



Hospital Compare Quality Measure Results for CAHs, 2017

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INTRODUCTION

This report summarizes reporting rates and performance among all U.S. Critical Access Hospitals (CAHs) on Hospital Compare inpatient and outpatient process of care and structural measures for calendar year 2017. The Flex Monitoring Team also produces state-specific CAH reports with more detailed results.

BACKGROUND

Since 2004, acute care hospitals paid under the Medicare Prospective Payment System (PPS) have had a financial incentive to publicly report quality measure data on the Centers for Medicare & Medicaid Services' (CMS) Hospital Compare website. Although CAHs do not face the same financial incentives as PPS hospitals to participate, the Hospital Compare initiative provides an important opportunity for CAHs to publicly report, assess, and improve their performance on national standards of care.

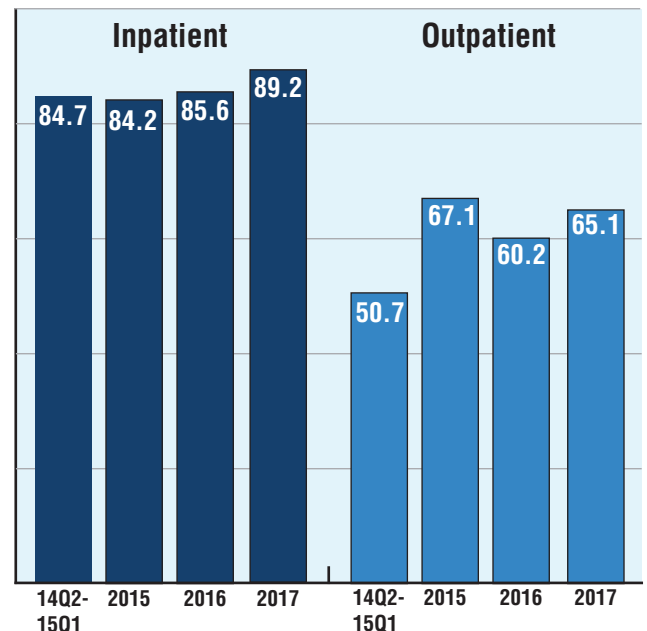
DATA AND APPROACH

The report used the following data sources:

- Publicly-available Hospital Compare data downloaded from the CMS Hospital Compare website on inpatient and outpatient process measures and structural measures for 2017.
- Data for 2017 on process measures for which CAHs reported ten or fewer cases, which CMS suppresses from the Hospital Compare website, but makes available to the Federal Office of Rural Health Policy for aggregate CAH analyses.

Since the last national report, 1 structural measure was added, and 2 inpatient measures and 2 structural measures were removed from Hospital Compare. This report includes 18 process of care measures and 5 structural measures that are potentially relevant to CAHs and for which some CAHs nationally have reported data. Reporting is defined as reporting data with a denominator of 1 or more for inpatient and outpatient measures. Definitions of the measures used in the report are provided on pages 5-6.

Figure 1. CAH Participation in Hospital Compare, 2017 (N=1,348¹)



1. N value refers to most recent data (2017). Prior years' N values are as follows: 14Q2-15Q1, 1,336; 2015, 1,332; 2016, 1,343



For the inpatient and outpatient process of care measures (except the median time process measures), the percentages of patients that received recommended care were calculated by dividing the total number of patients in all CAHs nationally who received the recommended care by the total number of eligible patients in all CAHs nationally for each measure. Median scores were calculated for median time process measures by first arranging the median time from all available quarterly data together from all CAHs nationally. Then, the median value of these times was selected. On the median time measures, lower scores, indicating shorter median times, are better. For each structural measure, the percentages of CAHs that reported no data and those that reported yes or no on each measure were calculated. The Hospital Compare data in this report include several measures that are also measures for the Medicare Beneficiary Quality Improvement Project (MBQIP). Although the majority of CAHs report data on these measures to both Hospital Compare and MBQIP, the data in this report may differ from MBQIP reports because some CAHs only report data to one of these programs.

