



## Public Reporting of Quality by Critical Access Hospitals: The Key Issues, January 2012

The National Rural Health Association (NRHA) has long advocated the need for rural providers to engage in quality improvement and public reporting movement. **NRHA strongly believes in the proposition that rural communities deserve and demand the same high quality as other Americans.**

This policy paper intends to update the NRHA's existing Policy Brief *Public Reporting of Hospital Quality in Rural Communities: An Initial set of Key Issues* published May 2005. The authors will review the progress made in rural hospital public reporting of quality over the last 6 years; the increased emphasis and use of data for measuring performance and maintaining payment and the current challenges that exist for Critical Access Hospitals (CAH) to participate in quality reporting.

### Progress Made in Rural Hospital Public Reporting

Since the 2005 Policy Brief, there has been improvement in public reporting in by rural hospitals with regard to 1) increased participation in Hospital Compare, 2) improvements in results, and 3) additions of rural relevant measures.

In 2004 only 41% of CAHs were participating in Hospital Compare to some degree (by submitting data on at least one measure).<sup>1</sup> After six years the participation has increased significantly with 71% of CAHs having submitted data for at least one inpatient process measure for 2009. Results also indicated that a subset of CAHs (40%) have expanded their public reporting efforts beyond inpatient measures to include additional types of quality measures. At the same time, over one fourth of CAHs (27%) are not publicly reporting quality data of any kind to Hospital Compare. By state, the percent of participation varies. Six states had 100% participation, whereas 6 others had less than half of their CAHs reporting.<sup>2</sup> In addition, the research indicates that accredited CAHs are more likely to participate in Hospital Compare as well as CAHs that have more beds and a higher average daily census.

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<sup>1</sup> [CAH Participation in Hospital Compare and Initial Results](#) Flex Monitoring Team Briefing Paper Date Feb 2006

<sup>2</sup> [Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results \(Policy Brief\)](#)  
Flex Monitoring Team, Date: April 2011

Comparison of process of care results over the 2006-2009 timeframe shows the improvement for CAHs on all measures.<sup>3</sup> However, performance of rural Prospective Payment System (PPS) and urban PPS hospitals has also improved, continuing the performance gap between CAHs and PPS hospitals on most measures. Conversely, CAHs had higher average scores than patients in all United States hospitals for all measures reported by Hospital Consumer Assessment of Healthcare Providers (HCAHPS) data 2008. The thirty day risk-adjusted readmission and mortality rates were either, not computed or not different from the US hospital rates.

In 2005 the Hospital Compare measure set included 18 measures for three conditions: acute myocardial infarction (AMI), heart failure and pneumonia. As noted in NRHA Policy Brief "*Quality of Rural Health Care,*" rural America has unique factors that must be acknowledged and analyzed. A working paper on *Measuring Rural Hospital Quality* was produced by the University of Minnesota Rural Health Research Center that studied the important issues for measuring rural hospital quality and defined a set of quality measures that were relevant to rural hospitals. Criteria for rural relevance was defined by: 1) the prevalence of the condition in small rural hospitals, 2) the ease of data collection effort, 3) the internal usefulness of the measure for small rural hospitals, and 4) the external usefulness for small rural hospitals. Value was placed on process measures versus structure and outcome measures since structure measures tend to be indirectly related to quality and outcomes measures can be affected by different institutional settings.<sup>4</sup> By 2009 Hospital Compare quality measures include 28 inpatient process of care; 7 outpatient AMI/chest pain and surgical process of care measures; 10 HCAHPS survey questions; and hospital 30 day risk-adjusted mortality and readmission rates for AMI, heart failure and pneumonia calculated by CMS using Medicare claims data. The addition of outpatient and HCAHPS data is more relevant for small rural hospitals as these are process measures. It is somewhat surprising that more CAHs are not reporting these measures, however, given that the outpatient measures are relatively new to Hospital Compare, it may just take more time for CAHs to become familiar with them. Conversely, the addition of outcomes measures for 30 day risk-adjusted readmission and mortality rates are not useful for CAHs, since few CAHs have rates that are either better than or worse than the US rates for all hospitals.<sup>5</sup>

## **Increased Emphasis /Use of Data for Measuring Performance & Maintaining Payment**

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<sup>3</sup> [Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results \(Policy Brief\)](#)  
Flex Monitoring Team, Date: April 2011

<sup>4</sup> [Measuring Rural Hospital Quality](#) (Working Paper) University of Minnesota Rural Health Research Center, Date April 2004.

