitals certified as rural Critical Access Hospitals (CAHs) in voluntarily reporting quality measures that are aligned with those collected by the Centers for Medicare and Medicaid Services (CMS) and other Federal programs. The Flex Monitoring Team (FMT) has been producing state-level annual reports on quality measures for over a decade, and this annual report from the FMT focuses specifically on MBQIP measures using data collected under the four MBQIP domains: Patient Safety/Inpatient, Outpatient, Patient Engagement, and Care Transitions.

Data and Approach

The data used for this report are reported to CMS and extracted from QualityNet, or to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) annual survey. Emergency Department Transfer Communication (EDTC) data used for this report are from the Federal Office of Rural Health Policy (FORHP) as reported by CAHs to State Flex Programs. The data values in this report only include CAHs with a signed MBQIP Memorandum of Understanding (MOU). Quality measures included in this report are limited to MBQIP measures, including: eight Patient Safety/Inpatient measures (HCP/IMM-3; Antibiotic Stewardship; CLABSI; CAUTI; SSI:C; SSI:H; MRSA; CDI), four Outpatient measures (OP-2; OP-22; OP-3b; OP-18b), ten Patient Engagement measures (from the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS survey), and the Care Transitions (EDTC) measure. The six Healthcare-Associated Infections (HAI) measures (CLABSI; CAUTI; SSI:C; SSI:H; MRSA; CDI) are part of the MBQIP program, but not in the “core” measure set, and instead are a part of the “additional” measures set which is not required. For each of the four domains, there are two sections of analyses: reporting and performance. Data are aggregated to the state and national levels. In all domains, data are not displayed for measures where the aggregated state or national data include fewer than 25 patients/cases/surveys.

Reporting identifies the number of CAHs reporting in each domain, and CAHs were considered reporting for any domain if they reported data in any quarter for any one measure with a denominator of one or more for that domain (indicating they had at least one patient, case, or survey for the applicable measure). Beginning in Q4 2020, population and sampling data (indicating if CAHs did not have an applicable population for a given measure) were included for measures OP-2, OP-3b, and OP-18b which may affect the number of CAHs reporting for those measures and/or Outpatient reporting totals after that time. Beginning in Q3 2022, the FMT received and included data for CAHs who were reporting data, but had volumes too low to be displayed. These CAHs are now considered to be “reporting” where previously they were not due to a lack of data indicating their low volume. Analysis for the HAI measures also included data reported for these 6 measures where CAHs indicated they had a 0 denominator (0 patients in 2022 that would fall under any of these HAI categories). The reporting denominator of all CAHs in the U.S. for 2022 is 1,358 CAHs (the total number of CAHs designated on December 31, 2022), and the reporting numerator includes all CAHs with a signed MBQIP MOU reporting for the specific domain or measure. Please see the Appendix for additional information about the calculation for performance score values and statistical testing in each domain.

Missing or excluded data are indicated in trend figures by a missing data point, and a missing line indicates data are not available for any of the previous three years or the current year. Trend figures are not included for OP-22 (due to low annual variation) or HAI measures (due to concerns with SIR calculation for CAHs). For measures OP-2, OP-3b, and OP-18b, in instances where states do not have any hospitals reporting data values greater than 0 (shown by an * in the tables), the trend figures will also have a missing data point for that year.

Benchmarks are included for all measures in this report except the six HAI measures. Benchmarks for HCP/IMM-3, Antibiotic Stewardship, and the EDTC measure are set at 100% to align with the benchmarks used in FORHP’s MBQIP Performance Score (<https://www.ruralcenter.org/resource-library/mbqip-performance-score>). Benchmarks for OP-2, OP-22, OP-3b, and OP-18b are set at the national 90th percentiles of CAHs with MOUs during 2022. Benchmarks used for the HCAHPS measures come from the benchmarks selected for CMS’ Hospital Value-Based Purchasing Program in 2021. HCAHPS Question 19 (patient recommendation) does not have a benchmark as part of these standards, and HCAHPS questions 8 and 9 (quietness and cleanliness) receive a joint benchmark.

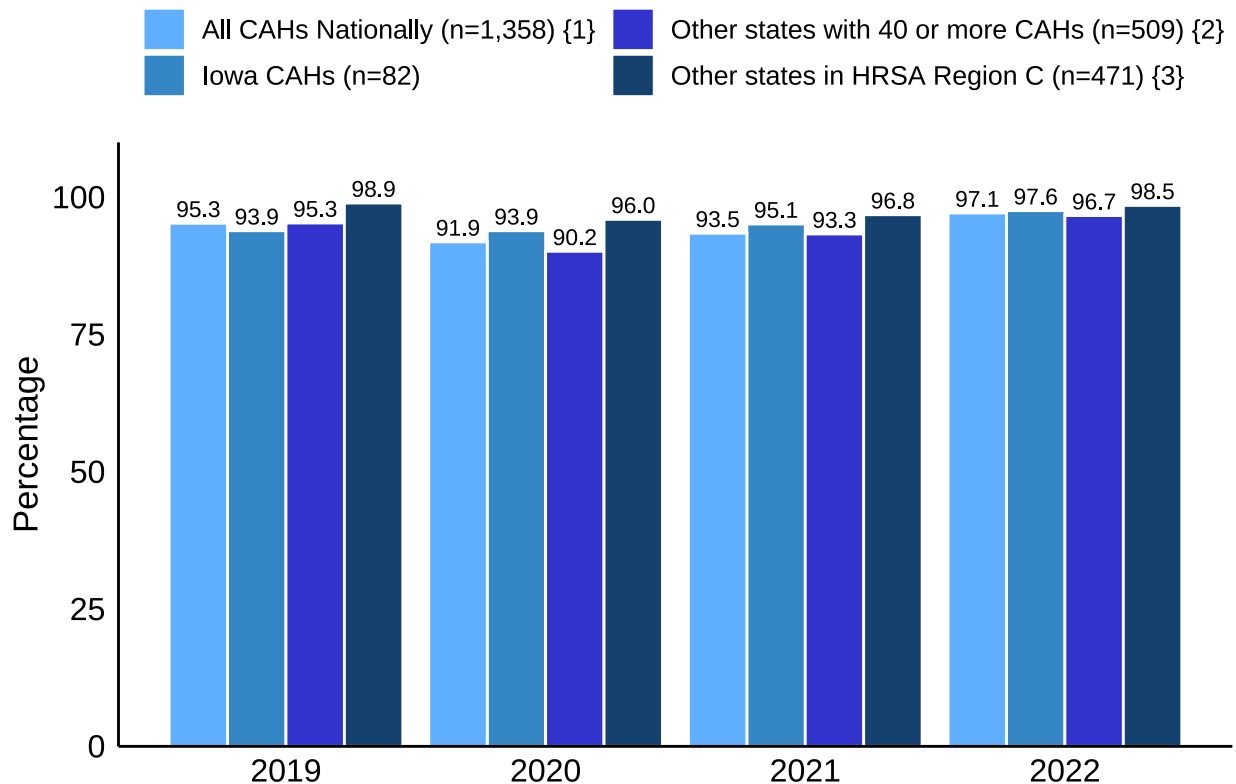
Patient Safety/Inpatient Domain

Patient Safety/Inpatient CAH Reporting

Results

The percent of CAHs reporting Patient Safety/Inpatient quality data varied considerably across states. In Iowa, 97.6% of 82 CAHs reported data on at least one Patient Safety/Inpatient quality measure in 2022, and Figure 1 displays data for 2019-2022 among CAHs in four groups: those in Iowa, all CAHs nationally, other states with a similar number of CAHs as Iowa, and other states located in the same Health Resources and Services Administration (HRSA) geographic region as Iowa. Table 1 compares the Patient Safety/Inpatient reporting rates of CAHs in Iowa to those located in the other 44 states participating in the Flex Program as well as the rate for all CAHs nationally. The Iowa CAH Patient Safety/Inpatient reporting rate of 97.6% ranks #28 nationally. The number of CAHs reporting individual quality measures may differ by measure for several reasons. Some measures only apply to a portion of patients; others exclude patients with contraindications, or only apply to conditions not treated or procedures not performed in some CAHs.

