

**OSHPD Technical Note
for Producing
Agency for Healthcare
Research and Quality
Inpatient Mortality Indicators,
2010 and 2011 Data**

Office of Statewide Health Planning and Development

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Background

This Technical Note explains how the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicator (IQI) software was applied to California's patient discharge data collected by the Office of Statewide Health Planning and Development (OSHPD) to generate hospital results for 12 of the 15 available Inpatient Mortality Indicators (IMIs) for which AHRQ calculates risk-adjusted mortality rates and quality ratings.

The data tables were produced by OSHPD's Healthcare Outcomes Center in the Healthcare Information Division using AHRQ Quality Indicators software version 4.4 for SAS® released in March 2012 with 2010 and 2011 inpatient data. OSHPD made California-specific modifications to the software which were discussed with and supported by AHRQ.

The 2010 and 2011 reports include data from 331 state-licensed general acute care hospitals. Other AHRQ IQI reports can also be found on the OSHPD [website](#) including hospital-level volume and utilization measures.

How are the Inpatient Mortality Indicators useful?

The AHRQ quality indicators and related software, provided at no cost to states, use readily available patient discharge data to highlight possible differences in the quality of care provided by hospitals. These results may provide the foundation for more in-depth analyses of healthcare quality, and are intended to contribute to quality improvement efforts made by hospital administrators, clinicians, quality assurance personnel, and other stakeholders interested in healthcare quality. In addition, when the information is carefully considered along with its limitations and in conjunction with other reliable healthcare provider information, it may inform policy maker, patient, or healthcare purchaser decision making.

Do the Inpatient Mortality Indicators measure actual quality of hospital care?

These measures are *indicators* of healthcare provider quality but are not *definitive* determinations of quality. Rather, they are meant to serve as a starting point for further investigation and in-depth analyses, to prompt more extensive data scrutiny and in-depth validation of the health outcomes and associated processes of care, and to facilitate additional data validation and reliability analyses.

In addition to the Inpatient Mortality Indicators, OSHPD has produced hospital-specific risk-adjusted health outcome reports (available on its [website](#)) on heart attack, community-acquired pneumonia, and heart bypass surgery, using validated risk-adjusted measures of quality with California data. These "gold-standard" reports generally require many years of work to carefully construct risk models and validate the data. As a result, OSHPD has produced only a few such reports to date. Prompted by increasing demand for quality metrics and additional risk-adjusted hospital-specific outcome reports, beginning in 2008 OSHPD has produced and publicly reported additional measures, updated annually, using many of the AHRQ Inpatient Mortality Indicators.

It is important to note that the 2010 and 2011 hospital results come with several caveats:

1. California hospital medical record data for the reported medical conditions and procedures have not been validated through medical record reabstraction (with a few exceptions) to demonstrate that patient severity-of-illness and complications are accurately and reliably coded across all hospitals;
2. OSHPD has not performed detailed clinical analyses to identify the processes of care that lead to improved risk-adjusted mortality rates; and
3. OSHPD has not performed analyses to establish that the risk models for these medical conditions and procedures, using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), perform well compared to gold-standard clinical models that include information such as laboratory values, vital signs, and imaging studies.

How does OSHPD's California implementation of the AHRQ Inpatient Mortality Indicators differ from the approach used by most states?

AHRQ modified its IMI software in version 3.2 to address a deficiency in the All Patient Refined Diagnosis Related Groups (APR-DRG) risk-adjustment algorithm employed by the indicators.^{1,2,3,4} The APR-DRG algorithm is a proprietary tool of the 3M Health Information Systems Corporation. In essence, the AHRQ modification improves the risk-adjustment method by including unique information contained in the California patient discharge data: the Present on Admission (POA) data fields.

In all states, hospital information systems use the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) protocol to convert medical chart information to numeric codes. This approach lacks a way of distinguishing between complications of care that arise post-hospitalization and acute medical conditions that exist prior to admission. The original APR-DRG risk adjustment, built on ICD-9-CM, therefore cannot generally distinguish between pre-existing risks and complications of care. This deficiency may result in hospitals with many treatment complications unfairly benefiting from the risk algorithm while hospitals with fewer complications are penalized.