<sup>5</sup> [Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results \(Policy Brief\)](#)  
Flex Monitoring Team, Date: April 2011

As defined in the legislation, a central goal of the Medicare Rural Hospital Flexibility Grant program (Flex) is to help CAHs develop and sustain effective quality improvement programs. States are required to undertake programs and activities that support the quality performance measurement and reporting. Some states have developed statewide or regional multi-CAH quality improvement initiatives. In a Flex Monitoring Report on *Models for Quality Improvement In Critical Access Hospitals: The Role Of State Flex Programs* it was concluded that the Flex program needs outcome data to measure effectiveness. The study also suggested that a consistent core set of quality measures is needed for all CAHs along with a system to collect and report on these measures. Finally, incentives are needed to encourage those not publicly reporting.<sup>6</sup> The long term viability of the Flex Program depends on having national data to show program effectiveness.

The passage of meaningful use and the Affordable Care Act heightened national attention on quality activities and reporting. In the environment of meaningful use, pay for performance, bundled payments, and accountable care organizations (ACO), CAHs may soon be compared with their urban counterparts to ensure public confidence in their quality of health services. A study published in the *New England Journal of Medicine* concluded that Hospitals that engaged in both public reporting and pay for performance achieved modestly greater improvements in quality than did hospitals engaged in only public reporting.<sup>7</sup> CAHs need to be well-equipped and prepared to meet these expectations.

The IOM Committee developed five strategies to address the quality challenges in rural communities in their report *Quality Through Collaboration: The Future of Rural Health Care*. The second strategy identified the need to establish a stronger quality improvement support structure to assist rural health systems and professionals in acquiring knowledge and tools to improve quality and further thought should be given to how best to adapt quality improvement knowledge and tools (e.g., evidence-based reports, practice guidelines, standardized performance measure sets) to support an integrated approach to decision making.<sup>8</sup> To this end, the Department of Health and Human Services through the Office of Rural Health Policy (ORHP) created the Flex Medicare Beneficiary Quality Improvement Project (MBQIP). The primary goal of this project is for CAHs to implement informed quality improvement initiatives to improve

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<sup>6</sup> [Models For Quality Improvement In Critical Access Hospitals: The Role of State Flex Programs](#), Flex Monitoring Team, Date March 2010

<sup>7</sup> [Public Reporting and Pay for Performance in Hospital Quality Improvement](#), *New England Journal of Medicine*, Date: Feb 2007

<sup>8</sup> [Quality Through Collaboration](#) (Report) IOM Committee on the Future of Rural Health Care, Date 2005

their patient care and operations. MSQIP will provide Flex funding to support CAHs with technical assistance and national benchmarks to improve health care outcomes.<sup>9</sup>

### **Current Challenges For Rural Public Reporting**

Challenges for public reporting continues to be issues related to a central, coordinated point for data submission; volume; a standard set of rural relevance of measures; and need for technical assistance.

A typical CAH reports measures to 15 different entities including CMS, the Centers for Disease Control, state hospital associations, health departments, quality improvement organizations and private payors. In addition, many CAHs have chosen to use other benchmarking tools and may not have seen a reason to report the same data into Hospital Compare since it may not provide the same types of reports and feedback that help make improvements at their hospitals. However, it is the data tool that all other types of hospitals are required to report into and therefore it is the source of information that lawmakers will be looking at when making funding decisions. For that reason, it has become vitally important for CAHs to be represented in that system as well.

Small numbers creates a challenge for CAH public reporting in two ways. First, because of lower volumes and prevalence rates, many times scores are not conclusive or statistically significant, so no results are published. The lack of data or skewed results from outliers, can reflect poorly on quality. There is concern that small amounts of data are merely reported as N/A, providing no useful information to hospitals or patients. However, the MBQIP program is planning on having CAHs sign an MOU that will give HRSA permission to analyze that data for CAHs and also to use aggregated data (without identifying any specific hospital) to justify continued funding for programs benefitting CAHs. Secondly, because the program is still voluntary, participation is not consistent or comprehensive, so the data from the public reporting system for CAHs is not conclusive. Although the percent of CAHs participating in Hospital Compare has increased, participating and non-participating CAHs still differ significantly on several organizational characteristics (e.g. average number of beds, average daily census, accreditation status, type of ownership, and year of CAH certification). Thus, the quality measure results of CAHs that voluntarily participate in Hospital Compare may not be representative of all CAHs.<sup>10</sup> It has been noted however, that statewide quality reporting initiatives, efforts by the State Flex Programs/State Offices of Rural Health,

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<sup>9</sup> FLEX Medicare Beneficiary Quality Improvement  
<http://www.ruralcenter.org/sites/default/files/MBQIP%20Dec%20202010%20Flex%20Coordinator%20Call.pdf>  
Project (MBQIP) Overview, December, 2011

<sup>10</sup> [Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results \(Policy Brief\)](#)  
Flex Monitoring Team, Date: April, 2011

QIOs and state hospital associations make a difference in increasing CAH participation in public reporting.

