If you don't know where you are going, any road will get you there.

Lewis Carroll
The days of the solitary physician toiling in isolation are long gone. Increasingly, physicians are practicing in teams within complex organizations, and the quality and safety of health care depend on all team members and the system in which they work. Physicians could make a much stronger case for continued self-governance if they took a more visible and vigorous leadership role in efforts that led to major improvements in the quality and safety of patient care.

Aiming Higher to Enhance Professionalism Beyond Accreditation and Certification
Mark R. Chassin, David W. Baker, JAMA. 2015;313(18)
Data sources for hospital and physician ratings

1. Readmission Reduction Program
2. Value-Based Purchasing (VBP)
3. Hospital Acquired Condition (HAC) Reduction Program
Readmission Reduction

Applicable conditions

- For FY 2013 penalties
  - Acute myocardial infarction (AMI)
  - Heart Failure (HF)
  - Pneumonia (PNE)
- For FY 2015-2017 penalties add
  - Chronic Obstructive Pulmonary Disease (COPD);
  - Orthopedic Total Knee/Hip Arthroplasty (THA/ TKA);
  - Post op Coronary Artery Bypass Grafting (CABG);

Data source

- Medicare administrative claims data
- Risk adjustment based on hospital case mix

Readmission definition

- Return to hospital within 30-days of eligible index admission
- All-cause readmissions
CMS: Value Based Purchasing (VBP)

- Penalties applied starting in FY 2013
  - Clinical process - Core Measures - AMI, HF, PNE, SCIP
  - Patient experience - Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS)
  - Expanded
    - Outcomes/Safety domain
      - 2014 - Mortality - AMI, HF, PNE
      - 2015 - PSI-90 and CLABSI
      - 2016 - CAUTI and SSI
    - Efficiency domain - spending per Medicare beneficiary - 2015

- At risk – CMS payments and your reputation
- Two year lag from data collection and penalties
- Hospital performance is relative to other hospitals
<table>
<thead>
<tr>
<th>AMI</th>
<th>Aspirin prescribed at discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fibrinolytic agent received within 30 minutes of arrival</td>
</tr>
<tr>
<td></td>
<td>Primary percutaneous intervention (PCI) within 90 minutes of arrival</td>
</tr>
<tr>
<td>HF</td>
<td>Discharge instructions</td>
</tr>
<tr>
<td></td>
<td>Evaluation of left ventricular systolic function</td>
</tr>
<tr>
<td></td>
<td>ACE-I or ARB for left ventricular systolic dysfunction</td>
</tr>
<tr>
<td>Pneu</td>
<td>Blood culture performed before first antibiotic</td>
</tr>
<tr>
<td></td>
<td>Appropriate antibiotic selection</td>
</tr>
<tr>
<td>SCIP</td>
<td>Venous thromboembolism prophylaxis within 24 hrs of surgery</td>
</tr>
<tr>
<td></td>
<td>Prophylactic antibiotic within 1 hour prior to surgery</td>
</tr>
<tr>
<td></td>
<td>Prophylactic antibiotic selection for surgical patients</td>
</tr>
<tr>
<td></td>
<td>Prophylactic antibiotic discontinued within 24 hours (48 hrs for CTS)</td>
</tr>
<tr>
<td></td>
<td>Cardiac surgery patients with 6 AM controlled glucose (PO day 1 &amp; 2)</td>
</tr>
<tr>
<td></td>
<td>Urinary catheter removed on post-op day 1 or 2</td>
</tr>
<tr>
<td></td>
<td>Surgery patients who received beta blockers perioperatively</td>
</tr>
</tbody>
</table>
Experience: Assessment of Healthcare System (HCAHPS)

<table>
<thead>
<tr>
<th>HCAHPS Survey Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with nurses</td>
</tr>
<tr>
<td>Communication with doctors</td>
</tr>
<tr>
<td>Responsiveness of hospital staff</td>
</tr>
<tr>
<td>Pain management</td>
</tr>
<tr>
<td>Communication about medications</td>
</tr>
<tr>
<td>Cleanliness and quietness</td>
</tr>
<tr>
<td>Discharge information</td>
</tr>
<tr>
<td>Overall rating of hospital</td>
</tr>
</tbody>
</table>
Changes in VBP Indicator Weighting: from Process to Outcome

