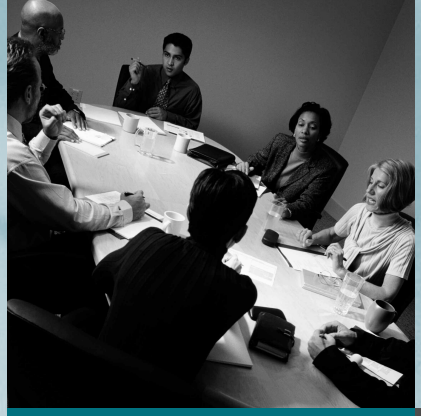

NQF

NATIONAL QUALITY FORUM

CONSUMER-FOCUSED PUBLIC REPORTING

National Voluntary Consensus Standards for Hospital Care 2007—Guidelines for Consumer-Focused Public Reporting

A CONSENSUS REPORT

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Foreword

In this era of transparency, many sources of information about the quality of healthcare exist, including "report cards" grading the performance of various healthcare providers. Many of these sources provide useful information to consumers to help them make decisions about their health and healthcare options, but in virtually all cases, there is room for improvement.

In order to ensure that publicly available information is salient and useful to the public, the National Quality Forum (NQF) has endorsed a set of information reporting guidelines. This report, the product of that effort, presents seven national voluntary consensus standards that, together, comprise guidance for design and implementation strategies for Internet-based public reporting on the healthcare quality of acute care hospitals in the United States. Numerous healthcare stakeholders, including both organizations that report such information and those that represent consumers who use it, vetted these guidelines through NQF's Consensus Development Process.

NQF thanks the members of the Hospital Care 2007 Steering Committee and its Public Reporting Technical Advisory Panel for their guidance of this project and NQF Members for their commitment to informing the public about healthcare quality. These organizations are helping achieve the vision of a healthcare system in which patients can easily obtain usable, understandable information from multiple reliable sources when making choices about their healthcare.

Janet M. Corrigan, PhD, MBA
President and Chief Executive Officer

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

This work was conducted with funding by the Agency for Healthcare Research and Quality (www.ahrq.gov).

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Executive Summary

EVIDENCE SUGGESTS that healthcare quality reports and public report cards that contain information that conflicts with information found elsewhere and that are poorly constructed may impair the ability of consumers to use the information presented and also may cause consumers to make decisions that are not consistent with their goals. This highlights the need for national consensus on public reporting strategies and for standardization of the approach to public reporting to help change these outcomes. As a step in that direction, this document presents guidelines for implementing a standardized approach to public reporting that can assist sponsors in their efforts to create and improve healthcare quality reporting and reporting sites for consumers.

This report specifically provides guidance for Internet-based public reporting on the healthcare quality performance of U.S. acute care hospitals, but most of the guidance also can be applied to the public reporting of quality performance data from other locations. It is intended for use by those who sponsor public reports of quality performance information to help them develop and/or refine their efforts. This document does not recommend what performance measures should be reported. Instead, it focuses on how to select and report the performance data by providing evidence-, expert-, and consensus-based guidance on how to standardize the approach to public reporting of quality information and by identifying additional resources that can be used in report construction and content development.

The information provided reinforces and supplements the National Quality Forum-endorsed® recommendations on public reporting of healthcare quality data provided in *A Comprehensive Framework for Hospital Care Performance Evaluation: A Consensus Report.*

National Voluntary Consensus Standards for Consumer-Focused Public Reporting

Guidelines

- Identify the purpose of the web-based report, its intended main consumer audience(s), and how the report will be made known to the audience; also identify secondary audiences and how their unique needs will be addressed.
- Develop the web-based report using a transparent process that involves consumers and other relevant stakeholders.
- At the beginning of the report, set the stage by communicating what quality is, how quality varies, and how making quality comparisons can be of value to consumers.
- Ensure that the measures included in a consumer-focused public report are meaningful to consumers, transparent, and meet widely accepted, rigorous criteria, including important, scientifically acceptable, feasible, and usable.
- Present and explain the data clearly and objectively in ways that help consumers understand and use the information.
- Ensure that report design and navigation features enhance report usability.
- Regularly review and assess reports to ensure their effectiveness, usability, and currency.

Introduction

THIS REPORT PROVIDES GUIDANCE for Internet-based public reporting[i] on the healthcare quality performance of U.S. hospitals. It is intended for use by those who sponsor public reports of quality performance information to help them develop and/or refine their efforts. This document does not recommend what performance measures should be reported. Instead, it focuses on how to select and report the performance data by providing evidence-, expert-, and consensus-based guidance on how to standardize the approach to public reporting of quality information and by identifying additional resources that can be used in report construction and content development. The guidelines advanced in this report specifically address consumer-focused, Internet-based public reporting of healthcare quality performance information about acute care hospitals, but most of the guidance also can be applied to the public reporting of quality performance data from other healthcare locations. Also, it is important to acknowledge that because not all consumers have Internet access, other methods of disseminating information remain important.

The guidance offers public report design and implementation strategies to increase the value and usefulness of publicly reported information to consumers and to stimulate industry action toward improvement in quality of care, patient safety, and patient-centeredness. Public reporting involves balancing competing interests, including reporting objectives and various constraints both within and outside the report sponsor. The challenges will be compounded by changes that will occur over time such as the evolution of public reporting knowledge; sponsor priorities, abilities, and mandates; and technologies that support reporting, to name a few. Notwithstanding the decisions and compromises inherent in public report sponsorship, this guidance should help the industry to achieve a standardized approach to reports.

The information provided in this document reinforces and supplements the National Quality Forum (NQF)-endorsed® recommendations on public reporting of healthcare quality data provided in *A Comprehensive Framework for Hospital Care Performance Evaluation: A Consensus Report.*[1]

[i] Public reporting, as used in this document, refers to the disclosure of information to consumers, to a community, or to a group of people who share a common interest in order to help them make better healthcare choices or to institutions to help them meet their obligations or duty to make information about their actions or performance available.

Although the guidelines offered in this report are specific to the public reporting of healthcare quality information for consumers,[ii] other audiences can use the information and benefit from it. For example, members of the media may find many of the concepts presented to be helpful in providing objective, balanced information on quality and quality reporting to the public.

Notably, interest in publicly reporting information about the quality of healthcare (and its cost[iii])—in order to help make the healthcare system more accountable, to improve consumer understanding and decisionmaking, and to improve quality—has been increasing and is expected to continue to increase, even though reports about the degree to which consumers are actually using this information are mixed.[2,3,4] There is no doubt that consumers bring an essential perspective to the development of healthcare quality reporting that will help lead to a care system that is more responsive and accountable to those it serves—and that there are some areas of system performance that would never be examined if consumers did not have a strong voice in the process.[5] However, studies have shown that consumers do not always seek out or use the information that is available to guide healthcare choices.[6,7] There are a number of explanations for this: 1) consumers may not know that these reports exist; 2) consumers are more likely to consult other sources for this information (trusted family, friends, and physicians, for example) and will continue to do so until they become aware that public reports are available and come to trust them;[8] 3) the information consumers indicate they want has not proven to be a good match for what they actually find relevant to their decisionmaking needs;[9] and 4) the information provided in public reports often is not "evaluable"—that is, frequently it is not presented in a way that consumers can understand, including its key points and overall meaning, and connect with emotionally in order to be able to make healthcare choices and decisions that are consistent with their goals.[10]

But the most compelling and challenging reason that consumers do not always seek or use publicly reported information is that they have not identified a need for it. Many consumers do not understand what information is included in healthcare quality reporting and how it can be used to identify serious gaps that can then be addressed and eventually closed. Thus, to date, most public reports have been difficult to understand and use, have not adequately communicated what quality[11] of care is, and have not convinced consumers to pay attention to quality. Without that essential knowledge, they cannot appreciate that there are potentially serious consequences of getting poor quality or unsafe care.

Fortunately, there is a growing body of knowledge about public reporting that,

[ii] The term *consumers* is defined as patients (those currently using healthcare services) and potential patients (those who are making choices prior to using healthcare services); it also includes patients' families.

[iii] The issue of cost as part of a healthcare value equation, although important, is not addressed in this report. It is discussed in detail in the National Quality Forum's 2007 *Background Paper on Healthcare Cost and Price Transparency: Useable, Audience-Specific Information on Costs and Price.* See www.qualityforum.org/pdf/projects/transparency/cost%20price%20txfinal.pdf.

although still at a nascent stage, can be used to improve public reports. This knowledge is dynamic and should continue to be advanced through ongoing study and use. In addition, the effectiveness of public reporting per se, as well as the formats, approaches, and content used, must be systematically evaluated as part of the process.[12]

The sponsors of public reports on healthcare quality have a responsibility to use this growing body of knowledge to educate consumers about quality, and they must work to deal with the conflicts and contradictions that inevitably will occur as they craft messages to inform consumers and select performance information to be reported that conveys the level of quality that is provided at specific institutions. Sponsors must embrace the challenges involved in producing reports that are credible and that will be trusted and that, therefore, will be more likely to be widely used by consumers. In fact, a fundamental obligation of those who sponsor public reports is to ensure that these reports are objective and balanced and that they portray the data accurately.[13,14,15]

In summary, there is evidence suggesting that healthcare quality reports and public report cards that contain information that conflicts with information found elsewhere and that are poorly constructed may impair consumers' ability to use the information presented and also may cause consumers to make decisions that are not consistent with their goals.[16,17] This highlights the need for a national consensus on public reporting strategies and for the standardization of the approach to public reporting to help change these outcomes.[18,19] As a step in that direction, this document presents guidelines for implementing a standardized approach to reporting that can assist sponsors in their efforts to create and improve healthcare quality reporting and reporting sites for consumers.

Background

As early as 1984, the Health Care Financing Administration publicly reported hospital mortality rates for Medicare patients as part of its oversight responsibilities. However, severe criticism of the methodology brought this reporting to an end after only a few years.[20] In the early 1990s, several states, of which Maryland, New York, and Pennsylvania were among the first, began publicly reporting information on healthcare quality. But it was not until the late 1990s that the broader public reporting effort was rekindled, largely as a result of the publication of the report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.[21] In 2001, the Institute of Medicine (IOM) recommended that "All healthcare organizations, professional groups, and private and public purchasers should pursue six major aims: specifically, healthcare should be safe, effective, patient-centered, timely, efficient, and equitable."[22] In doing so, IOM laid out a framework for measurement (and ultimately for reporting). In that same year, the National Committee for Quality Assurance developed a framework for understanding quality of care that focused on three of the six IOM "aims for improvement"—effectiveness, safety, and patient-centeredness. The work of these and other groups helped to establish the

expectations that the public should have information about healthcare quality and that such reports could and should be generated.

In 2002, NQF published *A National Framework for Healthcare Quality Measurement and Reporting: A Consensus Report,* which established a platform and a set of principles for U.S. healthcare quality improvement. One of the principles NQF endorsed in this report states that national goals for healthcare quality improvement should be consistent with the six IOM aims.[iv] The consistent use of the IOM "aims," or categories of performance, reinforces the message that these categories define high-quality care and describe what consumers should expect to know when making healthcare choices.[23]

In 2003, NQF endorsed a framework for hospital care performance evaluation in its report, *A Comprehensive Framework for Hospital Care Performance Evaluation*. Reporting the performance measurement results to the public was one of six areas emphasized to standardize hospital care performance measurement that was endorsed through the Consensus Development Process (CDP) of NQF, which at that time included more than 160 NQF member organizations representing consumers, providers, health plans, purchasers, researchers, and quality improvement organizations. As part of the reporting recommendations that were offered, specific expectations were articulated regarding the selection and use of performance measures, the generation of reports, the verification of report results, the distribution and dissemination of reports, and the need for consumer research. In addition, clear consensus statements were offered regarding stakeholder expectations related to report accuracy, a consumer orientation, and the need for a standardized approach to reporting. Since that time, a number of organizations and efforts, including the Consumer-Purchaser Disclosure Project, the AQA, the Hospital Quality Alliance, and the Agency for Healthcare Research and Quality's (AHRQ's) TalkingQuality initiative, have offered their opinions regarding the approaches to and selection of content for public reporting and have helped to inform a way forward. In 2007, NQF established the National Priorities Partners to work in partnership with other healthcare leadership organizations to establish national priorities and goals for performance measurement and public reporting. All of these efforts emphasize these groups' enduring interest in and commitment to advancing and improving public reporting on healthcare quality.