Figure 1: Percentage of CAHs Reporting at Least One Patient Safety/Inpatient Measure



Footnotes:

{1} Listed n values refer to most recent data (2022) only

{2} Group includes states with 40 or more CAHs: IL(52), KS(82), MN(77), MT(49), NE(63), OK(40), TX(88), WI(58)

{3} HRSA Region C includes: IL(52), IN(34), KS(82), MI(37), MN(77), MO(35), NE(63), OH(33), WI(58)

Table 1: State Ranking of CAH Reporting Rates for Patient Safety/Inpatient Quality Measures, 2022

Rank	State	CAHs reporting	% of CAHs	Rank	State	CAHs reporting	% of CAHs
1	Kansas	82	100.0	1	Alabama	5	100.0
1	Wisconsin	58	100.0	1	Massachusetts	3	100.0
1	Illinois	52	100.0	1	South Carolina	3	100.0
1	Montana	49	100.0	27	Minnesota	76	98.7
1	South Dakota	39	100.0	28	Iowa	80	97.6
1	Michigan	37	100.0	29	Oklahoma	39	97.5
1	California	36	100.0	30	Washington	38	97.4
1	Indiana	34	100.0	31	North Dakota	36	97.3
1	Colorado	32	100.0		National	1,319	97.1
1	Georgia	30	100.0	32	Mississippi	31	96.9
1	Arkansas	28	100.0	33	Nebraska	61	96.8
1	Idaho	27	100.0	34	Kentucky	27	96.4
1	Oregon	25	100.0	35	New York	17	94.4
1	West Virginia	21	100.0	36	Missouri	33	94.3
1	Arizona	16	100.0	37	Ohio	31	93.9
1	Maine	16	100.0	38	New Hampshire	12	92.3
1	Pennsylvania	16	100.0	38	Utah	12	92.3
1	Wyoming	16	100.0	40	North Carolina	18	90.0
1	Alaska	13	100.0	40	Florida	9	90.0
1	Nevada	13	100.0	42	Louisiana	24	88.9
1	New Mexico	11	100.0	42	Hawaii	8	88.9
1	Vermont	8	100.0	44	Tennessee	14	87.5
1	Virginia	8	100.0	45	Texas	75	85.2

Patient Safety/Inpatient CAH Performance

Results

Table 2 displays the results for performance of CAHs on core Patient Safety/Inpatient measures for Iowa and all CAHs nationally. Compared with all CAHs nationally, CAHs in Iowa scored significantly better on 1 measure, significantly worse on 0 measures, and did not have significantly different performance on 1 measure. Figures 2 and 3 show the performance trends for HCP/IMM-3 and Antibiotic Stewardship for Iowa and all CAHs nationally between 2019 and 2022.

Table 2: Patient Safety/Inpatient Quality Measure Results in Iowa and All CAHs Nationally, 2022

■ Significantly better than all CAHs nationally
 ■ Significantly worse than all CAHs nationally

Measure	Description	IA CAHs (n=82)		All CAHs (n=1,358)		Benchmark (%)
		CAHs reporting	Performance (%) {1}{2}	CAHs reporting	Performance (%) {2}	
HCP/IMM-3	Healthcare workers given influenza vaccination	52	88.1	671	78.8	100.0
Antibiotic Stewardship	Fulfill antibiotic stewardship core elements	79	91.1	1,238	91.3	100.0

Footnotes:

{1} Rates without highlights were not significantly different from comparable rates in all CAHs nationally.

{2} HCP/IMM-3 is expressed as the percentage of health care workers immunized, and Antibiotic Stewardship is the percentage of CAHs fulfilling all antibiotic stewardship core elements.

† Indicates insufficient data to calculate rate (<25 patients)