- **Process**: 70% in 2013, 45% in 2014, 30% in 2015, 25% in 2016, 25% in 2017
- **Outcome/Safety**: 30% in 2013, 25% in 2014, 30% in 2015, 25% in 2016, 25% in 2017
- **Patient Experience**: 30% in 2013, 30% in 2014, 30% in 2015, 30% in 2016, 30% in 2017
- **Efficiency**: 0% in 2013, 0% in 2014, 0% in 2015, 0% in 2016, 0% in 2017
FY 2017 Domain Weights and Measures

Domain Weights

Patient- and Caregiver-Centered Experience of Care/Care Coordination: 25%
Clinical Care: 25%
Efficiency and Cost Reduction: 25%
Safety: 20%

Efficiency and Cost Reduction: 5% Process

Clinical Care
- Outcomes
  - MORT-30-AMI
  - MORT-30-HF
  - MORT-30-PN
- Process
  - AMI-7a
  - IMM-2
  - PC-01*

Safety
- CLABSI
- CAUTI
- SSI: Colon & Abdominal Hysterectomy
- MRSA Infections*
- C-difficile Infections*
- AHRQ PSI-90

Montefiore
THE UNIVERSITY HOSPITAL
Albert Einstein College of Medicine
Agency for Health Care Research and Quality (AHRQ)  
Patient Safety Indicators (PSI-90)  
Administrative data based on documentation

PSI-3: Pressure Ulcer rate - 2.4%  
PSI-6: Iatrogenic pneumothorax rate – 7.1%  
PSI-7: CLABSI – 6.5%  
PSI-8: Post operative hip fracture rate – 0.1%  
PSI-12: Perioperative PE/DVT rate – 25.8%  
PSI-13: Post Operative sepsis rate - 7.4%  
PSI-14: Wound dehiscence rate - 1.7%  
PSI-15: Accidental puncture and laceration – 49.2%
**HAC Reduction Program Framework 2017**
Bottom 25% of hospitals penalized

### Domain 1
(AHRQ Measure)

**Weighted 25%**

**AHRQ PSI-90 Composite**
This measure consists of performance period from July 1, 2012 – June 30, 2014:
- PSI-3: pressure Ulcer rate - 2.4%
- PSI-6: iatrogenic pneumothorax rate – 7.1%
- PSI-7: central venous catheter-related blood stream infection rate – 6.5%
- PSI-8: Post operative hip fracture rate – 0.1%
- PSI-12: Perioperative PE/DVT rate – 25.8%
- PSI-13: Post Operative sepsis rate - 7.4%
- PSI-14: wound dehiscence rate - 1.7%
- PSI-15: accidental puncture and laceration – 49.2%

### Domain 2
(CDC Measures)

**Weighted 75%**

- CAUTI
- CLABSI
- Surgical Site Infection
  - Colon Surgery
  - Abdominal Hysterectomy
- MRSA
- C Diff
Overlap between VBP and HAC programs

• Surgical Site Infections
  – Colorectal surgery
  – Hysterectomy

• Patient Safety Indicators

• Catheter Associated Urinary Tract Infections (CAUTI)

• Central Line Associated Blood Stream Infections (CLABSI)

• Methicillin-resistant *Staphylococcus aureus*

• *Clostridium difficile*
Hospitals reputation can affect your reputation

Doctors have admitting privileges—permission to treat patients—at certain hospitals. That’s right. You can’t choose any doctor you want and expect to be treated at any hospital you want. If your doctor’s hospital falls short in quality, you should find a doctor who treats patients at a hospital likely to offer you the best possible outcome. In other words, you may need to limit your search to doctors who can treat you at a hospital with 5 stars for the treatment you need. Healthgrades shows you the doctor’s hospital affiliation(s) so that you can make clear choices.

Now you can choose a doctor based on knowledge. Not chance.
To get the right care, you need the right doctor and the right hospital. Now there’s a way to find them.

Right Doctor
Healthgrades lets you search by health condition or medical procedure to find a doctor experienced in your treatment.