Strategic Directions for NQF

As NQF nears completion of its first decade, consideration of strategic issues to guide current and future activities has resulted in an expansion of NQF's mission to include three parts: setting national priorities and goals for performance improvement; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. As greater numbers of quality measures are developed

[iv] "Beneficial" was substituted for "effective" in setting out the aims.

and brought to NQF for consideration, NQF must assist stakeholders in measuring "what makes a difference" and addressing what is important to achieve the best outcomes for patients and populations. An updated Measurement Framework, reviewed by NQF Members in December 2007, promotes shared accountability and measurement across episodes of care with a focus on outcomes and patient engagement in decisionmaking coupled with measures of the healthcare process and cost/resource use.

Several strategic directions have been identified to guide the consideration of candidate measures:

- **Drive toward high performance.** Over time, the bar of performance expectations should be raised to encourage achievement of higher levels of system performance.
- **Emphasize composite measures.** Composite measures provide much needed summary information pertaining to multiple dimensions of performance and are more comprehensible to patients and consumers.
- **Move toward outcome measurement.** Outcome measures provide information of keen interest to consumers and purchasers, and when coupled with healthcare process measures, they provide useful and actionable information to providers. Outcome measures also focus attention on much-needed system-level improvements, because achieving the best patient outcomes often requires carefully designed care processes, teamwork, and coordinated action on the part of many providers.
- **Focus on disparities in all that we do.** Some of the greatest performance gaps relate to care of minority populations. Particular attention should be focused on the most relevant race/ethnicity/language/socioeconomic strata to identify relevant measures for reporting.

These strategic directions are reflected in the guidelines for consumer-focused public reporting.

Challenges and Opportunities

Public reports on healthcare quality are sponsored by many types of organizations and entities, including the federal government; states; nonprofit groups, including consumer organizations; hospital accrediting organizations; business coalitions; hospital associations; hospitals; and health plans and payers.[24,25] Because of this diversity, the type of information typically provided does not provide a consistent view of the level of healthcare quality to be found at the institutions that are the focus of the reporting.[26] The production and dissemination of public report cards is a multimillion dollar industry,[27] yet there is little evidence-based information about how they are constructed or what their benefits are to consumers or to the healthcare industry.[28,29] Furthermore, a review of Internet-based hospital reports indicates that the breadth and depth of information available may depend on geography or on other factors such as employment or health plan or hospital choices.[30] In this regard, employers are an important stakeholder group as they, on behalf of consumers, may require greater detail and transparency regarding performance of providers in the health plans they offer.

The challenges involved in producing accurate, useful reports include gaining an understanding about what constitutes a useful report, having available mature measure sets that convey a well-rounded picture of care, and ensuring that reports support consumer understanding of quality and healthcare choice. In all of these areas, it is important to test reports with the intended consumer audience.

The work generated through the groups and efforts described above, and others, has set the direction for standardizing the approach to healthcare quality measurement and reporting. In moving forward to meet the key challenge of helping consumers understand what quality of care means and of providing reports that are accessible, the use of symbols, graphics, and stories that are meaningful to consumers will help. Consumers also need to be able to "see" the differences in quality of care across institutions, which can be accomplished by illustrating the numerical differences with graphics, tiering, and other techniques. To reach consumers, it is often more useful to provide examples of the value or consequences of receiving care at specific institutions (e.g., chances of dying or of developing serious problems) than it is to provide mortality or morbidity data alone. To do this, sponsors must identify what is known about quality in terms of existing measures and data, assess where gaps in data exist, and then apply what is known to the development of objective, accurate, and well-rounded reports. Additionally, sponsors should determine up front what they must do to make consumers aware that the reports are available.

Sponsors must be mindful of the potential for unintended consequences. Although the transparency that is inherent in the public reporting of healthcare quality data accelerates quality improvement, and particularly competition to achieve greater performance improvement, there is concern about the pressure that healthcare institutions may experience to "perform to the measures." Institutions and report sponsors must work to avoid focusing on their performance as related to the measures to the extent that they focus less on other important aspects of providing care. In addition, although the evidence in this area is not consistent, the belief that the public disclosure of performance information may encourage physicians to refuse to treat high-risk patients also is a concern. Though there is conflicting evidence about this, it is important to ensure that risk-adjustment methods take health status into account[31,32] and that audiences are informed about how to interpret the data. Another concern relates to what may be a perceived threat to market share. In fact, a limited number of studies have shown that although hospital image may be affected, no meaningful impact to market share appears to result from the public reporting of healthcare quality information.[33,34,35]

Sponsors and other stakeholders should accept the challenge of continuing to develop the evidence base related to public reporting. This will involve testing the theories of experts and garnering the input of target audiences.[v]

[v] The *target audience* is the audience that the report sponsor has identified as the intended user of the report.

It also is important to understand the knowledge already available that can help move this effort forward and to use this information to create new opportunities to improve public reporting for consumers. We know that a consistent approach to public reporting depends on the availability of performance measures that meet consensus-based criteria and that are widely accepted as accurate and reliable,[36,37] and we know that public reporting can and does stimulate efforts to improve performance.[38,39,40] We also know that consumer use of public reports is inconsistent in large part because the reports do not convey information in meaningful ways, are not accessible when they are needed, have not become trusted sources of information, and have provided inconsistent information about the same institution. In addition, we know that there is a lack of guidance regarding how to navigate the data.[41,42] Finally, we know that the challenge of developing and using a standardized approach to reporting is further compounded by the fact that there are myriad report sponsors with varied reporting goals.

NQF-Endorsed Guidelines for Consumer-Focused Public Reporting

Overview of Endorsed Guidance

The guidance provided in this report was developed from evidence-, expert-, and consensus-based guidance for standardizing the approach and explanatory content of public reports. The work began with the development of a set of assumptions about public reporting and public reports, a set of principles about public reporting and consumer-based public reports, and a list of guidelines derived from the literature that described public reports/reporting. Once the list was modified as a starting point, a group of public report sponsors and researchers[vi] were invited to provide information in response to a set of structured questions constructed by the Technical Advisory Panel (TAP) (see Appendix C for interview questions). In addition to responding to the questions, some of the individuals interviewed provided additional information—for example, publications and the content of related presentations. The primary developer[vii] of the AHRQ Model Reports (Appendix D) was then interviewed. She provided her perspective on the rationale for developing a model report, the development process, and the role of sponsors of public reports and

[vi] Gulzar Shah, MStat, MSS, PhD, Director of Research, National Association of Health Data Organizations; Kristin L. Carman, PhD, Principal Research Scientist, American Institutes for Research; Christopher Queram, MA, and Joel Walker, Wisconsin Collaborative for Healthcare Quality; and David Miranda, PhD, Elizabeth Goldstein, PhD, Neil Gittings, MA, and Benedicta Abel-Steinberg, Centers for Medicare & Medicaid Services.

[vii] Shoshanna Sofaer, DrPH, School of Public Affairs, Baruch College.

responded to questions previously posed to others interviewed.

Subsequent to the interviews, the TAP began shaping the product that resulted in the guidance in this report. It did so over a period of months of regular meetings during which the guidance was developed in a deliberate, internal consensus-building, and iterative manner. Comments received during the review and voting phases of the CDP helped refine the guidelines and expand the implementation considerations.

The guidelines and implementation considerations for Internet-based, consumer-focused public reports presented in this report were evaluated by the Steering Committee, which made refinements to the guidelines and added to the implementation considerations. The Steering Committee made clear that the guidance is and should remain dynamic as the evidence and experience around public reporting continues to evolve.

Goals of Consumer-Focused Public Reporting

As noted earlier, this report addresses consumer-focused, Internet-based public reporting of healthcare quality performance information about acute care hospitals, although most of the information can be generalized to other settings. The guidance offers public report design and implementation strategies to increase the value and usefulness of publicly reported information to consumers and to stimulate industry action toward improvement in quality of care, patient safety, and patient-centeredness.

The purpose of consumer-focused public reporting, supported by this guidance, is to:

- increase consumer motivation to use public reports by making reports more understandable and relevant;
- provide objective, unbiased, actionable, and evaluable performance information to the public;
- improve the quality of care provided across the industry; and
- stimulate further evolution of the quality and comparability of public reporting at the organization, state, and national levels.

As these goals are addressed, it is important that sponsors continuously pursue public reporting approaches that reflect current evidence, decrease consumers' confusion, and increase consumers' ability to utilize information to make decisions about their healthcare independently and with their providers. In doing so, sponsors should address consumer information challenges and add to the knowledge base about consumer-focused public reporting through research and dissemination.

Scope of the Guidance

This guidance:

- was developed from knowledge gained from the literature, from the expertise of individual researchers, and from consensus-based determinations, including those from relevant NQF-endorsed consensus standards;
- focuses on reporting healthcare quality data from acute care hospitals in a web-based format;

- is intended primarily for use by sponsors of consumer-focused sites to help consumers understand quality of care so that they can participate in shared decisionmaking with health professionals, which may include making shared decisions about where to seek care and treatment; and
- can be used for both single and composite measures of quality, although the guidance does not address the measures themselves.

The organization of the guidance is not intended to suggest the use of a static, stepwise approach. Rather, it is expected that use of the guidelines will occur as part of a dynamic process that will proceed taking into consideration the principles presented below.

Guiding Principles

To be of value, public reports should stimulate consumer interest in the information being provided, enable consumers to understand what quality is, and facilitate the use of comparative data in making healthcare choices. Reports should be designed to be evaluable—that is, they must present data in a way that helps users understand the information, including the key points and the data's overall meaning. This means that the information must be effectively interpreted and summarized. Reports also should be designed so that they address quality in terms of the delivery of care that is needed, as well as care that is safe, effective, patient centered, timely, efficient, and equitable; so that they include objective (methodologic, evidence-based) measures of care; and so that quality-related differences are highlighted effectively. The following principles underlie how these reports should be constructed:

- The public and other healthcare stakeholders have the fundamental right to have access to objective measures of quality of care provided by organizations in which they receive care, in which they deliver care, from which they purchase care, and for which they provide funding or regulation. All stakeholders also have the right to receive the information in an understandable format.
- Because healthcare organizations and health professionals respond to publicly available information, a corollary use of the guidance is to provide incentives to improve quality.
- To be most useful, information should be provided and displayed for an array of common and cross-cutting healthcare conditions; it should be provided for consumers of all ages; and it should be available across all of a healthcare provider's organizational departments or service lines, and over time.
- It is important to be aware of and understand the values and biases that are present in the reporting process in order to convey performance information in a responsible manner.

Because performance reports must appeal to the intended audience and take its needs into account, the report sponsor must accept responsibility for establishing policies that guide the development of report content and format, the report's production and distribution, and the tasks involving educating users about the information and diffusing the information.[43] When report sponsors begin to formulate specific plans for launching or improving their existing public reports, they should already have achieved a measure of clarity regarding

these responsibilities. In addition, the target audiences for the report should be identified, as should the goals to be achieved by reporting, how the quality of information and of the report itself will be ensured, how the report will be supported, maintained, and updated over time, and what the political and organizational realities are that will influence what information can or will be used. Of note, it should be clear that the primary audiences are the consumers.

Implementation of the guidelines will help standardize the approach to public reporting. For ease of use, the guidelines are presented in a table (see the following page), along with detailed discussion of each guideline.

Guidelines for Consumer-Focused Public Reporting

Identify the Purpose, the Audience, and How to Reach the Audience

Clarity about the report purpose and the approach that will be used to reach the target audience is the first consideration; understanding the scope of the report will help in this regard. Will the focus be on a single aspect of quality (such as a surgical care), or will it be to develop a complete profile of quality (such as overall hospital care)? Will individual and composite measures be included? What providers will be included and how? Will they be presented by type, geographic area, ownership, or in other ways? The target audiences should include the group of consumers for whom the report is expected to provide a service as well as the secondary audiences that will find the report of interest, including healthcare providers and policymakers.

