# Hospital Quality Initiative
# Overview
### CENTERS FOR MEDICARE & MEDICAID SERVICES
### July 2008

**Background**
Quality health care is a high priority for the Bush administration, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). In November 2001, HHS announced the Quality Initiative to assure quality health care for all Americans through accountability and public disclosure. The Initiative is intended to (a) empower consumers with quality of care information to make more informed decisions about their health care, and (b) encourage providers and clinicians to improve the quality of health care.

With the March 2008 addition of information from Medicare patients about their hospital stays, information about the number of certain elective hospital procedures provided to those patients and what Medicare pays for those services, for the first time, consumers have the three critical elements -- quality information, patient satisfaction survey information, and pricing information for specific procedures -- they need to make effective decisions about the quality and value of the health care available to them through local hospitals.

In July 2008, a third outcome of care measure, pneumonia 30-day mortality, was added to Hospital Compare. In addition, for the first time hospital-level risk-standardized mortality rates, associated interval estimates and the number of Medicare patients included in the calculation of the mortality rates were accessible by consumers. Finally, two quality measures of hospital inpatient care for pediatric asthma admissions were added to Hospital Compare as asthma is a common cause of hospitalization of children. Reporting children's asthma care measures also enables hospitals that do not generally treat adult patients to report quality data on Hospital Compare. The children's asthma care data are shared by The Joint Commission (www.jointcommission.org) with CMS in order for the data to be posted on Hospital Compare

**Objective**
The Hospital Quality Initiative uses a variety of tools to help stimulate and support improvements in the quality of care delivered by hospitals. The intent is to help improve hospitals' quality of care by distributing objective, easy to understand data on hospital performance, quality information from the consumer perspectives, and Medicare payment and volume information. This will encourage consumers and their physicians to discuss and make better informed decisions on how to get the best hospital care, create incentives for hospitals to improve care, and support public accountability.

CMS is working in conjunction with the Hospital Quality Alliance (HQA, www.hospitalqualityalliance.org), a public-private collaboration on hospital measurement and reporting. This collaboration includes the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges, and is supported by Agency for Healthcare Research Quality (AHRQ), CMS and other organizations such as

the National Quality Forum, The Joint Commission, American Medical Association, Consumer-Purchaser Disclosure Project, AFL-CIO, AARP and the U.S. Chamber of Commerce. Through this initiative, a robust, prioritized and standardized set of hospital quality measures has been refined for use in voluntary public reporting. As the first step, *Hospital Compare*, a new website/webtool developed to publicly report valid, credible and user-friendly information about the quality of care delivered in the nation's hospitals, debuted in April 2005 at www.hospitalcompare.hhs.gov and www.medicare.gov.

**Critical Components: Broadly Accepted Hospital Quality Measures and Voluntary Reporting**

The Hospital Quality Initiative is complex and differs in several ways from the Nursing Home Quality Initiative and Home Health Quality Initiative. In the previous initiatives, CMS had well-studied and validated clinical data sets and standardized data transmission infrastructure from which to draw a number of pertinent quality measures for public reporting. In contrast with the earlier initiatives, there was no comprehensive data set on hospitals from which to develop the pertinent quality measures, nor are hospitals mandated to submit clinical performance data to CMS. However, section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided a strong incentive for eligible hospitals to submit quality data for ten quality measures known as the "starter set". The law stipulates that a hospital that does not submit performance data for the ten quality measures will receive a 0.4 percentage points reduction in its annual payment update from CMS for FY 2005, 2006 and 2007.

The measures currently reported on Hospital Compare include the ten starter measures plus additional measures that many hospitals also voluntarily report. The measures represent wide agreement from CMS, the hospital industry and public sector stakeholders such as The Joint Commission, the National Quality Forum (NQF), and the Agency for Healthcare Research and Quality (AHRQ).

The hospital quality measures currently listed on Hospital Compare have gone through years of extensive testing for validity and reliability by CMS and the QIOs, The Joint Commission, the HQA and researchers. The hospital quality measures are also endorsed by the National Quality Forum, a national standards setting entity.