Find the Right Doctor

Right Hospital
Our exclusive hospital ratings help you find a doctor who can treat you at a 5-star hospital, dramatically lowering your risks.

Find the Right Hospital

Right Care
Time with your doctor is precious. We help you get the most out of your appointments for the best possible care.

Find the Right Care
FIND A CASTLE CONNOLLY TOP DOCTOR
Need to find a Top Doctor? There is no better place to start than right here on our website.

*Enter one or more of the fields below

Location:  
Enter City, State or Zip Code  AND/OR Enter Doctor's Name

Specialty:  
-- Select Specialty --

Find Top Doctors Now »

How Castle Connolly Identifies Top Doctors

The doctors included in Castle Connolly’s Top Doctor listings were selected after peer nomination, extensive research and careful review and screening by our doctor-directed research team. Doctors do not and cannot pay to be listed as a Castle Connolly Top Doctor.
ANGIE'S LIST GUIDE TO

General Surgery

General surgery is a specialty that focuses on the abdomen and the digestive system in addition to many diseases and conditions involving skin, breasts, soft tissues and hernias.

When looking for a general surgeon, find one who is properly licensed, trained and with whom you feel comfortable.
When are surgeons evaluated?

- Board certification
- Hospital credentialing
- Malpractice insurance
- Patient referrals
- Triple Aim/Gain Sharing and bonus programs
Why Rate Surgeons?
Number of Surgeons

Quality of Care

Number of Surgeons
Why Rate Surgeons?

• The public has a right to know the quality of surgical outcomes
• Ethical responsibility
• Benchmark for improvement
Origins of Quality in Surgery
Hammurabi King of Babylon, 1750 BC

Code of Hammurabi 218 (Quality):
  • If a physician make a large incision with the operating knife, and kill him, or open a tumor with the operating knife, and cut out the eye, his hands shall be cut off.
Lessons Learned for Cardiac Surgery

• Mostly driven by state requirements
• Society of Thoracic Surgery leadership
• Overall benefit of public reporting is unproven
• Provides transparency and accountability
• May facilitate quality improvement
• No substantial impact on patient referral patterns or market share
• Avoid excessive focus on process measures
• Unintended consequences include including gaming and risk aversion
Surgeon Scorecard

by Sisi Wei, Olga Pierce and Marshall Allen, ProPublica, Updated July 15, 2015

Guided by experts, ProPublica calculated death and complication rates for surgeons performing one of eight elective procedures in Medicare, carefully adjusting for differences in patient health, age and hospital quality. Use this database to know more about a surgeon before your operation.

Find Near Me  Find a Surgeon  Find a Hospital

Surgeons and Hospitals Near My Location

Use My Location

...or jump straight to your state: Pick a state
Eight Elective Procedures
We focused on procedures done thousands of times a day, mostly without incident. They are scheduled in advance and generally performed on patients in stable health. We excluded patients who came in through the emergency room or from facilities like nursing homes. Read our methodology »

Knee Replacement
Replace diseased knee joint with an artificial knee.

Hip Replacement
Replace diseased hip joint with an artificial hip joint.

Gallbladder Removal, Laparoscopic
Minimally invasive gallbladder removal.

Lumbar Spinal Fusion, Posterior Column
The fusing of two or more vertebrae in the lower back, performed on the back portion of the spine.

Lumbar Spinal Fusion, Anterior Column
The fusing of two or more vertebrae in the lower back, performed on the front portion of the spine.

Prostate Removal
The removal of the entire prostate gland via the open or laparoscopic or robotic method.

Prostate Resection
The resection and removal of a portion of the prostate through the urethra.

Cervical (Neck) Spinal Fusion
The fusing of two or more vertebrae of the neck, using orthopedic devices to hold them in place.

Surgeons, Not Hospitals
Conventional wisdom tells patients to simply choose a good hospital when they need surgery. But ProPublica has found that even within “good” hospitals, performance between surgeons can vary significantly. Half of all hospitals in America have surgeons with low and high complication rates. Read our story »

16,019
Surgeons rated in ProPublica’s analysis

63,173
Medicare patients were readmitted with complications between 2009 and 2013

3,405
Medicare patients died during a hospital stay for elective surgery between 2009 and 2013

Background Stories
How Many Die From Medical Mistakes in U.S. Hospitals?
An updated estimate says it could be at least 210,000 patients a year — more than twice the number in the Institute of Medicine’s frequently quoted report, “To Err is Human.”