Much work has been done to study the rural relevance of quality reporting measures and current work is being done to evaluate CMS outpatient and inpatient quality measures. It has been noted that there is a lack of measures that capture the initial contact role of rural hospitals and their triage and transfer responsibility. Relevant measures should reflect: (a) decision making and protocol availability and their use in decisions about where to treat a patient; (b) processes for stabilizing and transporting patients; and (c) care integration with referral hospitals and other care delivery systems. Criteria used for assessing rural relevance include prevalence/volume, usefulness and ease of data collection. The Rural Relevant Outpatient Measure Project and the Rural Relevant Inpatient Measure Project are rating measures based on rural relevant criteria and compiling a list of potential measures<sup>11</sup>. Although existing state and multi-state quality reporting and benchmarking efforts are important and should continue, comparable national data is needed. This can be achieved by establishing a core set of measures.

Lessons learned in the Flex Monitoring Report on *Models for Quality Improvement In Critical Access Hospitals: The Role Of State Flex Programs* found that efforts to increase participation in Hospital Compare benefit from the influence of stakeholder organizations and the development of materials for use by CAHs. In addition, networks and collaboratives to promote shared learning and resource exchange between hospitals are important, especially for CAHs that are not part of a hospital system.<sup>12</sup> The MBQIP will challenge Flex Coordinators to coordinate five key activities: 1) outreach to hospitals to enroll them in MBQIP, 2) assist hospitals in accessing needed technical assistance around data collection and reporting, 3) assist hospitals in analyzing their own and comparative data via Hospital Compare and the Flex Monitoring Team reports and any other tools in place at the state level, 4) determine funding allocation and appropriate partners to execute quality improvement activities, and 5) provide support for technical assistance around quality improvement activities.

The risk of not defining rural relevant measures and CAHs not participating in national reporting systems is that limited data can lead to misinformation. The recent article in Journal of the American Medical Association on the *Quality of Care and Patient Outcomes in Critical Access Rural Hospitals* and the editorial *Critical Access*

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<sup>11</sup> [CAHs, Quality Measurement and Evidence-Based Quality Improvement](#) (FLEX Conference Presentation) University of Minnesota Rural Health Research Center, Date: July, 2011.

<sup>12</sup> [Models For Quality Improvement In Critical Access Hospitals: The Role of State Flex Programs](#), Flex Monitoring Team, Date March 2010

*Hospitals and the Challenges to Quality Care* is a clear example.<sup>13</sup> The study focused on Medicare patients that had a diagnosis of one of three conditions: Congestive Heart Failure, Acute Myocardial Infarction, or Pneumonia. The study surveyed both CAHs and non-CAHs to attempt to measure quality. The authors state that 14 out of the 17 measures for quality, CAH's performed worse than non CAH's. The study then adjusted for some variables and found that there was still a discrepancy in mortality rates for AMI and CHF. One conclusion that the authors made was that rural hospitals have fewer professional and clinical resources which would be a challenge to providing quality care. The study found that CAH had fewer ICU's, fewer specialists, less instances of EHR's, fewer cardiac catheterization capabilities, and less ability to perform surgery. They also found that nursing levels between the two types of facilities were comparable. The responses given by the U of M Rural Health Research Center and Flex Monitoring Team indicated that there is much that the JAMA article failed to provide. Many of the points that the JAMA article criticized cannot and should not be changed in the CAHs. Such things include the transferring of patients, increase in the number of specialists, what quality measures have been in the past, and what is being done by various organizations to improve quality measures in CAHs. Quality measures for the three diagnoses studied have risen anywhere from 9 to 22 percentage points between the years of 2005-2009. The University of Minnesota and the Rural Health Research Center state that there has been monitoring of quality measures for CAHs at Hospital Compare. The reports document the substantial progress in quality improvement that CAHs have made during that time frame as well as the room for improvement that still exists. Joynt et al have simply provided a one-time snapshot rather than a longitudinal analysis. Furthermore, HRSA has implemented several programs that target quality improvement in CAHs. These programs have and we believe will continue to support quality improvement efforts in CAHs.<sup>14</sup>

NRHA has been leading the discussion of identifying rural relevant quality metrics for public reporting and developing new approaches to quality improvement. With the Flex Monitoring Team and other national rural health quality leaders, outpatient and inpatient quality measures for CAHs are being evaluated and proposed. Moreover, NRHA is engaged in the promotion of participation of CAHs in Hospital Compare and HCAHPS.

