

Michael P. Dinneen, MD, PhD  
Dir, Strategy Mgmt

Paul R. Cordts, MD, FACS  
Dep Dir, Healthcare OPs



## 2015 Defense Health Information Technology Symposium

# MHS Strategy, Performance and Transparency: Current State and The Path Forward



*“Medically Ready Force...Ready Medical Force”*

# Learning Objectives



- Describe what the MHS Partnership for Improvement (P4I) is and how it turns strategy to action
- Understand why the MHS chose the starter set of enterprise measures
- Understand what is meant by a “virtuous cycle of improvement” and why measurement is necessary, but not sufficient, for improvement
- Understand some of the challenges we face in changing our culture to advance high reliability and safety
- Recognize where the MHS is in the journey to meaningful transparency
- Become an advocate for transparency and a participant in data-driven, evidence-based performance improvement

***“Medically Ready Force...Ready Medical Force”***

# Partnership For Improvement

*AKA Performance Management System*



## SEC DEF MEMO

- By 1 JAN 2015 (within 90 days), establish a MHS Performance Management System (PMS) to support the Services as they manage and monitor MTF Performance
- The PMS will monitor MHS-wide core measures and dashboards for monitoring system-level improvement in all areas from the MHS Review
- By 15 JUL 2015, provide a report that clearly demonstrates the PMS capability to drive system-wide improvement in all areas in the MHS Review

***“Medically Ready Force...Ready Medical Force”***

# MHS Enterprise Dashboard – Aligning Measures with Strategy

Strategic Alignment		Performance Measure
Aim	Objective	
Readiness	Medically Ready Force	<u>Individual Medical Readiness (IMR)</u>
	Ready Medical Force	TBD
Better Health	Healthy People (PLS3)	TBD
	Improve Healthy Behaviors	HEDIS Cancer Screening Index
Better Care	Improve Clinical Outcomes and Consistent Patient Experience	Risk Adjusted Mortality (All Cases)
		<u>Inpatient: Recommend Hospital (Satisfaction)</u>
		<u>Overall Satisfaction w/Healthcare (Outpatient)</u>
	Improve Safety	<u>**HAI (CLABSI), Foreign Body Retention, National Surgical Quality Improvement Program (NSQIP) (30 Day) All Case Morbidity Index; Catheter Associated UTI, Wrong Site Surgery</u>
		<u>**HEDIS Diabetes Index, **HEDIS Appropriate Care Index (Low Back Pain, Pharyngitis, URI)</u>
	Improve Condition-Based Quality Care	<u>NPIC Post-Partum Hemorrhage; NPIC Vaginal Deliveries w/ Shoulder Dystocia</u>
		<u>HEDIS All Cause Readmission; HEDIS (30-Day) Mental Health Follow-Up; ORYX Transition of Care Index (Asthma, VTE, Inpt Psy(2))</u>
		<u>AHRQ Prevention Quality Indicator (PQI) Index</u>
	Improve Comprehensive Primary Care	<u>PCM Continuity; PCM Empowerment; Primary Care Leakage</u>
		<u>*Avg. No. of Days to 3rd Next Available Future Appointment; **Avg. No. of Days to Third Next Available 24 Hour Appointment (Primary Care)</u>
Optimize & Standardize Access & Other Care Support Processes	<u>**Percent of Direct Care Enrollees in Secure Messaging</u>	
	<u>*Satisfaction with Getting Care When Needed (Service Surveys)</u>	
Lower Cost	Improve Stewardship	<u>PMPM; Total Purchased Care Cost, Pharmacy Percent Retail Spend Private Sector Care Cost per Prime Enrollee</u>
		<u>OR Utilization</u>
		<u>**Total Enrollment</u>
		<u>Productivity Targets</u>

# Partnership for Improvement: Virtuous Cycle



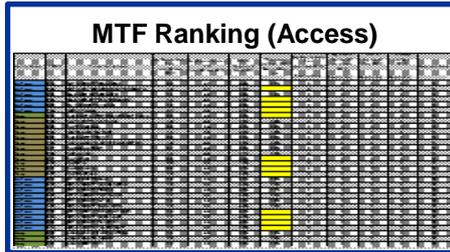
## A Set Our Priorities

**4 Priorities, 9 Measures by 2016**

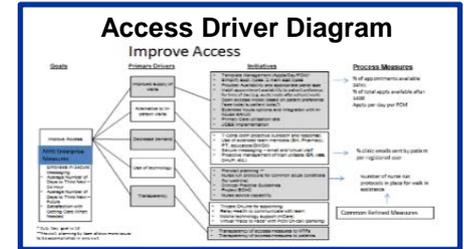
<p><b>Improve Access</b></p> <ul style="list-style-type: none"> <li>% of Direct Care Enrollees in Secure Messaging</li> <li>Avg. No. of Days to Third Next – 24 Hour</li> <li>Avg. No. of Days to Third Next – Future</li> <li>Satisfaction w/Getting Care When Needed</li> </ul>	<p><b>Increase Direct Care Primary Care Capacity</b></p> <ul style="list-style-type: none"> <li>Total Enrollment</li> </ul>
<p><b>Improve Quality Outcomes for Condition Based Care</b></p> <ul style="list-style-type: none"> <li>HEDIS Appropriate Care Index</li> <li>HEDIS Diabetes Index</li> </ul>	<p><b>Reduce Patient Harm</b></p> <ul style="list-style-type: none"> <li>HAI CLASSI</li> <li>PSI-5: Foreign Body Retention</li> </ul>

