

Hospital Compare June 2009 Release Preview Report Help Summary

The preview period is from **April 10, 2009 through May 9, 2009**. The 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 HQA Preview Report. You must be:

- a registered My QualityNet user – see [Registration Instructions](http://www.qualitynet.org/dcs/ContentServer?cid=1138115987954&pagename=QnetPublic%2FPage%2FQnetBasic&c=Page)
<http://www.qualitynet.org/dcs/ContentServer?cid=1138115987954&pagename=QnetPublic%2FPage%2FQnetBasic&c=Page>)
- AND**
- assigned the QIO Clinical Warehouse Feedback Report role (Contact your hospital's Security Administrator to have this role assigned to you)

Obtaining an HQA Preview Report

Preview Reports may be accessed through the HQA Preview Reports link located in the Reports section of My QualityNet. For detailed instructions on how to retrieve your HQA preview report, please refer to the [QualityNet Reports User's Guide](https://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/Page/QnetPopup&name=glh.SecureHelp.page) located in the Help section of My QualityNet.
<https://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/Page/QnetPopup&name=glh.SecureHelp.page>)

GENERAL INFORMATION

The Preview Report is divided into three sections: Clinical Process Measures, Outcome Measures and HCAHPS Survey.

The top portion of the Preview Report displays the hospital CMS Certification Number (CCN) followed by the name of the hospital. The CCN was previously referred to as the Medicare Provider Number. The section directly below contains a list of facility characteristics.

Facility Characteristics	
Address:	Type of Facility:
City, State, ZIP:	Type of Ownership:*
Phone Number:	Accreditation Status:**
County Name:	Emergency Service Provided:

*Type of Ownership is not publicly reported but is available in the downloadable Access database on Hospital Compare.

**CMS has temporarily suspended reporting the Accreditation Status on Hospital Compare. Accreditation Status is NOT available in the downloadable Access database.

If any of the facility characteristics data displayed is incorrect, the hospital should contact its state OSCAR/ASPEN coordinator in writing (see list found under "View a List of Hospital Compare Contact Information", located on the [Hospital Compare](http://www.hospitalcompare.hhs.gov/Hospital/Search/Welcome.asp?version=default&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home) website, OSCAR/ASPEN tab).

<http://www.hospitalcompare.hhs.gov/Hospital/Search/Welcome.asp?version=default&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home>

If the hospital's state OSCAR/ASPEN coordinator is unable to make the needed change, the hospital should contact its CMS Regional Office.

Included Providers

- Providers with an open status (Facility Closed Date field is null or blank in the Program Resource System, PRS) as of the open and close **deadline date (2/15/2009)** will be included in the Public Reporting for June 2009.
- Hospitals that have converted from an **Acute Care Hospital to a Critical Access Hospital** will have the option to carry forward their previously collected data for public reporting to consolidate the data under their new CMS Certification Number (CCN). Cross reference information must be entered into PRS by your QIO prior to the open and close deadline date (2/15/2009) in order for the hospital to be included in the Public Reporting for that period. To carry forward data to the new CCN, a converting hospital should contact their [QIO contact](http://www.qualitynet.org/dcs/ContentServer?cid=1138900288004&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page) as listed on the QualityNet website.
<http://www.qualitynet.org/dcs/ContentServer?cid=1138900288004&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page>

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GENERAL INFORMATION (cont.)

Included Providers (cont.)

- Open or Close status information entered into PRS **after** the open and close deadline date (2/15/2009) will **not** be included in Public Reporting for the June 2009 Hospital Compare release.

Technical Questions

If your hospital has technical issues in viewing its preview report, please contact the QualityNet Help Desk at qnetsupport@ifmc.sdps.org.

MEASURE DISPLAY AND SUPPRESSION – Special Cases

Data displayed on the Preview Report is based on the type of pledge the hospital has submitted. The table below summarizes select measures that are displayed on the Preview Reports by the various pledge type and suppression options available to the hospital. (Only measures with special circumstances are described in the table below. All other measures displaying on the Preview Report will display according to the pledge status of the provider.)

