



Critical Access Hospital Year 7 Hospital Compare Participation and Quality Measure Results

*Michelle Casey, MS, Bridget Barton, MPP, Peiyin Hung, MSPH and Ira Moscovice, PhD
University of Minnesota Rural Health Research Center*

Introduction

This report examines participation and quality measure results for Critical Access Hospitals (CAHs) in the seventh year of the Centers for Medicare and Medicaid Services (CMS) Hospital Compare public reporting database. Although CAHs do not face the same financial incentives as hospitals paid under the Medicare Prospective Payment System (PPS) to participate, the Hospital Compare initiative provides an important opportunity for CAHs to assess and improve their performance on national standards of care. This report updates previous national reports on Hospital Compare results for CAHs.¹⁻⁶ The Flex Monitoring Team has also prepared state level reports on 2006-2010 data.

Approach

The current Hospital Compare quality measures include inpatient process of care measures that reflect recommended treatments for acute myocardial infarction (AMI), heart failure, pneumonia, surgical care improvement, and outpatient AMI/ chest pain and surgical process of care measures; Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patients' assessment of care survey results; and hospital 30-day risk-adjusted mortality and readmission rates for AMI, heart failure, and pneumonia calculated by CMS using Medicare claims data.

Data on the inpatient and outpatient process of care measures and HCAHPS survey results for January through December 2010 were downloaded from the CMS Hospital Compare website when they became available in October of 2011. These data were linked with previously downloaded process of care data for 2005-2009; data on the 3 year (July 2007 to June 2010) mortality and readmission rates calculated by CMS; data on all CAHs maintained by the Flex Monitoring Team; and data on hospital characteristics from the Fiscal Year 2010 American

Key Findings

- The 2010 CAH national participation rate in Hospital Compare (defined as publicly reporting data on at least one inpatient process of care measure) is 74%.
- By state, CAH reporting on inpatient measures ranges from 22% to 100%. Eight states have 100% of CAHs reporting while five states have fewer than half of CAHs reporting.
- 21% of CAHs reported data on at least one outpatient measure. By state, outpatient reporting ranges from 0% to 84% of CAHs.
- 38% of CAHs reported HCAHPS data. State HCAHPS reporting ranges from 0% to 100% of CAHs.
- One-fourth of CAHs are not publicly reporting any quality data to Hospital Compare.
- The percent of CAH patients receiving recommended care has increased for nearly all measures, but CAHs continue to have lower scores relative to rural and urban PPS hospitals on several measures.
- On average, CAHs have significantly higher ratings on HCAHPS measures than all US hospitals.
- As of June 2012, over 1000 of the 1328 CAHs had signed a Memorandum of Understanding to participate in the Flex Medicare Beneficiary Quality Improvement Program.

Hospital Association Annual Survey.

The percentages of patients that received recommended care for the inpatient process of care quality measures were calculated by dividing the total number of patients who received the recommended care by the total number of eligible patients in all CAHs nationally. The percentages of patients reporting the highest response (e.g., always) on each HCAHPS measure were summed and averaged across all reporting CAHs nationally and for all reporting hospitals in the U.S.

CMS calculates hospital-level 30-day risk-standardized mortality and readmission rates for pneumonia, heart failure, and heart attack using Medicare fee-for-service claims and enrollment data and statistical modeling techniques. Rates are not calculated for hospitals that are not in the Hospital Compare database or for hospitals with less than 25 qualifying cases over the three-year period. For this report, the number and percent of CAHs for which CMS did not calculate risk-adjusted mortality rates and readmission rates were determined. The number and percent of CAHs whose rates for each condition were not different than, better than or worse than the national rates, as determined by CMS, were then summed nationally.