**E Report How We're Doing**

## B Provide Useful Information



## D Share With Each Other



## C Find Out What Works

**Component Lessons Learned**

- Simplify appointment types (2)
- Extend hours options
- Template management to match demand
- Use of extended team members
- Utilize mobile technology

# 4 Process Improvement Priorities

## 9 Measures by 2016



### Improve Access

- % Enrollees in Secure Messaging
- Average # of Days to 3rd Next – 24 Hour
- Av # of Days to 3rd Next – Future
- Satisfaction with Getting Care When Needed

### Improve Quality Outcomes for Condition Based Care

- HEDIS Appropriate Care Index
- HEDIS Diabetes Index

### Increase Direct Care Primary Care Capacity

- Total Enrollment

### Reduce Patient Harm

- HAI CLABSI
- PSI-5: Foreign Body Retention

***“Medically Ready Force...Ready Medical Force”***

# Deliver Timely Data on MTF Performance to identify opportunities for learning and improvement

Facility Service	PDMIS	Parent Facility Name	Avg Days to Acute Care (as of 30 June 2015)	Avg Days to Routine EST (as of 30 June 2015)	SMS % Registered (May 2015)	PC Leakage (Jan-April 2015) Goal is 24% or less	Avg Days to Acute Care (as of June 2015) Quartile Score	Avg Days to Routine EST (as of June 2015) Quartile Score	SMS % Registered (May 2015) Quartile Score	PC Leakage (Jan-April 2015) Quartile Score	Composite Score
			0.9	4.7	44%	21%	3	3	2	3	11
			1.2	5.7	55%		3	2	3	3	11
			1.1	4.9	30%	19%	3	3	2	3	11
			1.7	4.1	43%		3	3	2	3	11
			1	6.6	63%		3	2	3		11
			0	3.5	41%		3	3	2		11
				4.5	32%		3	3	2	3	11
				4.2	38%	24%	3	3	2	3	11
				3.4	62%	28%	3	3	3	2	11
				2.8	46%	18%	3	3	2	3	11
				3.6	51%	29%	3	3		2	11
				4.3	50%	30%	3	3		2	11
				4.6	35%	23%	3	3		3	11
				4.8	37%	23%	3	3		3	11
				5.8	65%		3	2	3	3	11
				5.5	72%					3	11
					37%					3	11
					36%					3	11
					51%	23%				3	10
					55%	23%				3	10
					49%	27%				2	10
			1.7	4.3	50%	25%				2	10
			1.3	5.2	53%	18%				3	10
			1.0	3.5	44%	26%				2	10
			1.4	4.6	42%					3	10
			1.7	5.9	49%					3	10
			1.9	6.5	49%		2	2	3	3	10
			1.2	4.2	28%		3	3	1	3	10
			1.5	4.9	29%	19%	2	3	2	3	10
			2.0	4.7	29%	20%	2	3	2	3	10
			1.2	3.2	25%	19%	3	3	1	3	10

Hospitals and Clinics

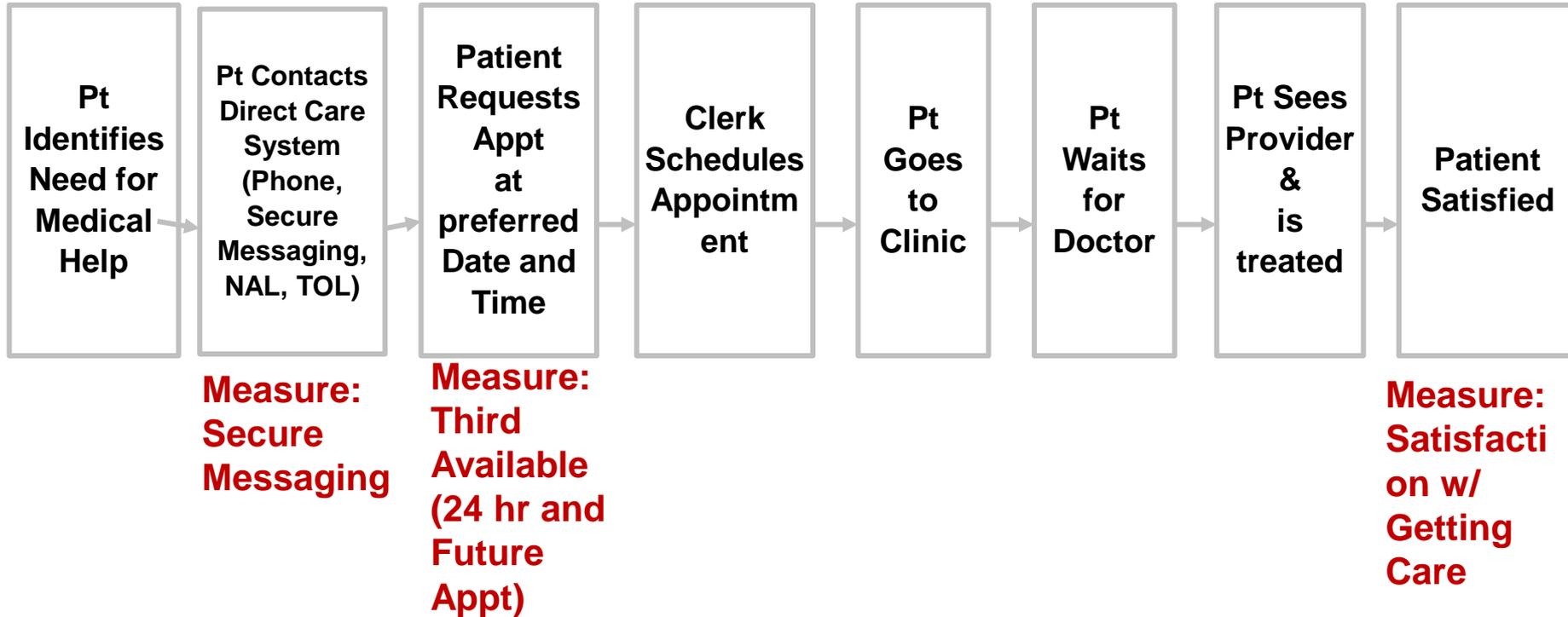
Most recent performance on each access measure