RHQDAPU AND HQA PLEDGE	
Report Display (if data available)	Suppression Options
AMI-6 <ul style="list-style-type: none"> • Not displayed • Required submission for RHQDAPU for discharges through 1Q09. Removed from Hospital Compare January 15, 2009 	Not displayed on Preview Report or Hospital Compare
PN-5b <ul style="list-style-type: none"> • Not displayed • Required submission for RHQDAPU for discharges through 4Q08 	Not displayed on Preview Report or Hospital Compare
PN-5c <ul style="list-style-type: none"> • Data displayed is calculated from PN-5b data 	May suppress
PN-7 <ul style="list-style-type: none"> • 4Q07 and 1Q08 data will include the entire quarter's data • 2Q08 and 3Q08 will display N/A 	May not suppress
SCIP-Inf-4 and SCIP-Inf-6 <ul style="list-style-type: none"> • 4Q07 will display N/A • 1Q08, 2Q08 and 3Q08 will display data 	May not suppress
Outcome Measures 30-Day Risk-Standardized Mortality Measures for AMI, HF and PN <ul style="list-style-type: none"> • Displays data for 3Q05 through 2Q08 • Hospitals with less than 25 cases will not display risk-standardized mortality rates (RSMR) on Preview Report or Hospital Compare; these rates will be included in the Hospital Specific Report (HSR) 30-Day Risk-Standardized Readmission Measures for AMI, HF and PN (NEW) <ul style="list-style-type: none"> • Displays data for 3Q05 through 2Q08 • Hospitals with less than 25 cases will not display the risk-standardized readmission rates (RSRR) on Preview Report or Hospital Compare; these rates will be included in the Hospital Specific Report (HSR) 	May not suppress
HCAHPS <ul style="list-style-type: none"> • RHQDAPU-pledged providers can no longer suppress beginning with March 2009 Hospital Compare release. 	May not suppress

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MEASURE DISPLAY AND SUPPRESSION – Special Cases (cont.)	
RHQDAPU PLEDGE ONLY	
Report Display (if data available)	Suppression Options
AMI-6 <ul style="list-style-type: none"> • Not displayed • Required submission for RHQDAPU for discharges through 1Q09. Removed from Hospital Compare January 15, 2009. 	Not displayed on Preview Report or Hospital Compare
PN-5b <ul style="list-style-type: none"> • Not displayed • Required submission for RHQDAPU for discharges through 4Q08 	Not displayed on Preview Report or Hospital Compare
PN-5c <ul style="list-style-type: none"> • Displays N/A(5) due to no HQA pledge • HQA pledge required to view Preview Report or publish on Hospital Compare 	May suppress if provider has HQA pledge
PN-7 <ul style="list-style-type: none"> • 4Q07 and 1Q08 will include the entire quarter's data • 2Q08 and 3Q08 will display N/A 	May not suppress
SCIP-Inf-4 and SCIP-Inf-6 <ul style="list-style-type: none"> • 4Q07 will display N/A • 1Q08, 2Q08 and 3Q08 will display data 	May not suppress
Outcome Measures 30-Day Risk-Standardized Mortality Measures for AMI, HF and PN <ul style="list-style-type: none"> • Displays data for 3Q05 through 2Q08 • Hospitals with less than 25 cases will not display the risk-standardized mortality rate (RSMR) on Preview Report or Hospital Compare; these rates will be included in the Hospital Specific Report (HSR) 30-Day Risk-Standardized Readmission Measures for AMI, HF and PN (NEW) <ul style="list-style-type: none"> • Displays data for 3Q05 through 2Q08 • Hospitals with less than 25 cases will not display the risk-standardized readmission rates (RSRR) on Preview Report or Hospital Compare; these rates will be included in the Hospital Specific Report (HSR) 	May not suppress
HCAHPS <ul style="list-style-type: none"> • RHQDAPU-pledged providers can no longer suppress beginning with March 2009 Hospital Compare release. 	May not suppress
HQA PLEDGE ONLY	
Report Display (if data available)	Suppression Options
<ul style="list-style-type: none"> • Displays as RHQDAPU & HQA pledge listed above 	May suppress all measures

