

# Critical Access Hospital Year 2 Hospital Compare Participation and Quality Measure Results

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## Introduction

This report examines the second 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. Although CAHs do not face the same financial incentives as hospitals paid under the Medicare Prospective Payment System (PPS) to participate, the Hospital Compare initiative provides an important opportunity for CAHs to assess and improve their performance on national standards of care. The current study updates the results of a previous study of Year 1 Hospital Compare results for CAHs.<sup>1</sup>

## Approach

This project used data on hospital participation and quality measure results from the Hospital Compare website <http://www.hospitalcompare.hhs.gov/>. The measures are based on data abstracted from patient records for hospital discharges in January through December 2005. In September 2006, the most current data from the website were downloaded and linked with data on all CAHs maintained by the Sheps Center at the University of North Carolina as part of its Flex Monitoring Team activities and data from the American Hospital Association Fiscal Year 2004 Annual Survey.

## CAH Participation in Hospital Compare

Overall, 53% of CAHs were participating in Hospital Compare (by submitting data on at least one measure for 2005 discharges) as of September 2006, a substantial increase from 41% in September 2005. By state, the percent of participating CAHs ranges from 0% to 100%.<sup>2</sup>

## Key Findings

- 53% of CAHs were participating in Hospital Compare (by submitting data on at least one measure for 2005 discharges) as of September 2006.
- Both CAHs and non-CAHs showed significant positive increases in the percent of patients receiving recommended care for the majority of quality measures.
- CAHs still have room for improvement, especially with regard to recommended care for acute myocardial infarction (heart attack or AMI) and heart failure patients.
- Low volume remains a problem for calculating a number of measures for CAHs, especially AMI measures, at the individual hospital level.

## Quality Measure Results

The Hospital Compare measure set for 2005 discharges included 20 measures that reflect recommended treatments for acute myocardial infarction, heart failure, pneumonia and surgical infection prevention. Although the number of CAH patients for whom measures were reported had increased since the previous year's analysis, many CAHs still had a very small number of patients for several measures, especially AMI measures. Therefore, aggregate scores were calculated across groups of CAHs and other hospitals.

The second year aggregate results are similar to the initial year results. CAHs are not doing as well on the AMI and heart failure measures as PPS hospitals. For pneumonia and surgical infection prevention, the results are mixed, with CAHs scoring as well or better than other hospitals on some measures, and not as well on a few measures.

Over the two years, all groups of hospitals showed significant positive increases in the percent of patients receiving recommended care for the majority of quality measures. Of the 19 measures for which CAHs had data for both years, 13 measures had significant positive increases in the percent of patients who received recommended care. The largest increases were for the heart attack smoking cessation advice, surgical infection prevention and pneumococcal vaccination measures. Five measures had increases that were not statistically significant, while one had a non-significant decrease. Rural and urban PPS hospitals showed significant positive increases for nearly all measures.

## Conclusions

CAHs still have room for improvement, especially with regard to recommended care for AMI and heart failure patients. However, it is encouraging that the group of CAHs that reported Hospital Compare data for both years significantly improved their performance on almost all pneumonia, heart failure, and surgical infection measures. Low volume remains a problem for calculating a number of measures, especially AMI measures, at the individual hospital level, and also will limit the usefulness of some new measures being added to Hospital Compare, such as 30-day mortality rates for AMI and heart failure. Additional research is needed to identify alternative methods of assessing and comparing quality performance at the hospital level for small rural hospitals. This research will be especially important as the CMS Medicare Value-based Purchasing initiative is developed and implemented.

*This policy brief is based on Flex Monitoring Team Briefing Paper No. 16, available at <http://www.flexmonitoring.org>. For more information, please contact Michelle Casey at [mcasey@umn.edu](mailto:mcasey@umn.edu)*

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## ENDNOTES

<sup>1</sup>Casey, M. and Moscovice, I. *CAH Participation in Hospital Compare and Initial Results*. Flex Monitoring Team Briefing Paper No. 9, February 2006

<sup>2</sup>As of the second quarter of 2006, 955 CAHs submitted data to the Quality Improvement Organization data warehouse, but 23% chose not to have their data publicly reported to Hospital Compare (personal communication, J. Lundblad, Stratis Health, March 28, 2007).