Figure 2: HCP/IMM-3 Trends in Iowa and All CAHs Nationally

Healthcare workers given influenza vaccination

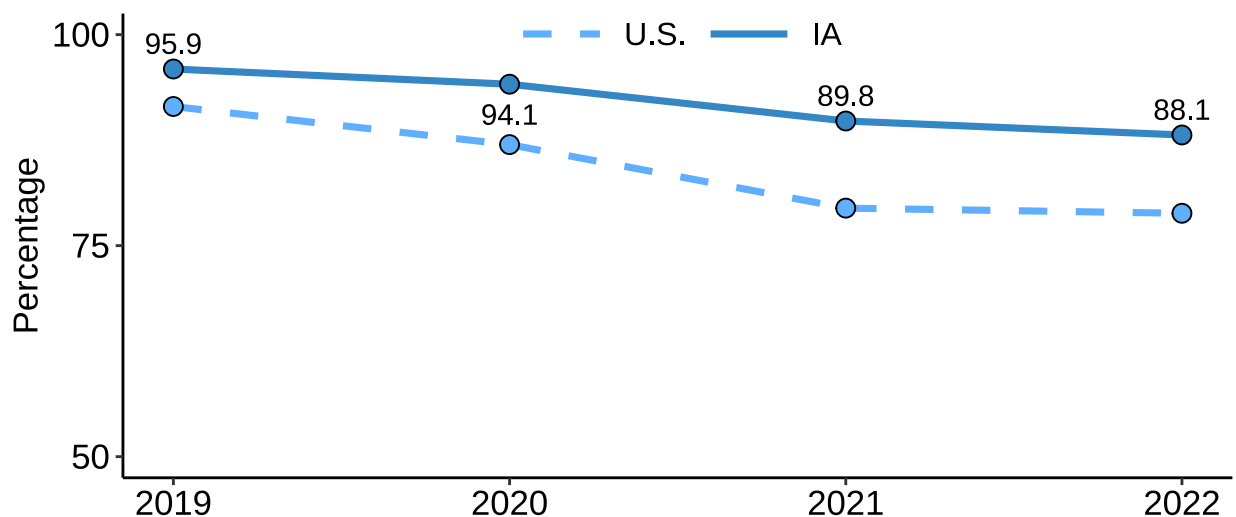


Figure 3: Antibiotic Stewardship Trends in Iowa and All CAHs Nationally

CAHs fulfilling the seven antibiotic stewardship core elements

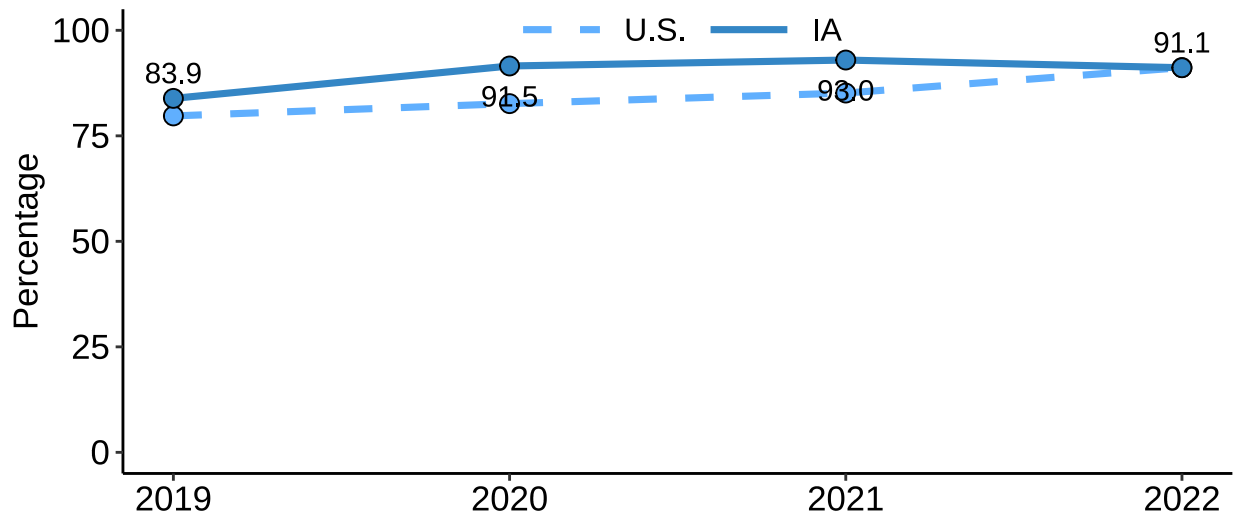


Table 3 displays HAI measures, including SIR performance results. Comparisons to other states are not provided for HAI measures because the majority of states did not meet the conditions for statistical comparisons. Performance trends for HAI measures are also not tracked due to concerns with SIR calculation for CAHs.

Table 3: Healthcare-Associated Infection Measures Results in Iowa and All CAHs Nationally, 2022

Measure	Description	IA CAHs (n=82)		All CAHs (n=1,358)	
		CAHs reporting	SIR {1}	CAHs reporting	SIR
HAI-1	Central-line-associated bloodstream infections (CLABSI)	70	1.1	1,157	0.8
HAI-2	Catheter-associated urinary tract infections (CAUTI)	74	0.8	1,197	0.7
HAI-3	Surgical site infections from colon surgery (SSI:C)	12	†	470	1.0
HAI-4	Surgical site infections from abdominal hysterectomy (SSI:H)	9	†	432	0.9
HAI-5	Methicillin-resistant Staphylococcus Aureus (MRSA) infections	65	0.4	954	1.1
HAI-6	Clostridium difficile (C.diff) intestinal infections	68	0.8	980	0.8

Footnotes:

{1} SIRs are a ratio of the total number of infections observed in 2022 divided by the predicted number of annual infections.

† Indicates insufficient data to calculate SIR

- Indicates no data available for this measure

Note: Significance tests for HAI Measures are not included as statistical tests are not able to be performed on these data.

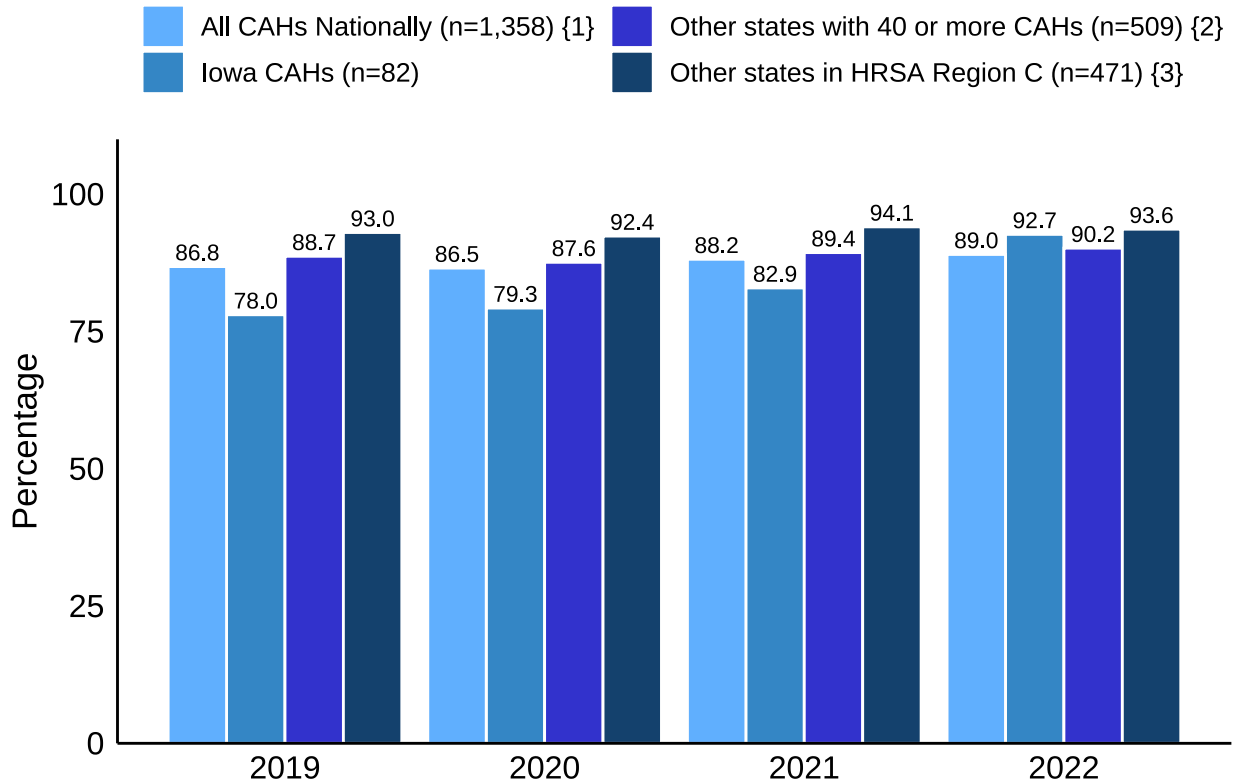
Outpatient Domain

Outpatient CAH Reporting

Results

The percent of CAHs reporting Outpatient quality data varied considerably across states. In Iowa, 92.7% of the 82 CAHs reported data on at least one Outpatient quality measure in 2022, and Figure 4 displays data for 2019-2022 among CAHs in four groups: those in Iowa, all CAHs nationally, other states with a similar number of CAHs as Iowa, and other states located in the same HRSA geographic region as Iowa. Table 4 compares the Outpatient reporting rates of CAHs in Iowa to those located in the other 44 states participating in the Flex Program as well as the rate for all CAHs nationally. The Iowa CAH Outpatient reporting rate of 92.7% ranks #20 nationally. The number of CAHs reporting individual quality measures may differ by measure for several reasons, other than missing data. Some measures may only apply to a portion of patients; others exclude patients with contraindications, or only apply to conditions not treated or procedures not performed in some CAHs.