OSHPD patient discharge data contain the Present on Admission (POA) data fields, adopted in 2007 as a national standard for providing information on the timing of acute conditions and complications.⁵ The APR-DRG risk method used previously was modified by AHRQ to take POA information into

¹ Glance LG, Osler TM, Mukamel DB, & Dick AW. (2008). Impact of the present-on-admission indicator on hospital quality measurement: experience with the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators. *Medical Care*, 46, (2), 112-119.

² Hughes JS, Averill RF, Goldfield NI, Gay JC, Muldoon J, McCullough E, & Xiang J. (2006). Identifying potentially preventable complications using a present on admission indicator. *Health Care Financing Review*, 27, (3), 63-82.

³ Romano PS & Chan BK. (2000). Risk-adjusting acute myocardial infarction mortality: are APR-DRGs the right tool? *Health Services Research*, 34, 1469-1489.

⁴ Iezzoni LI, Ash AS, Shwartz M, Daley J, Hughes JS & Mackiernan YD. (1995). Predicting who dies depends on how severity is measured: Implications for evaluating patient outcomes. *Annals of Internal Medicine*, 123 (10), 763-770.

⁵ In previous years of OSHPD patient discharge data, a similar set of present-on-admission fields were available called condition present on admission. These fields had slightly different data element definitions, and were changed in 2007 to adhere to national standards.

account. While this modification appears to be a major improvement, the effect this modification has on the existing APR-DRG method has not been well-researched. Unpublished OSHPD analyses indicate, however, that the adjustment appears to result in improved estimates of hospital risk-adjusted mortality rates.

In past versions of the software, users could apply the indicators to data with or without POA. The current version of the software (4.4), however, no longer provides this option and assumes that POA data are available for all or most patient records. For users without POA data, the model incorporates the likelihood that the co-morbidity was present on admission. The software applied to California data does not depend on statistical estimates for missing data.

How comparable are these Inpatient Mortality Indicators with other quality metrics produced by OSHPD or other organizations?

Hospital results using 2010 and 2011 OSHPD hospital data may not be comparable with quality ratings obtained using other methods, even when the clinical area of examination is the same. For example, coronary artery bypass graft (CABG) surgery risk-adjusted outcome reports issued by the OSHPD California CABG Outcomes Reporting Program (CCORP) are different from the AHRQ CABG mortality indicator in a number of important ways. Among other things, OSHPD's CABG report:

- Is based on a different outcome, “operative mortality” (including deaths occurring after discharge but within 30 days post-operation), while AHRQ's outcome is in-hospital mortality.
- Uses clinical registry data, while AHRQ's measure uses ICD-9-CM coded patient discharge data.
- Only includes clinically similar “isolated CABG” cases, while the AHRQ measure includes more types of CABG cases.
- Uses a risk model based on clinical logic, while the AHRQ risk model is empirically based.
- Computes risk-adjusted mortality rates using only California data, while the AHRQ algorithm incorporates comparison data from the 2009 [National Inpatient Sample](#), developed by AHRQ Healthcare Cost and Utilization Project (HCUP).
- Uses audited data, while the AHRQ measure does not.

The AHRQ IMIs also differ in several ways from OSHPD's gold-standard risk adjusted outcome reports that use administrative data (community-acquired pneumonia and heart attack). The OSHPD reports:

- Use a 98% confidence interval to identify hospitals whose performance differs significantly from the state average, while the AHRQ IMIs use a 95% confidence interval to identify hospital outliers.
- Use 30-day mortality post-admission or post-surgery as the outcome, while the AHRQ IMIs use in-hospital mortality.

- Use a risk model based on both clinical logic and empirical considerations, while the AHRQ IMI risk model is empirically based.
- Compute risk-adjusted mortality rates using only California data, while the AHRQ IMI algorithm incorporates data from other states.

