Inpatient Hospital Compare

Preview Report Help Guide

The target audience for this publication includes hospitals and Quality Improvement Organizations (QIOs). The document scope is limited to instructions for hospitals and QIOs on how to access and understand the data provided on the preview report prior to publication of data on Hospital Compare.

September 2013 Preview / December 2013 Hospital Compare Release
**TABLE OF CONTENTS**

**Section 1: Overview** ........................................................................................................................................... 4  
  Hospital Compare Overview ................................................................................................................................. 4  
  Inpatient Prospective Payment Systems (IPPS) Overview ...................................................................................... 4  
  Preview Period ..................................................................................................................................................... 4  

**Section 2: Preview Report Access** .................................................................................................................. 5  
  Registration Instructions ........................................................................................................................................ 5  
  Run Preview Report .............................................................................................................................................. 6  
  Report Viewer ........................................................................................................................................................ 9  

**Section 3: Preview Report Details** ................................................................................................................... 10  
  Preview Report Format .......................................................................................................................................... 10  
  Footnote Changes ................................................................................................................................................. 11  
  Preview Report Measures ..................................................................................................................................... 13  
    Clinical Process Measures ................................................................................................................................. 13  
  Clinical Process Measure Details .......................................................................................................................... 13  
    Influenza Immunization (IMM-2) ...................................................................................................................... 14  
    Perinatal Care (PC-01): Elective Delivery .......................................................................................................... 14  
    Clinical Process Measure Footnotes ................................................................................................................ 14  
    State and National Performance Rates ............................................................................................................ 15  
  Rounding Rules ................................................................................................................................................... 15  
  Questions Regarding Clinical Process Measures ................................................................................................ 15  
  HCAHPS Survey Data .......................................................................................................................................... 15  
    30-Day Risk-Standardized Mortality Measures ................................................................................................. 18  
    30-Day Risk-Standardized Readmission Measures .......................................................................................... 18  
  Surgical Complications ....................................................................................................................................... 19  
  Outcome Measure Details .................................................................................................................................... 19  
    State and U.S. National Rates ............................................................................................................................. 20  
    Questions Regarding Outcome Measures ....................................................................................................... 21  
    Hospital Readmissions Reduction Program ...................................................................................................... 21  
  Healthcare Associated Infection (HAI) .................................................................................................................. 22  
    HAI Hospital Quality Measures ........................................................................................................................ 22  
  Preview Report ...................................................................................................................................................... 23  
    Your Hospital’s Reported Number of Infections ............................................................................................... 23  
    Device or Patient Days/Procedures .................................................................................................................... 23  
    Your Hospital’s Predicted Number of Infections ............................................................................................... 23  
    Your Hospital’s Performance .............................................................................................................................. 24  
    State Standardized Infection Ratio (SIR) ............................................................................................................ 24
U.S. National Standardized Infection Ratio (SIR) .................................................. 24
Confidence Interval ............................................................................................... 24
Healthcare Personnel (HCP) Influenza Vaccination ................................................. 24
Influenza Vaccination Adherence Percentage ....................................................... 25
Your Hospital’s Performance .................................................................................... 25
The hospital’s performance will not be displayed for the 2012/2013 HCP
Influenza Vaccination measure. ............................................................................... 25
State Reported Adherence Percentage ................................................................. 25
U.S. National Reported Adherence Percentage ..................................................... 25
HAI Measure Footnotes .......................................................................................... 25
HAI Measure Footnote Table .................................................................................... 25
Questions Regarding HAI Measures ...................................................................... 26
Section 4: Withholding Data from Hospital Compare ............................................. 27
Suppression Overview ............................................................................................. 27
Procedure to Suppress Data .................................................................................... 27
Section 1: Overview

Hospital Compare Overview

The Centers for Medicare & Medicaid Services (CMS) and the nation's hospitals worked collaboratively to create and publicly report hospital quality performance information on the Hospital Compare website located at http://www.medicare.gov/hospitalcompare. Hospital Compare presents hospital performance data in a consistent, unified manner to ensure the availability of credible information about the care delivered in the nation's hospitals. Most of the participants are short-term acute care hospitals eligible to receive an incentive payment for voluntary submission of data initially established by Section 501(b) of the Medicare Modernization Act (MMA), which was extended and expanded by Section 5001(a) of the Deficit Reduction Act.

A substantial proportion of the hospitals have volunteered to provide information for Hospital Compare on measures not initially included in the financial incentive arrangement. Hospitals that volunteer to participate and submit cases for one or more measures may choose to have any or all of the information displayed on Hospital Compare.

