

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
MAY 26, 2005**

Category D: Implementing Safety Systems in Health Care Organizations

Performance Benchmarks (08): Adoption of performance benchmarks and measures related to patient safety measures.

Recommendation D2. The State of Michigan should have benchmarking information available for a variety of measures for HCO's. The methodology used to calculate benchmarks should be available to the public and follow an established methodology, including peer- group defined benchmarking. Incentives that are based on meeting the benchmarks should be supported by all payors, using 'centers of excellence', including longitudinal compliance and performance as part of the incentive.

Rationale:

Webster's Dictionary defines a benchmark as 'something that serves as a standard by which others can be measured'. Benchmarking is often based on subjective assessment rather than on measurements derived from data. As such, benchmarks may fail to yield an achievable level of excellence that can be replicated under specific conditions (Kiefe, 1998).

The IOM (2000) defines benchmarking as a way to compare oneself or one's organization against the "best in class". IOM suggests that while learning about and finding ways to implement the best practices, organizations can implement sets of practical time-series measures that can help them learn whether the steps they have taken are improving patient safety. In addition, organizations can collaborate with other facilities, even within their market areas, to understand patterns of error and new approaches to prevention. Review of the literature suggests that formal and informal benchmarking activities occur for a number of health care processes (HEDIS, JCAHO Core Measures, Emergency room – bedding time, Early discharge processes, Waiting time for outpatient visits, etc.).

Kiefe et al. (2001) conducted a randomized clinical trial to test in an ambulatory setting whether physician performance improves with specific feedback based on Achievable Benchmarks of Care (ABC's). Typical audit and feedback methods are based on the average comparison of a peer group, leading to modest benefits without long-term sustained results. ABC's methodology is calculated from the performance of all members of a peer group and represents a realistic standard of excellence attained by the top 10% performers in that group. The ABC methodology is neither resource intensive nor inherently hazardous. With high face validity, the peer-based, data-drive achievable benchmark method has many advantages and represents an advance in the methodology of quality measurement and improvement.

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Austin et al. (2004) reviewed hospital-specific mortality rates following admission for acute myocardial infarction (AMI). A number of factors are known to influence patient outcomes, such as hospital volume of AMI patients, academic status of the hospital, and physician training. Comparison of mortality rates based on various risk adjustment factors demonstrated that changing the benchmark against which hospitals are compared can result in a decreased number of hospitals being identified as having higher than expected mortality. The authors pose that hospitals may be more receptive to initiating improvement programs if they are compared within their own peer group.

A number of health care organizations have surveyed themselves to benchmark their culture-of-safety status, using a variety of surveys and checklists that assess the attitudes and perceptions of works. AHRQ and the federal government's Quality Interagency Coordination Task Force have developed the public-domain Hospital Survey on Patient Safety to assess issues of patient safety, medical error, and event reporting as they relate to an organization's safety culture. However, surveys are believed to be inadequate in evaluating the extent to which a culture of safety has been created without measurable indicators of the culture's effectiveness and benchmarking information from comparable organizations (Page, 2004).

Recommendations

Testimony indicated the need for a variety of benchmarking information available, for example for patient falls, nosocomial skin breakdown, medical errors not resulting in harm, pneumonia, shock, patient satisfaction, etc. In addition, data elements must have easily understood definitions that can be operationalized in a consistent manner across settings and made available to the public (105-B, W16-19, O24-29). Additional recommendations indicated the need to align incentives through all payors, using 'centers of excellence' with financial incentives for performance. The incentives should be based on longitudinal performance and demonstrated compliance over time (204B, W129-132). One recommendation pertained to the use of benchmarking techniques available in the commercial industries (110-W, W76-77).

A number of databases and consequent reporting systems are utilized within the healthcare industry. The extent of reporting and benchmarking information provided is variable. For example, the Hospital Compare initiative provides a search capability that allows specific hospital reporting and 90% benchmarking results. NCQA provides a similar service for health plans, benchmarking information is provided in the form of stars. Other benchmarking data may be more specific, but the database is typically open for members only, for example University Healthcare Consortium, the Vermont-Oxford network, and National Surgical Quality Improvement Project (NSQIP). UHC, Vermont-Oxford, and NSQIP provide its members with prepared benchmarking information and allow

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members to search the databases to gain a better understanding of factors that influenced their performance.

Evidence and information on comparable initiatives:

Hospital Compare (<http://www.hospitalcompare.hhs.gov/>)

HospitalCompare website was recently launched (March 2005). The website was created through the efforts of the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (DHHS) along with the Hospital Quality Alliance (HQA). The HQA is a public-private collaboration established to promote reporting on hospital quality of care. The HQA consists of organizations that represent consumers, hospitals, doctors, employers, accrediting organizations, and Federal agencies. The information on this website can be used by any adult needing hospital care.