Finally, it is important to note some of the differences between the previous OSHPD publication of the AHRQ IMIs (2006, 2007, 2008 and 2009 data) and this report. The AHRQ IMIs using 2010 and 2011 data:

- Use version 4.4 of the AHRQ software, while the previous reports used versions 3.2a (2006 and 2007) and 4.1a (2008 and 2009).
- Use the California statewide observed rate as the benchmark when recalibrating the patient indirect mortality rate and the hospital risk-adjusted rate, while the previous reports used the national reference rate when calibrating the patient indirect mortality rate. Importantly, this results in a more balanced number of high- and low-performing hospitals in the current report. In previous years, use of the national reference rate resulted in a larger proportion of “better” performing hospitals than “worse” performing hospitals and this bias has been corrected.

Even when data sources are similar, differences in the data years, inclusion and exclusion criteria, the risk model, the statistical methods employed, and decisions on how to categorize performance can lead to different results when comparing a given hospital using more than one metric.

What Inpatient Mortality Indicators and which hospitals are included in the 2010 and 2011 results for California hospitals?

The March 2012 release of AHRQ software allows the calculation of 15 IMIs, including 7 measures related to surgical procedures and 8 measures related to medical conditions. The results for 3 of the 15 available IMIs were not reported using OSHPD 2010 and 2011 data for the following reasons:

- For coronary artery bypass graft (CABG) surgery, OSHPD California CABG Outcomes Reporting Program (CCORP) already reports hospital and surgeon-level risk-adjusted mortality rates and quality ratings using data from a clinical registry expressly created for quality monitoring and reporting. This, along with other features of the data collected by CCORP, results in superior quality assessments to those obtained from the AHRQ CABG measure.
- For acute myocardial infarction (AMI), AHRQ IMIs include two measures: one includes all AMI patients and one excludes patients transferred to another acute care hospital. Upon advice from experts on its former Technical Advisory Committee (TAC), OSHPD decided to report only the measure that includes transfer patients. Analyses show that transfer patients were, on average, less severely ill and experienced lower mortality rates than non-transfer patients so hospitals that received large numbers of transfer patients were not disadvantaged by this decision.
- Finally, hip replacement was not included because it lacked National Quality Forum endorsement, had a very low mortality rate, and subsequently OSHPD’s former TAC questioned its value as a hospital-level reported measure.

As a result, the following indicators are included in this report (more detailed definitions, including technical specifications, may be found on the [AHRQ website](#)):

Surgical Procedures:

- **Esophageal Resection** – the number of deaths per 100 patients with an ICD-9-CM procedure code for esophageal resection and a diagnosis code of esophageal cancer in any field.
- **Pancreatic Resection** – the number of deaths per 100 patients with an ICD-9-CM procedure code for pancreatic resection and a diagnosis code of pancreatic cancer in any field.
- **Craniotomy** – the number of deaths per 100 discharges with a Diagnosis-Related Group (DRG) code for craniotomy (DRG 001, 002, 528, 529, 530, and 543), with and without co-morbidities and complications.
- **Carotid Endarterectomy** – the number of deaths per 100 patients with an ICD-9-CM procedure code for carotid endarterectomy.
- **Percutaneous Coronary Intervention (PCI)** – the number of deaths per 100 patients with an ICD-9-CM procedure code for PCI. Percutaneous Transluminal Coronary Angioplasty (PTCA) has been renamed Percutaneous Coronary Intervention (PCI) in AHRQ Version 4.4.
- **Abdominal Aortic Artery (AAA) Repair** – the number of deaths per 100 patients with an ICD-9-CM procedure code for AAA repair and a diagnosis of AAA in any field.

AHRQ currently produces a single AAA repair indicator that includes patients with both ruptured and unruptured aneurysms. The former OSHPD Technical Advisory Committee recommended that OSHPD exclude rupture cases, as defined by ICD-9-CM code 441.3 when calculating hospital risk-adjusted mortality rates. Patients with aneurysm rupture have an observed mortality rate of 42.4% and one of the key determinants of survival is the time elapsed since rupture, which is not available in these data as a risk adjuster. Excluding rupture cases removes approximately 9% of all AAA cases and reduces overall mortality from 5.9% to 2.4%.