Ranked by cumulative score



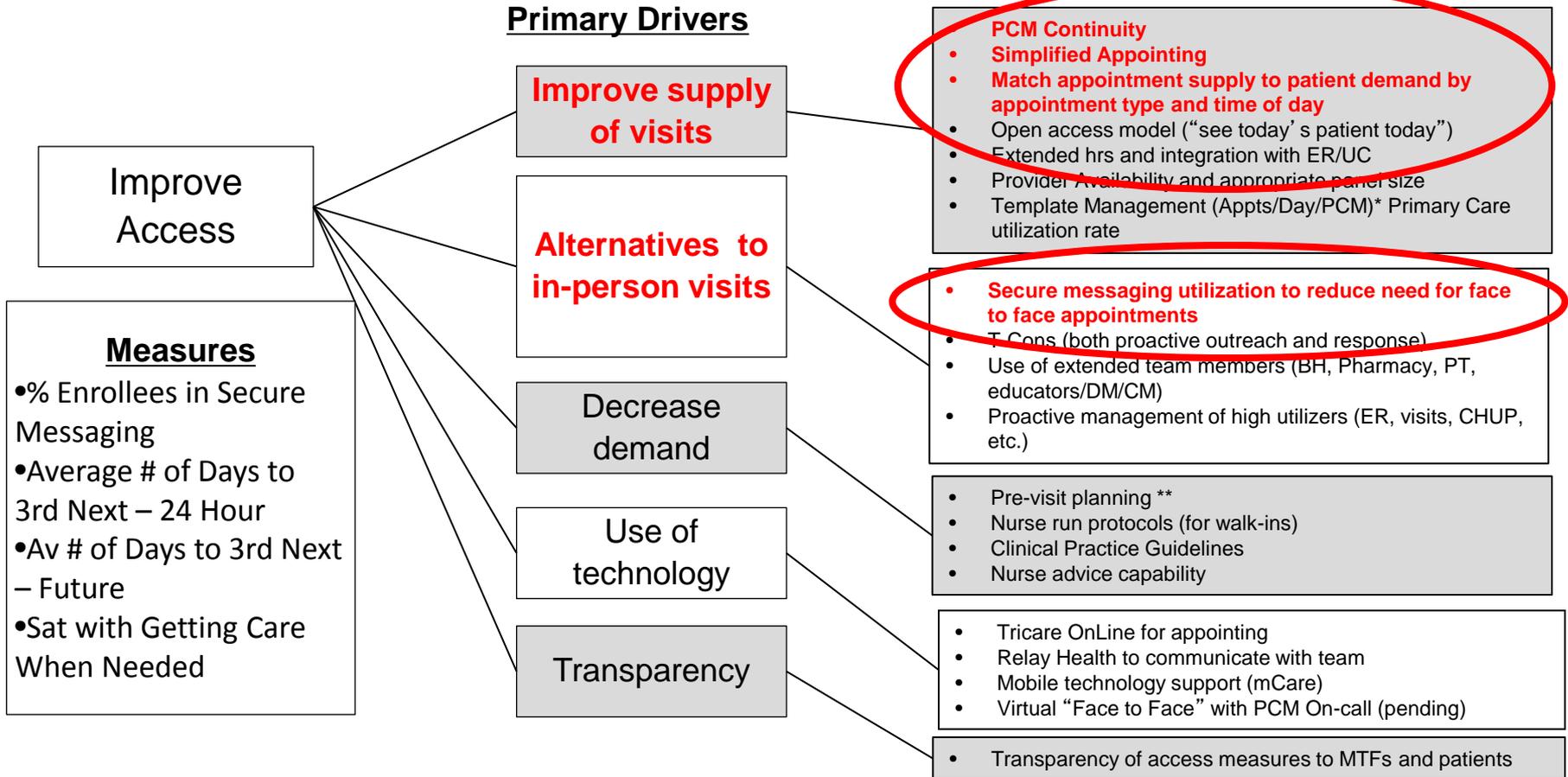
# Improving Access is a Process Improvement Challenge involving many interdependent processes -

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# Improve Access

## Initiatives



# MHS Partnership for Improvement

## *What have we learned so far?*



- We must have Strategic Measures that Matter to Front Line Workers!
- We can set priorities and create a virtuous cycle of improvement!
- We can use governance review meetings to learn, share and celebrate success.
- And, we continue to face cultural challenges:
  - ☞ Imagine: “Red as the new Gold”
  - ☞ Really! “Measurement is for improvement, not for judgement”
  - ☞ Seriously: “Soon is not a time, less is not a number!”

***“Medically Ready Force...Ready Medical Force”***

**How will we know that we are making progress in  
changing the culture ?**

**We will have meaningful transparency!**

## OCT 1, 2014 - SECDEF Sets Expectations

- “While we currently provide some information about the quality and safety of MHS care, it is difficult to find and even more difficult to understand.”
- “Within 30 days, the MHS will have a plan to provide all currently available aggregate statistical access, quality and safety information for all MTF and, to the extent possible, all purchased care providers publically available on health.mil. Further refinement of this information will take into consideration what our patients deem useful in making health decisions for themselves and their families.”