Inpatient Prospective Payment Systems (IPPS) Overview

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under the Inpatient Prospective Payment System (IPPS). Under IPPS, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of Medicare Severity – Diagnosis Related Groups (MS-DRGs).

Preview Period

Prior to the release of data on Hospital Compare, hospitals are given the opportunity to preview data for 30 days through My QualityNet, the only CMS-approved website for secure healthcare quality data exchange at https://www.qualitynet.org. The preview report is available to hospitals only during the 30 day preview period.

Note: CMS has modified the January Hospital Compare release date to be one month earlier than prior years. Hospitals can anticipate the January release to occur in December each year.
Section 2: Preview Report Access

The preview report can be accessed through My QualityNet, the secure website accessed via the public QualityNet website, https://www.qualitynet.org.

To access a preview report, the user must be:

1. Registered as a My QualityNet user. Registration instructions are available on the public QualityNet website by selecting the "Hospital Inpatient Quality Reporting Program" link from the [Hospitals - Inpatient] tab drop-down list. On the Hospital Inpatient Quality Reporting Program Overview web page, select the "How To Participate" left-side navigation link followed by the “QualityNet Registration” link (direct link):

2. Assigned the “Hospital Reporting Feedback – Inpatient Reports” role (roles are assigned by the hospital’s QualityNet Security Administrator).

Registration Instructions


2. Select “Hospitals – Inpatient” (located in the box on the top left section titled “QualityNet Registration”).

3. Follow the directions provided under “QualityNet Registration Hospitals - Inpatient”.

For questions regarding the registration process, contact the QualityNet Help Desk at the following e-mail address: qnetsupport@sdps.org.
Run Preview Report

The preview report is available from *My QualityNet*. Sign in with User ID and Password.


2. Select [Sign In], top, center, to open the secure Sign In web page for *My QualityNet*.

3. Read the Security Alert and select [OK] in the security alert box to proceed.

4. Enter your *My QualityNet* User ID and Password and select [Sign In]. If the password has been forgotten, select “Forgot your password?” link and follow the directions.
5. Read the Terms and Conditions statement and select [Accept] to proceed. **Note:** If [Decline] is selected, the program closes.


7. Select the drop-down arrow under “Report Category” and select “Public Reporting – Preview Reports” from the drop-down list.
8. The “Inpatient” option is auto-selected from the Report Program drop-down list by the system. Select [Go] to proceed to the next screen.  

**Note:** The preview report is only available during the preview period.

9. Select the “Public Reporting - Preview Reports” link under the “Report Name” section. **Note:** The help guide is available by selecting the “Need Help?” link.

10. Verify the correct state and hospital information is listed.

11. Select [Request Report].
12. Select the [View Reports] tab to open the “Report Viewer” screen.

Report Viewer

When a report status displays as “Complete”, the hospital or QIO may either view the report by selecting the [Magnifying glass] icon or download the report by selecting the [Download] icon (to the right of the [Magnifying glass]).

Note: The [Delete] icon removes the report permanently from the report viewer. Report Viewer icon details are provided below:
Section 3: Preview Report Details

Preview Report Format

The preview report displays the hospital characteristics information at the top of each section. Sections included in the preview report are: Clinical Process Measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, Mortality, Readmission, and Surgical Complication Outcome Measures and Healthcare Associated Infections (HAI).

The hospital CMS Certification Number (CCN) and name display above the hospital characteristics information. The hospital characteristics include the hospital’s address, city, state, ZIP code, telephone number, county name, type of facility, type of ownership, and emergency service provided status.

Type of ownership is not publicly reported; however, is available in the downloadable database on Hospital Compare. Accreditation Status is no longer included in the hospital characteristics displayed in the preview reports and the downloadable database on Hospital Compare.

When the hospital characteristics displayed are incorrect, the hospital should contact its state survey agency CASPER coordinator to complete the information. The state survey agency CASPER contact list is available from the Hospital Compare home page by selecting the [Resources] button located between the [About the Data] and [Help] buttons directly above the Find a Hospital selection area. Once the screen refreshes, select the “CASPER/ASPEN” link from the left-side navigation pane (direct link): http://www.medicare.gov/HospitalCompare/Resources/CASPER.aspx.

When the hospital’s state survey agency is unable to make the needed change, the hospital should contact its CMS regional office.
Footnote Changes

The table below provides a crosswalk of the previous footnotes appearing on *Hospital Compare* and on Preview Reports. **Note:** Some footnotes only appear on *Hospital Compare*.