The literature points out that the information needs of consumers will change based on changing priorities and health concerns and will vary based on age, ethnicity, culture, and level of healthcare literacy, among other factors. Often, there is opportunity to add context that will assist the specific audience in using the report.[44] For example, a superficial review of the characteristics of one group of consumers, older Americans (65+), illustrates why the identification and understanding of the consumer groups to be targeted is important. Older Americans have more disposable income to pay for healthcare costs, including insurance, than do younger Americans; most are covered by Medicare. But they are less likely to have completed high school, and their functional and health literacy levels are lower. Chronic diseases are prevalent in this group, and information about these diseases will be of interest. However, limitations in function and mental activity can interfere with their ability to access and use information. Distinguishing among the cohorts within this group can provide clues to their potential needs, interests, and challenges; for example, baby boomers are more likely to be proactive with respect to health, while those in older cohorts are believed to be more compliant with a paternalistic approach to healthcare.[45]

Once consumers believe that they need healthcare quality information in order to make good care choices, they can be expected to seek and demand it. Thus, it is essential to address the fact that consumers currently do not make use of publicly disclosed information

Table 1: National Voluntary Consensus Standards for Consumer-Focused Public Reporting

GUIDELINES
1. Identify the purpose of the web-based report, its intended main consumer audience(s), and how the report will be made known to the audience; also identify secondary audiences and how their unique needs will be addressed. 1a. Identify the nature and purpose of the report (what it will be about and what is to be accomplished by producing it). 1b. Identify the main consumer audiences for the report and describe their characteristics, their knowledge about the subject matter of the report, their information interests and needs, and how they will be expected to learn about and use the web-based report. (In planning for use, provide for layering of information that permits the user to drill down to the technical details.) 1c. Identify secondary audiences for the report, such as healthcare providers and policymakers, and describe how their report-specific interests and needs differ from those of the main consumer audiences. Determine how the report will accommodate the secondary audiences (such as allowing users to drill down to the technical details about measurement and statistical comparisons).
2. Develop the web-based report using a transparent process that involves consumers and other relevant stakeholders. 2a. Identify the various stakeholders for the web-based report (these include, at a minimum, the developers and sponsors of the report, the main consumer audiences and organizations that represent these audiences, and the entities that are being measured and compared), and clarify their roles and responsibilities. 2b. Establish governance and decisionmaking rules. 2c. Provide an opportunity for the entities that are being measured and compared to preview their data and comment on the data's accuracy before the report is released; errors/misconceptions should be corrected and policies and procedures for mediation established. 2d. Involve consumers in the development and refinement of the report by seeking their input into the report design and getting their feedback on draft versions of language and data displays. Conduct usability/ease-of-use testing with consumers before the report is released, and then collect their feedback after the launch to help evaluate it.
3. At the beginning of the report, set the stage by communicating what quality is, how quality varies, and how making quality comparisons can be of value to consumers. 3a. Provide a brief introduction about healthcare quality. 3b. Explain that quality varies within and across institutions and how the report can be used to make quality comparisons. 3c. Use consistent, simple, and familiar language to discuss quality and provide examples that will resonate with the main consumer audiences.
4. Ensure that the measures included in a consumer-focused public report are meaningful to consumers, transparent, and meet widely accepted, rigorous criteria, including important, scientifically acceptable, feasible, and usable. 4a. Because measures inherently have components that affect the way they should be reported, be clear about types of conclusions that can be reached. 4b. In choosing measures to be reported, take into account that the best measures: i. are relevant to the healthcare-related concerns of the consumer audience; ii. demonstrate variation and reflect care that those being measured can impact; and iii. provide information that reflects the overall quality of care provided by the institutions included in the report (providing additional information about limited dimensions of care for specialty institutions is acceptable).

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Table 1: National Voluntary Consensus Standards for Consumer-Focused Public Reporting

GUIDELINES

5. Present and explain the data clearly and objectively in ways that help consumers understand and use the information.
   - 5a. Help consumers quickly and easily arrive at correct and meaningful conclusions.
     - i. Display data in formats that have been shown to be evaluable. This means summarizing and displaying the data for the viewer in a way that facilitates interpretation (e.g., summary scores, labels).
     - ii. To help users make correct interpretations, report measures in a consistent way so that, within a report, either a high score or a low score consistently indicates better performance.
     - iii. Make presentations of information more vivid and compelling by including anecdotes or stories to illustrate the meaning of the data.
     - iv. Take advantage of web-based capabilities for subordinating and sorting information in order to make it responsive to the needs of users; that is, offer options that allow users to select which parts of the information they want to see and how they want to see it (e.g., listed in order of performance or alphabetically, shown in summary format or in detailed breakdowns).
   - 5b. In presenting comparative quality information:
     - i. use tools and methods such as rank ordering, color coding, and/or symbols that help users discern performance variation and quickly determine their best options;
     - ii. when possible, include benchmarks to provide users a better context for making comparisons and using the information;
     - iii. provide risk-adjusted rates and grouping of information into categories such as "better," "average" within standardized categories (such as by disease or by institution), when appropriate, and provide a simple explanation of why this was done; i.e., to make the comparisons fair and meaningful;
     - iv. label indicators using everyday language (not clinical or technical terms);
     - v. ensure that comparisons are accurate and supportable; and
     - vi. whenever possible, limit the use of statistics and terms that are difficult for most consumers to understand.
   - 5c. In presenting data from composite measures:
     - i. where measures are interpretable at the individual measure level, report all measures that comprise the composite without adding or deleting any individual component or make any change to the composite transparent (at a layer down from the initial data display); and
     - ii. report results for the composite and for each component measure (at a layer down from the initial composite data display).
   - 5d. In providing contextual information/decision support:
     - i. provide a clear contextual framework as part of the report introduction;
     - ii. make sure that key messages are included in the data display;
     - iii. whenever data are missing, provide a specific explanation for this and make the distinction clear between data that are missing because of small numbers (too few to report) and data that are missing because of refusal to provide the data;
     - iv. make information understandable by using everyday words and language;
     - v. use consumer testing to verify that the language and displays provided in the report are easy for the intended consumer audiences to understand and use (provide translations into languages other than English, if needed); and
     - vi. use reasonably current data, and display the dates/period that are covered by the data.
   - 5e. In presenting technical documentation:
     - i. include detailed measure definitions, specifications, and risk-adjustment methods;
     - ii. include resource information such as identification of the measure developer, sources of data, and interpretation guides; and
     - iii. provide details about methodology.

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Table 1: National Voluntary Consensus Standards for Consumer-Focused Public Reporting

GUIDELINES
6. Ensure that report design and navigation features enhance report usability. Design features should be used to: 6a. organize information in a way that lets users know what is available and lets them make their own choices; 6b. provide an engaging format and include intuitive and consistent navigation tools that are placed in consistent locations; 6c. make the report easy to skim and build in layering to provide the capability to drill down to information and to navigate back out; 6d. seek feedback and test the design and navigation with the intended audiences; and 6e. provide users a way to print the information in understandable and usable formats.
7. Regularly review and assess reports to ensure their effectiveness, usability, and currency. 7a. Conduct assessments of the use and impact of reports. 7b. Use a combination of methods to obtain and use feedback from the intended consumer audiences and the institutions that are the subject of the reporting. 7c. Involve stakeholders in revisions and seek their feedback after the report undergoes significant changes. 7d. Use what is learned to help inform and drive the improvement and usefulness of performance measures and the field of consumer public reporting.

about quality because of the shortcomings of reports, their complexity, and the limited relevance of the information they provide.[46] This is because to use the complex, comparative information in a report, consumers must be able to process the information, interpret it correctly, and then identify the important factors and use them in making decisions or choices.[47] Additionally, they must be able to find the information. For this reason, it is important to think up front about how the information will be disseminated.

GUIDELINE 1. Identify the purpose of the web-based report, its intended main consumer audience(s), and how the report will be made known to the audience; also identify secondary audiences and how their unique needs will be addressed.

1a. Identify the nature and purpose of the report (what it will be about and what is to be accomplished by producing it).

1b. Identify the main consumer audiences for the report and describe their characteristics, their knowledge about the subject matter of the report, their information interests and needs, and how they will be expected to learn about and use the web-based report. (In planning for use, provide for layering of information that permits the user to drill down to the technical details).

1c. Identify secondary audiences for the report, such as healthcare providers and policymakers, and describe how their report-specific interests and needs differ from those of the main consumer audiences. Determine how the report will accommodate the secondary audiences (such as allowing users to drill down to the technical details about measurement and statistical comparisons).

Use a Transparent Process That Involves Stakeholders

Public performance reports for consumer audiences must seek to meet their needs by obtaining and using the input, advice, and opinions of consumers throughout the entire process of site development from the formation of the concept, to the selection of what is to be reported, to testing, and to implementation, improvement, and retesting. To discern consumer information interests accurately (what they want versus what they may say they want), information should be collected in multiple ways. Input can be obtained through cognitive testing to determine audience interests, to determine how well the audience understands terms, and to find out how the audience interprets the data behaviorally as well as verbally, given the language used and the methods that are employed to convey them. One-on-one cognitive interviews are valuable in exploring the best ways to display varied types of information and in assessing the effectiveness of navigation tools. Such interviews also help in gaining an appreciation of whether consumers view the format and content as personally meaningful. Usability testing should be an ongoing activity that begins before large-scale rollout.

Additionally, report sponsors must consider and involve all relevant stakeholders in a transparent process. This means that the interests and needs of consumers and those of secondary audiences, which include health-care providers, policymakers, and others, must be addressed by involving them in the processes of development and improvement. Furthermore, those who collect and report the data should help providers achieve a common understanding of their roles and responsibilities in performance measurement.[48]

Stakeholder roles include helping to define the scope, format, and goals of the report. Data should be shared with the institutions on which reporting is being conducted, ideally by having them review the data display before it is presented publicly. In addition to providing prepublication feedback, mediation processes should be included.[49,50] These actions will help ensure data validity and reliability and help avoid errors in the reports. Report sponsors should be held accountable for errors in the reports they publish over which they have control. When errors occur, sponsors should publicly retract the error.[51]

Throughout the process, openness should be ensured with respect to process, methods of determining what and how to report, the results reported, and report sponsorship. This openness relates to the data as well as to information about site sponsors, funders, and the process of building the report.

GUIDELINE 2. Develop the web-based report using a transparent process that involves consumers and other relevant stakeholders.

2a. Identify the various stakeholders for the web-based report (these include, at a minimum, the developers and sponsors of the report, the main consumer audiences and organizations that represent these audiences, and the entities that are being measured and compared), and clarify their roles and responsibilities.

2b. Establish governance and decisionmaking rules.

2c. Provide an opportunity for the entities that are being measured and compared to preview their data and comment on the data's accuracy before the report is released; errors/misconceptions should be corrected and policies and procedures for mediation established.

2d. Involve consumers in the development and refinement of the report by seeking their input into the report design and getting their feedback on draft versions of language and data displays. Conduct usability/ease-of-use testing with consumers before the report is released, and then collect their feedback after the launch to help evaluate it.

Set the Stage by Communicating Information About Quality

The literature shows that when consumers are faced with complex and unfamiliar situations, they do not approach them with fixed ideas about what is important.[52] This suggests that before asking consumers what they want, it would be more useful to help them first understand the concept of quality and the elements that comprise it. This education about what constitutes quality care will help consumers appreciate what they need to know when they make healthcare choices.[53] Sponsors must then work to understand the desires and needs of the audiences that an understanding of quality will stimulate.

Once a construct for defining quality is selected, language that is familiar to the target audiences should be used to explain what the terms mean. For example, terms such as *effective* or *beneficial* may be best understood by consumers as receiving care that is proven to work best, and *safety* may be most clearly stated in terms of causing no harm. The construct, terms, and definitions used in setting the context for the report should be repeated and reinforced throughout, stressing the inferences that can be drawn as well as the limitations. It is important that consumers understand that no single measure can convey overall quality. For example, strong performance on a measure does not mean that overall performance is strong; conversely, weak performance does not mean that overall performance is weak.

In order to avoid overloading the audience with information, it is important to provide only essential introductory material. Additional explanatory information can, and should, be provided throughout the report in conjunction with the specific datasets—that is, "just in time."

GUIDELINE 3. At the beginning of the report, set the stage by communicating what quality is, how quality varies, and how making quality comparisons can be of value to consumers.

3a. Provide a brief introduction about healthcare quality.

3b. Explain that quality varies within and across institutions and how the report can be used to make quality comparisons.

3c. Use consistent, simple, and familiar language to discuss quality and provide examples that will resonate with the main consumer audiences.

Use Measures That Are Transparent and That Meet Widely Accepted, Rigorous Criteria

Ensuring the credibility of public reports requires meticulous attention to the quality and accuracy of the data and information conveyed. Performance data included in public reports must be

credible, transparent, actionable, valid, reliable, timely, important, scientifically sound, feasible, usable, and risk adjusted as needed to assure comparability.[54,55,56] Selecting measures that have been developed by and vetted through trusted sources with rigorous, standardized and transparent processes will help ensure these criteria are met and should, over time, gain consumer trust.

With a target audience of consumers, the information must be patient centered and meaningful to them. Currently, comprehensive sets of measures that provide a complete picture of any individual component of care, disease state, or institution do not exist. Although the availability of strong, evidence-based measures is improving, the diverse goals of public reporting make it difficult to identify criteria that can be uniformly used to assess the impact of public reporting of performance measures.[57] Additionally, until clinical data become widely available through electronic health records, the entire healthcare industry must rely mainly on administrative data—which may be clinically enriched with information such as laboratory results—and manually abstracted clinical information from which to derive quality-of-care conclusions. In selecting measures for reporting, it is essential that they be widely used and, as appropriate to the scope, that they reflect quality-of-care processes, access to care, treatment outcomes, and patient satisfaction. When adding new measures to a report, it is important to consider a pilot period that provides for feedback and refinement.