# MHS Commitment to Transparency



- “The MHS Action Plan, signed out by the Secretary of Defense October 1, reiterated our commitment to ensuring that our performance information is both available and useful to our beneficiaries.... Transparency is a key characteristic of high reliability organizations and our efforts to engage our patients in discussions about access, safety and quality will serve us well in the years ahead.”
  - Dr. Woodson, LTG Horoho, VADM Nathan, Lt Gen Travis, Lt Gen Robb
  - January 7, 2015

***“Medically Ready Force...Ready Medical Force”***

# Four Domains of Transparency\*



\* National Patient Safety Foundation®

***“Medically Ready Force...Ready Medical Force”***

# Four Domains of Transparency\*



**Between clinicians and patients**  
**(e.g., disclosure after a medical error)**

- Healthcare Resolutions Program
  - Being implemented MHS-wide
  - All staff hired and trained by Oct 2015
- Bottom Line: We have greater freedom to discuss the facts of cases, and to apologize, than our system may understand.

\*From The National Patient Safety Foundation®

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## A MESSAGE FROM PRESIDENT AND CEO JOE BOARDMAN ON TRAIN 188

The derailment of Northeast Regional Train 188 was a terrible tragedy that we are responding to with every resource we have available....

With truly heavy hearts, we mourn those who died....**Amtrak takes full responsibility and deeply apologizes** for our role in this tragic event.

Although our current focus is on the passengers and employees affected by this incident ... we must **also take time to learn** from this event. Passenger railroading is at its core about people; the safety of our passengers and employees was, is and always will be our number one priority. Our goal is to **fully understand what happened and how we can prevent a similar tragedy from occurring in the future.**

... Sincerely, Joe Boardman

President and Chief Executive Officer

***“Medically Ready Force...Ready Medical Force”***

# Four Domains of Transparency\*



With the public  
(e.g., public reporting of  
safety data)

- January 2015 -- Placed all existing MHS public information in a single location
- April 2015 – Migrated information to [www.tricare.mil](http://www.tricare.mil)
- April 2015 – Began meeting with beneficiary associations on feedback and re-design plans

\*From The National Patient Safety Foundation®

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# Mapping MHS Transparency Measures to Select Leading Organizations

MHS- Specific Measure	Measure Index	Organizations of Interest							Comments
		KP	VA	PH	CC	MC	IM	GH	
Percent of direct care enrollees in secure messaging	N/A	NR	NR		NR	NR	NR	NR	<ul style="list-style-type: none"> <li>Partners: Utilizes "electronic communications" (patient portals)</li> </ul>
PCM Continuity	N/A	NR	NR	NR	NR	NR	NR	NR	
PSI 5 - Foreign Body Retention	N/A		NR			NR	NR		<ul style="list-style-type: none"> <li>Kaiser: This measure is rolled up under "Hospital Acquired Injuries"</li> </ul>
HAI: CLABSI	CDC					NR	NR		<ul style="list-style-type: none"> <li>Measure Source: CDC/National Healthcare Safety Network</li> </ul>
Overall Satisfaction with Healthcare - Inpatient	TRISS								<ul style="list-style-type: none"> <li>TRISS &amp; TROSS are both MHS-specific measure; only Mayo reports similar to MHS (inpatient/outpatient segmentation)</li> <li>All other organizations report only overall patient satisfaction</li> </ul>
Overall Satisfaction with Healthcare - Outpatient	TROSS								
Sentinel Events/Serious Reportable Events			NR			NR	NR		<ul style="list-style-type: none"> <li>Partners: Reporting of all categories defined as SRE by NQF; Cleveland reports some SRE categories</li> <li>Kaiser and Geisinger: Limited reporting of specific SRE measures</li> <li>All Others: No external reporting, may track internally</li> </ul>

Legend	KP	VA	PH	CC	MC	IM	GH				NR
		Kaiser Permanente	Veterans Affairs	Partners Health	Cleveland Clinic	Mayo Clinic	Intermountain Health	Geisinger Health	Same specific measure	Subset of same measure	Same focus area, different measure

## Inova Fairfax Hospital

3300 Gallows Road  
Falls Church, VA 220423300  
[Map and Directions](#)

# Hospital Safety Score: Grading Individual Hospitals

This Hospital's Grade



► [Show Past Grades](#)

[Detailed table view](#)

Learn how to use the Hospital Safety Score



Safety Problems with Surgery

Staff Follows Steps to Make Surgery Safer

Infections and Safety Problems

Right Staffing to Prevent Safety Problems

Hospital Uses Standard Safety Procedures

[Click Each Measure to Learn More](#)

Hospital Performs Below Average Above Average

Infection in the blood during ICU stay



Infection in the urinary tract during ICU stay



Surgical site infection after colon surgery



Dangerous object left in patient's body



Air or gas bubble in the blood



Dangerous bed sores



Patient falls



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left in patient's body

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Safety Problems with  
Surgery

Staff Follows Steps to  
Make Surgery Safer

Infections and Safety  
Problems

Right Staffing to Prevent  
Safety Problems

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Safety Procedures

[Click Each Measure to Learn More](#)

Hospital Performs Below Average Above Average

Infection in the  
blood during ICU  
stay



Infection in the  
urinary tract during  
ICU stay



Surgical site  
infection after colon  
surgery



Dangerous object  
left in patient's body



Air or gas bubble in  
the blood



Dangerous bed  
sores



Patient falls



# University Health System

4502 Medical Dr  
San Antonio, TX 782294493  
[Map and Directions](#)

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Patient falls



# Sibley Memorial Hospital

5255 Loughboro Road NW  
Washington, DC 200162695  
[Map and Directions](#)

## Hospital Safety Score: Grading Individual Hospitals



► [Show Past Grades](#)