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MEASURE DISPLAY AND SUPPRESSION – Special Cases (cont.)	
NO RHQDAPU OR HQA PLEDGE	
Report Display (if data available)	Suppression Options
<p>Only CMS Certification Number (CCN) [previously referred to as Medicare Provider Number] and Hospital Name display with the following statement:</p> <p style="padding-left: 40px;">“You do not have an active pledge status for Annual Payment Update (APU) nor Hospital Quality Alliance (HQA) or you are a closed provider 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.”</p> <p>Note: If this message is received in error, the hospital must contact its QIO Hospital Public Reporting contact no later than QIO COB 5/9/2009.</p>	<p>None</p>
<p>NOTES:</p> <ul style="list-style-type: none"> • AMI-6 was removed from Hospital Compare on January 15, 2009. It will no longer display on the Preview Report or on the Hospital Compare website. AMI-6 is a required submission for RHQDAPU requirements for discharges through 1Q09. • To view PN-5c on the Preview Report or publicly report PN-5c results on Hospital Compare, a hospital must have an active HQA pledge. • If a hospital does not have an active HQA pledge and elects to publicly report PN-5c results, the hospital must submit an HQA pledge to their QIO Hospital Public Reporting contact. • If the QIO receives and enters a pledge in PRS prior to the last day of the Preview Period, the hospital will be able to preview the data. • Suppressions entered during the current preview report period will ONLY be reflected in the data reported for this Public Reporting Period. • If a hospital elects to suppress its data, they must submit an “HQA Request for Withholding Data From Public Reporting” form to its QIO no later than QIO COB 5/9/2009. • Hospitals are not required to submit data for the 30-Day Risk-Standardized Mortality Measures or 30-Day Risk-Standardized Readmission Measures; CMS calculates these measures from claims and enrollment data. 	

CLINICAL PROCESS MEASURE INFORMATION ONLY

The Preview Report displays individual quarterly rates for each of the measures as well as aggregate rates for each measure. The aggregate rates reflect up to four quarters of data (4th quarter 2007 through 3rd quarter 2008 discharges). **ONLY THE AGGREGATE RATES WILL DISPLAY** on the Hospital Compare website for the June 2009 posting.

State and National Rates

For the Preview Report, state and national un-weighted average rates and the 90th percentile national rate for each measure are calculated based on all data available in the QIO Clinical Warehouse, regardless of whether that data was suppressed for previous releases. The final state and national average rates and the 90th percentile national rate for each measure (displayed on the website) **will be recalculated** after the preview period to reflect only the unsuppressed rates.

Rounding Rules

All rates being reported (Provider Level Rates, State Rates and National Rates) will be reported as percentage values rounded to the nearest whole number. For example: 67%, 86% after applying rounding.

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CLINICAL PROCESS MEASURE INFORMATION ONLY (cont.)

Rounding Rules (cont.)

General rule for rounded results:

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.

Footnotes

#	Description	Application
1	The number of cases is too small ($n < 25$) for purposes of reliably predicting hospital performance.	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 at the topic level, e.g. AMI, HF If any case was sampled for the topic for the quarter, the footnote is applied to all measures in that quarter as well as the aggregate.
3	Rate reflects fewer than maximum possible quarters of data.	Applied to only the aggregate rates when a hospital did not successfully submit data to the QIO Clinical 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 quarter(s) for a hospital(s) that submitted inaccurate information to the QIO Clinical Warehouse for that quarter(s).
5	No data are available for publication from the hospital for this measure.	Applied to individual quarters and aggregate rates for instances where a hospital elected to not submit data for a particular measure or where a hospital elected to suppress a rate after preview.
0	0 Patients	Applied when a hospital treated patients in a topic but no patients met the criteria for inclusion in the measure calculation. For this scenario, the preview report will display "0 patients".

Questions

If your hospital has questions regarding the Clinical Process Measures or believes there is an error in the data for the Clinical Process Measures in your preview report, please contact your QIO contact listed on the [QualityNet](http://www.qualitynet.org) website.

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

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OUTCOME MEASURES INFORMATION ONLY

30-Day Risk-Standardized Mortality Rate Measures

- 30-Day Risk-Standardized Mortality Measures include Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN) mortality measures
- The hospital's data reflects up to three years of data (3rd quarter 2005 through 2nd quarter 2008 discharges), depending on the number of years during which your 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)], 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 follows: "The number of cases is too small (fewer than 25) to reliably tell how the hospital is performing." While these cases are included in the measure calculation, Hospital Compare will not report the mortality rate or interval estimates for the relevant measure(s) for these hospitals
- Hospitals that have pledged in the **HQA program only** will be allowed to suppress any or all three mortality measures
- Hospitals are **NOT** required to submit any Mortality Measure data; CMS calculates these measures from claims and enrollment data

