

Our New Reality of Public Reporting: Shame Rather Than Blame?

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The number of organizations issuing reports on hospital and physician quality performance has increased markedly over the past decade. Differences in the measures, data sources, and scoring methodologies produce contradictory results that lead to confusion for the public, providers, and governing boards, and impair the public's ability to make well-informed choices about health care providers [1]. This variability continues today and points to concerns about validity and the ultimate reliability of the measures used by these groups.

The hospital community and surgeons as a whole support the principle of accountability through public reporting of health care performance data. However, performance data that are inappropriately collected, analyzed, and displayed may add more confusion than clarity to the health care quality question [1]. For data to be understood and for results to be comparable, publicly reported data should adhere to a set of guiding principles. With that goal in mind, the Association of American Medical Colleges (AAMC) convened a panel of experts in 2012 and 2013 to develop a set of guiding principles that can be used to evaluate quality reports. The principles were organized into three broad categories: purpose, transparency, and validity.

Under the domain of purpose, the AAMC recognized that public reporting and performance measurement should occur for a variety of reasons, including consumer education, provider quality improvement, and purchaser decision making. Relative to transparency, the AAMC believed that methodologic details should be clearly discerned as they can impact both providers' performance data and the appropriate interpretation of the data. Transparency also requires that all information necessary to understand the data be available to and interpretable by the reader. Limitations in data collection and methodology as well as relevant financial interests should always be disclosed in language that is discernable. Lastly, validity of the data must ensure that the methodology, data collection, scoring, and benchmarks produce an accurate reflection of the characteristic being measured and reflect the care being provided by the hospital or physician. These guiding principles were expanded and proposed by the AAMC to facilitate adherence and to ensure appropriate interpretation of

performance as public reporting becomes truly a cottage industry.

Federally Facilitated Quality and Patient Programs

In the recent and final Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital policy for fiscal year 2015, the Centers for Medicare and Medicaid Services (CMS) aimed at promoting high-value and high-quality care using a program that is targeted at a specific set of preventable infections, events, and conditions that occur in the inpatient setting, referred to as hospital-acquired conditions (HAC). Similar to CMS value-based purchasing and readmissions reduction programs, this HAC reduction program has significant implications for academic centers, particularly major teaching hospitals. In its current iteration, the program can only be defined as a penalty program with a current 1% withholding [2]. The program reduces payments to hospitals that rank in the worst performing quartile. The worst performing quartile is identified by calculating the total HAC score, which is based on the hospital's performance on four risk-adjusted quality measures (patient safety indicator 90 composite, central-line associated bloodstream infection, catheter-associated urinary tract infection, and surgical site infection for colon surgery and hysterectomy). Hospitals with a total HAC score above the 75th percentile of the total HAC score distribution are subject to payment reduction [3]. An analysis of the preliminary penalties suggested that major teaching hospitals are 2.9 times more likely to be penalized in this program than nonteaching hospitals [4, 5]. Additionally, CMS estimates that 56% of major teaching hospitals will be penalized [2]. Ultimately, many could face substantial penalties from all three pay-for-performance programs developed by CMS. One has to surmise that the most acutely ill and complex patients will acquire these HACs and that such a hefty penalty program will promote risk-averse behavior, resulting in reluctance of physicians and systems to accept these patients. The results of this HAC program, good or bad, are publicly reported, and this publicly reported score is the basis for both nonpayment and penalties. Not surprisingly, this methodology has been widely scrutinized.