[Detailed table view](#)

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### Patient falls

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Hospital Performs Below Average  Above Average

Infection in the blood during ICU stay



Infection in the urinary tract during ICU stay



Surgical site infection after colon surgery



Dangerous object left in patient's body



Air or gas bubble in the blood



Dangerous bed sores



Patient falls



## Explore how often one harmful infection occurs at hospitals near you

by Soo Oh on July 9, 2015

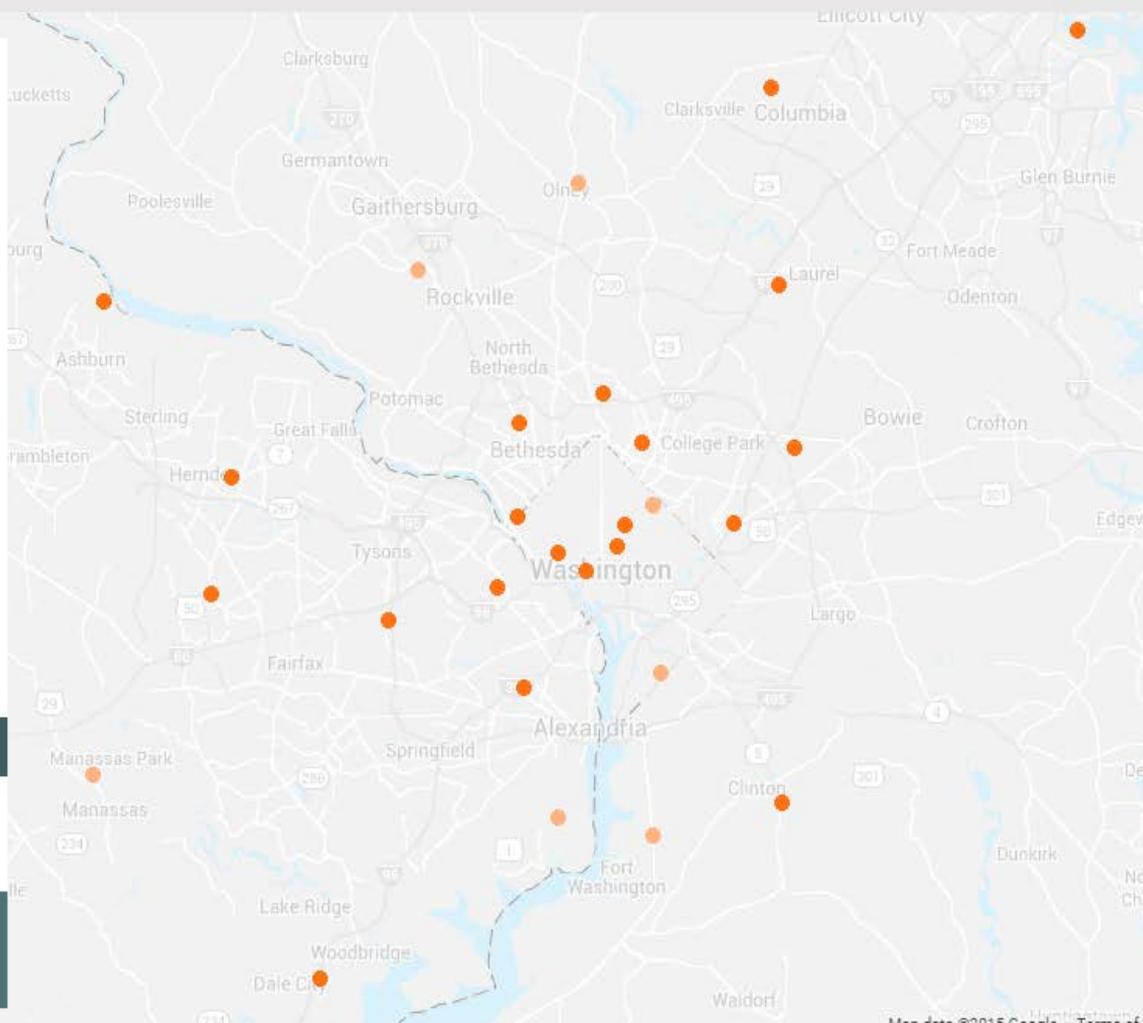
From July 2013 to June 2014, patients contracted over 9,500 central line infections, **a dangerous and often preventable complication**. Search for hospitals in your area, click on a point to show information, and explore more below.

- Hospitals reporting at least one central line infection
- Hospitals reporting no central line infections
- Hospital info is not available or not applicable **SHOW**

### SEARCH YOUR LOCATION

### FILTER BY RATE

### FILTER BY CASES AND DAYS



- Hospitals reporting at least one central line infection
- Hospitals reporting no central line infections
- Hospital info is not available or not applicable **SHOW**

