

Hospital Compare December 2009 Release Preview Report Help Summary

The preview period is from **October 6, 2009 through November 4, 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 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**
- 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 located in the Help section of My QualityNet. The QualityNet Reports 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>.

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 a list of facility characteristics.

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

If any of the facility 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.

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

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

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Hospitals Included on the Preview Reports

- Hospitals with an open status in PRS and data entered prior to 8/6/2009
- Hospitals that have converted from an Acute Care Hospital to a Critical Access Hospital will have the option to carry forward their previously collected public reporting data to consolidate the data under their new CCN. Cross reference information must be entered into PRS by the QIO prior to 8/6/2009. To carry forward data to the new CCN, a converting hospital should contact their QIO contact.

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

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

General Questions

If your hospital has technical issues in viewing its Preview Report, please contact the QualityNet Help Desk at qnet support@sdps.org.

Changes for December

Report Design/Format - The Clinical Process Measures (AMI, HF, PN and SCIP) no longer display the hospital's quarterly rates. The measure rates display as an aggregate rate of the four quarters of data. This change allows consistency between the other measures displayed on the preview report and on Hospital Compare.

Structural Measure - Participation in a Systematic Database for Cardiac Surgery, displays on the far right column of the facility characteristics section of the preview report

PN-1 - Oxygenation Assessment, no longer displays on the preview report

SCIP-Card-2 - Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period, displays on the preview report for the first time

Select Measure Highlights and Suppression Options

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
- RHQDAPU- pledged hospitals may not suppress

AMI-6 - Not displayed on Preview Report or Hospital Compare but required submission for RHQDAPU for discharges through 1Q09. Removed from Hospital Compare 1/15/09

PN-1 - Not displayed on Preview Report or Hospital Compare

PN-5b - Not displayed on Preview Report or Hospital Compare but required submission for RHQDAPU for discharges through 4Q08

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PN-5c

- Became part of RHQDAPU effective 1Q09
- Hospitals with RHQDAPU pledge only:
 - Aggregate rate includes 1Q09 data only
 - May not suppress
 - 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. A list of the QIO contacts is located at the website/link provided on page 2.
- Hospitals with an HQA pledge and a RHQDAPU pledge:
 - 2Q08 through 4Q08 includes 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 2Q08 through 4Q08. If suppressed, the aggregate rate will reflect 1Q09 data only

PN-7

- Aggregate rate includes 4Q08 and 1Q09 data
- Hospitals with a RHQDAPU pledge may not suppress

SCIP-Card-2 - Aggregate rate includes 1Q09 data only

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

- 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 were included in the Hospital Specific Report (HSR) received in April 2009 for the July 2009 reporting.
- Hospitals with a RHQDAPU pledge may not suppress

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

- 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 were included in the Hospital Specific Report (HSR) received in April 2009 for the July 2009 reporting.
- Hospitals with a RHQDAPU pledge may not suppress
- Maryland hospitals data has been suppressed by CMS

HCAHPS - Hospitals with a RHQDAPU pledge 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), 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.”

If this message is received in error, the provider must contact its QIO Hospital Public Reporting contact **no later than QIO COB 11/4/2009**. A list of the QIO contacts is located at the website/link provided on page 2.

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Clinical Process Measure Information Only

The aggregate rate for the clinical process measures reflect four quarters of data.

Clinical Process Measure 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 no patients met the criteria for inclusion in the measure calculation

State and National Rates

The state and national un-weighted average rates and the 90th 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.

Questions regarding Clinical Process Measures

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 QualityNet. A list of the QIO contacts is located at the website/link provided on page 2.

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Outcome Measures Information Only

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.

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 (3Q05 through 2Q08 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)], 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 only the HQA program will be allowed to suppress any or all mortality measures
- Hospitals are **not** required to submit 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 (3Q05 through 2Q08 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 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 only the HQA program will be allowed to suppress any or all readmission measures
- Hospitals are **not** required to submit Readmission Measure data; CMS calculates these measures from claims and enrollment data
- Maryland Hospitals information has been suppressed by CMS due to the way Maryland hospitals are paid and the potential impact on their readmission rates

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Outcome Measures 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> <p>If data are suppressed for one of the outcome measures; or If the provider has an HQA and/or APU pledge but no data are available for reporting for the outcome measure</p> <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> <p>If data are suppressed for one of the outcome measures; or If the provider has an HQA and/or APU pledge but no data are available for reporting for the outcome measure</p>

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 Specific Report (HSR)

Hospitals can request a copy of their June 2009 Outcome Measures HSR by sending an email to HSRrequest@iaqio.sdps.org.

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 or readmissionmeasures@mathematica-mpr.com

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HCAHPS Information Only

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 contain aggregate results. These aggregate rates reflect four quarters of data (2Q08 through 1Q09 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 number of completed surveys and its survey response rate for the period.

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 and non-IPPS hospitals will continue to 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 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)

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)

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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. 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	<p>Applied in the Preview Report in the following situations:</p> <p>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;</p> <p>When a hospital participated in HCAHPS but for only a portion of the period covered by the Preview Report; or</p> <p>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).</p>
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.

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

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