It is essential to convey the strengths and limitations of the types of measures being used and of the data and to avoid selectively choosing measures that support a particular position ("cherry picking"). However, providing additional information about limited dimensions of care that are provided by specialty organizations is appropriate. Data should be used only from well-documented measures that include an analysis of their strengths, weaknesses, and limitations, and it is important to be explicit, both internally (within the sponsoring entity) and externally (to the consumer audiences), about why the measures are included. When available, measures of outcome, such as mortality or adverse events, are the most desirable, but they are not always available. When outcome measures are not available, process measures such as those involving immunization, assessment, or prophylaxis may serve as proxies for outcomes as well as descriptors of important elements of the care continuum. Structural measures such as staffing and utilization may be useful within measure sets. Patient experiences of care, derived from standardized surveys of satisfaction, are outcome measures that are of particular interest to consumers.[58]

Whether the report sponsor is faced with a dearth of measures or a large number of them, the selection of which measures to use and how they should be conveyed always will require a thoughtful balancing of what is available against what is desirable; what conveys the most accurate and objective account of the quality of care provided within institutions; and what represents the current state of the quality of care as well as how to balance the need for clarity against the need to avoid overwhelming the user. It is important to be clear about what conclusions can and

cannot be reached from the measures that are reported.

GUIDELINE 4. Ensure that the measures included in a consumer-focused public report are meaningful to consumers, transparent, and meet widely accepted, rigorous criteria, including important, scientifically acceptable, feasible, and usable.[59]

4a. Because measures inherently have components that affect the way they should be reported, be clear about the types of conclusions that can be reached.

4b. In choosing measures to be reported, take into account that the best measures:[viii]

i. are relevant to the healthcare-related concerns of the consumer audience;

ii. demonstrate variation and reflect care that those who are being measured can impact; and

iii. provide information that reflects the overall quality of care provided by the institutions included in the report (providing additional information about limited dimensions of care for specialty institutions is acceptable).

Present and Explain the Data

To be useful, all information to be considered in making decisions about quality of care must be put in context and presented in a way that can be understood by the consumer, with a particular emphasis on information that may be complex and unfamiliar. Information presented also must be reasonably current—that is, no more than two years old.[60]

Messages for different consumer audiences, such as parents, prospective parents, and caregivers, will require different approaches. The cultural background of target audiences can influence how they receive the content, and this in part will be affected by the way in which the information is framed.

Information must be evaluable—that is, consumers, when making decisions, must be able to comprehend the information and connect with it in a personally meaningful way and then correctly process, interpret, identify, and weight it in order to select the "best" option for them.[61,62,63] Data displays that facilitate this evaluation reduce the cognitive burden on the user and make it easy for him or her to quickly grasp the key points and overall meaning. This requires that the data be summarized and displayed in a way that makes them interpretable by the user. Strategies such as ordering by performance, labeling the meaning of data (good, bad, average), and using summary measures can be employed to make the data more evaluable. The complexity and amount of information; the experience, skill, and motivation of the users; and the nature of the choices to be made are important considerations in preparing evaluable information displays.

When it comes to tailoring reports to the specific audience, interactive web-based reports provide far more flexibility and capability than do those presented through other media. With these web-based reports, the ability to embed decision tools and provide links to other resources increases that capability, and the cognitive burden on the users can be reduced by using specific presentation

[viii] Information included in this section has been drawn from work done by a number of organizations including NQF, IOM, Hospital Quality Alliance, AQA, AHRQ, and RAND.

techniques to organize information.[64] Providing summary information is important, and allowing users to drill down to the technical details permits them to select the amount of information they want.

The types of information to be displayed should influence how the information is displayed; for example, making comparisons across organizations on single dimensions of care requires a different approach than presenting "whole pictures" of performance using composite measures. However, when different approaches to displaying information about various aspects of care are used, employing similar scales and providing consistent cues to help users summarize data can help enhance consumer understanding and decrease any confusion that may occur. In all cases, the goal is to present the information clearly, accurately, and objectively in order to support consumer understanding and decision-making. Some approaches to presenting information in accessible and memorable ways are included in the implementation guidance included in Appendix A. However, it is important to remember that providing large amounts of data does not necessarily translate into providing better information or facilitating better decisions; in fact, offering too much data can lead to poor or inaccurate decision-making.

The matter of missing data, when this occurs, should be addressed. Thoughtful explanation of missing data could reduce or eliminate misunderstandings or mistrust.

GUIDELINE 5. Present and explain the data clearly and objectively in ways that help consumers understand and use the information.

5a. Help consumers quickly and easily arrive at correct and meaningful conclusions.

- i. Display data in formats that have been shown to be evaluable.[65] This means summarizing and displaying the data for the viewer in a way that facilitates interpretation (e.g., summary scores, labels).
- ii. To help users make correct interpretations, report measures in a consistent way so that, within a report, either a high score or a low score consistently indicates better performance.
- iii. Make presentations of information more vivid and compelling by including anecdotes or stories to illustrate the meaning of the data.
- iv. Take advantage of web-based capabilities for subordinating and sorting information in order to make it responsive to the needs of users—that is, offer options that allow users to select which parts of the information they want to see and how they want to see it (e.g., listed in order of performance or alphabetically, shown in summary format or in detailed breakdowns).

5b. In presenting comparative quality information:

- i. use tools and methods such as rank ordering, color coding, and/or symbols that help users discern performance variation and quickly determine their best options;
- ii. when possible, include benchmarks to provide users a better context for making comparisons and using the information;
- iii. provide risk-adjusted rates and grouping of information into categories such as "better," "average" within standardized categories (such as by disease or by institution), when appropriate, and provide a simple explanation of why this is being done; i.e., to make the comparisons fair and meaningful.

iv. label indicators using everyday language (not clinical or technical terms);

v. ensure that comparisons are accurate and supportable; and

vi. whenever possible, limit the use of statistics and terms that are difficult for most consumers to understand.

5c. In presenting data from composite measures:

i. where measures are interpretable at the individual measure level, report all measures that comprise the composite without adding or deleting any individual component or make any change to the composite transparent (at a layer down from the initial data display); and

ii. report results for the composite and for each component measure (at a layer down from the initial composite data display).

5d. In providing contextual information/decision support:

i. provide a clear contextual framework as part of the report introduction;

ii. make sure that key messages are included in the data display;

iii. whenever data are missing, provide a specific explanation for this, and make the distinction clear between data that are missing because of small numbers (too few to report) and data that are missing because of a refusal to provide the data;

iv. make information understandable by using everyday words and language;

v. use consumer testing to verify that the language and displays provided in the report are easy for the intended consumer audiences to understand and use (provide translations into languages other than English, if needed); and

vi. use reasonably current data and display the dates/period that are covered by the data.

5e. In presenting technical documentation:

i. include detailed measure definitions, specifications, and risk-adjustment methods;

ii. include resource information such as identification of the measure developer, sources of data, and interpretation guides; and

iii. provide details about methodology.

Ensure That the Report Design and Its Navigation Features Enhance Usability

Setting clear goals and involving the target audiences in design and testing is key to developing a report that is responsive to its audiences. Construction of Internet-based reports requires specific web expertise and will involve, as does construction of all reports, addressing competing issues. An important consideration is that of ensuring report accessibility to individuals with disabilities. Section 508 of the Rehabilitation Act of 1973 provides guidance in this regard.

Report design should provide clear navigation cues. For web-based reports, this means providing a site map; an index; "tabs" that the user can select to get to various areas of the report; and effective search functions. The navigation scheme should allow for vertical (adding information within a topic area) and horizontal (adding additional topics) expansion as experience with the report is gained.

For web-based reports, computer-aided navigational tools will enable users to process smaller amounts of information faster, and it will help them to select information based on their values and preferences. These tools can

provide legends that explain the information in data displays and notations (such as "to find your hospital") that can be used to help direct users to additional, more specific information about the institution in which they are interested. In an electronic report, legends can be presented as "pop-up" or "roll-over" displays that accompany the data display. Interactive web-based reports also should offer navigational tools such as drop-down menus to facilitate movement through the report. A wide range of useful and practical information for Internet-based reports is available at www.usability.gov.

The selected format should make the report easy to skim and permit users to print information for later use. This will allow consumers to select and access the information or subsets of information they want without having to read the entire report and can be accomplished by using some default order schema. Ordering by performance is generally preferable to alphabetical ordering. An interactive database is preferred because it permits the user to select the ordering convention that best facilitates the display of the desired information.

Once a format is designed, it is important to seek feedback on it from both experienced and inexperienced users. The process of seeking feedback should be one that takes into consideration preferences within target audiences—for example, younger users generally like to use links and are more likely to read information that is visually emphasized (through the use of caps and bolding).

GUIDELINE 6. Ensure that design and navigation features enhance report usability. Design features should be used to:

6a. organize information in a way that lets users know what is available and lets them make their own choices;

6b. provide an engaging format and include intuitive and consistent navigation tools that are placed in consistent locations;

6c. make the report easy to skim and build in layering to provide the capability to drill down to information and to navigate back out;

6d. seek feedback and test the design and navigation with the intended audiences; and

6e. provide users a way to print the information in understandable and usable formats.

Evaluate and Improve the Report

The importance of evaluating the effectiveness of public reporting cannot be overstated. It is essential that report sponsors regularly review and assess their reports to ensure they remain consistent with the initial structure and stay current and accurate. The relevance of the measures (metric definition, data collection, analysis, reporting) also should be regularly reviewed.[66] Furthermore, conducting research, encouraging additional research, and using the results of such research to increase knowledge about what makes public reports more useful for consumers and as a way to stimulate provider performance improvement will help ensure the continued relevance of public reports and also will help them to develop in such a way that they meet the needs and desires of consumers as they become increasingly sophisticated and knowledgeable in this area. Such research may exceed the financial

capacity or scope of the report sponsor. The research recommendations advanced herein are intended to challenge both sponsors and funding agencies.

GUIDELINE 7. Regularly review and assess reports to ensure their effectiveness, usability, and currency.

7a. Conduct assessments of the use and impact of reports.

7b. Use a combination of methods to obtain and use feedback from the intended consumer audiences and the institutions that are the subject of the reporting.

7c. Involve stakeholders in revisions and seek their feedback after the report undergoes significant change.

7d. Use what is learned to help inform and drive the improvement and usefulness of performance measures and the field of consumer public reporting.

Recommendations

Public reports are relatively new, and little research has been conducted regarding what makes them valuable to consumers. Thus a number of recommendations are offered for both basic and applied research in this area. Research that is longitudinal in design and that addresses both behavior change and impact beyond consumer choice should be part of the portfolio going forward. Additionally, research conducted by the various stakeholder groups should be encouraged to ensure the different perspectives and values are explored and that creativity and innovation are fostered. Such research is needed to advance knowledge and enable its application to the building of scientifically sound and useful public reports that will facilitate consumer understanding and choice and stimulate ongoing improvement in reporting and quality improvement. The NQF membership, by consensus, supports the following recommendations.

Research is recommended regarding:

1. **the impact of public reporting** in terms of communicating about and improving quality, patient safety, and patient-centeredness; informed choice; pay for performance; and understanding of "just in time" consumer activation;
2. **the content of public reports** in terms of how to balance quality and timeliness of reported measures, including when and how to retire obsolete measures and how to best obtain user input and feedback in order to construct and maintain the strongest possible reports; and
3. **techniques of Internet-based reporting** that will ensure that information is as accessible, clear, and evaluable as possible.

In addition, research in the following areas would be helpful in facilitating the expansion of these reports:

- determining the impact of specific web-based report sites in terms of the guidelines that facilitate or hinder usability;
- gathering and interpreting data that would result from comparing and contrasting different reporting systems;
- finding ways to deal with areas identified as gaps that public reporting should fill (such as sentinel events and physician-level indicators, including how to align physician-level indicators with hospital indicators);
- understanding how to better display price/cost in appropriate contexts;
- gathering and reporting information about physician volume and outcomes;

- exploring the legal implications of reporting, such as protections, impact on future case law at the state and federal levels, and the possibility that reports could be used in medical malpractice or healthcare fraud cases;
- evaluating the potential unintended consequences of reporting data related to disparate population groups and developing stronger linkages at the level of analysis;
- determining the impact and implication of using differing report formats and constructs that aim to present similar information;
- exploring effective ways to include the voice of the consumer in developing measures and reports;
- learning what constitutes a well-rounded picture of healthcare quality at the hospital level—that is, what kind of measures are needed and how many;
- determining what is needed for "just-in-time" reporting from the consumer perspective;
- understanding the issues related to cultural competence, linguistic access, and health disparities with regard to public reporting; and
- understanding the effect of public reporting on the outcomes of improving patient safety and patient-centeredness.