The Two Things That Rarely Happen After a Medical Mistake
Patients seldom are told or get an apology when they are harmed during medical care, according to a new study based on results from ProPublica’s Patient Harm Questionnaire.

We’re Still Not Tracking Patient Harm
Top patient-safety experts call on Congress to step in and, among other steps, give the Centers for Disease Control and Prevention wider responsibility for measuring medical mistakes.

Read the entire series »
ProPublica Rational to Attribute Outcomes to the Surgeon

“The best interest of the patient is thus optimally served because of the surgeon's comprehensive knowledge of the patient's disease and surgical management. “

https://www.facs.org/about-acsc/statements/25-perioperative#sthash.lMw4TDGW.dpuf
**MONTEFIORE MEDICAL CENTER**

111 EAST 210TH STREET, BRONX, NEW YORK, 10467, PHONE: 718-920-4321

**How Surgeons at This Hospital Perform, by Procedure**

**KEY:**
- 🔄 An individual surgeon who performs this procedure at this hospital.
- ⚠ At least one surgeon performing this procedure has a high adjusted rate of complications.

**How we calculated these rates:** Guided by top researchers and doctors, ProPublica used Medicare data from 2009-2013 to identify cases where a patient died in the hospital or had to be readmitted within 30 days for a problem related to one of these elective procedures. We then calculated complication rates for surgeons, carefully accounting for differences in patient health, age and hospital quality. These rates are calculated using data from Medicare records, which do not include patients with private insurance or in another program like Medicaid. A surgeon’s rate spans all hospitals at which he or she operates and is not unique to a given hospital. Read our methodology »

**Important:** Some surgeons may no longer be operating at this hospital. Hover over underlined items to see details.
ProPublica Surgeon Scorecard

Cohort Selection

• Medicare fee for service in-patient 2009 – 2013
• Excluded trauma, transfers, high-risk cases with complications beyond surgeon’s control
• Common elective surgeries in 3,575 hospitals
• 16,827 surgeons with ≥20 cases

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Procedure</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.23</td>
<td>Laparoscopic cholecystectomy</td>
<td>201,351</td>
</tr>
<tr>
<td>60.5</td>
<td>Radical prostatectomy</td>
<td>78,763</td>
</tr>
<tr>
<td>60.29</td>
<td>Transurethral prostatectomy (TURP)</td>
<td>73,752</td>
</tr>
<tr>
<td>81.02</td>
<td>Cervical fusion of the anterior column, anterior technique</td>
<td>52,972</td>
</tr>
<tr>
<td>81.07</td>
<td>Lumbar and lumbosacral fusion of the posterior column, posterior technique</td>
<td>106,689</td>
</tr>
<tr>
<td>81.08</td>
<td>Lumbar and lumbosacral fusion of the anterior column, posterior technique</td>
<td>102,716</td>
</tr>
<tr>
<td>81.51</td>
<td>Total hip replacement</td>
<td>494,576</td>
</tr>
<tr>
<td>81.54</td>
<td>Total knee replacement</td>
<td>1,190,631</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,376,851</td>
</tr>
</tbody>
</table>
Outcomes: “adjusted “ complication rates

- 3,405 who died within 30 days
- 63,173 patients readmitted within 30 days with complication

