

## Hospital Compare June 2010 Release Preview Report Help Summary

The preview period is from **April 9, 2010 through May 8, 2010**. This Preview Report Help Summary document is intended to assist hospitals in understanding the content of each section of the preview report.

### Access to My QualityNet

In order to access your preview report, you must be:

- a registered My QualityNet user – see Registration Instructions at the website/link provided below:  
<http://www.qualitynet.org/dcs/ContentServer?cid=1138115987954&pagename=QnetPublic%2FPage%2FQnetBasic&c=Page>; **and**
- granted the QIO Clinical Warehouse Feedback Report role (assigned by the hospital's security administrator)

### How to access an HQA Preview Report

- Select the 'Run' link located in the Reports section of My QualityNet
- Select 'HQA Preview Reports' from the dropdown options under Report Category, then select 'Go'
- Select 'Hospital Quality Alliance (HQA) Preview Report' link located under Report Name

Detailed instructions on how to retrieve your HQA Preview Report is located in the QualityNet Reports User's Guide located in the Help section of My QualityNet. This user's guide is located at the website/link provided below:

<https://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/Page/QnetPopup&name=glh.SecureHelp.pag>.

### Hospitals Receiving a Preview Report

- Open status and data entry in PRS completed prior to 2/10/2010
- Cross reference information entered in PRS prior to 2/10/2010 for hospitals that have converted from an acute care hospital to a critical access hospital.

### General Information

The preview report is divided into three sections: Clinical Process Measures, Outcome Measures and HCAHPS Survey. The top portion displays the hospital CMS Certification Number (CCN) followed by the name of the hospital. The table below contains the list of hospital characteristics.

Address:	Type of Facility:
City, State, ZIP:	Type of Ownership: <sup>1</sup>
Phone Number:	Accreditation Status: <sup>2</sup>
County Name:	Emergency Service Provided:

<sup>1</sup> Type of Ownership is not publicly reported but is available in the downloadable Access database on Hospital Compare.

<sup>2</sup> CMS has temporarily suspended reporting the Accreditation Status on Hospital Compare. Accreditation Status is not available in the downloadable Access database.

## Hospital Compare June 2010 Release Preview Report Help Summary

If any of the hospital characteristics data displayed is incorrect, the hospital should contact its state OSCAR/ASPEN coordinator in writing. A list of the OSCAR/ASPEN coordinators is located at the website/link provided below. If the hospital's state OSCAR/ASPEN coordinator is unable to make the needed change, the hospital should contact its CMS Regional Office.

[http://www.hospitalcompare.hhs.gov/Hospital/Static/Contact\\_tabset.asp?activeTab=3&language=English&version=default](http://www.hospitalcompare.hhs.gov/Hospital/Static/Contact_tabset.asp?activeTab=3&language=English&version=default).

### General Questions

If your hospital has technical issues viewing its preview report, please contact the QualityNet Help Desk at [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org).

### Select Measure Highlights and Suppression Options

Reporting of measures is in accordance with a hospital's pledge status. The select measures listed below have special circumstances that affect the display or the suppression options available to a hospital based on the hospital's pledge status. If a pledge is received and entered in PRS by the QIO prior to the end of the preview period, the hospital will be able to preview their data.

- Hospitals with **only an HQA pledge** may suppress any measure
- Hospitals with a **RHQDAPU and an HQA pledge** may not suppress RHQDAPU measures
- Hospitals with **only a RHQDAPU pledge** may not suppress RHQDAPU measures

### Structural Measure - Participation in a Systematic Database for Cardiac Surgery

- Data collected from 7/1/09 through 8/15/09
- Participation during 1Q09 and 2Q09
- Data is updated annually with the December Hospital Compare release
- RHQDAPU-pledged hospitals may not suppress

### PN-5c

- Became part of RHQDAPU effective 1Q09
- Hospitals with **RHQDAPU pledge only**:
  - Aggregate rate includes 1Q09, 2Q09 and 3Q09 data
  - May not suppress
  - If a hospital does not have an active HQA pledge and elects to publicly report PN-5c results for 4Q08, the hospital must submit an HQA pledge to their QIO Hospital Public Reporting contact no later than QIO COB 5/8/2010
- Hospitals with **HQA pledge and RHQDAPU pledge**:
  - 4Q08 data may include data calculated from PN-5b as well as PN-5c
  - Beginning with 1Q09, RHQDAPU-pledged hospitals must submit PN5c only
  - Hospitals may suppress data for 4Q08. If suppressed, the aggregate rate will reflect 1Q09, 2Q09 and 3Q09 data

### PN-7

- Aggregate rate includes 4Q08 and 1Q09 data
- RHQDAPU-pledged hospitals may not suppress

### SCIP-Card-2

- Aggregate rate includes 1Q09, 2Q09 and 3Q09 data
- RHQDAPU-pledged hospitals may not suppress