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| Acute Myocardial Infarction (AMI) – Heart Attack | Aspirin at Arrival |
| | Aspirin Prescribed at Discharge |
| | ACE Inhibitor or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction |
| | Adult Smoking Cessation Advice/Counseling |
| | Beta-Blocker Prescribed at Discharge |
| | Beta-Blocker at Arrival |
| | Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival |
| | Primary Percutaneous Coronary Intervention (PCI) within 90 Minutes of Hospital Arrival |
| | AMI 30-day Mortality |
| Heart Failure (HF) | Discharge Instructions |
| | Evaluation of Left Ventricular Systolic Function |
| | ACE Inhibitor or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction |
| | Adult Smoking Cessation Advice/Counseling |
| | HF 30-day Mortality |
| Pneumonia (PN) | Oxygenation Assessment |
| | Pneumococcal Vaccination |
| | Blood Culture Performed in the Emergency |

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| | Department Prior to Initial Antibiotic Received in the Hospital |
| | Adult Smoking Cessation Advice/Counseling |
| | Initial Antibiotic Received within 6 Hours of Hospital Arrival |
| | Appropriate Initial Antibiotic Selection |
| | Influenza Vaccination |
| | PN 30-day Mortality |
| Surgical Care Improvement Project (SCIP) | Prophylactic Antibiotic Received One Hour Prior to Surgical Incision |
| | Prophylactic Antibiotic Selection for Surgical Patients |
| | Prophylactic Antibiotics Discontinued within 24 Hours After Surgery End Time |
| | Surgery Patients with Recommended Venous Thromboembolism (VTE) Prophylaxis Ordered |
| | Surgery Patients Who Received Recommended Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery |
| Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) | Communication with nurses |
| | Communication with doctors |
| | Responsiveness of hospital staff |
| | Pain management |
| | Communication about medicines |
| | Discharge information |
| | Cleanliness of hospital environment |
| | Quietness of hospital environment |
| | Overall rating of hospital |
| | Willingness to recommend hospital |
| Children's Asthma Care | Use of relievers for inpatient asthma |
| | Use of systemic corticosteroids for inpatient asthma |

These measures were chosen because they are related to three serious medical conditions and surgical care improvement and it is possible for hospitals to submit information for public reporting today. Both The Joint Commission and CMS provide their own processes to submit data and use data edit procedures to check data for completeness and accuracy. In addition, the quality measures are well understood by providers and stakeholders and can be validated by CMS with existing resources through its QIO program. The ultimate goal of CMS and its collaborators in the HQA is for this set of measures to be reported by all hospitals, and accepted by all purchasers, oversight and accrediting entities, payers and providers In the future, additional quality measures will be added to Hospital Compare.

The Hospital Outcome of Care Measures include the 30-day Risk-Adjusted Death (Mortality) rates and are produced from Medicare claims and enrollment data using a complex statistical model. The model predicts patient deaths for any cause within 30 days

of hospital admission for heart attack, heart failure and pneumonia, whether the patients die while still in the hospital or after discharge. Thirty-day mortality is used because this is the time period when deaths are most likely to be related to the care patients received in the hospital. Deaths that occur outside the hospital within 30 days are included along with deaths that occur in the hospital, because some hospitals discharge patients sooner than others. By "risk-adjusted" we mean that the model calculates a death (mortality) rate that adjusts for the kinds of patient who go to that hospital so that hospitals that take care of sicker patients won't have a worse rate just because their patients were sicker before they arrived at the hospital.

CMS, along with its sister agency AHRQ, has developed a standardized survey of patient perspectives of their hospital care, known as Hospital CAHPS (HCAHPS). Information from this survey was first publicly reported on Hospital Compare in March 2008. The survey has been tested by hospitals in Arizona, Maryland and New York as part of a CMS pilot project. Additional testing occurred in Connecticut and select sites around the country. Public reporting of standardized measures on patients' perspectives of the quality of hospital care will encourage consumers and their physicians to discuss and make more informed decisions on how to get the best hospital care, as well as increase the public accountability of hospitals.