**VIRGINIA HOSPITAL CENTER**

1701 NORTH GEORGE MASON DRIVE  
ARLINGTON, VA 22205

Hospital type      Acute care hospitals

Ownership          Voluntary nonprofit:  
private

Provides emergency  
services            Yes

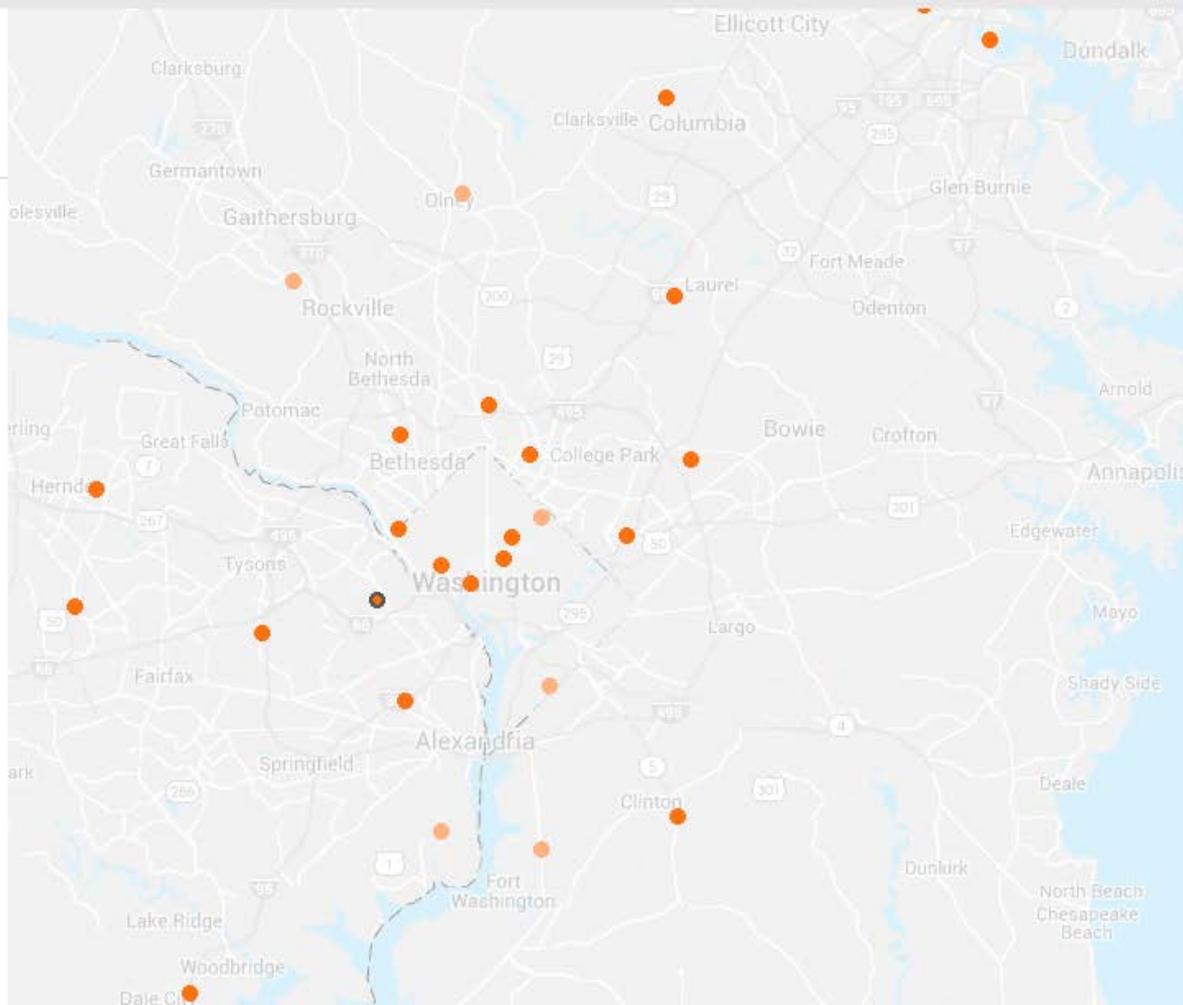
**Observed**        1

**Days**              2,671

**SIR**                0.194

**Rate per 1,000**    0.374

The data shows the period from July 2013 through June 2014. Hospital locations on map are based on government-provided data and may not be exact. **Download the data.**



- Hospitals reporting at least one central line infection
- Hospitals reporting no central line infections
- Hospital info is not available or not applicable *SHOW*