Reporting of Inpatient and Outpatient Process of Care Measures

Nationally, participation in Hospital Compare (defined as publicly reporting data on at least one inpatient process of care measure) increased from 41% of CAHs in 2004 to 74% of CAHs in 2010. By state, the percent of CAHs reporting inpatient process of care measures for 2010 ranged from 22% to 100%. Of the 45 states in the Medicare Rural Hospital Flexibility (Flex) Program, eight states had 100% of their CAHs publicly reporting in 2010, while five states had less than half of their CAHs reporting.

CAHs were more likely to report data on the

pneumonia and heart failure measures than on the AMI and surgical care improvement measures. Nearly half (47%) of participating CAHs did not report data on any of the eight AMI measures, while 45% reported data on three or more measures. In contrast, 64% reported data on all four heart failure measures, while only 7% did not report data on any heart failure measures. Similarly, 81% of participating CAHs reported data on all six pneumonia measures and an additional 12% reported data on five measures; only 1% did not report data on any pneumonia measures. For the surgical care measures, 52% of participating CAHs did not report data on any of the eight measures, while 42% reported data on six or more measures.

A total of 282 CAHs (21.2%) publicly reported data on at least one outpatient process of care measure for 2010 discharges, up from 15.9% for 2009 discharges. Sixty-one percent CAHs reporting outpatient data reported four or more outpatient measures. By state, the percent of CAHs reporting outpatient process of care measures ranged from 0% to 84%.

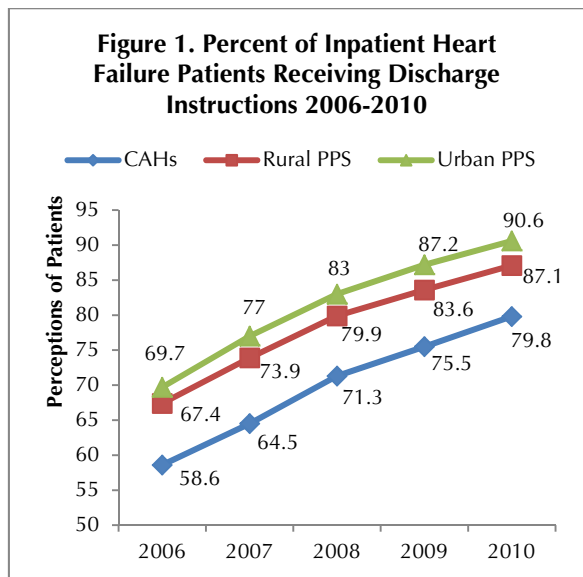
The most commonly reported outpatient measure were two AMI/chest pain measures (aspirin within 24 hours of arrival and median minutes to ECG).

Inpatient Process of Care Results

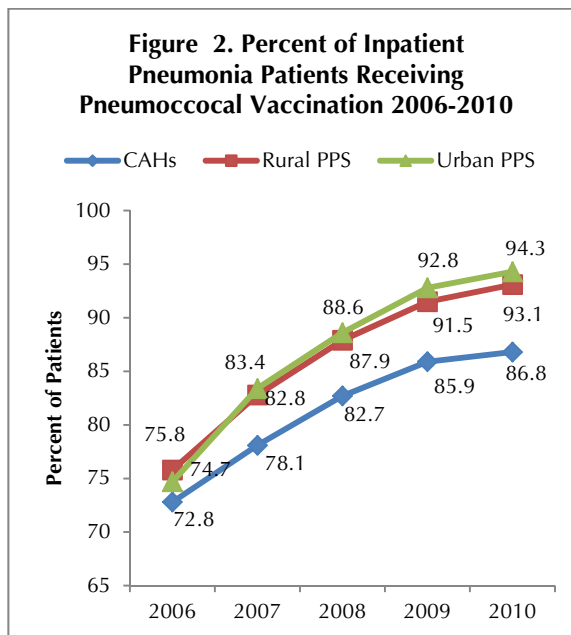
For 2010 discharges, CAHs as a group did not perform as well as rural and urban PPS hospitals on many of the inpatient process of care measures. From 2005-2010, the percent of CAH patients receiving recommended care increased annually for nearly all measures. However, the percent of rural and urban PPS hospital patients receiving recommended care also increased similarly during this time period. Thus, while showing improvement, CAHs continued to have lower scores relative to rural and urban PPS hospitals on most measures.