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Appendix A
National Voluntary Consensus Standards for Consumer-Focused Public Reporting: Guidelines

GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
1. Identify the purpose of the web-based report, its intended main consumer audience(s), and how the report will be made known to the audience; also identify secondary audiences and how their unique needs will be addressed.	▌ One purpose of public reporting is to make the healthcare system more externally accountable. ▌ Sponsors should think upfront about how to make consumers aware of their reports; e.g., think about where the target audience will review a report, choose methods to publicize the report. ▌ Consider the need to publicize the report through venues that target specific populations; e.g., non-English speaking, advocacy groups. ▌ For web-based reports, consider partnering with organizations with similar interests and create links to their sites; create banner ads on such sites to point to the report location. Seek support of entities that can make the report available or publicize it; e.g., states, provider offices, local libraries, national libraries, newspapers.
1a. Identify the nature and purpose of the report (what it will be about and what is to be accomplished by producing it).	
1b. Identify the main consumer audiences for the report and describe their characteristics, their knowledge about the subject matter of the report, their information interests and needs, and how they will be expected to learn about and use the web-based report. (In planning for use, provide for layering of information that permits the user to drill down to the technical details.)	▌ Information can be used to add audience-specific context and issues, needs, interests. ▌ Consider use of a screening tool such as discussed by Hibbard et al[b] that consists of age, education, and self-reported health to help consumers use information.
1c. Identify secondary audiences for the report, such as healthcare providers and policymakers, and describe how their report-specific interests and needs differ from those of the main consumer audiences. Determine how the report will accommodate the secondary audiences (such as allowing users to drill down to the technical details about measurement and statistical comparisons).	

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[a] Implementation considerations amplify the Guidelines. They are drawn from a number of sources including NQF-endorsed recommendations contained in *A Comprehensive Framework for Hospital Care Performance Evaluation: A Consensus Report* as well as research, expert opinion, and experience of report sponsors and users. It is neither comprehensive nor uniform across the guidelines. Report sponsors may find additional information useful to their unique needs from resources such as TalkingQuality, Usability.gov, and other sources including literature referenced in this report.

[b] Hibbard JH, Slovic P, Peters E, et al., Is the informed-choice policy approach appropriate for Medicare beneficiaries? *Health Aff,* 20:199-203.

GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
2. Develop the web-based report using a transparent process that involves consumers and other relevant stakeholders.	▮ Sponsors should acknowledge their reasons for reporting (e.g., consumer choice, regulatory compliance) that have shaped their report's content and emphasis.
2a. Identify the various stakeholders for the web-based report (these include, at a minimum, the developers and sponsors of the report, the main consumer audiences and organizations that represent these audiences, and the entities that are being measured and compared), and clarify their roles and responsibilities.	▮ Consumers should be involved throughout the process from concept to refinement. ▮ Roles include helping define the scope, format, and goals of the report.
2b. Establish governance and decisionmaking rules.	
2c. Provide an opportunity for the entities that are being measured and compared to preview their data and comment on the data's accuracy before the report is released; errors/ misconceptions should be corrected and policies and procedures for mediation established.	▮ Consider providing access to comments received from providers. ▮ Establish reasonable time for such review and comment to enable comment without causing undue delay that might affect data currency.
2d. Involve consumers in the development and refinement of the report by seeking their input into the report design and getting their feedback on draft versions of language and data displays. Conduct usability/ease-of-use testing with consumers before the report is released, and then collect their feedback after the launch to help evaluate it.	▮ Collect information in multiple ways; e.g., cognitive testing, one on one cognitive interviewing, usability testing.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
3. At the beginning of the report, set the stage by communicating what quality is, how quality varies, and how making quality comparisons can be of value to consumers.	▮ Provide a context for understanding quality of care in terms of what defines good or poor quality and what each can mean to individual's health. ▮ Ensure that the introduction does not become a barrier to getting to the data by making it succinct and by providing a search feature on the report home page.
3a. Provide a brief introduction about healthcare quality.	One example of such an introduction is included below.[c] ▮ Quality in healthcare, including in hospitals, can be described as "doing the right thing, at the right time, in the right way—and having the best possible results." ▮ This report provides information on how well all the hospitals in (insert location) care for patients with a wide range of health problems. ▮ It can help you choose a hospital for yourself, provide useful information for your loved ones if they need hospital care, encourage hospitals to improve their quality, and help everyone learn more about hospital quality. ▮ Don't people get good care in any hospital their doctor recommends? Here are the facts: • All hospitals do not provide the same quality of care. Some hospitals are better than others. • A particular hospital might do a very good job on some health problems and not such a good job on other health problems. • Whenever anyone goes to the hospital, he or she risks getting a new health problem while getting medical care for an existing problem. Hospitals vary in how well they protect patients from these risks. • Your doctor, or the specialist or surgeon he or she recommends, may be highly skilled, but hospital quality also depends on how well all the hospital staff, such as the nurses, take care of you, and on how well the hospital is organized.
3b. Explain that quality varies within and across institutions and how the report can be used to make quality comparisons.	▮ Be clear that no single measure can convey overall quality; e.g., strong performance on a measure does not mean overall performance is strong and conversely, weak performance does not mean overall performance is weak. ▮ Explain any limitations of the ability of the existing data to accurately reflect quality.
3c. Use consistent, simple, and familiar language to discuss quality and provide examples that will resonate with the main consumer audiences.	▮ "Effective" or "beneficial" may be better understood as getting care that is proven to work best; "safety" may be clearer when stated in terms of no harm. ▮ Ensure appropriate language and messaging choices by including discussion of these issues in consumer stakeholder input discussions.

[c] Excerpt from AHRQ's *Hospital Quality Model Report: Health Topics*. See Appendix D.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
4. Ensure that the measures included in a consumer-focused public report are meaningful to consumers, transparent, and meet widely accepted, rigorous criteria, including important, scientifically acceptable, feasible, and usable.	▪ Measures selected for reporting should be risk adjusted, as appropriate. ▪ If measuring other than direct outcomes, be explicit about the strength of the evidence supporting the measures and linking them to important outcomes. When multiple similar measures are available, choose those with the strongest evidence base. Avoid measures that do not have at least expert consensus-based support. ▪ Use measures for which data are analyzed by a source independent of the provider. Any self-reported results should be distinguished from externally validated results. ▪ Measures should be standardized with results that are available for institutions represented and are comparable, evaluable, distinguishable, replicable, presented in a timely way, and complementary. ▪ Measures should be balanced, comprehensive, and robust when used in sets and when possible, have been tested as a set. ▪ Use only data from well-documented measures that include an analysis of strengths, weaknesses, limitations of the data, and be both internally and externally clear and explicit about why the measures are included. ▪ Select measures that focus on areas having the greatest impact on the IOM aims and the national priorities identified by the NQF National Priorities Partnership.
4a. Because measures inherently have components that affect the way they should be reported, be clear about types of conclusions that can be reached.	▪ For example, it is not appropriate to report mortality for one condition and suggest directly or by inference that it applies beyond that one condition.
4b. In choosing measures to be reported, take into account that the best measures:	
i. are relevant to the healthcare-related concerns of the consumer audience;	▪ Ensure presentation of meaningful data in evaluable displays about healthcare outcome and patient experience. ▪ Consider audience preferences, to the extent known/discernible.
ii. demonstrate variation and reflect care that those being measured can impact; and	▪ Consider the impact on providers serving vulnerable and disparate populations; e.g., potential effect of serving high-risk patients on performance numbers.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
iii. provide information that reflects the overall quality of care provided by the institutions included in the report (providing additional information about limited dimensions of care for specialty institutions is acceptable).	▌ Information in reports should reflect outcomes—treatment, access to care, patient satisfaction, as well as quality of care processes appropriate to report scope. ▌ When deciding which measures to use, the potential for public benefit should outweigh the burden of data collection. ▌ Select measures for which the population is large enough to obtain an appropriate sample. (A minimum of 30 annual cases in the denominator of a measure has been generally accepted, and aggregating the data over multiple years has been used to achieve needed sample size.) ▌ Differences in types of facilities (rural/urban, specialty/general) that influence how measures should be interpreted should be taken into consideration by the sponsor and should be explicit in the report.
5. Present and explain the data clearly and objectively in ways that help consumers understand and use the information.	▌ Questions, about the institutions on which reported, to be answered by the report include: • Have they achieved goals? • Are they where they should be? • Are they improving? • Are they better than others? ▌ Ensure that reports take into account the needs of users with varying abilities, including limited sight. ▌ In summarizing data, include information about their strengths and weaknesses and the uses to which they should and should not be put. ▌ Ensure that conclusions reported can be supported by the strength of the metric. ▌ Acknowledge differences between the type of information available and what the audiences are believed to want.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
5a. Help consumers quickly and easily arrive at correct and meaningful conclusions.	▌Interactive web-based reports offer greater flexibility and capability to tailor reports to the audience than do other media.
i. Display data in formats that have been shown to be evaluable. This means summarizing and displaying the data for the viewer in a way that facilitates interpretation (e.g., summary scores, labels).	▌An evaluable data display is one where the best options "pop" out easily for the viewer.
ii. To help users make correct interpretations, report measures in a consistent way so that, within a report, either a high score or a low score consistently indicates better performance.	▌Avoid a mix as this will likely be confusing to the user. ▌Reduce the cognitive burden by using such things as computer-aided decision tools, visual displays, explanatory narratives.
iii. Make presentations of information more vivid and compelling by including anecdotes or stories to illustrate the meaning of the data.	▌When providing hospital-specific detail, include things such as satisfaction scores accompanied by actual patient comments. Vivid presentations can assist consumers in making judgments and choices by helping them comprehend what the actual experience of a choice might be; e.g., relaying a 50 percent complication rate by noting that 5 out of 10 people who have X procedure develop complications.
iv. Take advantage of web-based capabilities for subordinating and sorting information in order to make it responsive to the needs of users; that is, offer options that allow users to select which parts of the information they want to see and how they want to see it (e.g., listed in order of performance or alphabetically, shown in summary format or in detailed breakdowns).	▌Provide displays that layer information and provide cues for drill down to find additional information; e.g.; "To find your hospital"; "For more information." Embed decision tools in information presentations, and provide links to additional resources to increase the options for supporting choices. ▌Don't put technical information at the first level of data display.
5b. In presenting comparative quality information:	▌Tools to help readers differentiate levels of performance across hospitals are very helpful. ▌However, in presenting comparative information, avoid making differentiations that are not supported by the data. • For example, rank ordering should not be done unless it is statistically meaningful. ▌Set cutpoints to discriminate among providers on the reported measures, with reasonable allowance for statistical confidence (e.g., interval bands around cutpoints).

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
i. use tools and methods such as rank ordering, color coding, and/or symbols that help users discern performance variation and quickly determine their best options;	▌It is recommended, based on strong evidence,[d] that the following four presentation strategies be used in any data display to help consumers understand and use comparative performance information in making choices: • a summary measure. • ordering by performance. • the use of inherently meaningful symbols (as compared to the use of numbers). • fewer rather than more indicators (5 vs. 9). ▌Balance comprehensiveness and complexity with relevance and functionality. ▌Use strategies to convey the big picture through summary information; e.g., performance on a set of measures related to a particular health problem accompanied by access to the individual components. *Note: As the science evolves, composite measures may prove to be especially useful in doing this.* ▌Provide enough flexibility to allow for cross-cutting and condition-specific analysis of data and exploration of consumer sub-population exploration of interest areas; e.g., geographic, health condition, and personal characteristics such as ethnicity, age, race, gender, and health insurance coverage. ▌Provide information to help users understand the "trade-offs" in simplifying presentations; e.g., a provider may fall into one category rather than another by a slight numerical difference. ▌Where appropriate, include adjustments for characteristics of rural and urban providers as well as information about comparability across such settings.
ii. when possible, include benchmarks to provide users a better context for making comparisons and using the information;	
iii. provide risk-adjusted rates and grouping of information into categories such as "better," "average" within standardized categories (such as by disease or by institution), when appropriate, and provide a simple explanation of why this was done; i.e., to make the comparisons fair and meaningful;	▌Use summaries and visual cues to facilitate understanding. ▌For credibility and transparency, provide a "drill-down" to the technical details underlying the groupings/categories; however, recognize and address the fact that providing detail can create confusion if information is displayed in multiple ways that then result in it being displayed in more than one strata (tier, band). ▌Explain the rationale and handling of rates that are not risk adjusted. ▌Don't rely on numbers that require inferences and calculations.