**Footnote Change Table**

<table>
<thead>
<tr>
<th>Revised Footnotes</th>
<th>Previous Footnotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1:</strong> The number of cases/patients is too few to report.</td>
<td>f: An asterisk (*) appears in the table where data cannot be disclosed to protect personal health information due to the small number of Medicare patients (fewer than 11).</td>
</tr>
<tr>
<td></td>
<td>i: The number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing.</td>
</tr>
<tr>
<td></td>
<td>j: Medicare requires hospitals to have at least 25 qualifying cases to have their results reported. This hospital had less than 25 cases.</td>
</tr>
<tr>
<td></td>
<td>1: The number of cases is too small to reliably tell how well a hospital is performing.</td>
</tr>
<tr>
<td></td>
<td>9: No or very few patients were eligible for the HCAHPS survey.</td>
</tr>
<tr>
<td></td>
<td>16: The number of cases is too small (fewer than 10) to reliably tell how well a hospital is performing.</td>
</tr>
<tr>
<td></td>
<td>18: The number of cases is too small (fewer than 25) to report an excess readmission ratio.</td>
</tr>
<tr>
<td><strong>2:</strong> Data submitted were based on a sample of cases/patients.</td>
<td>2: The hospital indicated that the data submitted for this measure were based on a sample of cases.</td>
</tr>
<tr>
<td></td>
<td>3: Data were collected during a shorter period (fewer quarters) than the maximum possible time for this measure.</td>
</tr>
<tr>
<td></td>
<td>7: Survey results are based on less than 12 months of data.</td>
</tr>
<tr>
<td><strong>3:</strong> Results are based on a shorter time period than required.</td>
<td>4: Suppressed for one or more quarters by CMS.</td>
</tr>
<tr>
<td></td>
<td>5: No data are available from the hospital for this measure.</td>
</tr>
<tr>
<td></td>
<td>8: Survey results are not available for this reporting period.</td>
</tr>
<tr>
<td></td>
<td>17: No data are available from the hospital for this measure.</td>
</tr>
<tr>
<td>Revised Footnotes</td>
<td>Previous Footnotes</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6: Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.</td>
<td>No recommended changes to this footnote.</td>
</tr>
<tr>
<td>7: No cases met the criteria for this measure.</td>
<td>† (0 patients): No patients met the criteria for inclusion in the measure calculation.</td>
</tr>
<tr>
<td>8: The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.</td>
<td>22. The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.</td>
</tr>
<tr>
<td>9: No data are available from the state/territory for this reporting period.</td>
<td>10: A state average was not calculated because too few hospitals in the state submitted data.</td>
</tr>
<tr>
<td>10: Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.</td>
<td>Change from number 12 to number 10.</td>
</tr>
<tr>
<td>11: There were discrepancies in the data collection process.</td>
<td>11: There were discrepancies in the data collection process.</td>
</tr>
<tr>
<td>12: This measure does not apply to this hospital for this reporting period.</td>
<td>14: No data are available for publication from the hospital for this measure because there were zero central line days.</td>
</tr>
<tr>
<td></td>
<td>15: No data are available for publication from the hospital for this measure because this hospital does not have ICU locations.</td>
</tr>
<tr>
<td></td>
<td>20: Data aren’t available for reporting as this hospital is a new member of the surgical registry and didn’t have an opportunity to submit any cases for the measure.</td>
</tr>
<tr>
<td></td>
<td>21: Data aren’t available for the voluntary public reporting of this measure.</td>
</tr>
<tr>
<td>13: Results cannot be calculated for this reporting period.</td>
<td>No previous footnote.</td>
</tr>
<tr>
<td>14: The results for this state are combined with nearby states to protect confidentiality.</td>
<td>No previous footnote.</td>
</tr>
</tbody>
</table>
Preview Report Measures

Structural Measures

Structural measures display following the hospital characteristics section. Data is entered in the My QualityNet web-based data collection tool from April 1 through May 15 annually and updated with the December Hospital Compare release.

Clinical Process Measures

The Clinical Process Measure sets include: Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), Surgical Care Improvement Project (SCIP), Emergency Department (ED), Immunization Measures (IMM), Stroke (STK), Venous Thromboembolism (VTE), and Perinatal Care (PC). The measure sets contain up to four quarters of data and display as an aggregate rate.

Each measure displays:

- Your Hospital Performance for All Quarters (when submitted)
- 10% of All Hospitals Submitting Data Performed Equal to or Better Than (e.g., 90th percentile)
- State Performance
- National Performance

Clinical Process Measure Details

The preview report displays an aggregate of four rolling quarters of data (a new quarter of data is added and the oldest quarter removed). The clinical process measures data is updated quarterly.
**Influenza Immunization (IMM-2)**

The aggregate rate for IMM-2 includes data collected only during the influenza season quarters. IMM-2 data collection began with first quarter 2013 discharges. CMS requested not to include multiple flu seasons in the aggregate data. Therefore, the quarters of data included in the aggregate must be contiguous. The April, July and December preview reports will display aggregate data for a full influenza season (fourth quarter of one year and first quarter of the following year). The December preview report will contain influenza season quarters that are not contiguous. The quarters of data included for the December release include the first quarter data from the previous influenza season and the fourth quarter data from the most recent influenza season; therefore, only fourth quarter data will display.