Figure 4: Percentage of CAHs Reporting at Least One Outpatient Measure



Footnotes:

{1} Listed n values refer to most recent data (2022) only

{2} Group includes states with 40 or more CAHs: IL(52), KS(82), MN(77), MT(49), NE(63), OK(40), TX(88), WI(58)

{3} HRSA Region C includes: IL(52), IN(34), KS(82), MI(37), MN(77), MO(35), NE(63), OH(33), WI(58)

Table 4: State Ranking of CAH Reporting Rates for Outpatient Quality Measures, 2022

Rank	State	CAHs reporting	% of CAHs	Rank	State	CAHs reporting	% of CAHs
1	South Dakota	39	100.0	24	Oklahoma	36	90.0
1	Michigan	37	100.0	24	Florida	9	90.0
1	North Dakota	37	100.0	26	Arkansas	25	89.3
1	Georgia	30	100.0		National	1,209	89.0
1	New York	18	100.0	27	Missouri	31	88.6
1	Pennsylvania	16	100.0	28	Oregon	22	88.0
1	Tennessee	16	100.0	29	Ohio	29	87.9
1	Nevada	13	100.0	30	Alaska	11	84.6
1	New Hampshire	13	100.0	30	Utah	11	84.6
1	Hawaii	9	100.0	32	Colorado	27	84.4
1	Virginia	8	100.0	33	Arizona	13	81.2
1	Massachusetts	3	100.0	34	California	29	80.6
13	Kansas	81	98.8	35	North Carolina	16	80.0
14	Minnesota	76	98.7	35	Alabama	4	80.0
15	Nebraska	61	96.8	37	Illinois	39	75.0
16	Wisconsin	56	96.6	37	Kentucky	21	75.0
17	Idaho	26	96.3	37	Wyoming	12	75.0
18	West Virginia	20	95.2	40	Washington	29	74.4
19	Maine	15	93.8	41	Texas	65	73.9
20	Iowa	76	92.7	42	Louisiana	19	70.4
21	Montana	45	91.8	43	South Carolina	2	66.7
22	Indiana	31	91.2	44	Mississippi	21	65.6
23	New Mexico	10	90.9	45	Vermont	2	25.0



Outpatient CAH Performance

Results

Tables 5 and 6 display the results for performance of CAHs on Outpatient measures for Iowa and all CAHs nationally. Table 6 displays results for median time measures (lower scores, indicating shorter median times, are better). Compared with all CAHs nationally, CAHs in Iowa scored significantly better on 2 measures, significantly worse on 1 measure, and did not have significantly different performance on 1 measure.

Table 5: Outpatient Quality Measure Results in Iowa and All CAHs Nationally, 2022

 Significantly better than all CAHs nationally  Significantly worse than all CAHs nationally

Measure	Description	IA CAHs (n=82)		All CAHs (n=1,358)		Benchmark (%)
		CAHs reporting	% of patients {1}	CAHs reporting	% of patients	
OP-2	Fibrinolytic therapy received within 30 minutes	70	 36.6	1,131	48.4	100.0
OP-22	Patients left without being seen (lower is better)	69	 0.5	976	1.5	0.1

Footnotes:

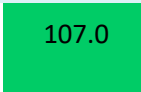
{1} Rates without highlights were not significantly different from comparable rates in all CAHs nationally.

† Indicates insufficient data to calculate rate (<25 patients)

* Indicates that no CAHs in the state submitted data values for eligible patients, but that one or more CAHs in the state either reported a population of 0 or submitted eligible cases to CMS that were excluded for the measure.

Table 6: Outpatient Median Quality Measure Results in Iowa and All CAHs Nationally, 2022

 Significantly better than all CAHs nationally  Significantly worse than all CAHs nationally

Measure	Description	IA CAHs (n=82)		All CAHs (n=1,358)		Benchmark (minutes)
		CAHs reporting	Minutes {1}	CAHs reporting	Minutes	
OP-3b	Median time to transfer to another facility - acute coronary intervention	70	80.0	1,131	72.0	38.0
OP-18b	Median time from ED arrival to ED departure for discharged patients	69	 107.0	1,147	115.0	85.0

Footnotes:

{1} Median minutes to receiving care. Lower is better for all measures. Rates without highlights were not significantly different from comparable rates in all CAHs nationally.

† Indicates insufficient data to calculate rate (<25 patients)

* Indicates that no CAHs in the state submitted data values for eligible patients, but that one or more CAHs in the state either reported a population of 0 or submitted eligible cases to CMS that were excluded for the measure.

Figures 5-7 show the performance trends for the Outpatient measures for Iowa and all CAHs nationally between 2019 and 2022. The OP-22 trend is not displayed due to the measure's low annual variation.

Figure 5: OP-2 Trends in Iowa and All CAHs Nationally

Fibrinolytic therapy received within 30 minutes

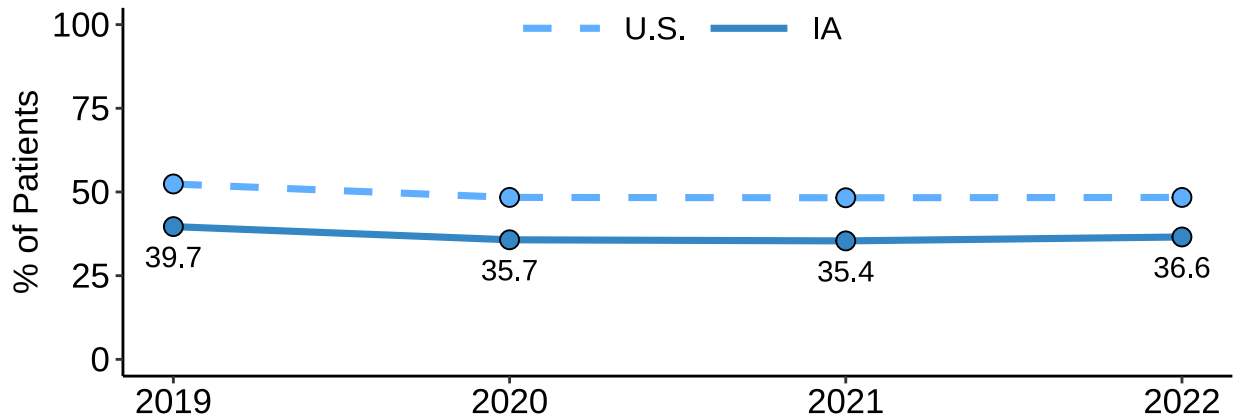


Figure 6: OP-3b Trends in Iowa and All CAHs Nationally

Median time to transfer to another facility - acute coronary intervention (lower is better)