Hospital Compare as of March 2008 includes inpatient hospital payment information and the number of Medicare patients treated (volume) for certain illnesses. Diagnosis Related Groups (DRGs) are payment groups. Patients that have similar clinical characteristics and similar costs are assigned to a DRG. The DRG will be associated with a fixed payment amount based on the average cost of patients in the group. Patients are assigned to a DRG based on diagnosis, surgical procedures, age and other information. Medicare uses this information that is provided by hospitals on their bill to decide how much they should be paid. Hospital Compare shows information for each hospital on selected DRGs from October 2005 through September 2006. If a DRG has "Complications or Pre-Existing Condition" in its title, it means the hospital may have treated more complicated patients. Patients that are more complicated (i.e. have higher severity of illness) will be paid more than patients that are uncomplicated. The payment and volume information is for acute care hospitals . "Critical access hospitals (CAH)" are not included because they are paid using another method.

**The Quality Strategy**

The Quality Initiative employs a multi-pronged approach to support, provide incentives and drive systems and facilities – including the clinicians and professionals working in those settings – toward superior care through:

- Ongoing regulation and enforcement conducted by State survey agencies and CMS

- New consumer hospital quality information on our websites, www.hospitalcompare.hhs.gov and www.medicare.gov, and at 1-800-MEDICARE

• The testing of rewards for superior performance on certain measures of quality

• Continual, community-based quality improvement resources through the QIOs

• Collaboration and partnership to leverage knowledge and resources

Regulation and Enforcement

CMS will continue to conduct regulation and enforcement activities to ensure that Medicare hospitals comply with federal standards for patient health and safety and quality of care. The survey and certification program is a joint effort of the federal and state governments to ensure safety and improve the quality of care in health care facilities. These activities provide an important view of the quality of care in hospitals.

Consumer Information on Quality of Care

CMS and the HQA will conduct an integrated communications campaign to encourage consumers and their physicians to discuss and make informed decisions on how to get the best hospital care. They will encourage patients to access hospital quality information on www.hospitalcompare.hhs.gov and www.medicare.gov or by calling 1-800-MEDICARE. CMS will also direct the QIOs to promote awareness, understanding and use of quality measures by working with clinicians and intermediaries including primary care physicians, community organizations, and the media.

Rewarding Superior Performance

As part of the Hospital Quality Initiative, CMS is exploring pay-for-performance via the Premier Hospital Quality Incentive Demonstration. Under the demonstration, hospitals will receive bonuses based on their performance on quality measures selected for inpatients with specific clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Hospitals will be scored on the quality measures related to each condition measured. Composite scores will be calculated annually for each demonstration hospital. Separate scores will be calculated for each clinical condition by "rolling up" individual measures into an overall score. CMS will categorize the distribution of hospital scores into deciles to identify top performers for each condition. For each condition, all of the hospitals in the top 50% will be reported as top performers. Those hospitals in the top 20% will be recognized and given a financial bonus. By the end of the demonstration, it is anticipated that participating hospitals will show improvement from performance in year one. In year three, hospitals will receive lower payments if they score below clinical baselines set in the first year for the bottom 20% of hospitals.

CMS approved the extension of the HQID from fiscal year 2007 through fiscal year 2009. Only hospitals that completed year 3 of the current demonstration are eligible to participate. The extension begins with October 1, 2006 discharges. The extension includes the basic terms of the current demonstration project. The most notable changes are in the payment methodology. The objective will be to test new payment models, ways to measure quality, and methods to provide information to support designing value-based purchasing models.

Community-based Quality Improvement

The QIOs will continue to work with hospitals to improve performance on the hospital-reported measures and to develop and implement continuous quality improvement programs. The QIOs have worked with physicians, hospitals, and other providers on improvement activities for several decades and have seen providers achieve a substantial improvement in performance. QIOs have been working with hospitals to improve performance on many of the hospital quality measures. During this period, performance on these measures has improved across the country. As part of this initiative, the QIOs are also working with community, health care and business organizations, and with the local media to provide quality information to the public and encourage hospitals to use the information to improve care.

Collaboration and Partnership

To be effective, the Hospital Quality Initiative must truly be a collaborative effort with hospitals and their associations, physicians, other clinicians, federal and state agencies, QIOs, independent health care quality organizations, private purchasers, accrediting organizations, and consumer advocates. The initiative is designed to improve communication among all parties to positively impact quality of care. By collaborating to expand knowledge and resources, all partners can achieve greater and immediate improvements in the quality of hospital care. The HQA, mentioned earlier, is a prime example of a cooperative effort in the Hospital Quality Initiative