National Rural Health Association (NRHA) Policy Brief

Public Reporting of Hospital Quality in Rural Communities: an Initial Set of Key Issues

As Adopted by the NRHA Rural Health Policy Board on May 20th, 2005

The NRHA has long advocated the need for rural providers to engage in the 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 brief intends to build on the National Rural Health Association's existing Policy Brief *Quality of Rural Health Care* and in particular focus on issues related to the public reporting of hospital quality in rural communities. The development of this brief was triggered by the question, "How, from a rural perspective, can the Hospital Compare website (www.hospitalcompare.hhs.gov) be improved?" However, these recommendations are intended to be relevant to all public reporting initiatives about hospital quality.

Given that public reporting of hospital quality is very much a "work in progress," this policy brief does not pretend to address all issues or be the last word on the complex set of issues related to quality reporting and improvement. In particular it does not address the difficult question of how much should be invested in generating quality measures when medical records are still primarily paper and require manual abstracting. At a minimum, future NRHA policy briefs will be needed to address issues related to the public reporting of the quality of other providers and clinicians in rural communities.

However, given the significant resources already being invested in quality reporting and the potential impact on local rural communities and the hospitals upon which they depend, an initial set of public reporting principals or guidelines from a rural perspective is needed.

While relatively few people currently use information found on websites to make choices about where they seek health care, this is likely to change. Precedent is now being set. During this time of development we must ensure that the public reporting websites do not inadvertently carry forward biases against rural communities, providers and clinicians.

NRHA emphasizes the unique context of rural healthcare and that models, policies and measures developed in an urban context may or may not work well in a rural context. As noted in "*Quality of Rural Health Care*," rural America has unique factors that must be acknowledged and analyzed.

This work has been started, most notably by Ira Moscovice and colleagues at the University of Minnesota Rural Health Research Center. From the Center's recent paper, *Measuring Rural Hospital Quality*: "While rural and urban hospitals share similar types of opportunities and challenges for organizing high quality of care, the relative importance of opportunities and challenges varies as a function of the hospital context. The work completed in this study identified the most relevant quality measures for rural hospitals with less than 50 beds from

existing quality measurement systems. In the future, emphasis needs to be placed on developing relevant quality measures for core rural hospital functions (e.g. triage, stabilization and transfer; emergency care; integration of care with other local community providers) not considered in existing measurement sets."

The appropriate comparisons are for the services rendered, not the size of institution. Hospitals in rural communities should only be labeled as "small," "limited service" and "remote" when hospitals in urban communities are described as "huge," "offering an excessive amount of services" and "built on top of each other" (i.e. neither description is a fair generalization).

High quality hospitals are those hospitals that accomplish the Institute of Medicine's six aims for health care and with their community, population health: safe, effective, patient-centered, timely, efficient and equitable. Hospitals in rural communities are "acute care hospitals" even when they may have lower volumes, may not offer all specialty services, and may not be paid through the "Prospective Payment System." A hospital does not need to do brain surgery or heart transplants to be a hospital; it needs to address the medical and health needs of its community in the most appropriate manner, and that is the mission of most rural hospitals.

POLICY RECOMMENDATIONS:

1. Consumers should be able, at a minimum, to readily compare all hospitals in their "hospital referral region," i.e. within the geographic service area in which the preponderance of patients are treated and referred.

2. Hospital comparisons should be based on a core set of standard measures, even if lower volume hospitals must collect data for longer intervals to generate reliable results. Additional measures should be included to further describe the quality care in an array of more specific contexts, including but not limited to rural communities.

3. Hospitals in rural communities should fully engage in the quality improvement and public reporting movement, actively preparing for a future when public reporting is a higher priority among payers and consumers.

4. In all public reports, hospitals in rural communities should be presented in a manner that make it clear that they are "acute care hospitals," defined by the Centers for Medicaid and Medicare Services on the Hospital Compare web site as "providing inpatient medical care and other related services for surgery, acute medical conditions or injuries."

5. Information about how Medicare categorizes a hospital for payment purposes should be available to the public but should not be the primary basis for organizing a public report on hospital quality.

6. The appropriate comparisons are for the services rendered, not the size of institution

7. All relevant stakeholders should be actively involved in the complete development process of public reporting websites targeted at rural communities, from measure selection to report

presentation. All public reporting websites should be pre-tested with a representative sample of consumers and hospitals located from affected communities.

8. While all hospitals should have the opportunity to comment on the accuracy of the description of their organization and services before a website goes public, the primary responsibility is with the web site owner to assure the accuracy of the information it offers. All sources of data and their known limitations must be cited. The site should have an on-line ability for site users to provide feedback.

9. While the National Quality Forum recommends NOT publishing performance rates when the denominator is smaller than 30 (other sources cite 25), there is significant disagreement about whether or not to publish the raw data in such instances; more research and debate is needed.

10. The visual presentation and graphics used on a website or in a report convey at least as much meaning as the text or data itself and must be as rigorously tested with the relevant audiences for unintended messages.

11. The visual presentation, graphics and text accompanying a hospital with small numbers should always put the onus on the website, not the hospital, for the statistical challenges related to interpreting small numbers (e.g. "we have not yet collected enough information to reliably predict future performance" rather than "be careful when drawing conclusions for these hospitals because of the small number of patients treated.")

12. When there is a statistical challenge related to interpreting small numbers, symbols such as red flags or warning symbols should be avoided; "neutral" symbols should be selected so as to not suggest that there is a problem with the hospital.

13. Public reports need to be careful to not imply from partial inpatient data what services are available in other inpatient areas as well as the outpatient and emergency room departments (e.g. a hospital may provide care to a significant number of heart attack patients in its emergency room that are transferred rather than admitted.)

14. The national quality reporting movement must address the number of public reporting organizations and the continuing need for a common set of reporting formats and definitions.

This Policy Brief was informed by:

"Quality Through Collaboration: *The NRHA Quality Initiative*," a web site at <http://nrharural.org/quality/index.html> as downloaded on April 20th, 2005

"Dartmouth Atlas of Health," a website at <http://geiger.dartmouth.edu/> as downloaded on April 20th, 2005

"Hospital Compare - *A quality tool for adults, including people with Medicare*," a website at <http://www.hospitalcompare.hhs.gov/> as downloaded on April 1st, 2005

Guidelines for Purchaser, Consumer and Health Plan Measurement of Provider Performance by

the Consumer-Purchaser Disclosure Project, January 2005

Quality Through Collaboration: The Future of Rural Health Care. Committee on the Future of Rural Health Care, Board on Health Care Services, Institute of Medicine, *National Academies Press*. (2005).

Moscovice, I., Wholey, D., Klingner, J., and Knott, A., *Measuring Rural Hospital Quality,* April 2004.

A Comprehensive Framework for Hospital Care Performance Evaluation, a consensus report, the National Quality Forum, May, 2003

Quality of Rural Health Care, NRHA Policy Brief , December 2003