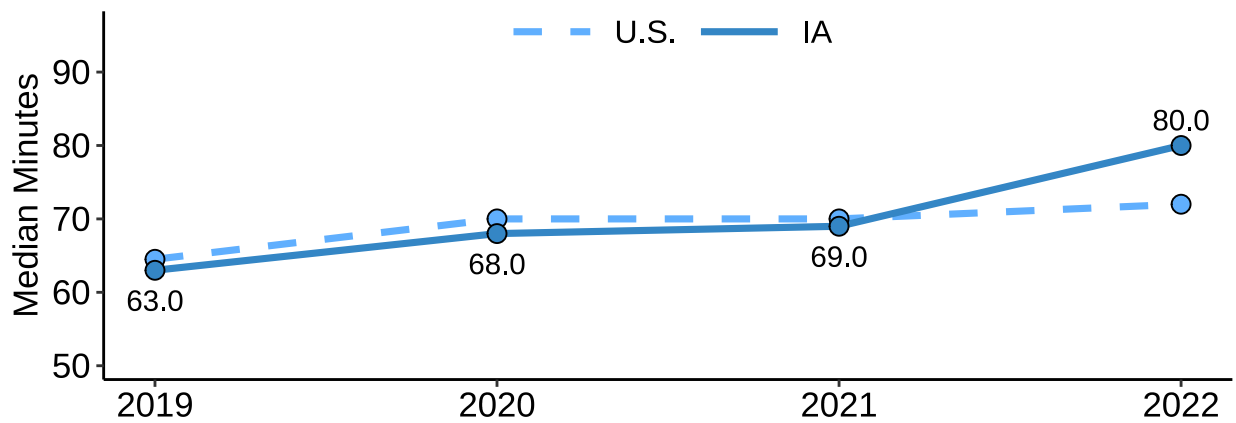
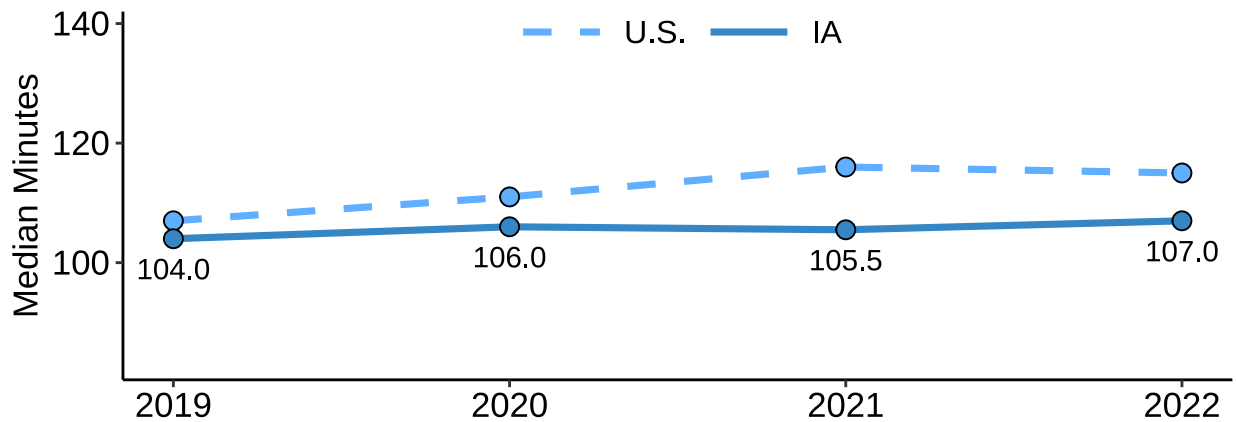


Figure 7: OP-18b Trends in Iowa and All CAHs Nationally

Median time from ED arrival to ED departure for discharged patients (lower is better)



Patient Engagement Domain

HCAHPS CAH Reporting

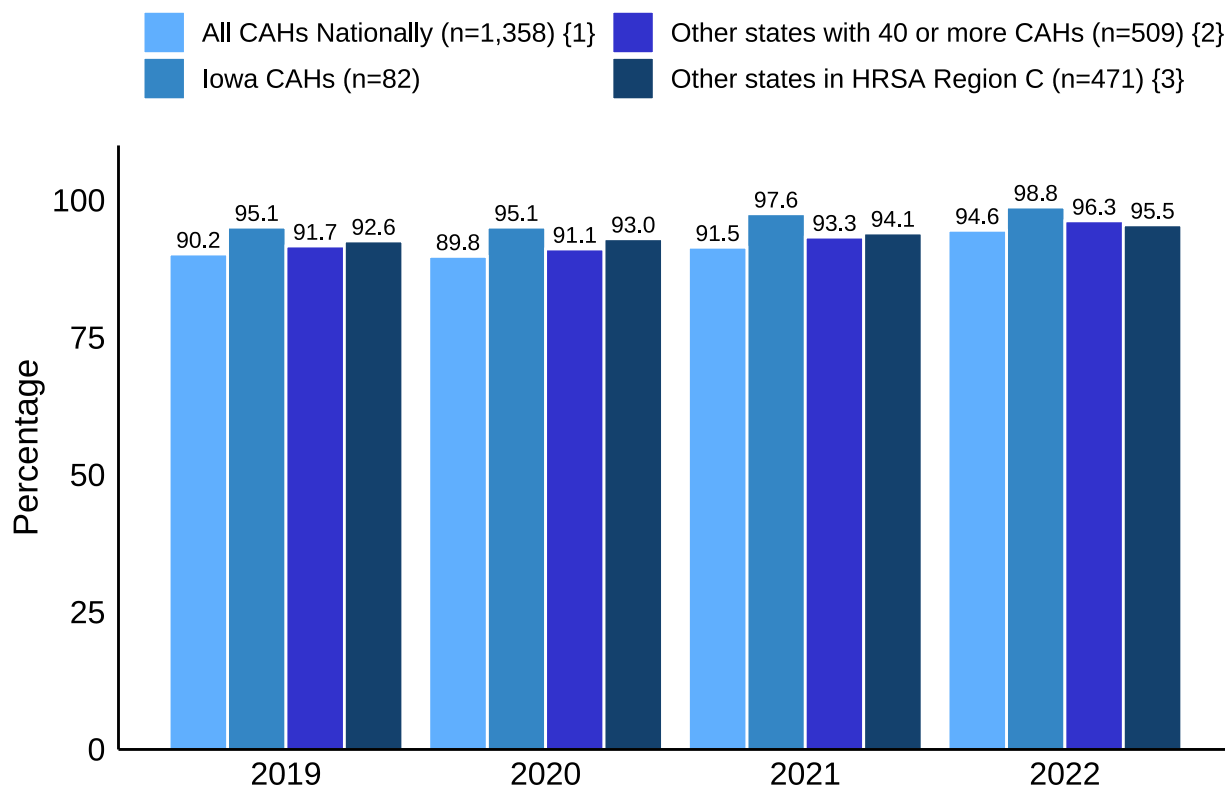
Results

The HCAHPS reporting rate for Iowa was 98.8% in 2022. Figure 8 compares reporting rates from 2019-2022 in the Patient Engagement domain (HCAHPS) over time among four groups: CAHs in Iowa, all CAHs nationally, CAHs in other states with a similar number of CAHs, and CAHs in the same HRSA region as Iowa.

Table 7 shows the number of completed HCAHPS surveys per CAH in Iowa and nationally in the five survey completion and three survey response rate categories. Hospitals with 100 or more completed surveys over a four-quarter period receive HCAHPS Star Ratings from CMS. CMS recommends that each hospital obtain 300 completed HCAHPS surveys annually, to be more confident that the survey results are reliable for assessing a hospital's performance. However, smaller hospitals may sample all of their HCAHPS-eligible discharges and still have fewer than 300 completed surveys. Caution should be exercised in comparing results for states that have few CAHs reporting results and/or CAHs whose results are based on fewer than 100 completed surveys. In 2020, HCAHPS data only included two quarters (Q3 2020 and Q4 2020) instead of the typical four, and as a result CAHs submitted fewer completed surveys that year. Beginning in Q3 2022, the FMT received and included data for CAHs who were reporting data, but had volumes too low to be displayed. These CAHs are now considered to be "reporting" where previously they were not due to a lack of data indicating their low volume.

Table 8 compares HCAHPS reporting rates of CAHs in Iowa to those in the other 44 Flex states as well as all CAHs nationally. The Iowa HCAHPS reporting rate of 98.8% ranks #22 nationally.