**Perinatal Care (PC-01): Elective Delivery**

The aggregate rate is generated from count data reported as a percentage of patients with elective deliveries. Aggregate data submitted includes total perinatal care ‘mother’s’ initial patient population, sample size, sampling frequency, numerator, denominator, and exclusion counts. Data entry for discharges began first quarter 2013. Data entry is by vendor or hospital using the *My QualityNet* web-based data collection tool.

**Clinical Process Measure Footnotes**

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The number of cases/patients is too few to report.</td>
<td>Applied to any measure rate where the denominators are greater than 0 and less than 11. Data will not display on <em>Hospital Compare</em>.</td>
</tr>
<tr>
<td>2</td>
<td>Data submitted were based on a sample of cases/patients.</td>
<td>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).</td>
</tr>
<tr>
<td>3</td>
<td>Results are based on a shorter time period than required.</td>
<td>Applied when a hospital elected not to submit data, had no data to submit or did not successfully submit data to the warehouse for a measure for one or more but not all possible quarters.</td>
</tr>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS.</td>
</tr>
<tr>
<td>5</td>
<td>Results are not available for this reporting period.</td>
<td>Applied when a hospital either elected not to submit data or the hospital had no data to submit for a particular measure; or when a hospital elected to suppress a measure.</td>
</tr>
<tr>
<td>7</td>
<td>No cases met the criteria for this measure.</td>
<td>Applied when a hospital treated patients for a particular topic but no patients met the criteria for inclusion in the measure calculation.</td>
</tr>
</tbody>
</table>
State and National Performance Rates

The state and national performance rates for the clinical process measures are calculated based on the data in the warehouse, regardless of whether the hospital elected to opt-out of publicly reporting data on Hospital Compare.

**State Performance:** The state performance rate is derived by summing the numerators for all cases in the state divided by the sum of the denominators in the state. Median times are identified using all cases in the state.

**National Performance:** The national performance rate is derived by summing the numerators for all cases in the nation divided by the sum of the denominators in the nation. Median times are identified using all cases in the nation.

The 90th percentile is calculated for each measure using the un-weighted average or median for each eligible hospital and identifying the top ten percent of hospitals.

Rounding Rules

All rates (provider, state and national) are rounded to the nearest whole number (e.g. 67%) using the following rounding logic, unless otherwise stated:

- Above [x.5] - Round up to the nearest whole number
- Below [x.5] - Round down to the nearest whole number
- Equal to [x.5] and x is an even number - Round down to the nearest whole number
- Equal to [x.5] and x is an odd number - Round up to the nearest whole number

Questions Regarding Clinical Process Measures

For questions regarding the clinical process measures, contact the state QIO. A list of QIO contacts for hospitals organized by state is available on the QualityNet website by selecting the “Hospital Inpatient Quality Reporting Program” link from the [Hospitals – Inpatient] tab followed by selecting the “QIO Contacts” link from the left-side navigational pane (direct link):


HCAHPS Survey Data

The HCAHPS Survey Data section of the report contains Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data. The HCAHPS survey results contain four quarters of data and display as aggregate results. Each hospital’s aggregate results are compared to state and U.S. averages. Also, the preview report contains the hospital’s number of completed surveys and survey response rate for the reporting period.
The HCAHPS Survey Results has three sections:
- HCAHPS Survey Completion and Response Rate
- HCAHPS Composites and Individual Items
- HCAHPS Global Items

**HCAHPS Survey Completion and Response Rate** section:
- Number of Completed Surveys
- Survey Response Rate

**HCAHPS Composites and Individual Items** section:

**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**
- Cleanliness of Hospital Environment (Q8)
- Quietness of Hospital Environment (Q9)

**Discharge Information Composite**
- Composite 6 Discharge Information (Q19, Q20)

**HCAHPS Global Items** section contains:
- Overall Rating of Hospital (Q21)
- Willingness to Recommend this Hospital (Q22)

**HCAHPS Measure Details**
All IPPS hospitals must continuously collect and submit HCAHPS data in order to qualify for the full Annual Payment Update (APU). All participating hospitals receive a preview report and non-IPPS hospitals have the option of withholding HCAHPS results from being publicly reported on Hospital Compare. The HCAHPS measure data is updated quarterly.
## HCAHPS Measure Footnotes