For example, the percent of CAH heart failure patients that received recommended discharge

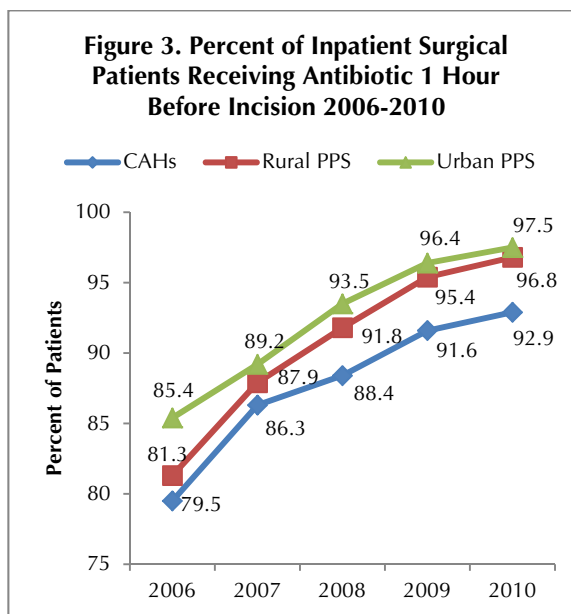
instructions increased from 58.6% in 2006 to 79.8% in 2010 (Figure 1). At the same time, however, the percent of rural PPS patients receiving the recommended discharge instructions increased from 67.4% to 87.1% and the percent of urban PPS patients receiving the recommended discharge instructions increased from 69.7% to 90.6%. Similar patterns hold true for several AMI, heart failure, and pneumonia measures.



In 2006, 72.8% of CAH pneumonia patients received a pneumococcal vaccination (vs. 74.7% for rural PPS and 75.8% for urban PPS hospitals) (Figure 2). While CAH performance improved to 86.8% in 2010, rural PPS and urban PPS hospitals also improved to 93.1% and 94.3%, respectively.



Similarly, in 2006, 79.5% of CAH surgical patients received an initial preventative antibiotic one hour before their incision (vs. 81.3% for rural PPS and 85.4% for urban PPS hospitals.) CAH performance improved to 92.9% in 2010, while rural PPS and urban PPS hospitals also improved to 96.8% and 97.5%.



Outpatient Process of Care Results

For 2010 outpatient discharges, CAHs as a group performed similarly to rural and urban PPS hospitals on one AMI/chest pain measure (aspirin within 24 hours of arrival, Figure 4), but not as well on the outpatient fibrinolytic or surgical antibiotic measures (Figure 5).

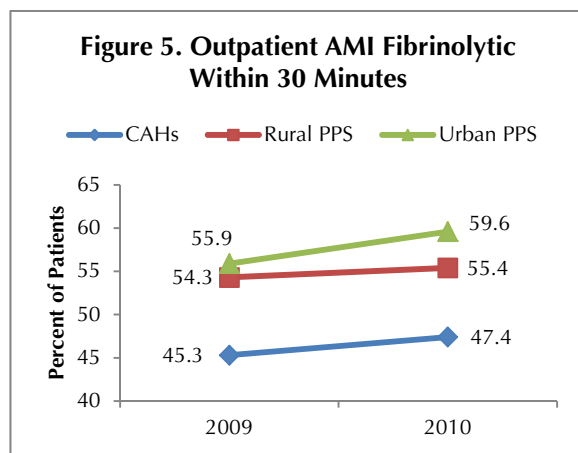
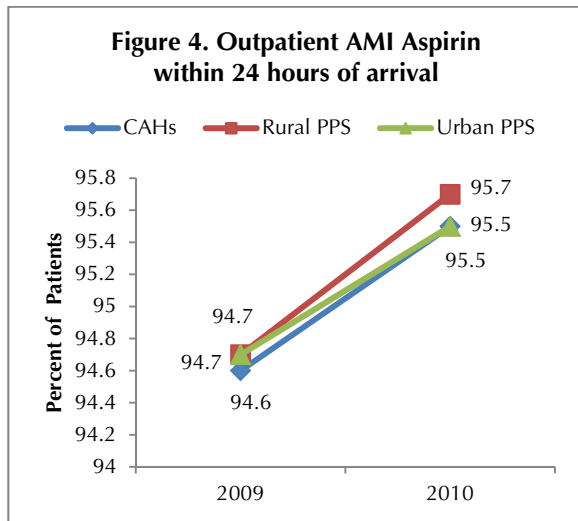