### GEORGE WASHINGTON UNIV HOSPITAL

900 23RD ST NW

WASHINGTON, DC 20037

Hospital type      Acute care hospitals

Ownership          Proprietary

Provides emergency services      Yes

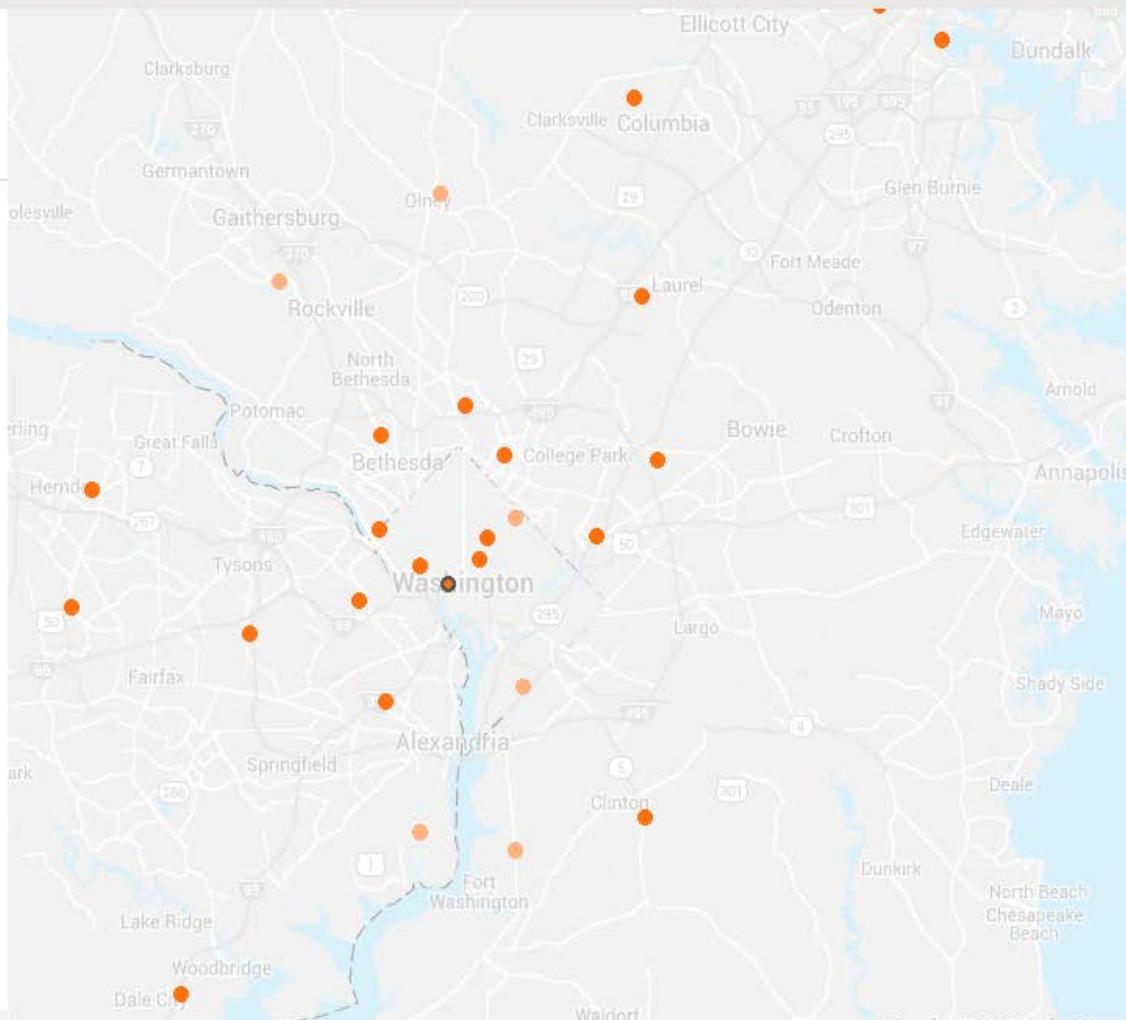
**Observed**              23

**Days**                    7,958

**SIR**                     1,299

**Rate per 1,000**      2.890

The data shows the period from July 2013 through June 2014. Hospital locations on map are based on government-provided data and may not be exact. [Download the data.](#)



# Four Domains of Transparency\*

- Among organizations
  - (e.g., regional collaboratives)

- National Efforts
  - Medicare's Hospital Compare
  - American College of Surgeons Partnership
  - Institute for Healthcare Improvement
- Regional Collaboration
  - Work in progress
  - Our aim is to be supportive

\*From The National Patient Safety Foundation®

"All the News  
That's Fit to Print"

# The New York Times

Late Edition

Today, partly sunny, high 84. To-  
night, partly cloudy, low 64. To-  
morrow, clouds and sun, after-  
noon shower or thundershower,  
high 83. Weather map, Page 28.

VOL. CLXIII · No. 56,547

© 2014 The New York Times

NEW YORK, SUNDAY, JUNE 29, 2014

50 beyond the greater New York metropolitan area.

\$5.00

## A REIGNITED WAR DRIVES IRAQIS OUT IN HUGE NUMBERS

### ESCAPING THE FIGHTING

A Million Leave Homes,  
Many Not for the  
First Time

By TIM ARANGO

DARBANDIKHAN, Iraq — As  
Sunnī rebels advanced across  
Iraq in recent weeks, hundreds of  
thousands of Iraqis were driven  
from their homes. For many, it  
was not the first time.

There have been very few pro-  
longed periods of peace in Iraq  
over the last several decades, and  
for civilians seemingly perpetual  
flight. More than a million Iraqis  
have been displaced this year,  
half within the last couple of  
weeks, the United Nations says.

For Akheel Ahmed, a Sunnī  
Arab who fled his home in the  
central Iraq town of Balad, fear  
and uncertainty were accompa-  
nied by familiarity. He arrived in  
this mountain village along the  
Iranian border a few days ago  
with his three sons, the second  
time in recent years that he has  
become a refugee in his own  
country.

Using hand gestures, he de-  
scribed the battlefield that his  
hometown had become.

"Here is ISIS," he said, refer-  
ring to the Sunnī militant group  
the Islamic State in Iraq and Syr-  
ia, "and here are the Shiite mil-  
itias. We are in between."

He then checked off the names of  
his sons, to emphasize the ur-  
gency of his exodus.

"I have an Omar, an Othman  
and an Asha," he said, all recog-  
nizable as Sunni names, making  
them targets for the Shiite mil-  
itias now working alongside the  
Iraqi Army. "They will slaughter  
them."

The rapid advances of ISIS and  
other Sunnī militant groups

Continued on Page 12



## In Military Care, a Pattern Of Errors but Not Scrutiny

Mistakes and a Culture of Secrecy Persist;  
So Do Avoidable Injuries and Deaths

By SHARON LEFRANIERE and ANDREW W. LEHREN

FORT SILL, Okla. — Jessica  
Zeppo, five months pregnant, the  
wife of a soldier, showed up four  
times at Reynolds Army Continu-  
ing Hospital here in pain, weak,  
barely able to swallow and fight-  
ing a fever. The last time, she de-  
clared that she was not leaving  
until she could get warm.

Without reviewing her file,  
nurses sent her home anyway,  
with an appointment to see an  
oral surgeon to extract her wisdom  
teeth.