## **Hospital Compare June 2010 Release Preview Report Help Summary**

### **30-Day Risk-Standardized Mortality and Readmission Measures for AMI, HF and PN**

- Displays data for 3Q06 through 2Q09
- Data is updated annually with the June Hospital Compare release
- Hospitals with less than 25 cases will not display risk-standardized mortality rates (RSMR) or risk-standardized readmission rates (RSRR) on the preview report or on hospital compare
- Hospitals will also receive a Hospital Specific Report (HSR) in their My QualityNet inbox with more detailed information on the mortality and readmission measures
- RHQDAPU-pledged hospitals may not suppress

### **HCAHPS**

- RHQDAPU-pledged hospitals may not suppress

### **Hospitals with No RHQDAPU or HQA Pledge will display only the CCN and hospital name along with the following message:**

“You do not have an active pledge status for Annual Payment Update (APU) nor Hospital Quality Alliance (HQA) for the preview report period. If you think this is an error, contact your QIO Hospital Public Reporting contact prior to the preview period closing date.”

If this message is received in error, the hospital must contact its QIO Hospital Public Reporting contact **no later than QIO COB 5/8/2010**.

### **Clinical Process Measure Information**

The preview report no longer displays the hospital's quarterly rates. Instead, the four quarters of data are rolled up and display as an aggregate rate for the clinical process measures.

### **State and National Rates**

The state and national un-weighted average rates and the 90<sup>th</sup> percentile national rate for each measure is calculated based on all data available in the QIO Clinical Warehouse regardless of whether that data was suppressed for previous releases.

### **Rounding Rules**

All rates (provider, state and national) will be reported as percentage values rounded to the nearest whole number. For example: 67%, 86% after applying rounding.

The calculated results will be rounded to the nearest whole number using standard rounding logic, unless otherwise stated.

- If above x.5, round up to the nearest whole number.
- If below x.5, round down to the nearest whole number.
- If exactly x.5 and x is an even number, round down to the nearest whole number. If exactly x.5 and x is an odd number, round up to the nearest whole number.

**Hospital Compare June 2010 Release  
Preview Report Help Summary**

**Clinical Process Measure Footnotes**

#	Description	Application
1	The number of cases is too small to reliably tell how well a hospital is performing.	Applied to any measure rate where the number of cases reported is less than 25.
2	Measure reflects the hospital's indication that its submission was based upon a sample of its relevant discharges	Applied when any case submitted to the warehouse was sampled for a reported quarter for a topic. Applied at the topic level (e.g. AMI).
3	Rate reflects fewer than maximum possible quarters of data	Applied when a hospital did not successfully submit data to the warehouse for a measure for all possible quarters.
4	Inaccurate information submitted and suppressed for one or more quarters	Reserved for CMS use to indicate the suppression of a measure for a hospital that submitted inaccurate information to the QIO Clinical Warehouse.
5	No data are available for publication from the hospital for this measure	Applied when a hospital elected not to submit data for a particular measure or when a hospital elected to suppress a rate.
0	0 Patients	Applied when no patients met the criteria for inclusion in the measure calculation.

**Questions regarding Clinical Process Measures**

If your hospital has questions regarding the Clinical Process Measures or believes there is an error in the data displayed in your preview report, please contact your QIO contact listed on QualityNet.

The list of QIO contacts is located at the website/link below:

<http://www.qualitynet.org/dcs/ContentServer?cid=1138900288004&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page>.

**Outcome Measures Information**

The Outcome Measures data displayed on the preview report is updated on an annual basis. Changes in your hospital data will only occur during the June Hospital Compare release.

**Hospital Specific Report (HSR)**

Hospitals will receive an HSR in their My QualityNet inbox with more detailed information on the mortality and readmission measures. If a hospital is unable to locate their HSR, they may request a copy of their June 2010 Outcome Measures HSR by sending an email to [HSRrequest@iaqio.sdps.org](mailto:HSRrequest@iaqio.sdps.org). In order to process your request, please include your hospital CCN.

**State and National Rates**

The state risk-standardized rates are not reported on the preview report; however the average risk-standardized rates for hospitals in a state were published in their HSRs. The national rates are crude (unadjusted) rates.

## Hospital Compare June 2010 Release Preview Report Help Summary

### 30-Day Risk-Standardized Mortality and Readmission Measures

- 30-Day Risk-Standardized Mortality and 30-Day Risk-Standardized Readmission Measures include Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN)
- The hospital's data reflects up to three years of data (3Q06 through 2Q09 discharges), depending on the number of years during which the hospital had eligible cases for the individual measures
- In addition to the hospital's performance category (better, worse, or no different than U.S. national rate), the estimated risk-adjusted 30-day death rate [risk-standardized mortality rates (RSMRs)] and the estimated risk-adjusted 30-day readmission rate [risk-standardized readmission rates (RSRRs)], interval estimates and number of patients (cases) included in the model will be displayed on the Hospital Compare website
- Hospitals with fewer than 25 eligible cases for a measure are assigned to a separate category, described as: "The number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing." While these cases are included in the measure calculation, Hospital Compare will not report the mortality and readmission rate or interval estimates for the relevant measure(s) for these hospitals
- Hospitals that have only an HQA pledge will be allowed to suppress mortality and readmission measures
- Hospitals are **not** required to submit Mortality or Readmission Measure data; CMS calculates these measures from claims and enrollment data