<table>
<thead>
<tr>
<th>Complication type</th>
<th>N</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>13,899</td>
<td>998.59 - Postoperative infection</td>
</tr>
<tr>
<td>Clot</td>
<td>7,732</td>
<td>415.11 - Iatrogenic pulmonary embolism</td>
</tr>
<tr>
<td>Reaction</td>
<td>5,164</td>
<td>996.6 - Infection and inflammatory reaction due to internal joint prosthesis</td>
</tr>
<tr>
<td>Mechanical</td>
<td>4,850</td>
<td>996.47 - Mechanical complication of prosthetic joint implant</td>
</tr>
<tr>
<td>Sepsis</td>
<td>4,702</td>
<td>03.89 - Septicemia</td>
</tr>
<tr>
<td>Bone</td>
<td>3,535</td>
<td>996.44 - Peri-prosthetic fracture around prosthetic joint</td>
</tr>
<tr>
<td>Death</td>
<td>3,470</td>
<td></td>
</tr>
<tr>
<td>Hematoma</td>
<td>3,168</td>
<td>998.12 - Hematoma complicating a procedure</td>
</tr>
<tr>
<td>Wound</td>
<td>2,793</td>
<td>998.2 - Accidental puncture or laceration during a procedure</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>2,698</td>
<td>998.11 - Hemorrhage complicating a procedure</td>
</tr>
<tr>
<td>Pain</td>
<td>2,169</td>
<td>338.18 - Acute postoperative pain</td>
</tr>
<tr>
<td>Digestive</td>
<td>1,957</td>
<td>997.49 - Digestive system complications</td>
</tr>
<tr>
<td>C.diff</td>
<td>1,843</td>
<td>00.845 - Intestinal infection due to Clostridium difficile</td>
</tr>
<tr>
<td>Misc. Comp.</td>
<td>1,531</td>
<td>787.22 - Dysphagia, oropharyngeal phase</td>
</tr>
<tr>
<td>Vascular</td>
<td>1,159</td>
<td>997.2 - Surgical complications of the peripheral vascular system</td>
</tr>
<tr>
<td>Inflammation</td>
<td>931</td>
<td>604.99 - Orchitis, epididymitis, and epididymo-orchitis, no mention of abscess</td>
</tr>
<tr>
<td>Seroma</td>
<td>673</td>
<td>998.13 - Seroma complicating a procedure</td>
</tr>
<tr>
<td>Fever</td>
<td>520</td>
<td>780.62 - Postprocedural fever</td>
</tr>
<tr>
<td>Urinary</td>
<td>486</td>
<td>997.5 - Surgical complications of the urinary tract</td>
</tr>
</tbody>
</table>
Concerns about ProPublica Surgeon Scorecard

• Focus on readmissions
  – Complication plausibly associated with surgery
  – But most complications (67%) occur with in the index admission
• Does not consider hospital to hospital differences
• Relies on claims data
• Risk adjustment- not validated
American College of Surgeons (ACS) National Surgical Quality Improvement Program

- Started by the Veterans Health Administration in 1991
- Implemented by ACS into private sector hospitals 2001
- Worldwide there are >400 participating hospitals
- Abstracted from medical record not claims data
- Data-driven, risk-adjusted, 30 day outcomes
- Satisfies CMS structural measure for Hospital Inpatient Quality Reporting (IQR) Program
- Can be used for ABS MOC requirement, and JC OPPE
- Surgeon specific to hospital reports with benchmarks
Surgical Risk Calculator

Procedure: 44140 - Colectomy, partial; with anastomosis
Age: 65-74, Male, Partially dependent functional status, ASA III, Clean/Contaminated wound, Chronic steroids, Diabetes (insulin), HTN, Previous cardiac, Dyspnea with exertion, Smoker, Overweight

Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Estimated Risk</th>
<th>Chance of Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Complication</td>
<td>28%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Any Complication</td>
<td>46%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>10%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Cardiac Complication</td>
<td>6%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Surgical Site Infection</td>
<td>23%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>6%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>3%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>6%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Return to OR</td>
<td>12%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Death</td>
<td>6%</td>
<td>Above Average</td>
</tr>
<tr>
<td>Discharge to Nursing or Rehab Facility</td>
<td>18%</td>
<td>Above Average</td>
</tr>
</tbody>
</table>

Predicted Length of Hospital Stay: 6.0 days

How to Interpret the Graph Above:

Surgeon Adjustment of Risks

This will need to be used infrequently, but surgeons may adjust the estimated risks if they feel the calculated risks are underestimated. This should only be done if the reason for the increased risks was NOT already entered into the risk calculator.

Montefiore
Preparing for your report card (choosing the road)

- Know your hospital's performance on publicly reported measures
- Participate in hospital PI projects
- Review your performance
  - Know your outcomes
  - Make a plan to continuously improve
  - Minimize variability
  - Monitor patient comments