Figure 8: Percentage of CAHs Reporting at Least One Patient Engagement Measure (HCAHPS)



Footnotes:

{1} Listed n values refer to most recent data (2022) only

{2} Group includes states with 40 or more CAHs: IL(52), KS(82), MN(77), MT(49), NE(63), OK(40), TX(88), WI(58)

{3} HRSA Region C includes: IL(52), IN(34), KS(82), MI(37), MN(77), MO(35), NE(63), OH(33), WI(58)

Table 7: Number of Completed HCAHPS Surveys and Response Rates in Iowa and All CAHs Nationally, 2022

	Total CAHs reporting	Number of Completed HCAHPS Surveys					HCAHPS Survey Response Rates		
		<25	25-49	50-99	100-299	300+	<25%	25-50%	>50%
National	1,284	344	261	344	316	19	550	712	22
Iowa	81	13	23	22	22	1	10	69	2

Table 8: State Ranking of CAH Reporting Rates for HCAHPS Quality Measures, 2022

Rank	State	CAHs reporting	% of CAHs	Rank	State	CAHs reporting	% of CAHs
1	Nebraska	63	100.0	24	California	35	97.2
1	Wisconsin	58	100.0	25	Ohio	32	97.0
1	Illinois	52	100.0	26	Colorado	31	96.9
1	South Dakota	39	100.0	27	Minnesota	74	96.1
1	Georgia	30	100.0	28	Oklahoma	38	95.0
1	Idaho	27	100.0		National	1,284	94.6
1	Oregon	25	100.0	29	North Dakota	35	94.6
1	West Virginia	21	100.0	30	Montana	46	93.9
1	New York	18	100.0	31	Mississippi	30	93.8
1	Maine	16	100.0	32	Arkansas	26	92.9
1	Pennsylvania	16	100.0	32	Kentucky	26	92.9
1	Wyoming	16	100.0	34	Utah	12	92.3
1	Nevada	13	100.0	35	North Carolina	18	90.0
1	New Hampshire	13	100.0	36	Michigan	33	89.2
1	New Mexico	11	100.0	37	Texas	78	88.6
1	Hawaii	9	100.0	37	Missouri	31	88.6
1	Vermont	8	100.0	39	Washington	34	87.2
1	Virginia	8	100.0	40	Tennessee	13	81.3
1	Alabama	5	100.0	41	Florida	8	80.0
1	Massachusetts	3	100.0	42	Louisiana	21	77.8
1	South Carolina	3	100.0	43	Indiana	26	76.5
22	Iowa	81	98.8	44	Arizona	12	75.0
22	Kansas	81	98.8	45	Alaska	9	69.2

HCHAPS CAH Performance

Results

Table 9 displays the results for performance on Patient Engagement (HCAHPS) measures for Iowa and all CAHs nationally. Compared with all CAHs nationally, CAHs in Iowa scored significantly better on 6 measures, significantly worse on 0 measures, and did not have significantly different performance on 4 measures.

Table 9: HCAHPS Results for CAHs in Iowa and All CAHs Nationally, 2022

 Significantly better than all CAHs nationally  Significantly worse than all CAHs nationally

HCAHPS Measure	Percentage of patients that gave the highest level of response (e.g., “always”)		
	IA CAHs (n=82)	All CAHs (n=1,358)	Benchmark (%)
CAHs Reporting	n=81	n=1,284	
Nurses always communicated well	83.9	83.0	87.7
Doctors always communicated well	84.8	83.1	88.0
Patients always received help as soon as wanted	74.1	73.4	81.2
Staff always explained medications before giving them to patients	66.0	65.9	74.1
Staff always provided information about what to do during recovery at home	88.7	88.1	92.2
Patients strongly understood their care when they left the hospital	57.0	54.7	63.6
Patient’s room and bathroom were always clean	80.5	78.1	79.6
Area around patient’s room was always quiet at night	69.4	66.3	79.6
Patient gave a rating 9 or 10 [high] on a 1-10 scale	80.2	76.0	85.7
Patient would definitely recommend the hospital to friends and family	78.1	73.8	NA

Footnotes:

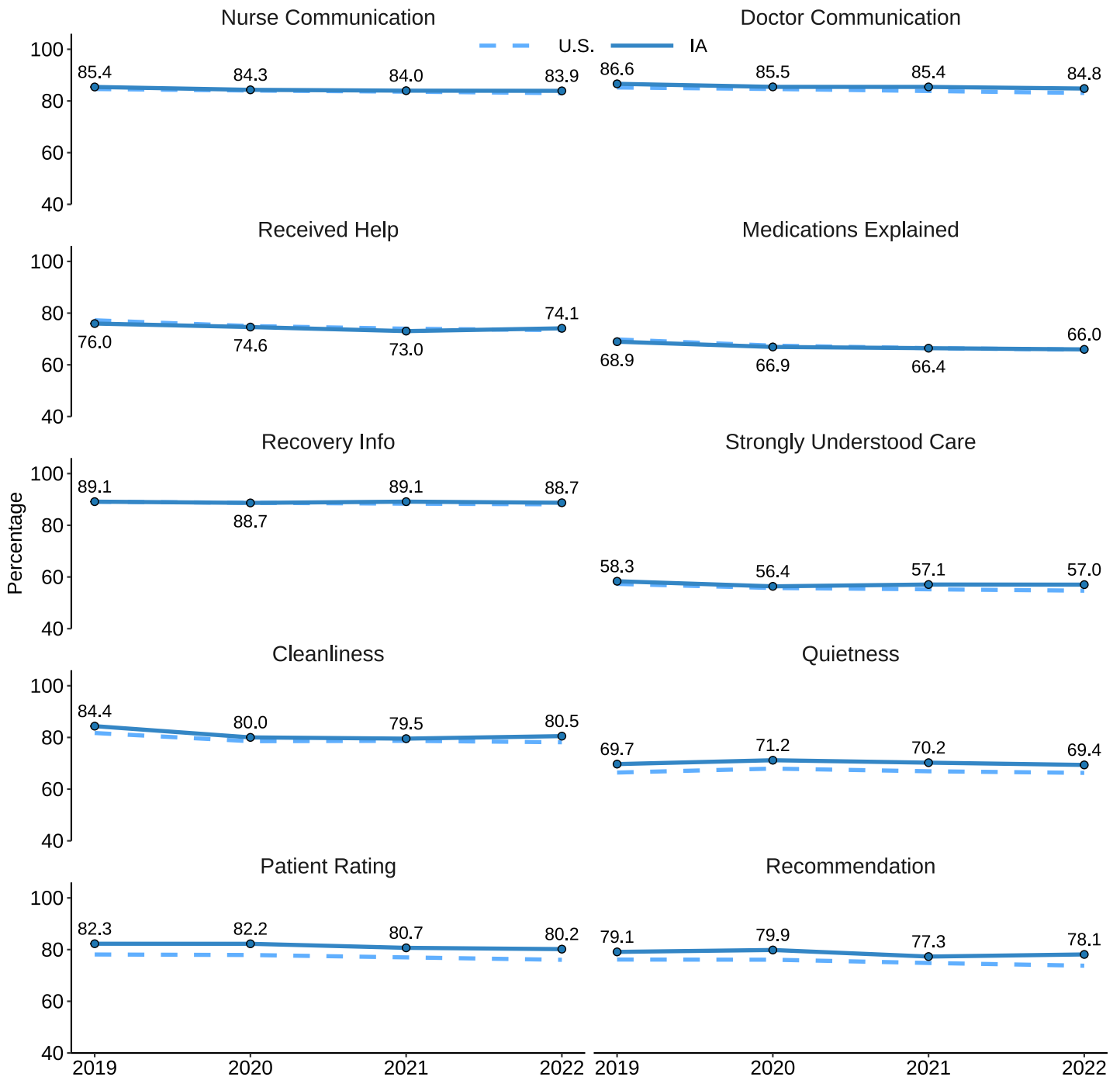
† Indicates insufficient data to calculate rate (<25 patients)

* Indicates that no CAHs in the state submitted data values for eligible patients, but that one or more CAHs in the state either reported a population of 0 or submitted eligible cases to CMS that were excluded for the measure.