RESULTS

For 2017, 89.2% of CAHs reported data to Hospital Compare on at least one inpatient measure, while 65.1% of CAHs reported data on at least one outpatient measure (Figure 1). The inpatient and outpatient reporting percentages represent slight increases from the previous reporting period. Tables 1 and 2 show state rankings on inpatient and outpatient reporting rates.

Table 3 displays the number of CAHs reporting and their performance on each of the inpatient and outpatient process of care measures (except the median time process measures) for 2017 discharges for CAHs nationally and for the 45 Flex states. Table 4 displays the national and state results for the median time measures. Table 5 provides results for CAHs nationally that reported data for structural quality measures in 2017; nationally, at least 70% of CAHs did not report these data.

TOOLS AND RESOURCES

The Flex Monitoring Team provides free access to all publications and presentations on our website, <http://www.flexmonitoring.org>, including a series of policy briefs on evidence-based QI programs and strategies that could be implemented by CAHs.

The Technical Assistance Services Center (TASC) provides resources for State Flex Programs and CAHs on their website. For profiles of State Flex Programs, State Contacts, and examples of Flex activities to support quality improvement, visit <http://www.ruralcenter.org/tasc/flexprofile>.

For resources focused on the Medicare Beneficiary Quality Improvement Program (MBQIP), visit <https://www.ruralcenter.org/tasc/mbqip>.

REFERENCES

1. The Flex Monitoring Team has published national Hospital Compare reports since 2006. All are available for free download at <http://www.flexmonitoring.org/publications/>.

(Tables 1-5 and measure definitions begin on next page)



CAH Hospital Compare Quality Measure Results, 2017

Table 1. State Rankings of CAH Reporting Rates for Inpatient Quality Measures, 2017

| Rank | State | CAHs reporting | % of CAHs | | |
|------|-----------------|----------------|-------------|----|------|
| 1 | Michigan | 36 | 100.0 | | |
| | Georgia | 30 | | | |
| | Arkansas | 29 | | | |
| | Oregon | 25 | | | |
| | Maine | 16 | | | |
| | Pennsylvania | 15 | | | |
| | New Hampshire | 13 | | | |
| | Utah | 13 | | | |
| | Virginia | 7 | | | |
| | South Carolina | 5 | | | |
| | Alabama | 4 | | | |
| | Massachusetts | 3 | | | |
| | 13 | Minnesota | | 77 | 98.7 |
| | 14 | Wisconsin | | 57 | 98.3 |
| 15 | Illinois | 50 | 98.0 | | |
| 16 | Indiana | 34 | 97.1 | | |
| 17 | Nebraska | 62 | 96.9 | | |
| 18 | West Virginia | 19 | 95.0 | | |
| 19 | Washington | 37 | 94.9 | | |
| 20 | North Dakota | 34 | 94.4 | | |
| 21 | Wyoming | 15 | 93.8 | | |
| 22 | Kansas | 78 | 92.9 | | |
| | Alaska | 13 | | | |
| 24 | California | 31 | 91.2 | | |
| 25 | Ohio | 30 | 90.9 | | |
| | All CAHs | 1,203 | 89.2 | | |
| 26 | Iowa | 73 | 89.0 | | |
| 27 | Idaho | 24 | 88.9 | | |
| | Kentucky | 24 | | | |
| | New York | 16 | | | |
| 30 | Montana | 42 | 87.5 | | |
| | Vermont | 7 | | | |
| 32 | North Carolina | 18 | 85.7 | | |
| | Tennessee | 12 | | | |
| 34 | Nevada | 11 | 84.6 | | |
| 35 | Mississippi | 26 | 83.9 | | |
| 36 | Oklahoma | 31 | 81.6 | | |
| 37 | New Mexico | 8 | 80.0 | | |
| 38 | South Dakota | 30 | 78.9 | | |
| 39 | Arizona | 11 | 78.6 | | |
| 40 | Colorado | 25 | 78.1 | | |
| 41 | Missouri | 28 | 77.8 | | |
| 42 | Florida | 8 | 66.7 | | |
| | Hawaii | 6 | | | |
| 44 | Texas | 54 | 63.5 | | |
| 45 | Louisiana | 16 | 59.3 | | |