Medical Conditions:

- **Acute Stroke** – the number of deaths per 100 patient discharges with an ICD-9-CM principal diagnosis code for stroke.
- **Gastrointestinal (GI) Hemorrhage** – the number of deaths per 100 patient discharges with an ICD-9-CM principal diagnosis code for GI hemorrhage.
- **Hip Fracture** – the number of deaths per 100 patient discharges with an ICD-9-CM principal diagnosis code for hip fracture.
- **Heart Failure** – the number of deaths per 100 patient discharges with an ICD-9-CM principal diagnosis code for heart failure. Congestive Heart Failure (CHF) has been renamed Heart Failure in AHRQ Version 4.4.
- **Acute Myocardial Infarction (AMI)** – the number of deaths per 100 patient discharges with an ICD-9-CM principal diagnosis code for AMI.

- **Pneumonia** – the number of deaths per 100 patient discharges with an ICD-9-CM principal diagnosis code for pneumonia.

Hospital Selection:

To be included in this report, a California general acute care hospital (444 facilities total in 2010 and 443 facilities total in 2011) had to have at least one patient eligible for inclusion in the IMIs (374 facilities in 2010 and 2011). In addition, 37 hospitals were excluded for the following reasons:

- Twenty-three were excluded based on their categorization by the Center for Medicare and Medicaid Services (CMS) as long-term acute care hospitals, or having an average length of stay that exceeded CMS-designated long-term acute care hospitals – these facilities treat patients with long-term acute conditions (e.g., requiring respiratory care) and have an average length of stay greater than 25 days;
- One facility was excluded because it provided only hospice care; and
- Thirteen facilities specializing in pediatric care were excluded.

The excluded hospitals are listed in Table 1.

Table 1. Hospitals excluded from AHRQ IMI reports using 2010 and 2011 OSHPD data due to provision of long-term acute care (CMS determination), hospice care, or pediatric facility designation

Type of Exclusion	Hospital Name
CMS Long-term Acute Care	1. Barlow Respiratory Hospital
	2. Kentfield Rehabilitation Hospital
	3. Kindred Hospital – Baldwin Park
	4. Kindred Hospital – Brea
	5. Kindred Hospital – La Mirada
	6. Kindred Hospital – Los Angeles
	7. Kindred Hospital – Ontario
	8. Kindred Hospital – Rancho
	9. Kindred Hospital – Riverside
	10. Kindred Hospital – Sacramento
	11. Kindred Hospital – San Diego
	12. Kindred Hospital – San Francisco Bay Area
	13. Kindred Hospital – Santa Ana
	14. Kindred Hospital – South Bay
	15. Kindred Hospital – Westminster
	16. Los Angeles County/Rancho Los Amigos National Rehabilitation Center
	17. Monrovia Medical Center
	18. Newport Specialty Hospital
	19. Northern California Rehabilitation Hospital
	20. Promise Hospital of East Los Angeles – East Los Angeles Campus
	21. Promise Hospital of San Diego

CMS Long-term Acute Care (continued)	22. San Joaquin Valley Rehabilitation Hospital
	23. Vibra Hospital of San Diego
Hospice Care	1. San Diego Hospice and Palliative Care – Acute Care Center
Pediatric Facility	1. Children’s Hospital and Research Center at Oakland
	2. Children’s Hospital at Mission
	3. Children’s Hospital Central California
	4. Children’s Hospital of Los Angeles
	5. Children’s Hospital of Orange County
	6. Earl and Lorraine Miller Children’s Hospital
	7. Lucile Salter Packard Children’s Hospital at Stanford
	8. Rady Children’s Hospital – San Diego
	9. Sharp Mary Birch Hospital for Women and Newborns
	10. Shriners Hospital for Children – Los Angeles
	11. Shriners Hospital for Children Northern California
	12. Sutter Maternity and Surgery Center of Santa Cruz
	13. University of Southern California Kenneth Norris, Jr. Cancer Hospital

The final exclusion criterion relates to the volume of patients for each AHRQ IMI. The AHRQ software will not report results for a specific IMI if there were two or fewer cases in the denominator for a given hospital. Hence, hospitals with two or fewer cases in the denominator for all indicators do not appear in the report. Hospitals excluded based on this criterion are listed in Table 2. After exclusions, 331 hospitals remain and are included in this report.