Figure 10 shows the trends for each HCAHPS measure for Iowa and all CAHs nationally between 2019 and 2022.

Figure 10: HCAHPS Trends for CAHs in Iowa and All CAHs Nationally

Percentage of respondents that gave the highest level of response (e.g. "always")



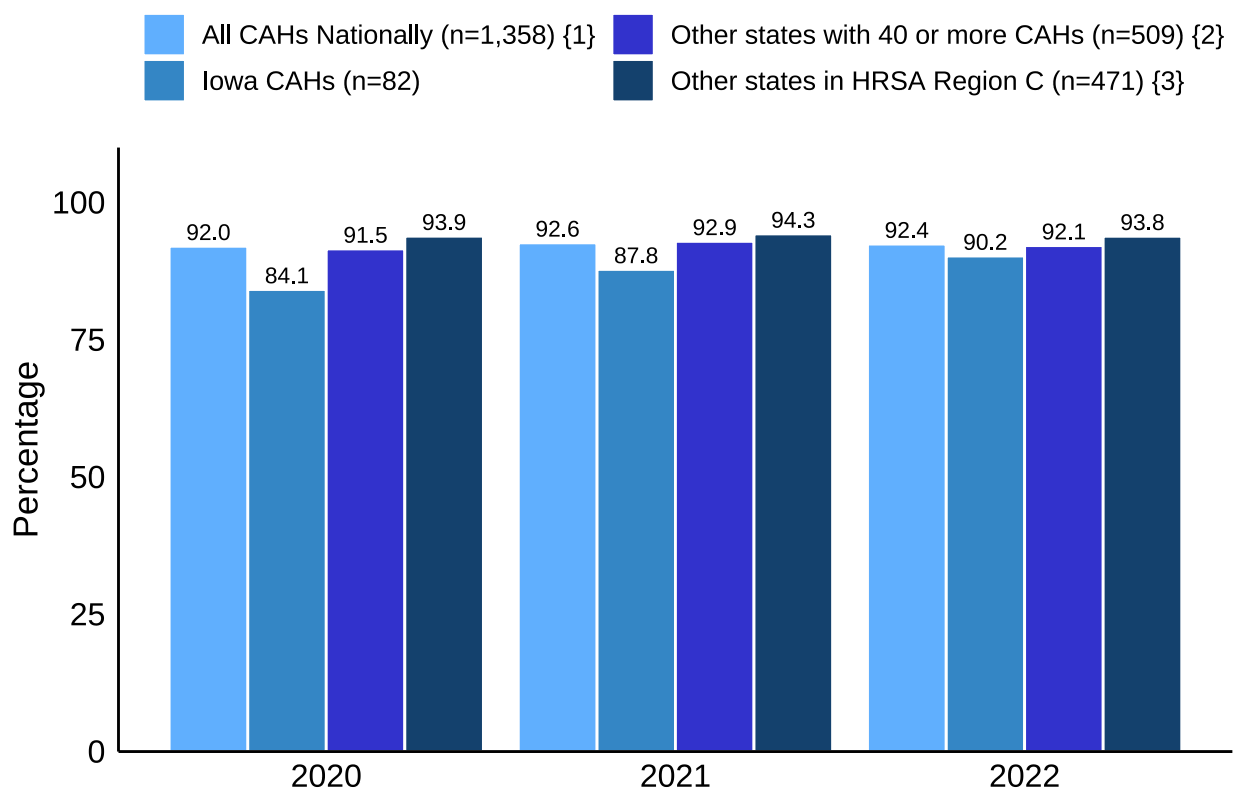
Care Transitions Domain

EDTC CAH Reporting

Results

Figure 11 compares reporting in the Care Transitions domain (EDTC) for Iowa and all CAHs nationally for 2022, indicating that 90.2% of Iowa CAHs reported the EDTC measure. Collection and reporting procedures for the EDTC measure changed beginning in 2020. This and future reports only include data for the new measure. Table 10 compares the EDTC reporting rates of CAHs in Iowa to those located in the other 44 states participating in the Flex Program as well as the rate for all CAHs nationally. The Iowa EDTC reporting rate of 90.2% ranks #33 nationally.

Figure 11: Percentage of CAHs Reporting Care Transitions Measure (EDTC)



Footnotes:

{1} Listed n values refer to most recent data (2022) only

{2} Group includes states with 40 or more CAHs: IL(52), KS(82), MN(77), MT(49), NE(63), OK(40), TX(88), WI(58)

{3} HRSA Region C includes: IL(52), IN(34), KS(82), MI(37), MN(77), MO(35), NE(63), OH(33), WI(58)

Table 10: State Ranking of CAH Reporting Rates for EDTC Quality Measure, 2022

Rank	State	CAHs reporting	% of CAHs	Rank	State	CAHs reporting	% of CAHs
1	Kansas	82	100.0	24	Wisconsin	56	96.6
1	Oklahoma	40	100.0	25	New York	17	94.4
1	South Dakota	39	100.0	26	Arizona	15	93.8
1	North Dakota	37	100.0	26	Maine	15	93.8
1	California	36	100.0	26	Wyoming	15	93.8
1	Georgia	30	100.0	29	Louisiana	25	92.6
1	Arkansas	28	100.0		National	1,255	92.4
1	Idaho	27	100.0	30	Washington	36	92.3
1	West Virginia	21	100.0	30	Alaska	12	92.3
1	Pennsylvania	16	100.0	32	Mississippi	29	90.6
1	Nevada	13	100.0	33	Iowa	74	90.2
1	New Hampshire	13	100.0	34	Kentucky	25	89.3
1	Utah	13	100.0	35	Michigan	33	89.2
1	New Mexico	11	100.0	36	Missouri	31	88.6
1	Florida	10	100.0	37	Montana	42	85.7
1	Hawaii	9	100.0	38	Illinois	44	84.6
1	Virginia	8	100.0	39	Colorado	27	84.4
1	Alabama	5	100.0	40	Tennessee	13	81.3
1	Massachusetts	3	100.0	41	Oregon	20	80.0
1	South Carolina	3	100.0	41	North Carolina	16	80.0
21	Minnesota	76	98.7	43	Ohio	26	78.8
22	Indiana	33	97.1	44	Texas	68	77.3
23	Nebraska	61	96.8	45	Vermont	2	25.0

EDTC CAH Performance

Results

Table 11 displays the results for performance on the Care Transitions (EDTC) measure for Iowa and all CAHs nationally. Compared with all CAHs nationally, CAHs in Iowa scored significantly better on 3 measures, significantly worse on 2 measures, and did not have significantly different performance on 4 measures. Figure 12 shows performance data for EDTC over time, though data on this measure are only available for 2020-2022.