30-Day Risk-Standardized Readmission Rate Measures

- 30-Day Risk-Standardized Readmission Measures include Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN) readmission measures
- The hospital's data reflects up to three years of data (3rd quarter 2005 through 2nd quarter 2008 discharges), depending on the number of years during which your 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 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 follows: "The number of cases is too small (fewer than 25) to reliably tell how the hospital is performing." While these cases are included in the measure calculation, Hospital Compare will not report the readmission rate or interval estimates for the relevant measure(s) for these hospitals
- Hospitals that have pledged in the **HQA program only** will be allowed to suppress any or all three readmission measures
- Hospitals are **NOT** required to submit any Readmission Measure data; CMS calculates these measures from claims and enrollment data

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 will be published in the HSRs. The national rates are crude (unadjusted) rates. The national rates will **NOT** be recalculated after the preview period; they will continue to reflect all hospitals that had data regardless of their suppression status.

Hospital Specific Report (HSR)

The Outcome Measures HSR was uploaded to hospital users' QualityNet Inbox. In order to access the HSR, each user must be assigned two roles: (1) QIO Clinical Warehouse Feedback Report role in order to receive the report and (2) File Exchange & Search role in order to download the report from My QualityNet. If the HSR was not downloaded during the initial allotted timeframe, the hospital may request a re-upload of the report by submitting a request to HSRrequest@iaqio.sdps.org.

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OUTCOME MEASURES INFORMATION ONLY (cont.)

Footnotes

#	Description	Application
5	No data are available for publication from the hospital for this measure	<p>Mortality Measures: The columns displaying “Your Hospital Performance”, “Your Hospital’s Number of Eligible Medicare Admissions”, and “Your Hospital’s Risk Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)” will display N/A (5) in the following conditions:</p> <ul style="list-style-type: none"> • If data are suppressed for one of the outcome measures during the preview period • If the provider has an HQA and/or APU pledge but no data are available for reporting for the outcome measure <p>Readmission Measures: The columns displaying “Your Hospital Performance”, “Your Hospital’s Number of Eligible Medicare Discharges”, and “Your Hospital’s Risk Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)” will display N/A (5) in the following conditions:</p> <ul style="list-style-type: none"> • If data are suppressed for one of the outcome measures during the preview period • If the provider has an HQA and/or APU pledge but no data are available for reporting for the outcome measure

Questions

If you have questions regarding your hospital’s **mortality data** or believe that there is an error in your preview report, please send an email to the Outcomes Measures implementation team at mortalitymeasures@mathematica-mpr.com

If you have questions regarding your hospital’s **readmission data** or believe that there is an error in your preview report, please send an email to the Outcomes Measures implementation team at readmissionmeasures@mathematica-mpr.com

HCAHPS INFORMATION ONLY

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

The Preview Report of the HCAHPS survey results contains aggregate results. These aggregate rates reflect four quarters of data (4th quarter 2007 through 3rd quarter 2008 discharges). Individual quarters or months in the reporting period 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 exact number of completed surveys and its survey response rate for the period.

The report is divided into three sections:
HCAHPS Survey Completion and Response Rate
HCAHPS Composites and Items
HCAHPS Overall Ratings

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

1. Number of Completed Surveys
2. Survey Response Rate

The **HCAHPS Composites and 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) |

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HCAHPS INFORMATION ONLY (cont.)

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 **Overall Ratings** section contains:

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

Note: Beginning with the March 2009 Hospital Compare release, Inpatient Prospective Payment System (IPPS) hospitals participating in the RHQDAPU program are **no longer** allowed to suppress their HCAHPS results. All hospitals will continue to receive a Preview Report prior to public reporting. Non-IPPS hospitals with an active HQA pledge will continue to have the option of withholding their HCAHPS results from public reporting.

State and National Rates

For the Preview Report, state and national un-weighted average rates for each HCAHPS measure are calculated based on all data available in the HCAHPS Data Warehouse. The final state and national average rates for each HCAHPS measure **will be recalculated** after the preview period to reflect only the unsuppressed rates.

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. The preview report will display footnote # 6 only in the column "Number of Completed Surveys".
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 Preview Report in the following situations: <ul style="list-style-type: none"> • 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 for public reporting 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).
9	No patients were eligible for the HCAHPS Survey.	Applied when a hospital has no patients eligible to participate in the HCAHPS survey.
11	There were discrepancies in the data collection process.	Applied when there have been deviations from HCAHPS data collection protocols.

Questions

Any questions regarding data in the HCAHPS Preview Report should be directed to the HCAHPS Project Team via email at hcahps@azqio.sdps.org