[d] When all four of these strategies are used in a data display (as compared to none of them), consumers had almost a five-fold increase in comprehension.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
iv. label indicators using everyday language (not clinical or technical terms);	▮ Don't make users click through to learn the meaning of an indicator—they are more likely to ignore than to click.
v. ensure that comparisons are accurate and supportable; and	▮ Results presented as rates or percentages should be accompanied by the number of observations, and results from surveys should include the response rate. ▮ Be clear about the meaning of differences since difference in numbers does not necessarily mean a difference in performance.
vi. whenever possible, limit the use of statistics and terms that are difficult for most consumers to understand.	▮ This applies specifically to the initial view; it is not intended to limit access to appropriate detail on more granular views. ▮ Use summaries and visual cues (see Presenting the Data). ▮ Consider the use of explanatory narratives to clarify the meaning of statistics. *Consumers have a preference for narratives, which can facilitate statistical and experiential understanding.* ▮ Don't require consumer understanding of confidence intervals to interpret performance.
5c. In presenting data from composite measures:	
i. where measures are interpretable at the individual measure level, report all measures that comprise the composite without adding or deleting any individual component or make any change to the composite transparent (at a layer down from the initial data display); and	▮ Include an explanation of how the composite, as a roll-up of component measures, makes sense as a construct for quality. ▮ In web-based reports, detail about individual component measures, weights assigned to the measures, and rationale for weighting can be made available through such things as drop-down menus; thus both the composite and component parts can be viewed in visual isolation. ▮ Measures should have been tested in a composite (i.e., bundled) form.
ii. report results for the composite and for each component measure (at a layer down from the initial composite data display).	▮ This convention should be observed until such time as the evidence clarifies what information is most useful and meaningful to include. ▮ Composite measures should convey an aggregated index of a group of related measures. As one example, when reporting mortality, report companion volume information.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
5d. In providing contextual information/decision support:	
i. provide a clear contextual framework as part of the report introduction;	▌Succinctly, tell users why the information is important, where it came from, how it is relevant to them, how it is organized, and how they can use it.[e] ▌Do NOT overwhelm the reader with a lot of text.
ii. make sure that key messages are included in the data display;	▌Many viewers will only look at the data display and will not read the text.
iii. whenever data are missing, provide a specific explanation for this and make the distinction clear between data that are missing because of small numbers (too few to report) and data that are missing because of refusal to provide the data;	▌Explain in nontechnical language the impact that missing data may have on the results.
iv. make information understandable by using everyday words and language;	▌Do NOT use unfamiliar terms. ▌While a glossary of terms is unlikely to be used by consumers, when definitions are needed, incorporate them where the term or concept is mentioned. ▌TalkingQuality is a website sponsored by AHRQ that includes suggestions about communicating with consumers.
v. use consumer testing to verify that the language and displays provided in the report are easy for the intended consumer audiences to understand and use (provide translations into languages other than English, if needed); and	▌Test to determine interests, understanding of terms, interpretation of data. ▌Interview one on one for feedback about how the site works and to understand emotional engagement.
vi. use reasonably current data, and display the dates/period that are covered by the data.	▌Provide statements regarding what constitutes currency. ▌Update published reports at least annually. ▌Reported data should be no more than two years old, unless trends are important to the website's message.

[e] TalkingQuality; available at www.talkingquality.gov/.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
5e. In presenting technical documentation:	
i. include detailed measure definitions, specifications, and risk-adjustment methods;	▌ Include this information at the back end of report, and provide access from summary information. ▌ Do NOT make users read this information unless they want to do so; in electronic displays, put it at the next level down from the data display.
ii. include resource information such as identification of the measure developer, sources of data, and interpretation guides; and	▌ Identify measure steward. ▌ Include caveats about the source of the data. ▌ Provide interpretation guides about uses and limitations. ▌ Interpretation guides should address uses and limitations of the information without creating barriers to the data.
iii. provide details about methodology.	▌ Details should include implications of small numbers, including those reported as counts, and how numbers are "bucketed." ▌ Do NOT put details at the first level of data display.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
6. Ensure that report design and navigation features enhance report usability. Design features should be used to:	
6a. organize information in a way that lets users know what is available and lets them make their own choices;	▌ Provide notations to lead to additional information; e.g., "People who looked at this information frequently also reviewed X." ▌ Provide links to patient education.
6b. provide an engaging format and include intuitive and consistent navigation tools that are placed in consistent locations;	▌ Such tools include tabs, drop-down menus, and clear, informative headings.
6c. make the report easy to skim and build in layering to provide the capability to drill down to information and to navigate back out;	▌ Provide for cross-linking to related information such as other information on the general topic that may be of interest, e.g., general information about heart disease or myocardial infarction to the viewer of AMI measures. ▌ Use clickable links to control length of pages and permit access to expanded sets of information in other locations. ▌ Use a small, carefully selected combination of elements to present information, reduce clutter, and ensure succinct presentations.
6d. seek feedback and test the design and navigation with the intended audiences; and	▌ Feedback should include information about how users found the site, how they used it, as well as comprehension of content, intuitiveness, interpretation, and salience. ▌ Methods of obtaining feedback include those used in creating the report; e.g., focus groups and one-on-one interviews as well as pop-up surveys and web-based locations for posting comments.
6e. provide users a way to print the information in understandable and usable formats.	▌ PDF formats are one example, though not all can be read by screen readers. ▌ Effort to enable access to those with various physical and cognitive limitations should be made. Consult Section 508 of the Rehabilitiation Act of 1973 for guidance.

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GUIDELINES	IMPLEMENTATION CONSIDERATIONS[a]
7. Regularly review and assess reports to ensure their effectiveness, usability, and currency.	▮ Reports to consumers should be updated at least annually unless the specifications of measure(s) necessitate data reporting less frequently. A review and assessment should occur in conjunction with such updates. ▮ Analyze and endeavor to understand consumer interpretation of the data/information conveyed in reports to improve understandability and correct interpretation.
7a. Conduct assessments of the use and impact of reports.	▮ Seek feedback from both experienced and naïve users of public reports.
7b. Use a combination of methods to obtain and use feedback from the intended consumer audiences and the institutions that are the subject of the reporting.	▮ Consumer feedback can/should be collected in a number of different ways; e.g., focus groups, one-on-one interviews, surveys. ▮ Feedback should be sought from providers, including that of healthcare professionals, about whom data is reported. ▮ Consider where the audience will likely review the report; e.g., home, workplace, library, physician offices.
7c. Involve stakeholders in revisions and seek their feedback after the report undergoes significant changes.	▮ Elicit support of stakeholders that can make the report available or publicize it; e.g., states, libraries, news media, providers. ▮ Feedback should be sought from measure developers whose measures are reported to help ensure currency and accuracy of the measures and to obtain their suggestions regarding reporting. ▮ To provide context and expand consumer understanding of health issues, consider partnering with organizations with similar interests and create links to sites that offer related educational/ explanatory information.
7d. Use what is learned to help inform and drive the improvement and usefulness of performance measures and the field of consumer public reporting.	▮ Be involved in collaborations among public reporters and in policymaking about both reporting and measures to be used.

Appendix B
Technical Advisory Panel

Public Reporting

Carol Cronin (Chair)
Informed Patient Institute
Annapolis, MD

Katherine Browne, MHA
National Partnership for Women and Families
Washington, DC

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INTEGRIS Health
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Appendix C
Questions for Report Sponsors and Researchers

Structured Questions for Report Sponsors

Overall

- What was your purpose in setting up a public reporting site? To what were you responding?
- What was the process of putting the site together?
  - Did you do any testing?
  - What gap does your site fill for consumers?
- Who uses your site and why?
  - How do you make users aware of your site?
  - How successful were your strategies?
- What parts of your site are most effective? Which are least effective?
  - Why?
  - Please rank the elements based on their importance.
- Have you done any assessments of your site's impact, formal or informal?
  - What were your findings?
  - What would you do differently now that the site has been in use? Why?
  - What are the plans/next steps for your site?
- Do you believe the measures you now report are the best at publicly conveying quality and safety?
  - Why?
  - On what bases should future measures be chosen?

- Does the information on your site conflict with any existing public reporting of measures or expected public reporting of measures in terms of measures chosen, calculation of measures, or categorization of entity performance?
  - Why?
  - What effect will this have on consumers' use of publicly reported data?
  - Is there a plan for harmonization of public results in the future?

Display

- What were your goals regarding displaying information?
- Please tell us about your choices and rationale regarding the display of information on your site. We would like to hear about:
  - why you chose the display you use and whether you considered other options;
  - any testing of displays you did before settling on the one you use;
  - what works and what doesn't work in the way information is displayed on the site including graphic and visual displays;
  - whether your users can tell the relative performance of hospitals from your data display and how you discern this;
  - how you gather and use information to change/improve the site;
  - any reactions from other stakeholders to your display; and
  - any unintended consequences.
- We would like you to speak to specific things related to your data display including:
  - the type of and rationale for the contextual information or introduction used on your site;
  - the framework you use;
  - if/how benchmarks are used;
  - how the display helps consumers discriminate among hospitals' performance; e.g., evaluability;
  - if/how you ensure data timeliness overall and that reporting periods are equivalent across healthcare organizations;
  - use of risk adjustment;
  - display of confidence intervals;
  - if/how you deal with small numbers, non-responders as well as breadth of information across settings;
  - the rationale for the types of and way of displaying different types of information; e.g., clinical, safety, patient experience; and
  - your experience or suggestions regarding composites or other ways to "bucket" information.

Ensuring Credibility

- What are the standards to which your data sources are held?
- What are the key considerations regarding data sources and data verification?

Structured Questions for Researchers

Overall

- What consumer need(s) are filled by publicly reporting organizational quality data/performance?
- Appreciating that public reporting and national goals exist, what gap remains that public reporting for consumers should fill?
- What do we really know about public reporting? (Your response could touch on how information is received and processed by consumers, how to assure objectivity in reports, what designs/site characteristics most facilitate use of the information, what behaviors change as a result of receiving public reports, etc.)

Constructing an Approach

- In sites designed primarily for consumers, what would be most useful in improving patient/clinician shared decisionmaking regarding where to obtain needed healthcare services?
- In identifying an approach to a web-based public reporting model, template, or framework, what has your experience taught you are the most important or most desirable:
  - Grounding principles.
  - Elements of the contextual framework or introduction.
  - Components of quality to include (ex. patient centered).
  - Types/categories of measures to report (e.g., those consumers access most often) for inclusion in public reports.
  - Ways to insure comparability across organizations and over time.
- What are the elements (e.g., rank order, use of color codes) you have found to be most important to effective consumer reporting sites? What are least effective? Why?
  - Please rank order the elements based on their importance.
- What parameters or boundaries around amount of data to be reported should be set?
- What existing public reporting sites would you rank in the top five of such sites? (They may be national, health plan, etc.)

Ensuring Credibility

- What are the standards to which data sources should be held?
- How should a public reporting approach (framework, model, template) be tested?
- How and from whom should feedback regarding the reporting site and content be obtained?
- What are the key considerations regarding data sources and data verification?
- What do we need to know to improve public reporting, and how do we get at it? What are the unanswered questions?

Appendix D
AHRQ Model Reports Compared to National Voluntary Consensus Standards for Consumer-Focused Public Reporting

THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ) has two draft Model Reports for public reporting that were developed by a research team from Weill Cornell Medical College's Department of Public Health and the School of Public Affairs, Baruch College. These reports—the Health Topics Model Report and the Composites Model Report—were designed specifically to report comparative information on hospital performance based on the AHRQ Quality Indicators (QIs). The Model Reports were developed for use by public report sponsors as guidance for incorporating results of the AHRQ QIs into their public reports. The table below provides a high-level review and assessment of the Model Reports as compared with the guidelines provided in this report. It should be noted that the differences in focus between the guidelines and the Model Reports may explain some of the comments and the assessment that are provided in the table.

Because AHRQ is aware that the art and science of public reporting are evolving, the agency opted to have the Model Reports assessed in comparison with the consumer-focused public reporting guidance rather than have them considered for endorsement. It is AHRQ's expressed intention to use the comments from this evaluation to inform the refinement of future iterations of the Model Reports.

The review was conducted by the Public Reporting Technical Advisory Panel (TAP) using the hard copy version of the Model Reports provided in this appendix. For this assessment, the TAP had at its disposal the Model Reports along with its recollection and documentation of an interview that it had conducted with the developer; however, the TAP had no additional documentation and did not engage in further consultation with AHRQ staff. Although the TAP offered suggestions for improvement of the Model Reports, it acknowledged the strong work that they represent and noted a number of their specific strengths.

It was the opinion of the TAP that the AHRQ Model Reports provide valuable tools for public reporting that should prove useful to sponsors that desire further examples of application of the guidelines to a reporting tool.