Table 2. Hospitals excluded from AHRQ IMI reports using 2010 and 2011 OSHPD data due to reporting fewer than three patients for all AHRQ IMIs

2010	2011
1. Fresno Surgical Hospital	1. Doctors Hospital of West Covina, Inc.
2. Doctors Hospital of West Covina, Inc.	2. Stanislaus Surgical Hospital
3. Surprise Valley Community Hospital	3. Sutter Surgical Hospital – North Valley

In cases of hospital name changes, the discharges were attributed to the name of the hospital in use at the time the services were provided. Table 3 shows hospitals that changed names between 2010 and 2011.

Table 3. Hospitals in AHRQ IMI Reports with Consolidated or Changed Name between 2010 and 2011

Hospital Name in 2010	Hospital Name in 2011
1. Kaiser Foundation Hospital – Sacramento/Roseville-Morse	1. Kaiser Foundation Hospital – Sacramento (unconsolidated with Roseville)
2. Kaiser Foundation Hospital – Sacramento/Roseville-Morse	2. Kaiser Foundation Hospital – Roseville (unconsolidated with Sacramento)
3. University of Southern California University Hospital	3. Keck Hospital of University of Southern California

Exactly how were the AHRQ Inpatient Mortality Indicators calculated?

OSHPD used a modified version of AHRQ Quality Indicators software version 4.4 for SAS, released in March 2012. AHRQ's free software and associated documentation are available online at <http://www.qualityindicators.ahrq.gov/software/SAS.aspx>.

The first step in calculating rates was to transform the data elements and values of the 2010 and 2011 patient discharge data into a format that can be read by the AHRQ software. Second, OSHPD specified the number of diagnoses and procedures available in the dataset. Third, All Patient Refined Diagnosis Related Groups (APR-DRG) "groupers" and associated "risk of mortality" categories were added to each patient record by running the 3M Health Information Systems Corporation software licensed to AHRQ. Finally, the coefficients used in the risk-adjustment process (described below), as well as population rates, were constructed based on the 2009 National Inpatient Sample (NIS) compiled by AHRQ Healthcare Cost and Utilization Project (HCUP). The coefficients from the 2009 NIS were used for both the 2010 and 2011 reports. Once the data were transformed and the options were set, the software was run to automatically calculate the rates described below.

Standardizing the Patient Data

California hospitals electronically submit inpatient data including patient age, length of stay, gender, race, ICD-9-CM codes, and related information to OSHPD. The OSHPD Healthcare Information Division Patient Data Section then applies thousands of quality control automated "edits" using a custom software program that flags data values submitted by hospitals to OSHPD as invalid or likely wrong. If certain thresholds are reached, hospitals are contacted and asked to review the data and make any necessary changes. Once the data have been finalized, OSHPD researchers use SAS software to transform the data elements to conform to the standards specified in the AHRQ documentation. These are the same standards that AHRQ applies to the State Inpatient Database and the National Inpatient Sample, collected from many states and maintained by the federal government.

Calculation of Observed Rates

The AHRQ IMI software produces numerators, denominators, observed rates, expected rates, risk-adjusted rates, and additional information to evaluate confidence intervals and reliability of the indicators. The 2010 and 2011 reports produced by OSHPD focus on risk-adjusted rates and confidence intervals for California acute care hospitals. Terminology and methodology used for determining these rates are described below to help explain the process of generating risk-adjusted rates.

Numerator – The number of inpatient deaths that occurred in a specific denominator population. For example, the number of patients who died within the hospital after being admitted for heart failure (after excluding patient records based on the denominator definition).

Denominator – For each IMI, expert clinicians used ICD-9-CM codes to select patient discharge records with diagnoses or procedures that indicate a particular condition or procedure. For example, heart failure is a complex condition that can be defined by numerous diagnoses, thus clinicians select only the specific codes that represent the intended concept of the indicator. From the initial cohorts of patients, some records were excluded. For example, patients that were transferred to another short-term hospital were excluded for some cohorts (see [AHRQ documentation for additional](#)

[exclusion criteria](#)). In addition, maternal patients were excluded when constructing most of the indicators. In sum, the denominators represent the total number of patients for specific conditions or procedures that are “at risk” of dying during their hospital stay.

Observed Rates – An observed mortality rate is defined as the number of patient deaths that occur within a specified group of patients admitted to the hospital for a medical condition or surgical procedure.

