Going Public

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Norton Healthcare Quality Report

We don’t have to do this, but …

In a spirit of openness and accountability, we will show the public our performance on nationally endorsed **<u>lists</u>** of quality indicators and practices.

- Not: invent or choose indicators that make us look **good**
- Not: hide or redefine indicators that make us look **bad**

>270 indicators + safe practices

- National Quality Forum (NQF)
  - Hospital care
  - Adult cardiac surgery
  - Nursing-sensitive indicators
  - Safe practices
  - Shell in place for ambulatory indicators
- JCAHO
  - JCAHO/CMS adult core measures
  - National patient safety goals
- **AHRQ**
  - **Patient safety indicators (PSIs)**
  - **Inpatient quality indicators (IQIs)**
- Others (e.g., pediatric ORYX, NICU mortality)

Also: financials, patient satisfaction

Surgery

brief description	desired	AUD	NH	SW	SUB	KCH	KY	U.S.
% select surg. patients given preop. antibiotic on time	high	**80**	**80**		**96**		63	69
% select surg. patients given recom. preop. antibiotic	high							
% select surg. pats. w/antibiotic discontinued on time	high	**58**	**80**		**81**		68	64
% gall bladder surgery done laparoscopically	high	**87**	**84**		79	*77*	**91**	75
% incidental appendectomy in those over 64 years old	low	0	1.5		0.2		2.6	2.4
% inpatients with a reported complication of anesthesia	low	0.07	0.13		0.05	*0.06*	0.07	0.08
% surgeries where foreign body was unintentionally left	low	0	0.01		0	*0.02*	0.00	0.01
% select surgeries encountering technical difficulties	low	**0.10**	**0.81**		0.23	*0.41*	0.34	0.35

Red or green if outside 99% C.I. based on U.S.

September 14, 2005 posting

How we use PSIs and IQIs

- Publicly report rolling 12 months
- Risk-adjusted (not smoothed) rates straight from AHRQ software. Period.
- Use KY hospital discharge database, despite limited # of diagnosis codes
- Create service line report cards (only that patient population; no U.S.)

Surgery

brief description	desired	AUD	NH	SW	SUB	KCH	KY	U.S.
% surgeries w/ postoperative bleeding	low	0.15	0.23		0.30	*0.19*	0.22	0.22
% abdominal surgeries w/ postop wound dehiscence	low	0.00	0.20		0.22	*0.24*	0.16	0.20
% w/ pneumothorax resulting from medical care	low	0.09	0.08		0.05	*0.07*	0.07	0.08
% surgeries w/ postoperative physiologic derangement	low	0.05	0.09		0.05	*0.03*	0.09	0.11
% surgeries w/ postoperative respiratory failure	low	0.6	**1.6**		0.6	*0.9*	**0.8**	0.4
% surgeries w/ postoperative PE or DVT	low	1.1	**1.5**		0.8	*0.8*	0.9	0.9
% surgeries w/ postoperative sepsis	low	**5.2**	**3.1**		1.8	*0*	**1.9**	1.2
% craniotomy patients who die (AHRQ risk-adjusted)	low	6.5	6.8		6.6		7.4	7.4

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September 14, 2005 posting

Chart review vs. administrative data

- Our data validation process
  - Secondary review of measure failures
  - Interrater reliability reviews on data from retrospective medical records
- Rarely find a coding error
- Initial physician reaction:
  Then I just won’t write that down.

PSI 13. Postop. sepsis

- **Include**
  - Elective surgery inpatients with a stay of 4+ days
- **Exclude**
  - Principal dx of sepsis or certain infections
  - Any dx of immunocompromised state or cancer
- **Adjust for**
  - Patient age, sex
  - DRG
  - comorbid secondary dx

Although they were correctly coded,
as many as 50% of these patients did not have postop sepsis.

- **PSI 1 – complications of anesthesia**
  Nurse reviewer uncomfortable that any true post-admission complication found in 4 of the 5 cases (1 hx-only from previous admission; 2 PONV)
- **PSI 7 – infection due to medical care (IV lines)**
  Comments on 23% of 97 reviews.
  POA; redness only w/ no or negative cultures
- **PSI 8 – postop hip fracture**
  In 3 of 5 cases the hip fx was pre-admission.
- **PSI 10 – postop physiologic derangement**
  2/5 present on admission
- **PSI 11 – postop respiratory failure**
  Comments on 49% of 84 reviews. POA or missed risk factor.
- **PSI 15 – accidental puncture or laceration in surgery**
  Mostly accurate, but many unavoidable or trivial.
- **PSI 19/28 – vaginal deliveries with “3rd- & 4th-degree lacerations”**
  Many not 3rd/4th. Near vs. injury to…

Results

- New pressures and attention on physician documentation and medical records coding. Financial still first, but clinical now relevant.
- Physicians generally accepting so far
- **Go Green**
- KHA has patient safety committee (AHRQ)
- Kentucky govt. may publish PSIs/IQIs
- More scrutiny of indicator definitions

Some requests

- Imitate AHRQ in documenting inclusions, exclusions, risk adjustment, etc.
- Need more comparative data.
  Remove restrictions on use of aggregate data
- Guidance on analysis and display
- Fix obvious data gaps: present on admission, DNR
- Better documentation of rationale
  E.g., why not use the relevant 99 code?
- Name indicators operationally – not by their presumed cause ("failure to rescue")
- Recognize that the public is not the only audience in public reporting

Final thoughts

- Data do not become valid until used.
- The number is what the number is.
- Even lousy indicators improve care.