To our knowledge, there is no evidence that this type of administrative composite quality measure is linked to clinical validated risk-adjusted mortality, length of stay,

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Abbreviations and Acronyms

AAMC	= Association of American Medical Colleges
AHRQ	= Agency for Healthcare Research and Quality
CHSD	= Congenital Heart Surgery Database
CMS	= Centers for Medicare and Medicaid Services
HAC	= hospital-acquired condition
NHS	= National Health Service
OSUWMC	= Ohio State University Wexner Medical Center
PSI	= patient safety indicator
STS	= The Society of Thoracic Surgeons

and hospital charges. Yet, this information may be linked to hospitals' and health systems' pursuit of what Don Berwick and the Institute for Healthcare Improvement have called the "triple aim"—improving the experience of care, improving health of populations, and reducing per capita cost of health care [6]. A main concern is how health care systems, diverse training programs, and quaternary care centers can use the data to mitigate patient risk and at the same time maintain fiscal survival. Clearly, to stop providing the most specialized care to the sickest patients so as to avoid being penalized by administratively derived data is counterproductive.

In an effort to answer these questions, our group aimed to determine the effects of HACs on mortality, prolonged length of stay, and excessive hospital charges using the Nationwide Inpatient Sample, Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality (AHRQ), and the largest all-payer publically accessible database of inpatient visits in the United States. In a retrospective, cross-sectional analysis of weighted national estimates from the 2012 Nationwide Inpatient Sample data, we established the effects of at least one HAC on mortality, prolonged length of stay, and excessive hospital charges through univariate and multivariate logistic regression. Prolonged length of stay was defined as a stay longer than 4.5 days (greater than the 75th percentile of all hospital stays in 2012) and excessive hospital charges as a charge greater than \$40,448 (greater than the 75th percentile of all hospital charges in 2012). Our findings showed that patients with at least one HAC have a 54% higher likelihood of dying during an inpatient hospital stay than patients without a HAC. Additionally, the odds of patients with at least one HAC having a prolonged hospital stay and excessive charges are 1.64 and 1.85 times that of patients without, respectively (Table 1). In examining the impact of each HAC on mortality, we determined that pressure ulcers stages III and IV, manifestations of poor glycemic control, and vascular catheter-associated infections are the top three drivers of mortality. These findings are consistent with prior studies that have shown these HACs to be major causes of inpatient morbidity and mortality [7–9]. They

also underscore the value of national campaigns to reduce their occurrence.

There is no doubt, therefore, that HACs have a negative impact on patient outcomes and provide challenges for hospitals and payers. Currently, hospitals are being penalized and denied payment based on their respective HAC score. Yet, how this score is interpreted remains unclear, and its ability to measure the true performance and quality of an individual hospital is not well defined [10]. So what are these stakeholders to do? Should patients seek care at hospitals with the most favorable HAC score? Does penalizing hospitals promote or hurt their ability to improve performance when resources are so limited?

Resultant Ranking Systems: 700 Top 100 Hospitals

Attempts to assess the quality and safety of hospitals have proliferated, many without the AAMC guiding principles, and some may say have become a cottage industry and include a growing number of consumer-directed hospital rating systems. However, relatively little is known about what these rating systems reveal other than to confirm that there appear to be more than 700 "top 100" hospitals in America. To better understand differences in hospital ratings, Pronovost and colleagues [11] recently published a comparison of four national rating systems, including US News & World Report's "best hospitals" report, Leapfrog, CMS's Hospital Compare, Consumer Reports, and Healthgrades [11]. They designated high and low performers for each rating system and examined the overlap among rating systems and how hospital characteristics corresponded with performance on each. No American hospital was rated as a high performer by all four national rating systems, and only 10% of the 844 hospitals rated as a high performer by one rating system were rated as a high performer by any of the other rating systems. There was a general lack of agreement among the national hospital rating systems, a finding attributed to each system using its own rating methods, having a different focus to its ratings, and stressing different measures of performance. Furthermore, this research group found that differences across hospital ratings add complexity to ascertaining a hospital's actual quality, making it difficult for payers to recognize and reward hospitals for high-quality care, complicating decisions for hospital leadership regarding the focus of their improvement efforts, and most importantly, confounding medical judgment for current and prospective patients and families [11].

Patient Safety Indicator Story: An Example of Futility?

Inherent in many of the ranking systems and public reporting are entities referred to as patient safety indicators (PSIs). To address the need for quality monitoring, the AHRQ established a set of PSIs to assist in monitoring potentially preventable events for patients

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