### HCAHPS Measure Footnote Table

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The number of cases/patients is too few to report.</td>
<td>Applied when a hospital has zero cases, or 5 or fewer eligible HCAHPS patient discharges.</td>
</tr>
<tr>
<td>3</td>
<td>Results are based on a shorter time period than required.</td>
<td>Applied when CMS has opted to display HCAHPS results on fewer than the required months of survey data.</td>
</tr>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS.</td>
</tr>
<tr>
<td>5</td>
<td>Results are not available for this reporting period.</td>
<td>Applied in the following situations:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>When a hospital did not participate in HCAHPS during the period covered by the preview report;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>When a hospital participated in HCAHPS but only for a portion of the period covered by the preview report;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td></td>
<td>results on its preview report but results will be suppressed on Hospital Compare).</td>
</tr>
<tr>
<td>6</td>
<td>Fewer than 100 patients completed the HCAHPS survey. Use these scores with</td>
<td>Applied when the number of completed surveys is 50-99.</td>
</tr>
<tr>
<td></td>
<td>caution, as the number of surveys may be too low to reliably assess hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>performance.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Very few patients were eligible for the HCAHPS survey. The scores shown</td>
<td>Applied when the number of completed HCAHPS surveys is 1-49.</td>
</tr>
<tr>
<td></td>
<td>reflect fewer than 50 completed surveys. Use these scores with caution,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>as the number of surveys may be too low to reliably assess hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>performance.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>There were discrepancies in the data collection process.</td>
<td>Applied when there have been deviations from HCAHPS data collection protocols.</td>
</tr>
</tbody>
</table>

**Note:** Hospitals participating in the Hospital IQR Program may not suppress HCAHPS data.

**State and U.S. Average Rates**
State and U.S. un-weighted average rates for each HCAHPS measure are calculated based on all data available in the HCAHPS data warehouse.

**Questions Regarding HCAHPS Measures**
For questions regarding HCAHPS, contact the HCAHPS Project Team at the following e-mail address: hcahps@azqio.sdps.org.
Outcome Measures

Outcome Measures section of the preview report includes:

- 30-Day Risk-Standardized Mortality Measures
- 30-Day Risk-Standardized Readmission Measures
- Surgical Complication Measure

30-Day Risk-Standardized Mortality Measures

The Mortality Measures portion of the outcome measures section displays the 30-Day Risk-Standardized Mortality Measures for AMI, HF, and PN. In addition to the hospital’s performance category (Better than U.S. National Rate, Worse than U.S. National Rate, or No Different than U.S. National Rate), the hospital’s risk-standardized mortality rate (RSMRs), interval estimates, and number of eligible Medicare admissions will display on the preview report.

30-Day Risk-Standardized Readmission Measures

The Readmission Measures portion of the outcome measure section displays the 30-Day Risk-Standardized Readmission Measures for AMI, HF, PN, Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA), and Hospital Wide Readmission Measure. In addition to the hospital’s performance category (Better than U.S. National Rate, Worse than U.S. National Rate, or No Different than U.S. National Rate), the hospital’s risk-standardized readmission rate (RSRRs), interval estimates, and number of eligible Medicare discharges will display on the preview report.
Surgical Complications

The surgical complication portion of the preview report displays the Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA). In addition to the hospital’s performance category (Better than U.S. National Rate, Worse than U.S. National Rate, or No Different than U.S. National Rate), the hospital’s risk-standardized complication rate (RSCRs), interval estimates, and number of eligible Medicare admissions will display on the preview report.

Outcome Measure Details

The outcome measures data for 30-Day Risk-Standardized Mortality, 30-Day Risk-Standardized Readmission, Hospital Wide Readmission, and Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) Measures are updated annually during the July Hospital Compare release.

- Hospitals are not required to submit outcome measure data because CMS calculates the measures from claims and enrollment data.
- The hospital’s mortality and readmission measures are calculated using up to three years of data depending on the number of years the hospital had eligible cases for the individual measures.
- Hospitals with fewer than 25 eligible cases for the mortality and readmission measures 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” and are included in the measure calculation, but will not be reported on Hospital Compare.
- The complication outcome is a yes/no outcome. If a patient experiences one or more complications in the applicable time period, the complication outcome for that patient is counted in the measure as a “yes.” The measure adjusts for each hospital’s case mix (patient age, sex, and comorbidities), so that hospitals that care for older, sicker patients are on a “level playing field” with hospitals serving healthier patients.
• For each hospital, the complication measure estimates a RSCR. The measure outcome is one or more of the following eight complications within specified time periods:
  • Acute myocardial infarction (AMI), pneumonia, or sepsis/septicemia during the index admission or within seven (7) days of admission.
  • Surgical site bleeding, pulmonary embolism, or death during the index admission or within 30 days of admission.
  • Mechanical complication or periprosthetic joint infection/wound infection during the index admission or within 90 days of admission.
  • The complication measure is calculated using up to 33 months of data (July 1, 2009 through March 31, 2012) depending on the number of years the hospital had eligible cases for the individual measure. The reporting period for the hip/knee complication measure is slightly shorter than the time period used for the hip/knee readmission measure due to the longer 90-day outcome window in which complications are assessed.
  • Hospitals participating in the Hospital IQR Program may not suppress the outcome measures.