Table 2. State Rankings of CAH Reporting Rates for Outpatient Quality Measures, 2017

| Rank | State | CAHs reporting | % of CAHs |
|------|-----------------|----------------|-------------|
| 1 | Nebraska | 64 | 100.0 |
| | Pennsylvania | 15 | |
| | Alabama | 4 | |
| 4 | Georgia | 28 | 93.3 |
| 5 | New Hampshire | 12 | 92.3 |
| 6 | Michigan | 33 | 91.7 |
| 7 | Indiana | 32 | 91.4 |
| 8 | Minnesota | 70 | 89.7 |
| 9 | Maine | 14 | 87.5 |
| 10 | Nevada | 11 | 84.6 |
| 11 | Wisconsin | 48 | 82.8 |
| | Arkansas | 24 | |
| 13 | Wyoming | 13 | 81.3 |
| 14 | New York | 14 | 77.8 |
| 15 | Washington | 30 | 76.9 |
| | Utah | 10 | |
| 17 | Oregon | 19 | 76.0 |
| 18 | Oklahoma | 28 | 73.7 |
| 19 | Ohio | 24 | 72.7 |
| 20 | Tennessee | 10 | 71.4 |
| | Virginia | 5 | |
| 22 | North Dakota | 25 | 69.4 |
| 23 | Iowa | 55 | 67.1 |
| 24 | Massachusetts | 2 | 66.7 |
| | All CAHs | 878 | 65.1 |
| 25 | Illinois | 33 | 64.7 |
| 26 | Kentucky | 17 | 63.0 |
| 27 | North Carolina | 13 | 61.9 |
| 28 | West Virginia | 12 | 60.0 |
| | South Carolina | 3 | |
| 30 | Mississippi | 18 | 58.1 |
| 31 | Hawaii | 5 | 55.6 |
| 32 | Missouri | 18 | 50.0 |
| | Arizona | 7 | |
| | Florida | 6 | |
| | New Mexico | 5 | |
| 36 | Idaho | 13 | 48.1 |
| 37 | Kansas | 38 | 45.2 |
| 38 | Colorado | 13 | 40.6 |
| 39 | Montana | 19 | 39.6 |
| 40 | Texas | 32 | 37.6 |
| 41 | Louisiana | 10 | 37.0 |
| 42 | California | 12 | 35.3 |
| 43 | South Dakota | 10 | 26.3 |
| 44 | Alaska | 3 | 21.4 |
| 45 | Vermont | 1 | 12.5 |



Table 3. Inpatient and Outpatient Process of Care Results for Patients Discharged from CAHs, 2017

| | Code | Description | CAHs reporting | CAH performance ¹ |
|-------------------|--------------------------|--|----------------|------------------------------|
| Inpatient | IMM-2 [†] | Immunization for influenza | 1,011 | 88.4 |
| | OP-27/IMM-3 [†] | Healthcare workers given influenza vaccination | 1,028 | 88.3 |
| | PC-01 [‡] | Early elective delivery (lower is better) | 191 | 2.9 |
| | VTE-6 | Incidence of potentially-preventable VTE (lower is better) | 122 | 8.1 |
| | Code | Description | CAHs reporting | CAH performance ¹ |
| Outpatient | OP-2 [†] | Fibrinolytic therapy received within 30 minutes | 361 | 51.9 |
| | OP-4 [‡] | Aspirin at arrival | 818 | 95.2 |
| | OP-22 [†] | Patient left without being seen (lower is better) | 627 | 1.0 |
| | OP-23 | Received head CT scan interpretation within 45 minutes | 526 | 63.0 |
| | OP-29 | Appropriate follow-up interval, colonoscopy, average-risk patients | 177 | 84.2 |
| | OP-30 | Appropriate follow-up interval, colonoscopy, patients with polyps | 176 | 91.4 |

1. Expressed as a percentage of patients receiving recommended care (lower is better for PC-01, VTE-6, and OP-22), except for OP-27/IMM-3, which is the percentage of healthcare workers immunized.