The key to the ratings and color coding used in the assessment is provided on the first page of the table. The comments in the second column of the table relate to multiple guidelines within each group. The guidelines to which comments relate are identified by the numbers that precede the guidelines—that is, "Components 1, 1a., 1b., of this guideline are substantially met" refers to the guidelines identified by those numbers in the first column. Additionally, comments related to the guidelines are further grouped based on whether they were assessed as having met, partially met, or not met the guidelines and whether they could be assessed against the guidelines.

Appendix D—AHRQ Model Reports Compared to National Voluntary Consensus Standards for Consumer-Focused Public Reporting[a]

GUIDELINES	ASSESSMENT WITH RELATED COMMENTS
1. Identify the purpose of the web-based report, its intended main consumer audience(s), and how the report will be made known to the audience; also identify secondary audiences and how their unique needs will be addressed. 1a. Identify the nature and purpose of the report (what it will be about and what is to be accomplished by producing it). 1b. Identify the main consumer audiences for the report and describe their characteristics, their knowledge about the subject matter of the report, their information interests and needs, and how they will be expected to learn about and use the web-based report. (In planning for use, provide for layering of information that permits the user to drill down to the technical details.) 1c. Identify secondary audiences for the report, such as healthcare providers and policymakers, and describe how their report-specific interests and needs differ from those of the main consumer audiences. Determine how the report will accommodate the secondary audiences (such as allowing users to drill down to the technical details about measurement and statistical comparisons).	1. **M** – Components 1., 1a., and 1b. of this guideline are substantially met; 1c. could not be evaluated. The purpose is to display AHRQ Quality Indicators and give consumers (patients and potential patients) a way to select measures and to drill down into the information to make comparisons about hospitals. Secondary audiences and methods of dissemination could not be assessed. Since the Model Reports are intended for use by report sponsors, they would have significant responsibility for these aspects.

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a **M** (Green color) = **Meets** intent of guidelines;

PM (Yellow color) = **Partially meets** intent of guidelines;

NM (Red color) = Intent of guidelines is **Not Met.**

Blue color denotes either "Unable to evaluate for various reasons" or highlights comments. Of note, ratings are based on a relatively high-level review of the Model Reports without the benefit of additional documentation or discussions.

GUIDELINES	ASSESSMENT WITH RELATED COMMENTS
2. Develop the web-based report using a transparent process that involves consumers and other relevant stakeholders. 2a. Identify the various stakeholders for the web-based report (these include, at a minimum, the developers and sponsors of the report, the main consumer audiences and organizations that represent these audiences, and the entities that are being measured and compared), and clarify their roles and responsibilities. 2b. Establish governance and decisionmaking rules. 2c. Provide an opportunity for the entities that are being measured and compared to preview their data and comment on the data's accuracy before the report is released; errors/ misconceptions should be corrected and policies and procedures for mediation established. 2d. Involve consumers in the development and refinement of the report by seeking their input into the report design and getting their feedback on draft versions of language and data displays. Conduct usability/ease-of-use testing with consumers before the report is released, and then collect their feedback after the launch to help evaluate it.	2. **M** – Components 2., 2a., 2b., 2c., and 2d. of this guideline are substantially met. Understand that all measures were previewed (HQA preview process) before being included. Many are now NQF endorsed.® The following suggestions related to 2c. were offered: ▌ Be clear to sponsors regarding expectations about providing the opportunity for those who are being reported on to see their actual results before publishing. ▌ Involve reported entities in discussion of how to create and report "better than" and "worse than" categories.
3. At the beginning of the report, set the stage by communicating what quality is, how quality varies, and how making quality comparisons can be of value to consumers. 3a. Provide a brief introduction about healthcare quality. 3b. Explain that quality varies within and across institutions and how the report can be used to make quality comparisons. 3c. Use consistent, simple, and familiar language to discuss quality and provide examples that will resonate with the main consumer audiences.	3. **M** – Components 3a. and 3c. are substantially met. **PM** – Components 3a. and 3b. are partially met. The following suggestions related to those items were offered: ▌ While written clearly, consider reducing the introduction to fewer sentences focused on the definition of quality and how it varies and convert the second introductory page to a clickable FAQ format. ▌ Consider moving information in other sections to a brief statement up front clarifying that no single measure can tell the whole story and that all measures give only a partial picture.

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GUIDELINES	ASSESSMENT WITH RELATED COMMENTS
4. Ensure that the measures included in a consumer-focused public report are meaningful to consumers, transparent, and meet widely accepted, rigorous criteria, including important, scientifically acceptable, feasible, and usable. 4a. Because measures inherently have components that affect the way they should be reported, be clear about types of conclusions that can be reached. 4b. In choosing measures to be reported, take into account that the best measures: i. are relevant to the healthcare-related concerns of the consumer audience; ii. demonstrate variation and reflect care that those being measured can impact; and iii. provide information that reflects the overall quality of care provided by the institutions included in the report (providing additional information about limited dimensions of care for specialty institutions is acceptable).	4. **PM** – Components 4. and 4b.i–iii are partially met. The following suggestions were offered: ▌ Evaluate the array of measures included to ensure that they are meaningful to consumers. It was noted that there is good use of a wide range of measures that will be of interest to many people. Given that many of the QIs assess rare events, the composite measures are more likely to be useful to the majority of consumers. ▌ Consider alternatives to the current way in which measures with small volumes are conveyed to ensure that quality is accurately conveyed. ▌ Take advantage of web-based tools to facilitate navigation between individual measures and composites as well as to view all measures at once. ▌ Consider how hospital characteristics can be accounted for in the case mix or in discussion as a caveat. **NM** – 4a. Recommend that each reported measure have a note about what differences might be meaningful and that this performance should not be used to measure all aspects of quality.
5. Present and explain the data clearly and objectively in ways that help consumers understand and use the information. 5a. Help consumers quickly and easily arrive at correct and meaningful conclusions. i. Display data in formats that have been shown to be evaluable. This means summarizing and displaying the data for the viewer in a way that facilitates interpretation (e.g., summary scores, labels). ii. To help users make correct interpretations, report measures in a consistent way so that, within a report, either a high score or a low score consistently indicates better performance. iii. Make presentations of information more vivid and compelling by including anecdotes or stories to illustrate the meaning of the data.	5. **M** – Components 5a.i, 5b.ii, 5b.iii, 5b.vi, 5c.ii, 5d.iv, 5d.v, and 5d.vi are substantially met. Few suggestions were made regarding improving bar graph color coding and expanding comparisons such as including national benchmarks, best practices, decile level performance, etc. **PM** – Components 5a.ii, 5a.iii, 5b.i, 5b.ii, 5b.iii, 5d.i, and 5d.ii are substantially met. The following suggestions regarding information displays were offered: ▌ Using web tools, provide the option to increase sizes of fonts, graphics, etc. ▌ Consider including goal/desired measure performance to further clarify instructions and facilitate understanding of meaningful differences. ▌ Expand the use of interpretive information that explains why users should pay attention to the measures.

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GUIDELINES	ASSESSMENT WITH RELATED COMMENTS
iv. Take advantage of web-based capabilities for subordinating and sorting information in order to make it responsive to the needs of users; that is, offer options that allow users to select which parts of the information they want to see and how they want to see it (e.g., listed in order of performance or alphabetically, shown in summary format or in detailed breakdowns). 5b. In presenting comparative quality information: i. use tools and methods such as rank ordering, color coding, and/or symbols that help users discern performance variation and quickly determine their best options; ii. when possible, include benchmarks to provide users a better context for making comparisons and using the information; iii. provide risk-adjusted rates and grouping of information into categories such as "better" "average" within standardized categories (such as by disease or by institution), when appropriate, and provide a simple explanation of why this was done; i.e., to make the comparisons fair and meaningful; iv. label indicators using everyday language (not clinical or technical terms); v. ensure that comparisons are accurate and supportable; and vi. whenever possible, limit the use of statistics and terms that are difficult for most consumers to understand. 5c. In presenting data from composite measures: i. where measures are interpretable at the individual measure level, report all measures that comprise the composite without adding or deleting any individual component or make any change to the composite transparent (at a layer down from the initial data display); and ii. report results for the composite and for each component measure (at a layer down from the initial composite data display).	The following suggestions regarding comparative information were offered: ▌ Strengthen the evaluability of information displays by using the four strategies outlined in 5b.i Implementation Considerations. (See Appendix A.) ▌ Consider the use of web tools to enable a single view of provider performance across all measures and hospital characteristic adjustments to help understand their effect on the measures. ▌ Review reports for consistency regarding such things as the language used to convey technical terms, denominators, etc. The following suggestions regarding the provision of context were offered: ▌ Provide access to optional, additional information about the importance of information (e.g., why a specific measure is an important quality indicator). ▌ Consider reordering composite graph information to improve consumer understanding of information. **NM** – 5a.iv, 5c. The TAP recognized the limitations associated with the paper-based tools they were assessing and the fact that the work to date has focused on content; however, the TAP determined that Component 5.a.iv was not met. Suggestions offered were to now begin to focus on taking advantage of web-based tools to enable alternate displays of the information to meet varying needs/desires of the consumer audience. Component 5c. did not meet expectations regarding presenting data from composites. To address this, it was suggested that information be provided regarding why specific measures were chosen; how/if they are weighted. Components 5d.iii and 5e.i-iii could not be evaluated for various reasons, most of which related to inability to access items that will ultimately be linked.

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GUIDELINES	ASSESSMENT WITH RELATED COMMENTS
5d. In providing contextual information/decision support: i. provide a clear contextual framework as part of the report introduction; ii. make sure that key messages are included in the data display; iii. whenever data are missing, provide a specific explanation for this and make the distinction clear between data that are missing because of small numbers (too few to report) and data that are missing because of refusal to provide the data; iv. make information understandable by using everyday words and language; v. use consumer testing to verify that the language and displays provided in the report are easy for the intended consumer audiences to understand and use (provide translations into languages other than English, if needed); and vi. use reasonably current data, and the display dates/period that are covered by the data. 5e. In presenting technical documentation: i. include detailed measure definitions, specifications, and risk-adjustment methods; ii. include resource information such as identification of the measure developer, sources of data, and interpretation guides; and iii. provide details about methodology.	

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GUIDELINES	ASSESSMENT WITH RELATED COMMENTS
6. Ensure that report design and navigation features enhance report usability. Design features should be used to: 6a. organize information in a way that lets users know what is available and lets them make their own choices; 6b. provide an engaging format and include intuitive and consistent navigation tools that are placed in consistent locations; 6c. make the report easy to skim and build in layering to provide the capability to drill down to information and to navigate back out; 6d. seek feedback and test the design and navigation with the intended audiences; and 6e. provide users a way to print the information in understandable and usable formats.	6. Component 6d. is substantially met. Components 6a.-6c. are partially met. Suggestions for improving design features included: ▌ Increase navigation options, including the use of menus to facilitate movement within the report and the creation of new comparisons. ▌ Consider ways to make the format more engaging. ▌ Use web-based tools to increase ability to "skim" the report, drill down to and link to related information, and display provider performance across all measures in one view. Components 6 and 6e. As a stand-alone item, design and navigation features could not be fully evaluated, and print capability could not be assessed. The use of web-based navigation tools will ultimately facilitate both of these items.
7. Regularly review and assess reports to ensure their effectiveness, usability, and currency. 7a. Conduct assessments of the use and impact of reports. 7b. Use a combination of methods to obtain and use feedback from the intended consumer audiences and the institutions that are the subject of the reporting. 7c. Involve stakeholders in revisions and seek their feedback after the report undergoes significant changes. 7d. Use what is learned to help inform and drive the improvement and usefulness of performance measures and the field of consumer public reporting.	7. Components of this guideline could not be evaluated, since it is a new tool not yet put into use.

The AHRQ Model Reports follow. They are presented in three parts.

- Part I provides overall guidance to potential public report sponsors for using the Model Reports.
- Part II is the Hospital Model Report for Health Topics.
- Part III is the Hospital Model Report for Composites.

I. Guidance to Potential Sponsors in Using the AHRQ Hospital Quality Model Report

A research team from Weill Cornell Medical College's Department of Public Health and the School of Public Affairs, Baruch College, has developed the attached Hospital Quality Model Report for the Agency for Healthcare Research & Quality (AHRQ). The work was done in close collaboration with AHRQ staff and the AHRQ QI team. This memorandum briefly describes the research and development undertaken to develop this Model Report. It then provides guidance to sponsors who wish to utilize the Model Report in crafting public reports to their target audiences.

What informed this Model Report?