Table 11: EDTC Results for CAHs in Iowa and All CAHs Nationally, 2022

 Significantly better than all CAHs nationally  Significantly worse than all CAHs nationally

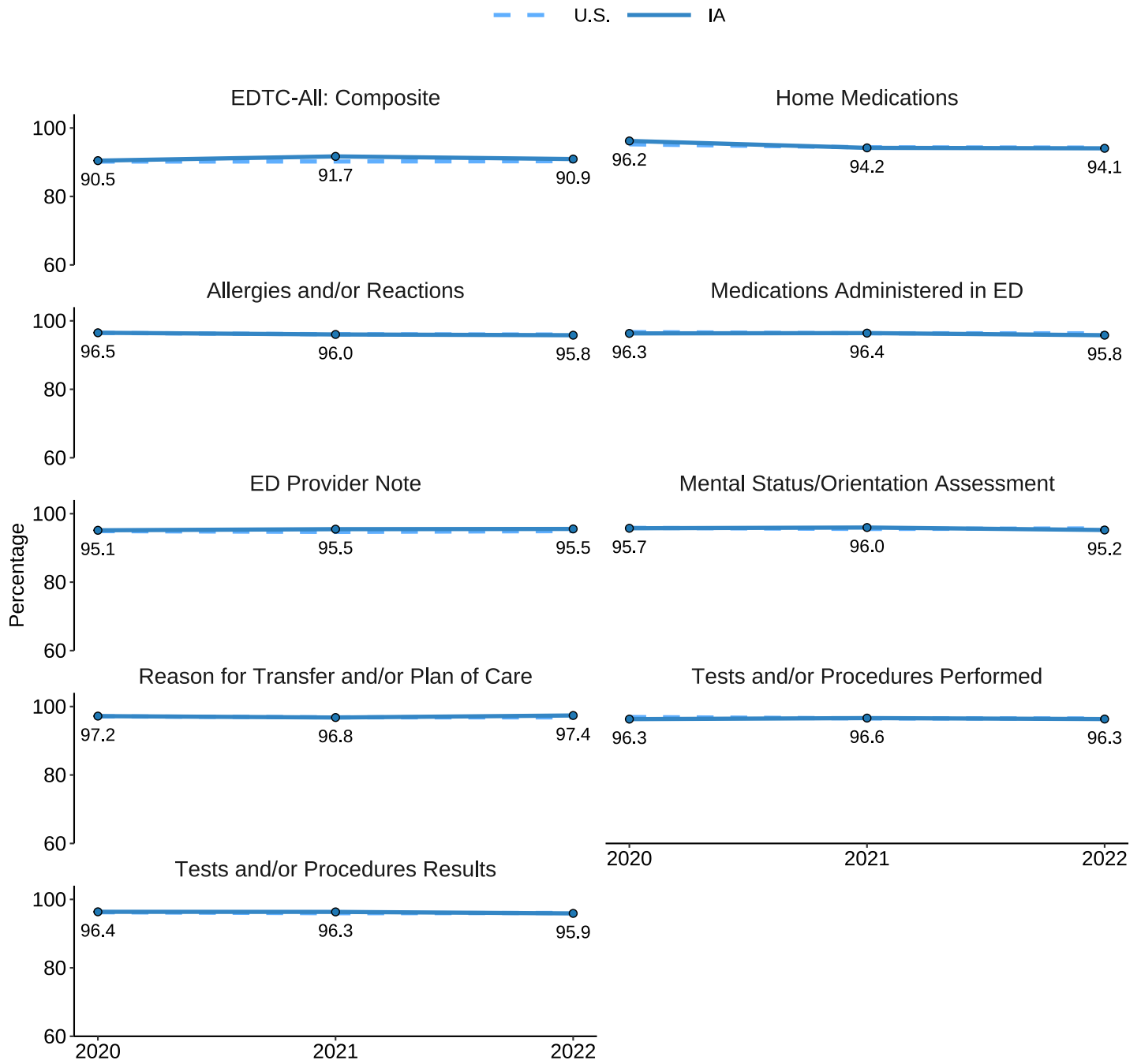
EDTC Measure	Average Percentage		
	Iowa CAHs (n=82)	All CAHs (n=1,358)	Benchmark (%)
CAHs Reporting	n=74	n=1,255	
EDTC-All: Composite	90.9	90.3	100
Home Medications	94.1	94.3	100
Allergies and/or Reactions	95.8	96.0	100
Medications Administered in ED	95.8	96.3	100
ED Provider Note	95.5	94.9	100
Mental Status/Orientation Assessment	95.2	95.7	100
Reason for Transfer and/or Plan of Care	97.4	96.8	100
Tests and/or Procedures Performed	96.3	96.5	100
Tests and/or Procedures Results	95.9	96.0	100

Footnotes:

† Indicates insufficient data to calculate rate (<25 patients)

Figure 12: EDTC Trends for CAHs in Iowa and All CAHs Nationally

Percentage of patients that met this element



Appendix

This appendix includes additional detailed information regarding the methods and data used in this report. Performance for each measure is shown in a variety of ways depending on the measure.

Percentages were calculated using the number of patients (or healthcare workers for the measure HCP/IMM-3) who met the measure criteria, divided by the number of patients or workers in the measure population, which are specifically defined for each measure. For antibiotic stewardship measures, this report showed the percentage of CAHs in your state that met the seven elements individually, as well as the percentage that met all elements. Values were rounded to the nearest decimal place. State performance was compared to the performance for all CAHs nationally using Chi-square tests ($p < 0.05$). The results of the state performance comparisons were classified as: 1) insufficient data (less than 25 total patients); 2) not significantly different than all CAHs nationally; 3) significantly better than all CAHs nationally; or 4) significantly worse than all CAHs nationally.

Median time includes the median number of minutes until the specified event occurs among patients who meet certain criteria, which are specifically defined for each measure. For median time measures, lower scores, indicating shorter median times, are better. Wilcoxon-Mann-Whitney tests were used to compare the median times for CAHs in each state to all CAHs nationally.

Antibiotic stewardship performance were measured as the percentage of CAHs that fulfilled all seven core elements of an antibiotic stewardship program. The questions in the NHSN address different activities CAHs can participate in to fulfill the core elements. For all years, antibiotic stewardship values only include data submitted by the March 31 NHSN deadline. The state-level performance on antibiotic stewardship was compared to the performance of all other CAHs nationally using Fisher's exact test.

Performance for each HAI measure was calculated using Standardized Infection Ratios (SIRs). SIRs are a ratio of the total number of infections observed in 2022 divided by the predicted number of annual infections. Predicted number of infections data were calculated and made available by the CDC. SIRs could only be calculated when there were one or more predicted infections for the time period. A lower SIR indicates better performance. Significance tests comparing state HAI performance to the performance all CAHs nationally were not performed because the majority of states did not meet the conditions for statistical comparisons: at least one predicted infection and the state's predicted number of infections multiplied by the SIR of all other CAHs must be equal to or greater than one.

For each HCAHPS measure, the percentage of patients reporting the highest response (e.g., "always") on each measure were summed and averaged across all reporting CAHs within a state and all CAHs nationally. HCAHPS data for 2020 only include two rolling quarters (Q3 2020 and Q4 2020) instead of the typical four quarters, as a result of CMS reporting changes due to the COVID-19 pandemic. Beginning in Q3 2022, the FMT received and included data for CAHs who were reporting data, but had volumes too low to be displayed. These CAHs are now considered to be "reporting" where previously they were not due to a lack of data indicating their low volume. Two-sample t-tests were used to compare whether the mean scores on each measure are significantly different between CAHs in each state and all CAHs nationally.

Performance for the EDTC measure was calculated as the percentage of patients that met all of the seven data elements. State performance was compared to the performance for all CAHs nationally using Chi-square tests ($p < 0.05$). Changes to the EDTC measure in 2020 focused on adjustments to help streamline and modernize the measure, including a reduction in the total number of data elements from 27 to 8 and clarifications to specific definitions of individual data elements.

All statistical analysis was carried out using R 4.3.0 (R Core Team, 2023) and the Tidyverse (Wickham et al., 2019), rmarkdown (Allaire et al., 2023), kableExtra (Zhu, 2021), and knitr (Xie, 2023) packages.

For more information on this report, please contact Megan Lahr at lahrx074@umn.edu.

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