Calculation of Expected Deaths at Each Hospital

The purpose of statistical risk adjustment is to provide an equitable comparison between hospitals by accounting for hospitals that treat sicker patients versus those that treat healthier ones. To make comparisons fair, it is necessary to hold the patient “case mix” of hospitals constant by adjusting for the illness severity of patients. To create risk-adjusted rates, the first step is to estimate how many people would be expected to die in a particular hospital if they had a mix of patients that was comparable to the average hospital from the reference population (the 2010 and 2011 California observed rates for this report). Although the particular methods require technical expertise, the process of generating expected rates is straightforward.

Step 1: Select Risk Factors to Predict Inpatient Death

Consulting with medical experts and statisticians, AHRQ chose risk factors that predicted hospital inpatient death. For most of the IMIs, the risk factors include patient age, gender, procedure/condition category, and a risk-of-mortality score associated with each procedure/condition category. To assign each patient into a procedure/condition category, AHRQ selected a proprietary tool from the 3M Health Information Systems Corporation—the All Patient Refined Diagnosis Related Groups (APR-DRGs). The APR-DRG system works with hospital administrative data and provides a way to categorize patients into procedure/condition groups, and, given membership to that group, to estimate the severity of patients’ diseases and the likelihood that they will die in the hospital. These estimates are calculated by looking at patient age, principal diagnosis, and secondary diagnoses to assign each patient into one of four categories (low, moderate, high, or very high) for disease severity and risk of mortality.

OSHPD staff used the AHRQ-licensed software from 3M to apply the APR-DRG fields to the standardized California hospital inpatient data described above. This creates the base APR-DRG category and the associated “risk of mortality” fields in the dataset.

Beginning with AHRQ Version 3.1, Present on Admission (POA) has been incorporated in the AHRQ Quality Indicator risk-adjustment methodology. It provides a means of distinguishing pre-existing co-morbidities from complications.

Step 2: Create Multivariate Model to Predict Inpatient Death

In past versions of the software, AHRQ used simple logistic regression to assign probabilities to each patient. Beginning with Version 4.1a the AHRQ software uses “general estimating equations” to improve the accuracy and precision of the regression estimates. This relatively new statistical approach allows for better estimation of patient case mix at hospitals with very ill patients. In addition, “Markov Chain Monte Carlo” techniques are used to differentiate the “true” impact of patient factors (e.g., avoiding giving too much credit to patients with rare co-morbidities). AHRQ has published a

more detailed summary of how these models work on its website (<http://www.qualityindicators.ahrq.gov/modules/Default.aspx>).

Step 3: Apply Model Coefficients to California Data to Calculate Direct Predicted Probability of Death

The software provided by AHRQ includes the coefficients or weights for each IMI that were created by producing the multivariate model on the 2009 National Inpatient Sample. To enable custom reports on new samples of data, the AHRQ software identifies which risk factor is present for each patient. Then the coefficients are appropriately applied to the California data so that a predicted probability of death is assigned to each patient. The predicted probability calculated from this step is also referred to as the “direct predicted rate.”

Step 4: Recalibrate the Expected Probability of Death

Most traditional regression models such as logistic regression result in estimates in which the predicted number of deaths for the entire sample is very close to or exactly the same as the observed number of deaths in the sample. The newer Bayesian modeling approach selected by AHRQ, however, creates estimates in which the expected number of deaths is lower than the observed number of deaths. AHRQ considered both “proportional” and “additive” alternatives to improve the model calibration, and its analyses suggested that the proportional method may be more appropriate. The “proportional” method has been implemented by AHRQ since Version 4.1b.

The “proportional” calculation of the AHRQ software is:

$$Y = (P / (P - C)) * E$$

Where:

P is the reference population rate

C is a constant

E is the patient’s expected probability of death

In the original AHRQ software, the national reference rate (*P*) and the constant (*C*) are provided by AHRQ. Since OSHPD uses the California statewide rate as the benchmark for quality ratings of Inpatient Mortality Indicators, it is appropriate to use the California statewide rate as the reference population rate when recalibrating the expected probability for California patients. In consultation with AHRQ, OSHPD decided to use the California statewide observed rate as the reference population rate *P*, and the difference between the statewide observed rate and the statewide “direct predicted rate” (calculated in step 3) as the constant *C*.