Mrs. Zeppo returned the next  
day, in an ambulance. She was  
admitted to a civilian hospital,  
where, despite relentless efforts  
to save her and her baby, she suf-  
fered a miscarriage and died on  
Oct. 22, 2009, of complications  
from severe sepsis, a bodywide  
infection. Medical experts hired  
by her family said later that be-  
cause she was young and other-  
wise healthy, she most likely  
would have survived had the  
medical staff at Reynolds properly  
diagnosed and treated her.

"She was 21 years old," her  
mother, Shelley Amosett, said.  
"They let this happen. This is  
what I want to know: Why did  
they let it slip? Why?"  
The hospital doesn't know, ei-  
ther.

Since 2001, the Defense De-  
partment has required military  
hospitals to conduct safety in-  
vestigations when patients unex-  
pectedly die or suffer severe inju-  
ry. The object is to expose and fix  
systemic errors, often in the most  
routine procedures, that can have  
disastrous consequences for the  
quality of care. Yet there is no evi-  
dence of such an inquiry into  
Mrs. Zeppo's death.

The Zeppo case is emblematic  
of persistent lapses in protecting  
patients that emerged from an  
examination by The New York  
Times of the nation's military  
hospitals, the hub of a sprawling  
medical network — entirely sep-

arate from the scandal-plagued  
veterans system — that cares for  
the 1.6 million active-duty service  
members and their families.

Internal documents obtained  
by The Times depict a system in  
which scrutiny is sporadic and  
avoidable errors are chronic.

As in the Zeppo case, records  
indicate that the mandated safety  
investigations often go undone:  
From 2001 to 2003, medical work-  
ers reported 239 unexpected  
deaths, but only 198 inquiries  
were forwarded to the Pentag-  
on's patient-safety center,  
where analysts recommend how  
to improve care. Cases involving  
permanent harm often remained  
unexamined as well.



SHARON LEFRANIERE FOR THE NEW YORK TIMES  
Justin Guill, with his mother,  
Kathleen, was born brain-dam-  
aged at a military hospital.

At the same time, by several  
measures considered crucial ba-  
rometers of patient safety, the  
military system has consistently  
had higher than expected rates of  
harm and complications in two  
central parts of its business —  
maternity care and surgery.

More than 51,000 babies are  
born at military hospitals each  
year, and they are twice as likely  
to be injured during delivery as  
newborns nationwide, the most  
recent statistics show. And their  
mothers were more likely to hem-  
orrhage after childbirth than

Continued on Page 22

# Surgeon Scorecard

*by Sisi Wei, Olga Pierce and Marshall Allen, ProPublica, July 14, 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.

## READ OUR STORY

**Making the Cut: Why Choosing the Right Surgeon Matters Even More Than You Know**

## METHODOLOGY

**Read how we calculated complications and the key questions we considered.**

## EDITOR'S NOTE

**Why ProPublica is naming surgeons and what experts are saying about it**

Find Near Me

Find a Surgeon

Find a Hospital

## Find a Surgeon by Name





### **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 Technique**

The fusing of two or more vertebrae in the lower back, performed on the back portion of the spine.



### **Lumbar Spinal Fusion, Anterior Technique**

The fusing of two or more vertebrae in the lower back, performed on the front portion of the spine.



### **Prostate Resection**

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

**16,827**

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

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## **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](#)

# Four Domains of Transparency\*

**Among clinicians  
(e.g., peer review)**

- Internal transparency
- Consider:
  - Promoting common understanding of existing MHS clinician-to-clinician transparency practices
  - Identifying enablers and barriers to MHS clinician-to-clinician transparency
  - Exploring inter- and intra-Service clinician-to-clinician transparency

\*From The National Patient Safety Foundation®

- **University of Utah Study**

- Everyone favors transparency...except when it comes to themselves
- The Risks
  - Patients can't understand it
  - Risk adjustment methodology is flawed
  - Hey – we're actually below average!

# Radical Transparency



- **Approach**

- Gradual, 4-year phased approach
- Survey everyone for every visit ... and post every comment for the public to see
- Expand to internal transparency ... every provider can see performance of every other provider
- More than marketing, and better than financial incentives

- **Outcome**

- 2009: Top 10 providers for satisfaction – 9%
- 2013: Top 10 providers for satisfaction – 46%

***“Medically Ready Force...Ready Medical Force”***

# Next Steps



- Continue **collaboration with Services** to set priorities
- **Improve public website** of all aggregate, statistically available information – supported by a comprehensive public outreach plan
- National roll-out of **Healthcare Resolutions Program** with improved marketing and communications
- Promote of national and regional **collaboratives**
- Greater **patient engagement** in healthcare decision making
- Continued investigation of **leading industry practices** within each domain

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# Health IT Role in Enhancing Transparency



- **Data Quality** is the foundation for accurate reporting and transparency
- Ever-expanding **repository of the health information** we collect provides a more meaningful and useful picture of which enables transparency for the organization and for the patient
- Emergence of more sophisticated **patient health records** will make it easier for patients to perform quality and safety comparisons
- **Data visualization capabilities** make health data available to a broader audience (to include the media)

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# Summary

## *Transparency in American Medicine*



- The Secretary of Defense demanded it; and the MHS committed to it
- CMS / Hospital Compare requires it
  - Tied to Medicare reimbursement
  - VA participates in it, and shares it on its website
- Leading high reliability organizations embody it, even when it is below benchmarks, and it can help drive improvement
- The media has access to the data, without needing to “ask” us (and if they ask, we are obligated to share it)
- Patients expect it
- We all benefit from it

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Please complete your evaluations

## Questions



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