### Outcome Measures Footnotes

#	Description	Application
5	No data are available for publication from the hospital for this measure	<p><b>Mortality and Readmission Measures:</b> The columns displaying Your Hospital Performance, Your Hospital's Number of Eligible Medicare Admissions (for Mortality)/ Discharges (for Readmission), and Your Hospital's Risk Standardized Mortality/Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate) will display N/A(5) in the following conditions:</p> <p>If data are suppressed for one of the outcome measures;</p> <p><b>or</b></p> <p>If the provider has an HQA and/or APU pledge but no data are available for reporting for the outcome measure.</p>

### Questions regarding Outcome Measures

If you have questions regarding your hospital's mortality data or readmission data or believe that there is an error in your preview report, please send an email to the Outcome Measures implementation team at [mortalitymeasures@mathematica-mpr.com](mailto:mortalitymeasures@mathematica-mpr.com) or [readmissionmeasures@mathematica-mpr.com](mailto:readmissionmeasures@mathematica-mpr.com)

## Hospital Compare June 2010 Release Preview Report Help Summary

### HCAHPS Information

HCAHPS (Hospital Consumer Assessment of Healthcare Providers & Systems) survey data collection began with October 2006 discharges. Beginning in July 2007(3Q07), all IPPS hospitals must continuously collect and submit HCAHPS data in order to qualify to receive their full Annual Payment Update (APU).

The HCAHPS survey results display as an aggregate rate of four quarters of data. Individual quarters or months are not available for review. Each hospital's aggregate results are compared to national and state averages. The preview report also contains the hospital's number of completed surveys and its survey response rate for the period.

Inpatient Prospective Payment System (IPPS) hospitals participating in the RHQDAPU program are not allowed to suppress their HCAHPS results. All participating hospitals will receive a preview report prior to public reporting, and non-IPPS hospitals have the option of withholding their HCAHPS results from public reporting.

The report is divided into three sections:

- HCAHPS Survey Completion and Response Rate
- HCAHPS Composites and Individual Items
- HCAHPS Global Items

The **HCAHPS Survey Completion and Response Rate** section contains:

1. Number of Completed Surveys
2. Survey Response Rate

The **HCAHPS Composites and Individual Items** section contains:

#### HCAHPS Composites

- Composite 1 Communication with Nurses (Q1, Q2, Q3)
- Composite 2 Communication with Doctors (Q5, Q6, Q7)
- Composite 3 Responsiveness of Hospital Staff (Q4, Q11)
- Composite 4 Pain Management (Q13, Q14)
- Composite 5 Communication About Medicines (Q16, Q17)

#### Hospital Environment Items

1. Cleanliness of Hospital Environment (Q8)
2. Quietness of Hospital Environment (Q9)

#### Discharge Information Composite

- Composite 6 Discharge Information (Q19, Q20)

The **HCAHPS Global Items** section contains:

1. Overall Rating of this Hospital (Q21)
2. Willingness to Recommend this Hospital (Q22)

## Hospital Compare June 2010 Release Preview Report Help Summary

### State and National Rates

State and national un-weighted average rates for each HCAHPS measure are calculated based on all data available in the HCAHPS Data Warehouse for the four quarters.

### HCAHPS Measures Footnotes

#	Description	Application
6	Fewer than 100 patients completed the HCAHPS survey. Use these rates with caution, as the number of surveys may be too low to reliably assess hospital performance	Applied when the number of completed surveys the hospital or its vendor provides to CMS is less than 100. Footnote 6 displays only in the "Number of Completed Surveys" column.
7	Survey results are based on less than 12 months of data	Applied when CMS has opted to display HCAHPS results on fewer than the required months of survey data.
8	Survey results are not available for this reporting period	Applied in the following situations:  When a hospital has results for other measures reported on the Preview Report but did not participate in HCAHPS during the period covered by the Preview Report;  When a hospital participated in HCAHPS but for only a portion of the period covered by the Preview Report;  or  When a hospital has HCAHPS results but chose to suppress the public reporting of its results (in this situation, a hospital will see its HCAHPS results on its Preview Report but results will be suppressed in public reporting). <b>Note:</b> Only non-IPPS hospitals may choose to suppress HCAHPS results.
9	No or very few patients were eligible for the HCAHPS survey. The scores shown, if any, reflect a very small number of surveys.	Applied when a hospital has no patients eligible to participate in the HCAHPS survey, or when HCAHPS scores are based on 10 or fewer completed surveys.
11	There were discrepancies in the data collection process	Applied when there have been deviations from HCAHPS data collection protocols.

### Questions regarding HCAHPS Measures

Any questions regarding data in the HCAHPS preview report should be directed to the HCAHPS Project Team via email at [hcahps@azqio.sdps.org](mailto:hcahps@azqio.sdps.org)

This material was prepared by IFMC, the RHQDAPU Quality Improvement Organization Support Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. 9SoW-IA-HPQIOSC-03/10-056