Step 5: Estimate Expected Deaths at Each Hospital

The first four steps assign a probability of death for each patient record. To obtain the expected number of deaths for each hospital, the software simply adds up all of the patient-level probabilities for each facility.

Calculation of Risk-Adjusted Rates

With observed and expected mortality rates available for each hospital, it is then possible to construct risk-adjusted rates. While it is sufficient to compare the difference between observed and expected

rates to assess higher and lower quality, adding a reference population makes it easier to compare rates. The risk-adjusted (or indirectly standardized) death rate at a hospital equals the State Observed Rate, multiplied by the ratio of the number of observed deaths to the number of expected deaths at that hospital (Observed Cases/Expected Case or “O/E” ratio). The O/E ratio provides a transparent and easy-to-understand assessment of that hospital’s performance. A ratio that is less than one indicates there were fewer actual deaths than expected (a good result) while a ratio greater than one indicates that there were more deaths than would be expected given the level of risk in the patient mix.

Calculation of Statistical Outliers

For each IMI, hospitals were rated as “better than expected” if their risk-adjusted death rates were significantly lower than the statewide observed rate. They were rated as “worse than expected” if their rates were significantly higher than the statewide risk-adjusted rate of the particular IMI. To calculate outlier ratings, OSHPD used the 95% upper and lower confidence intervals. The 4.4 version of the AHRQ software calculates confidence intervals (CI) using the normal approximation as follows:

$$\text{Lower CI} = \text{“Hospital A” risk-adjusted rate} - (1.96 * \text{Standard Error})$$

$$\text{Upper CI} = \text{“Hospital A” risk-adjusted rate} + (1.96 * \text{Standard Error})$$

The standard error for the risk-adjusted rate (for each hospital) is based on the following formula:

The Root Mean Squared Error (RMSE) for each hospital is:

$$\text{RMSE} = \text{square root (“Hospital A” risk-adjusted rate} * (1 - \text{“Hospital A” risk-adjusted rate}))$$

The Standard Error is:

$$\text{SE} = \text{RMSE} / \text{square root (“Hospital A” denominator)}$$

For example:

If “Hospital A” had a rate of 0.20 and a denominator of 500:

$$\text{Lower CI} = 0.20 - 1.96 * \text{sqrt} [(0.20 * (1 - 0.20)) / 500]$$

$$\text{Upper CI} = 0.20 + 1.96 * \text{sqrt} [(0.20 * (1 - 0.20)) / 500]$$

After discussions with AHRQ and University of California researchers, OSHPD staff modified the 4.4 version of the AHRQ software and implemented confidence intervals (CI) based on the exact method. All OSHPD outcome reports to date have employed the exact method in calculating CIs. The exact method is based on the exact probability of the number of observed deaths (or a more extreme number) occurring by chance, given the number of expected deaths at a hospital. This approach differs from the normal approximation method used by AHRQ that is described above in that it relies on fewer distributional assumptions and provides more conservative estimates for hospitals with

relatively few expected deaths.⁶ AHRQ agreed that the exact method is more appropriate for public reporting and may implement this improvement in future software releases.

To identify statistical outliers, OSHPD compared hospital risk-adjusted rates to the upper and lower CIs. If a hospital's upper CI is less than the statewide observed rate, it is designated as performing "better" than the average hospital. If a hospital's lower CI is greater than the state rate, it is designated as performing "worse" than the average state hospital. Using this approach, one can be 95% confident that a rating of "better than expected" or "worse than expected" was not obtained by chance. Smaller hospitals, however, have less statistical power to be classified as performance outliers, especially significantly "better" than the statewide rate. Their risk-adjusted death rates would have to be much higher or lower than a high-volume hospital's for them to be significantly different from the state average. Conversely, a large hospital with more patients for a particular indicator may be identified as significantly different even when its death rate differs only moderately from the state average.

⁶ Luft HS, Brown BW Jr. (1993). Calculating the probability of rare events: Why settle for an approximation? Health Services Research, 28, 419-439.