Table 1. HCAHPS Results for CAHs Nationally for 2010

Percent of patients who reported that:	Mean (average) for:	
	CAHs nationally (n=505)	Non-CAHs (n=3,321)
Nurses always communicated well	81%	76%
Doctors always communicated well	84%	80%
Patient always received help as soon as wanted	74%	63%
Pain was always well controlled	72%	69%
Staff always explained about medications before giving them to patient	66%	60%
Yes, staff gave patient information about what to do during recovery at home	84%	82%
Area around patient room was always quiet at night	63%	58%
Patient room and bathroom were always clean	80%	70%
They gave an overall hospital rating of 9 or 10 (high) on 1-10 scale	73%	67%
They would definitely recommend the hospital to friends and family	73%	69%

HCAHPS Survey Reporting and Results

Over one-third (38%) of CAHs publicly reported HCAHPS data to Hospital Compare in 2010. By state, the percent of CAHs publicly reporting HCAHPS data ranged from 0% to 100% of CAHs in 2010. Two states had 100% of their CAHs reporting HCAHPS data while only one state has 0% reporting.

Table 1 displays the mean (average) percentages of patients that gave the highest level of response (e.g., “always”) for each of the HCAHPS survey measures in two groups of hospitals that publicly reported HCAHPS data for 2010: CAHs nationally, and non-CAHs. For all ten HCAHPS measures, CAHs had higher average scores than non-CAHs.

Mortality and Readmission Results

Only 8% of CAHs had an AMI mortality rate calculated by CMS, and none had a rate that was different from the US rate for all hospitals. More CAHs had the minimum number of patients to reliably calculate mortality rates for heart failure (58%) and pneumonia (73%), but very few CAHs had mortality rates that are either better than or worse than the US rates for all hospitals (fewer than 1% of CAHs for heart failure and 3% of CAHs for pneumonia).

Only 3% of CAHs had an AMI readmission rate

calculated by CMS, and none had a rate that was different from the US rate for all hospitals. More CAHs had the minimum number of patients to reliably calculate readmission rates for heart failure (61%) and pneumonia (74%), but few CAHs had readmission rates that are either better than or worse than the US rates for all hospitals (0.2% of CAHs for heart failure and 0.2% of CAHs for pneumonia).

Conclusions

Factors likely to affect CAH quality reporting in the future include: 1) CMS changes to the Hospital Compare quality measure set; 2) implementation of the Flex Medicare Beneficiary Quality Improvement Project (MBQIP) by the Office of Rural Health Policy, which will encourage and assist CAHs in quality reporting; and 3) continued interest in payment reform at the national level, including the establishment of Value Based Purchasing demonstrations involving CAHs and other low volume hospitals.

Changes to CMS Hospital Compare

In January 2012, CMS made several changes to the Hospital Compare inpatient quality measure set that reduced the number of pneumonia, heart failure and AMI measures.¹⁰ These changes included: 1) retiring the pneumonia initial antibiotic timing measure, the pneumonia, heart failure and AMI smoking cessation advice measures and the pneumonia influenza and pneumococcal vaccination measures; 2) suspending data collection for three inpatient AMI measures (aspirin at arrival, ACEI/ARB for LVSD, and beta blocker at discharge); and 3) adding two new global influenza and pneumococcal vaccination measures.