[†] MBQIP core measure, FY 2018-21 (this table shows Hospital Compare data)

[‡] MBQIP additional improvement measure, FY 2018-21 (this table shows Hospital Compare data)

Table 4. Median Time to Patients Receiving Recommended Care at CAHs, 2017

| Code | Description | CAHs reporting | Median minutes ¹ |
|---------------------|---|----------------|-----------------------------|
| ED-1b [†] | Median time from ED admission to ED departure for admitted patients | 883 | 197.0 |
| ED-2b [†] | Admit decision time to ED departure time for admitted patients | 875 | 46.0 |
| OP-1 | Median time to fibrinolysis | 360 | 31.5 |
| OP-3b [†] | Median time to transfer to another facility - acute coronary intervention | 470 | 66.0 |
| OP-5 [†] | Median time to ECG | 819 | 7.5 |
| OP-18b [†] | Median time from ED arrival to ED departure for discharged patients | 800 | 105.0 |
| OP-20 [‡] | Median time from door to diagnostic evaluation | 800 | 16.0 |
| OP-21 | Median time to pain management for long bone fracture | 765 | 44.0 |

1. Median number of minutes to receiving recommended care (lower is better for all median time measures)

[†] MBQIP core measure, FY 2018-21 (this table shows Hospital Compare data)

[‡] MBQIP additional improvement measure, FY 2018-21 (this table shows Hospital Compare data)



Table 5. Structural Quality Measures Reported by CAHs, 2017

| Code | Description | No data | | No | | Yes | |
|--------------------------------|---|---------|------|-------|-----|-------|------|
| | | #CAHs | % | #CAHs | % | #CAHs | % |
| OP-12 | Ability to receive lab data directly to certified EHR | 969 | 71.9 | 31 | 2.3 | 348 | 25.8 |
| OP-17 | Ability to track clinical results between visits | 973 | 72.2 | 28 | 2.1 | 347 | 25.7 |
| OP-25 | Use of safe surgery checklist: outpatient | 943 | 70.0 | 19 | 1.4 | 386 | 28.6 |
| SM-HS-PATIENT-SAF [‡] | Use of hospital survey on patient safety culture | 995 | 73.8 | 101 | 7.5 | 252 | 18.7 |
| SM-SS-CHECK | Use of safe surgery checklist: inpatient | 959 | 71.1 | 21 | 1.6 | 368 | 27.3 |

‡ MBQIP additional improvement measure, FY 2018-21 (this table shows Hospital Compare data)

DEFINITIONS OF MEASURES

Note: higher numbers reflect better performance, except where indicated below.

- **ED-1b:** Admit Decision Time to Emergency Department (ED) Departure Time for Admitted Patients - median time from admit decision time to time of departure from the ED for patients admitted to inpatient status. (A lower number is better.)
- **ED-2b:** Median Time from Emergency Department (ED) Arrival to ED Departure for Admitted Patients - median time from ED arrival to time of departure from the ED for patients admitted to the facility from the ED (A lower number is better.)
- **IMM-2:** Influenza Vaccination – This prevention measure addresses acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine, and patients who received the vaccine during the current year’s influenza season but prior to the current hospitalization are captured as numerator events.
- **OP-1:** Median Time to Fibrinolysis - median time from arrival to fibrinolysis for patients that received fibrinolysis. (A lower number is better.)
- **OP-2:** Fibrinolytic therapy received within 30 minutes of arrival – Acute Myocardial Infarction (AMI) patients

receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.