Outcome Measure Footnotes

Mortality, Readmission, and Surgical Complication Measures Footnote Table

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The number of cases/patients is too few to report.</td>
<td>This footnote is applied to any hospital where the number of cases reported is too small (less than 25 and greater than 0) to reliably tell how well a hospital is performing.</td>
</tr>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS.</td>
</tr>
<tr>
<td>7</td>
<td>No cases met the criteria for this measure.</td>
<td>Applied when a hospital did not have any cases meet the inclusion criteria for a measure.</td>
</tr>
</tbody>
</table>

State and U.S. National Rates

The state rates for the Mortality, Readmission and Surgical Complication measures are not displayed on the preview report; however, the average 30-Day risk-standardized rates for hospitals in a state are published in the Hospital Specific Report (HSR) distributed to hospitals via My QualityNet.

The national crude (unadjusted) 30-Day mortality and readmission U.S. national risk-adjusted rates are all available in the HSRs distributed to hospitals.
Questions Regarding Outcome Measures

For questions regarding mortality outcome measures, contact the outcome measures implementation team at the following e-mail address: cmsmortalitymeasures@yale.edu. For questions regarding readmission outcome measures, contact the outcome measures implementation team at the following e-mail address: cmsreadmissionmeasures@yale.edu. For questions regarding the surgical complication measure, contact the measures implementation team at the following e-mail address: cmscomplicationmeasures@yale.edu.

Agency for Healthcare Research and Quality (AHRQ) Indicators

The AHRQ Indicators portion of the outcome measures section displays the AHRQ Patient Indicators (PSI).

- PSI-4  Rate of Death among Surgical Inpatients with Serious Treatable Complications
- PSI-90  Patient Safety for Selected Indicators (Composite Score)

While the following indicators display on the preview report, the indicators will only display in the downloadable file on Hospital Compare.

- PSI-6  Iatrogenic Pneumothorax
- PSI-12  Postoperative Pulmonary Embolism or Deep Vein Thrombosis
- PSI-14  Postoperative Wound Dehiscence
- PSI-15  Accidental Puncture or Laceration

In addition to the hospital’s performance category (better, worse, or no different than U.S. national rate), the hospital’s PSI rate (reported per 1,000 discharges) and IQI rate (reported per 100 discharges or as a percent), confidence interval, and number of eligible Medicare discharges display on the preview report.

Hospital Readmissions Reduction Program

The results for the Hospital Readmissions Reduction program are not part of the “public reporting 30-Day Risk-Standardized Readmission Measures” discussed in this document and are not part of the “public reporting preview period” for the Hospital IQR Program.
Healthcare Associated Infection (HAI)

Hospitals submit HAI data to the Centers for Disease Control and Prevention’s (CDC’s) National Healthcare Safety Network (NHSN) system. CDC provides the HAI data to CMS for display on Hospital Compare.

HAI Hospital Quality Measures

Central Line-Associated Blood Stream Infection (CLABSI)
The CLABSI measure includes the number of laboratory-confirmed cases of Central Line-Associated Bloodstream Infections among adult, pediatric and neonatal intensive care unit (ICU) patients for events identified within the displayed timeframe.

Catheter-Associated Urinary Tract Infection (CAUTI)
The CAUTI measure includes the number of laboratory-confirmed cases of Catheter-Associated Urinary Tract Infections among adult and pediatric intensive care unit (ICU) patients for events identified within the displayed timeframe.

Surgical Site Infections (SSI) for Colon Surgery
The SSI-colon surgery measure includes the number of surgical site infections identified among adults that occur within 30 days following criteria-specific colon surgeries performed for events identified within the displayed timeframe.

Surgical Site Infections (SSI) for Abdominal Hysterectomy Surgery
The SSI-abdominal hysterectomy measure includes the number of surgical site infections identified among adults that occur within 30 days following criteria-specific abdominal hysterectomy surgeries performed for events identified within the displayed timeframe.