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<sup>13</sup> Joynt, Karen E., Yael Harris, E. John Orav, and Ashish K. Jha., [Quality of Care and Patient Outcomes in Critical Access Rural Hospitals](#), Journal of the American Medical Association. 306.1 (2011): 45-52. Date: 7/2011

<sup>14</sup> [University of Minnesota Rural Health Research Center Flex Monitoring Team Response to JAMA Article on Quality in CAHs Published July 6, 2011](#) , Date: 07/2011

## Policy Recommendations

1. CAH quality measures need to be standardized metrics (core measures) and be rural relevant measures. Standardized metrics would consist of a core set of measures used by States, the Flex Program, CMS, payers and hospital associations. Rural relevant measures should reflect 1) care decision making, 2) processes for stabilizing and transporting patients and 3) care integration.
2. All CAHs should be encouraged to report in order to improve quality of care and for CAH benchmarking, but we understand the burden of reporting for small hospitals is very high in comparison to larger hospitals. As such, quality reporting should not be subject to individual, voluntary reporting, but required for CAHs receiving Flex funding. In return the Flex program will provide the much needed technical assistance and resources to facilitate CAH reporting.

### This Policy Brief was informed by:

1. [CAH Participation in Hospital Compare and initial Results](#). Flex Monitoring Team (Briefing Paper No 9)  
Date: Feb 2006  
Examines the participation of Critical Access Hospitals in public reporting of quality measure in the Centers for Medicare and Medicaid Services (CMS) Hospital Compare database and presents the initial Hospital Compare results for CAHs and comparisons with other groups of hospitals.
2. [Critical Access Hospital Year 5 Hospital Compare Participation and Quality Measure Results \(Policy Brief#15\)](#)  
Flex Monitoring Team  
Examines the fifth year participation and quality measure results for Critical Access Hospitals (CAHs) in the Centers for Medicare and Medicaid Services (CMS) Hospital Compare public reporting database. Date: 03/2010
3. [Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results](#)  
Flex Monitoring Team (Briefing paper No. 28)  
Examines the sixth year participation and quality measure results for Critical Access Hospitals (CAHs) in the Centers for Medicare and Medicaid Services (CMS) Hospital Compare public reporting database  
Date: April 2011
4. [Measuring Rural Hospital Quality](#).  
University of Minnesota Rural Health Research Center. (Working Paper Series #53)

Examines quality measurement for hospitals in rural settings and seeks to identify rural hospital quality measures that reflect quality in all hospitals and that are sensitive to the rural hospital context. Quality can be measured through structure, process and outcomes. Structural measures (physical characteristics, staffing, finances) are easy to measure but indirectly affect quality. Process measures (specific to a condition, steps in evidence-based medicine) show integration and unit performance. Outcomes measures (health statistics, occurrences) are direct measures of quality but may occur across different institutional settings (rural referral linkages) or affected by low volume.

Date: April 2004

5. [Models For Quality Improvement In Critical Access Hospitals: The Role Of State Flex Programs](#)

Flex Monitoring Team (Briefing Paper No.25)

Examines the range of multi-Critical Access Hospital (CAH) quality improvement and performance measurement reporting (QI) initiatives supported by the Medicare Rural Hospital Flexibility Program in nine states; assessed the role of State Flex Programs in developing and supporting these initiatives; and explored their impact on the QI programs of CAHs.

Date: 03/2010

6. [Public Reporting and P4P in Hospital Quality Improvement](#)

New England Journal of Medicine

Overview: Public reporting and pay for performance are intended to accelerate improvements in hospital care, yet little is known about the benefits of these methods of providing incentives for improving care. It was concluded that Hospitals engaged in both public reporting and pay for performance achieved modestly greater improvements in quality than did hospitals engaged only in public reporting.

Date: 02/2007

7. [Quality Through Collaboration: The Future of Rural Health Care.](#)

Committee on the Future of Rural Health Care, Institute of Medicine

Date: 2005

8. FLEX Medicare Beneficiary Quality Improvement Project (MBQIP) Brief

9. [CAHs, Quality Measurement and MBQIP](#)

University of Minnesota Rural Health Research Center

NRHA Annual Meeting Presentation

Date: 05/2011

10. [CAHs, Quality Measurement and Evidence-Based Quality Improvement](#)

University of Minnesota Rural Health Research Center

FLEX Conference Presentation

Date: 07/2011



11. NRHA Quality Metric Meeting Report Findings
12. Joynt, Karen E., Yael Harris, E. John Orav, and Ashish K. Jha., [Quality of Care and Patient Outcomes in Critical Access Rural Hospitals](#)  
JAMA Article  
Date: 7/2011
13. [Critical Access Hospitals and the Challenges to Quality Care](#)  
JAMA Editorial  
Date: 7/2011
14. [University of Minnesota Rural Health Research Center Flex Monitoring Team Response to JAMA Article on Quality in CAHs Published July 6, 2011](#)  
Date: 07/2011

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