The Medicare Beneficiary Quality Improvement Project

The Office of Rural Health Policy (ORHP) created the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Grant Program activity within the core area of quality improvement.

The primary goal of this project is for CAHs to implement quality improvement initiatives to improve their patient care. CAHs that opt to participate in MBQIP were asked to sign a Memorandum of Understanding (MOU) allowing ORHP to access their quality measure data. As of June 2012, over 1000 of the 1328 CAHs had signed MOUs.

The MBQIP measures include the CMS inpatient pneumonia and heart failure measures (to be implemented starting in 2011-2012); CMS outpatient AMI/chest pain, outpatient surgery, and HCAHPS measures (starting in 2012-2013); and outpatient Emergency Department Transfer Communication measures and Pharmacist CPOE/verification of medication orders within 24 hours (starting in 2013-2014).

Quality Reporting and Payment Reform

Beginning in FY 2013, the CMS Value-Based Purchasing (VBP) Program will provide Medicare incentive payments to acute care hospitals that are paid under the Prospective Payment System, based on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves from their baseline performance. Although CAHs are currently excluded from the CMS VBP Program, the Patient Protection and Affordable Care Act of 2010 included provisions for CMS to establish VBP demonstrations for CAHs and other low volume hospitals excluded from the VBP Program.

Impact on CAH Quality Reporting

It will be important to monitor the impact of these factors on CAH quality reporting, including CAH participation in public reporting and quality performance. The CMS changes to Hospital Compare are reducing the number of quality measures for pneumonia and heart failure, which are the most common inpatient conditions in CAHs, while adding new inpatient and outpatient measures for other conditions that

are relevant to CAHs. The impact of these changes will depend on the extent to which CAHs report data on existing and new measures. Both MBQIP and QIO efforts should increase the number of CAHs that are publicly reporting quality data, especially for outpatient and HCAHPS measures and improve CAH quality performance, since quality improvement activities are an integral part of these initiatives.

References

1. Casey, M. and Moscovice, I. CAH Participation in Hospital Compare and Initial Results. Flex Monitoring Team Briefing Paper No. 9, February 2006. http://www.flexmonitoring.org/documents/BriefingPaper9_HospitalCompare.pdf
2. Casey, M., Burlew, M. and Moscovice, I. Critical Access Hospital Year 2 Hospital Compare Participation and Quality Measure Results. Flex Monitoring Team Briefing Paper No. 16, April 2007. http://www.flexmonitoring.org/documents/BriefingPaper16_HospitalCompare2.pdf
3. Casey, M., Burlew, M. and Moscovice, I. Critical Access Hospital Year 3 Hospital Compare Participation and Quality Measure Results. Flex Monitoring Team Briefing Paper No. 20, August 2008. http://www.flexmonitoring.org/documents/BriefingPaper20_HospitalCompare3.pdf
4. Casey, M., Burlew, M. and Moscovice, I. Critical Access Hospital Year 4 Hospital Compare Participation and Quality Measure Results. Flex Monitoring Team Briefing Paper No. 22, October 2009. http://flexmonitoring.org/documents/BriefingPaper22_HospitalCompare4.pdf
5. Casey, M., Burlew, M. and Moscovice, I. Critical Access Hospital Year 5 Hospital Compare Participation and Quality Measure Results. Flex Monitoring Team Briefing Paper No. 26, March 2010.
6. Casey, M., Burlew, M. and Moscovice, I. Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results. Flex Monitoring Team Briefing Paper No. 26, April 2011.

This policy brief is based on Flex Monitoring Team Briefing Paper No.31 by Michelle Casey, Bridget Barton, Peiyin Hung and Ira Moscovice, available at www.flexmonitoring.org. For more information, please contact Michelle Casey at mcasey@umn.edu.