Methicillin-Resistant Staphylococcus aureus (MRSA) Blood Infections
The MRSA bacteremia measure includes the number of MRSA bacteremia LabID events that occur in all inpatient locations facility-wide within the displayed timeframe.

Clostridium difficile (C. difficile or C. diff) Infections
The C. difficile measure includes the number of C. difficile LabID events that occur in all inpatient locations facility-wide minus Neonatal ICUs, Well Baby Nurseries or Well Baby Clinics within the displayed timeframe.
Preview Report

Your Hospital’s Reported Number of Infections

Your hospital’s reported number of infections is the observed number of infections reported by the hospital in scope for quality reporting. The observed number of infections is used as the numerator by NHSN to calculate the hospital’s SIR.

Data submitted to NHSN after the submission deadline will display in NHSN reports; however, data submitted after the submission deadline will not be included in the data reported in the preview report or on Hospital Compare.

Device or Patient Days/Procedures

**CLABSI:** The number of central line days in hospital locations in scope (adult, pediatric and neonatal ICUs) for quality reporting.

**CAUTI:** The number of urinary catheter days in hospital locations in scope (adult and pediatric ICUs) for quality reporting.

**SSI-Colon:** The number of criteria-specific colon surgeries performed within the facility.

**SSI-Abdominal Hysterectomy:** The number of criteria-specific abdominal hysterectomy surgeries performed within the facility.

**MRSA:** The total number of patient days in hospital facility-wide inpatient locations in scope for quality reporting.

**C. diff:** The total number of patient days in hospital facility-wide inpatient locations (minus Neonatal ICUs, Well Baby Nurseries or Well Baby Clinics) in scope for quality reporting.

Your Hospital’s Predicted Number of Infections

Your Hospital’s Predicted Number of Infections is the predicted number of infections in scope for quality reporting. The predicted number of infections is used by NHSN as the denominator to calculate the hospital’s SIR.

Ratio of Reported to Predicted Infections (SIR)

The SIR is a summary measure used to track HAIs at a facility, state or national level over time. The SIR is calculated as observed number of infections (Numerator) divided by the predicted number of infections (Denominator).

**Note:** When a hospital’s SIR cannot be calculated because there are too few expected events, or because the hospitals’ MRSA or *C. difficile* prevalence rate is above the allowed threshold, the SIR displays N/A (with footnote13) to indicate the results could not be calculated.
Your Hospital’s Performance

The hospital’s performance phrase is determined by comparing the actual number of HAIs in a facility to a national benchmark based on previous years of reported data and adjusts the data based on several factors. A confidence interval with a lower and upper limit is displayed around each SIR to indicate a high degree of confidence that the true value of the SIR lies within that interval.

Performance phrases displayed in the “Your Hospital’s Performance” column are:

**Better than the U.S. National Benchmark:** displays if the hospital’s SIR has an upper limit that is less than the national benchmark of 1.

**No Different than U.S. National Benchmark:** displays if the hospital’s SIR has a confidence interval (lower to upper limit) that includes the national benchmark of 1.

**Worse than the U.S. National Benchmark:** displays if the hospital’s SIR has a lower limit that is greater than the national benchmark of 1.

State Standardized Infection Ratio (SIR)

The state-level SIR is calculated by dividing the state numerator in scope for quality reporting by the state denominator in scope for quality reporting, for a specific infection type.

U.S. National Standardized Infection Ratio (SIR)

The U.S National Standardized Infection Ratio (SIR) shown in this column is based on current aggregated data in scope for quality reporting from acute care facilities to meet the CMS rule from the same time period as the facility’s data. It is shown to demonstrate where the most recent overall national SIR stands. This ratio is not shown on Hospital Compare to avoid confusion between the National SIR Benchmark used to compare hospital performance.

Confidence Interval

The Confidence Interval column lists the hospital’s lower bound limit and upper bound limit of the hospital’s confidence interval. The lower and upper bound limits of the confidence interval (95%) for the facility’s SIR and Influenza vaccination adherence percentage is an indication of precision and allows interpretation in terms of statistical significance.

When the lower limit of the confidence interval cannot be calculated, due to the number of observed infections equaling zero, footnote 8 will be applied.

Healthcare Personnel (HCP) Influenza Vaccination

**Healthcare Personnel Influenza Vaccination Measure:** includes the number of HCP contributing towards successful influenza vaccination adherence within the displayed timeframe, regardless of clinical responsibility or patient contact.
For the 2012 - 2013 Influenza season, the HCP Influenza vaccination measure will be on the preview report; however, the data will not be reported on Hospital Compare. Hospitals’ quality measures will include the hospital’s reported adherence percentage, the hospitals performance, the state reported adherence percentage, and the U.S. national reported adherence percentage.