The Hospital Compare website presents quality measures on how often hospitals provide some of the recommended care to get the best results for most patients. The indicators posted on HospitalCompare are core measures for AMI (for example, aspirin and betablocker usage before / after AMI), heart failure (such as, LVF assessment, ACEI/ARB prescribed), and pneumonia (for example, initial antibiotic timing, pneumococcal vaccination). The data are collected following JCAHO's core measures technical specifications. The website allows for searching and comparison of specific core measures and indicates the rank of a particular hospital in comparison with national Top 10% of hospitals nationwide.

National Committee on Quality Assurance (NCQA)

A number of organizations provide benchmarking information. The National Committee on Quality Assurance provides details about HEDIS measures, a standard set of performance measures for HMO's (www.ncqa.org, accessed 5/22/05).

NCQA rates health plans on a number of topics based on the HEDIS measures: (1) Access and Service. NCQA evaluates how well the health plan provides its members with access to needed care and with good customer service. (2) Qualified Providers. NCQA evaluates health plan activities that ensure each doctor is licensed and trained to practice medicine and that the health plan's members are happy with their doctors. (3) Staying Healthy. NCQA evaluates health plan activities that help people maintain good health and avoid illness. (4) Getting Better. NCQA evaluates health plan activities that help people recover from illness. (5) Living with Illness. NCQA evaluates health plan activities that help people manage chronic illness.

HEDIS is NCQA's tool used by health plans to collect data about the quality of care and service they provide. HEDIS consists of a set of performance measures

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that tell how well health plans perform in key areas: quality of care, access to care and member satisfaction with the health plan and doctors. HEDIS requires health plans to collect data in a standardized way so that comparisons are fair and valid. Health plans can arrange to have their HEDIS results verified by an independent auditor.

NCQA Accreditation is used by most of the nation's Fortune 500 employers, federal and state governments, and consumers to help select among competing health plans. NCQA's Health Plan Report Card is based on a rigorous evaluation of clinical quality, member satisfaction and a comprehensive assessment of key systems and processes.

National Surgical Quality Improvement Project (NSQIP)

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) is a national, validated, outcomes-based, risk-adjusted program for the measurement and enhancement of surgical care. Eleven years ago the Veterans Health Administration (VHA) created the NSQIP to measure operative morbidity and mortality in V A Hospitals. After implementing the program in 128 hospitals, surgical mortality decreased 27% and morbidity decreased 45%.

In 2001, a collaboration of the VA and the American College of Surgeons (ACS) resulted in a grant from the Agency for Healthcare Research and Quality (AHRQ) to implement the NSQIP in private sector hospitals. As a result of the program's success in the V A and the private sector initiative, the ACS developed a business plan to offer this program, beginning with General and Vascular Surgery, to all interested and qualified hospitals. The ACS NSQIP is now being made available to all private sector hospitals that meet the minimum participation requirements, complete a hospital agreement, and pay an annual fee. (<http://www.facs.org/cqi/otherendeavors.html>, accessed 5/22/05)

University Healthcare Consortium

The University HealthSystem Consortium (UHC), formed in 1984, is an alliance of academic health centers situated mainly in the United States. As a membership organization, UHC provides its 90 full members and 123 associate members with a variety of resources aimed at improving performance levels in clinical, operational, and financial areas. The mission of the University HealthSystem Consortium is to advance knowledge, foster collaboration, and promote change to help members succeed in their respective markets. UHC conducts benchmarking studies on clinical and operational topics, provides comparative data on clinical and operational areas. The UHC data and reporting system is accessible to members who can query the data warehouse to conduct

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comparison and benchmarking studies. UHC also provides its membership (a.o.) with a quarterly report of the AHRQ Patient Safety Indicators where the Top 25%, Top 50% performance of the membership serves as a benchmark for a particular hospital. (www.uhc.edu, accessed 5/22/05).

Vermont Oxford Network

The Vermont Oxford Network is a non-profit voluntary collaboration of health care professionals dedicated to improving the quality and safety of medical care for newborn infants and their families. Established in 1988, the Network is today comprised of over 485 Neonatal Intensive Care Units, predominantly in the United States and including centers in Canada, Europe, Asia, Africa, and the Middle East.

In support of its mission, the Network maintains a Database including information about the care and outcomes of high-risk newborn infants. The Database provides unique, reliable and confidential data to participating units for use in quality management, process improvement, internal audit and peer review. Health care professionals from member institutions participate actively in clinical trials, long-term follow-up studies and epidemiologic and outcomes research. (<http://www.vtoxford.org>, accessed 5/22/05).

Pros:

- Comparison data for institutions that will help guide improvement activities
- Established definitions and specifications for the indicators that are made available for benchmarking
- HCO's interested in the benchmark are required to submit their own data
- Relatively low resource need to produce the benchmarks

Barriers:

- Benchmarking methodology must be agreeable and useful for the HCO's submitting the data
- Provision of benchmarks alone does not guarantee performance improvement by the institution

Implementation Steps:

Submitted testimony was not specific about the strategies to implement this recommendation.

Cost: TBD

Implementation Target: TBD

References

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