- **OP-3b:** Median Time to Transfer to Another Facility for Acute Coronary Intervention – Median number of minutes before outpatients with heart attack who needed specialized care were transferred to another hospital. (A lower number is better.)
- **OP-4:** Aspirin at arrival – Acute Myocardial Infarction (AMI) patients without aspirin contraindications who received aspirin within 24 hours before or after hospital arrival.
- **OP-5:** Median Time to echocardiogram (ECG) – median number of minutes before outpatients with heart attack (or with chest pain that suggests a possible heart attack) got an ECG. (A lower number is better.)
- **OP-12:** Ability to Receive Lab Data Directly to Electronic Health Record (EHR) – the ability for providers with Health Information Technology (HIT) to receive laboratory data directly into their ONC-certified EHR system as discrete searchable data.
- **OP-17:** Ability to Track Clinical Results between Visits – the ability for a facility to track pending laboratory tests, diagnostic studies, or patient referrals through the ONC-certified Electronic Health Record (EHR) system.
- **OP-18b:** Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged Patients - median time from ED arrival to time of departure from the ED for patients discharged from the ED (a lower number is better).



- **OP-20:** Door to Diagnostic Evaluation by Qualified Medical Personnel - median time from Emergency Department (ED) arrival to provider contact for ED patients (a lower number is better).
- **OP-21:** Median Time to Pain Management for Long Bone Fracture - median time from Emergency Department (ED) arrival to time of initial oral or parenteral pain medication administration for ED patients with a principal diagnosis of long bone fracture (a lower number is better).
- **OP-22:** Left Without Being Seen - percent of patients who leave the Emergency Department (ED) without being evaluated by a physician, advanced practice nurse (APN), or physician's assistant (PA). (A lower number is better.)
- **OP-23:** Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Emergency Department (ED) Arrival - percentage of acute ischemic stroke or hemorrhagic stroke patients who arrive at the ED within 2 hours of the onset of symptoms who have a head CT or MRI scan performed during the stay and have interpretation of the CT or MRI scan within 45 minutes of arrival.
- **OP-25:** Use of Safe Surgery Checklist (Outpatient) – whether or not a facility used a checklist for outpatient surgical procedures during each of the three critical perioperative periods (prior to administration of anesthesia, prior to skin incision, and closure of incision / prior to patient leaving the operating room).
- **OP-27 / IMM-3:** Health Care Workers Given Influenza Vaccination – Facilities must report vaccination data for three categories of Healthcare Personnel (HCP): employees on payroll; licensed independent practitioners (who are physicians, advanced practice nurses, and physician assistants affiliated with the hospital and not on payroll); and students, trainees, and volunteers aged 18 or older. Only HCP physically working in the facility for at least one day or more between October 1 and March 31 should be counted. Data on vaccinations received at the facility, vaccinations received outside of the facility, medical contraindications, and declinations are reported for the three categories of HCP.
- **OP-29:** Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients - Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.
- **OP-30:** Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings, who had a follow-up interval of 3 or more years since their last colonoscopy.
- **PC-01:** Elective Delivery - patients with elective vaginal deliveries or elective cesarean sections at greater than or equal to 37 and less than 39 weeks of gestation completed (a lower number is better).
- **SM-HS-PATIENT-SAF:** Use of hospital survey on patient safety culture.
- **SM-SS-CHECK (SM-5):** Use of Safe Surgery Checklist (inpatient) – whether or not a facility used a checklist for inpatient surgical procedures during each of the three critical perioperative periods (prior to administration of anesthesia, prior to skin incision, and closure of incision / prior to patient leaving the operating room).
- **VTE-6:** Hospital Acquired Potentially-Preventable Venous Thromboembolism (VTE) - the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date (a lower number is better).

For detailed measure specifications:

- Specifications Manual for National Hospital Inpatient Quality Measures www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic/Page/Qnet-Tier4&cid=1228772433589, accessed February 2019
- Specifications Manual for National Hospital Outpatient Quality Measures <http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/Page/Specs-ManualLicense>, accessed February 2019
- Prenatal measure specifications https://manual.joint-commission.org/releases/archive/TJC2012A/rsrc/Manual/TableOfContentsTJC/PC_v2012A.pdf, accessed February 2019



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