**Influenza Vaccination Adherence Percentage**

The adherence percentage is calculated as the total number of healthcare workers contributing to successful vaccination adherence divided by the total number of workers eligible to receive the Influenza vaccine per NHSN protocol.

**Your Hospital’s Performance**

The hospital’s performance will not be displayed for the 2012/2013 HCP Influenza Vaccination measure.

**State Reported Adherence Percentage**

The state adherence percentage is calculated as the total number of healthcare workers in the state contributing to successful vaccination adherence divided by the total number of workers in the state eligible to receive the Influenza vaccine per NHSN protocol.

**U.S. National Reported Adherence Percentage**

The national adherence percentage is calculated as the total number of healthcare workers in the nation contributing to successful vaccination adherence divided by the total number of workers in the nation eligible to receive the Influenza vaccine per NHSN protocol.

**HAI Measure Footnotes**

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Results are based on a shorter time period than required.</td>
<td>Applied when a hospital has less than the maximum number of quarters of data (one or more but not all possible quarters).</td>
</tr>
<tr>
<td>4</td>
<td>Data suppressed by CMS for one or more quarters.</td>
<td>Reserved for CMS.</td>
</tr>
<tr>
<td>5</td>
<td>Results are not available for this reporting period.</td>
<td>Applied when no data are available.</td>
</tr>
<tr>
<td>8</td>
<td>The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.</td>
<td>Applied when the lower limit of the confidence interval cannot be calculated.</td>
</tr>
<tr>
<td>#</td>
<td>Description</td>
<td>Application</td>
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<td>----</td>
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</tr>
</tbody>
</table>
| 12 | This measure does not apply to this hospital for this reporting period.     | Applied to the measure when either the hospital has a waiver or the hospital submitted to NHSN:  
  • Zero Central Line days  
  • Zero Catheter days  
  • Zero Surgical Procedures |
| 13 | Results cannot be calculated for this reporting period.                     | Applied when the hospital’s SIR cannot be calculated because:  
  • The number of predicted infections is less than 1.  
  • MRSA or *C. difficile* prevalence rate is greater than the established threshold. |

**Note:** The number of predicted infections will not be calculated for those facilities with an outlier MRSA or *C. difficile* prevalence rate.

**Questions Regarding HAI Measures**

For questions regarding the HAI measures, contact the Hospital IQR Program Support Contractor at the following e-mail address: [hrpqiosc@iaqio.sdps.org](mailto:hrpqiosc@iaqio.sdps.org).
Section 4: Withholding Data from Hospital Compare

Hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program agree to have data publicly reported on Hospital Compare.

Hospitals not participating in the Hospital Inpatient Quality Reporting (IQR) Program have an option to withhold data from public reporting on Hospital Compare. The option to suppress (withhold) data from Hospital Compare is only available to hospitals during the 30-day preview period.

Suppression Overview

To withhold (suppress) publication of data, a hospital must contact the QIO Hospital Public Reporting contact with the request to withhold data and transmit a completed Inpatient Hospital Compare Request for Withholding Data From Public Reporting form on or before the last day of the preview period.

Hospitals that do not have an appropriate notice of participation or pledge display only the CCN and hospital name along with the following message:

“You do not have an Inpatient Notice of Participation (pledge) to publicly report data for the preview report period. If you think this is an error, contact your QIO Hospital Contact prior to the preview period closing.”

Note: When a message is received in error, contact the hospital’s state QIO contact prior to the last day of the preview period.

A list of QIO contacts for hospitals organized by state is available on the QualityNet website by selecting the “Hospital Inpatient Quality Reporting Program” link from the [Hospitals – Inpatient] tab followed by selecting the “QIO Contacts” link from the left-side navigational pane (direct link): https://www.qualitynet.org/dcs/ContentServer?c=Page&pAGEnAMe=QnetPublic%2FPag e%2FQnetTier3&cid=1138900297541.

Procedure to Suppress Data

2. Place the cursor over the [Hospitals - Inpatient] tab.
3. Select the “Hospital Quality Alliance (HAQ)” link.

4. Select the “Forms” link from the left-side navigation pane.

5. Select the “Hospital Compare Request for Withholding Data Form Public Reporting” link. The hospital must print the form, complete the form, select “Hospital Quality Alliance (HQA)” from the drop-down list and fax the completed form to the QIO contact prior to the end of the preview period (to locate the correct QIO contact, select “QIO Contacts” link from the left navigation pane). **Note:** Any forms completed after the preview period will not be in effect for that preview period.