This Model Report is based on:

- Extensive search and analysis of the literature on hospital quality measurement and reporting, as well as public reporting on health care quality more broadly;
- Interviews with experts, purchasers, staff of purchasing coalitions, and executives of integrated health care delivery systems who were responsible for quality in their facilities;
- Two focus groups with chief medical officers of hospitals and/or systems and two focus groups with quality managers from a broad mix of hospitals;
- Four focus groups with members of the public who had recently experienced a hospital admission; and
- Two rounds of cognitive interviews (a total of 19 interviews) to test draft versions of the Model Report with members of the public with recent hospital experience, who had basic computer literacy but widely varying levels of education.

Key features of the Model Report

Form of dissemination:
The Model Report assumes that sponsors will use a website to disseminate hospital quality data. We assume the report will be a part of an existing sponsor website and that various aspects of the "look and feel" of the Model Report will reflect that existing website.

We have written language for the Home Page of the sponsor to introduce the Report on that Home Page and link users to the actual Report. This initial language is key, since it serves to legitimize the information in the report to public audiences that research consistently shows is appropriately skeptical about health related information. In our own research, for example, people stressed that they would not trust data that was collected and disseminated by individual hospitals. The sponsorship of a report is a major determinant of whether or not it will be trusted. So is willingness to provide details about how data are collected and analyzed, even though realistically very few members of the public (as compared to hospital staff and physicians) will ever look at those details.

Though this is a web-based model, a very large proportion of the material in the Model Report could be adapted to a print report, although this would limit the extent to which readers could select the particular kinds of data they see. The report is in English, and has been written so it can be read by most people. However, very low literacy individuals will likely not be able to read the report (although they may well be able to understand the graphics).

Indicators included:
The Model Report includes all indicators that are part of the current set of Inpatient Quality Indicators (IQIs) and the Patient Safety Indicators (PSIs).[1] It does not include Prevention Quality Indicators, since these are not viewed as reflecting hospital quality. This does not mean that some sponsors will not want to report them, simply that to focus the work in terms of hospital quality, it made sense to focus on the IQIs and PSIs.

Four of the indicators are included, but not labeled as "quality indicators." These are the four utilization rates for Caesarean sections and VBACs. After extensive discussion with AHRQ staff and the AHRQ QI team, we decided that since current evidence is not at all clear about what the "right" utilization rate is for these procedures, we cannot say whether a given rate is too high, too low, or just about right. We don't even know the general directionality people should look for. Therefore, there is a separate section of the report, in the childbirth topic, which includes these utilization rates, explaining that they are not quality indicators but rather information that may be of interest to some. Of course, since we do not know what would be "better" or "worse" than average, there is no comparison chart for these rates, only individual graphs.

More generally, the inclusion of all indicators in the Model Report does not imply that we expect or recommend that all sponsors include all indicators in their public reports. Indeed, we assume that sponsors will use their own judgment in selecting those indicators that they feel are most important to share with the public in their area. In some cases, when slightly different indicators (i.e., indicators with slightly different denominators) are available, the sponsor would be well advised to choose only one, since providing multiple highly similar indicators will likely confuse the public.

In addition, the report could be developed either to cover all of the hospitals in a single state, in part of a state, or across multiple states. It is again the sponsor who must select the hospitals to include, and who will have to write language to describe which facilities are included and which are not.

Front material:
The report begins with a few pages of front material to "frame" the data by introducing key concepts such as why you need to look at hospital quality data, what is meant by quality indicators, what are the elements of health care quality, how to use the report and things to keep in mind while using the report. There is always a tension between the desire to provide enough background to orient people to quality information and the desire to let people "get to the data" as soon as possible, which users find highly desirable. This is partially managed by letting people skip certain sections and go right to the section of the report that presents the data.

[1] Note that pursuant to the development of Pediatric Quality Indicators, indicators from the original IQIs and PSIs that are specific to children are not included in this version of the Model Report.

Organization by topic:
Given the large number of indicators to report, and the fact that the public does not resonate to terms such as Inpatient Quality Indicators and Patient Safety Indicators, we organized the indicators into nine topic areas. Sponsors can select the topic areas they want to include. They can also choose not to include all the indicators we have placed within a specific topic. However, our own and others' research makes it clear that people often think about going to a hospital, and thus want to look at hospital quality information, with respect to a particular disease condition and/or procedure that is immediately relevant to them or a loved one.

The report therefore permits users to choose the topics at which they will look. They can look at only one topic at a time. They will be able to choose as many hospitals included in the report as they would like with respect to scores on a given topic.

Comparison chart across indicators:
Each topic begins with a comparison chart that includes all the indicators in a topic. We are assuming that sponsors have the ability to let users choose only certain indicators for inclusion in the comparison chart. Our test subjects strongly preferred a website with this function, so if sponsors have the technical capability, we strongly recommend they do this, rather than force users to look at all the indicators under a topic even if they are only interested in a small sub-set.

The comparison chart is based on one extensively tested in recent laboratory studies conducted as part of the CAHPS II project by the American Institutes for Research and their collaborator, Dr. Judith Hibbard. Their research demonstrated that this kind of presentation of comparative data is far superior to other approaches (such as star charts) that are commonly used to compare entities to each other or to an average. Specifically, people are much more likely to be able to identify high and low performers accurately and much more likely to use the information in making a decision (in the case of the lab studies, a hypothetical decision).

Individual indicator graphs:
The comparison chart is constructed so that people can select indicators to examine in detail. Making this selection takes the user to a horizontal bar graph which shows absolute scores for each of the hospitals selected, on a given indicator. The state average (or the regional or multi-state average if that is the breadth of hospitals included) is included as an anchor. This graphic design is fairly standard, but has some features that are special.

First, the graph is structured so that hospitals are ordered by performance rather than some other characteristics. This approach is, again, strongly evidence based. Such reports are considered more "evaluable" and appear to have a positive effect not only on public comprehension but on the level and intensity of quality improvement activities undertaken by facilities.

Second, in some cases, graphs covering volume and mortality for the same procedure are paired. This is not always the case; we followed the AHRQ guidance in selecting when pairing would be done. However, it is important to note that once people had seen a pair of volume and mortality graphs together they wanted to see them together all the time. So sponsors need to use their judgment about these pairings.

Third, we designed the bar graph to maximize comprehension of the bar showing the state (or other) average. In doing so, we built on parallel research for CMS on their Hospital Compare website, in which we learned that many people are confused by the state and national average bars in their graphs. Our "fix" was (1) to avoid using a different color for this bar, and instead use the same color in a pattern and (2) to provide specific language about why the state average is there and how to use it.

Fourth, we structured the graphs to ensure that the numbers were always at least a whole integer (i.e., at least 1). Members of the public have great difficulty dealing with numbers like .35, and even more .035. This requires changing the denominator for the rate, so that in many cases it goes from 100 to 1000, or even 1,000,000.

"Back" material:
There is a special section of the report (*after* the data) that presents Technical Details. This report links to existing pages of the AHRQ QI website. It is designed primarily for health professionals rather than for the public, although our testing indicates that, with the exception of "all the acronyms," members of the public were able to deal with it. Previous research makes clear that even if people do not look at this kind of material, they want to know that it is there, because it indicates that the sponsor is willing to be "transparent" about their methods.

There is also a section of the report for Other Resources on Quality; we suggest some general resources, but sponsors can certainly add more. We recommend that sponsors add links to educational resources that are specific to a particular health condition on pages where that condition is addressed. Many people in our tests became very interested in learning more about particular procedures or conditions, and it never hurts to take advantage of the "teachable moment."

What Sponsors Have to Do
In addition to selecting the indicators and the hospitals, sponsors will have to make additional decisions and do additional development work to have an operational website. Specifically, they will need to:

- Build the actual website or incorporate the report into an existing website.
- Program the site to enable both internal and external linkages.
- Create and test a "hospital search" function that permits users to choose one or more hospitals whose scores they want to see, to limit their exposure to information which is, to them, extraneous.
- Create a set of "tabs" for the website to facilitate navigation. Ideally these tabs would be on the left hand side of the "page" but you might also want to look at the tabs used in Hospital Compare at the top of the page. We recommend in particular the following:
    - A tab on the Sponsor Home Page leading to the Report Home Page
    - The following tabs on the Report Home Page, and ideally visible wherever anyone is within the report website:
        - What is Hospital Quality?
        - Hospital Search

    - Health Topics
    - Things to Keep in Mind
    - Other Resources
    - Technical Details

- Make and implement decisions about the methods to be used in calculating the scores of individual hospitals, including whether "smoothing" or other statistical techniques will be used.
- Make decisions about methods and conventions to use in identifying statistically significant differences between scores.
- Develop language to be added to the website that describes these methodological decisions (the Model Report includes a place in the Technical Details page for such language to be inserted).
- Make and implement decisions about where volume and mortality indicator graphs will or will not be "paired."
- Make and implement decisions about information to be incorporated into the website (primarily through web links) on the "Other Resources on Quality" page.

We have done a lot of preliminary work to develop and test the Model Report. However, a sponsor may wish to conduct formal "usability" testing on their own adaptation of the Model Report, to make sure, in particular, that it is easy to navigate even for people who are not qualified for employment at Google.

Please consider the Model Report as a tool and a resource. We expect and hope that sponsors will adapt it and improve upon it. We would welcome your feedback on your experiences working with it.

II. HOSPITAL QUALITY MODEL REPORT: HEALTH TOPICS

SPONSOR HOME PAGE

This page would be the normal home page of whatever group is releasing the report in a particular state or community. The group might be, for example, the State Health Department. The page would have a direct link to the ***Report Home Page****. We are thinking about using the following language to introduce the Report. Note that throughout this document we will refer to the entire template as "the Report" but it is presumed that the name of the report will be chosen by the sponsor.*

Announcing!

(sponsor name) is proud to introduce a new tool to help the people and hospitals of (insert location) learn about and improve the quality of health care in our (community/state). The Report provides information that lets you compare how well our hospitals perform when they take care of patients with a wide range of health problems.

Whether you are choosing a hospital for yourself or a loved one, or just want to see where a particular hospital performs well and how it might improve its care, take advantage of this new resource. **Go to Report Home Page** *Note: this can be a "tab" on the website in addition to having a link here*

National experts in medicine and hospital quality, led by the federal government's lead agency for health care quality, provided the building blocks for this tool. They identified the most readily available information that can give an accurate picture of the quality and safety of care at different hospitals. **Click here to get Technical Details about the Quality Information in the Report** *Note: this can be a "tab" on the website in addition to having a link here*

They also asked people like you if this was information they would like to have, and their answer was "yes!"

We hope you find this tool valuable. If you have questions, or want to share your feedback on the tool, please email us at **(insert email address or provide link to feedback form).**

Report on Hospital Quality in [*community/state*]

Quality in health care, including in hospitals, can be described as "doing the right thing, at the right time, in the right way -- and having the best possible results."

This report provides information on how well all the hospitals in (insert location) care for patients with a wide range of health problems. It can:

- help you choose a hospital for yourself,
- provide useful information for your loved ones if they need hospital care,
- encourage hospitals to improve their quality, and
- help everyone learn more about hospital quality.

Why should you look at this information?

Don't people get good care in any hospital their doctor recommends? Here are the facts:

- All hospitals do not provide the same quality of care. Some hospitals are better than others.
- A particular hospital might do a very good job on some health problems and not such a good job on other health problems.
- Whenever anyone goes to the hospital, they risk getting a new health problem while getting medical care for an existing problem. Hospitals vary in how well they protect patients from these risks.
- Your doctor, or the specialist or surgeon he or she recommends, may be highly skilled, but hospital quality also depends on how well **all** the hospital staff, such as the nurses, take care of you, and on how well the hospital is organized.

Given those facts, our goal is to give you information you can use to increase your chances of getting the best possible hospital care when you need it.

What Information is available in the Report?

There are three types of information in this Report:

- how often patients had various medical complications while in the hospital
- how often patients died while in the hospital for certain health conditions and operations
- the number of times certain operations were done the way experts think they should be done.

This information is provided about [insert #] hospitals to help you compare them to each other.

There are many ways to judge hospital quality. We are reporting this information because experience shows it is accurate, easily available for most hospitals from their administrative records, and of interest to members of the public

Click here to start comparing hospitals' results

Getting Started…

The information in this Report is organized into [insert number] topics that relate to different types of health problems. We have information on how well [insert number] hospitals performed on these indicators. **Let's get started!**

Step One: Choose one or more hospitals to compare

Sponsors: This is where you set up a search function through which users will be able to enter information, such as a zip code or city/state, and then view a list of the hospitals in your area which are included in the report.

Go to Health Topics Selection Page

HEALTH TOPICS SELECTION PAGE

Step Two: Pick the health care quality topic you want to learn about.

Quality information is available for ten topics. Some of the topics will be interesting to many people; others will be interesting only to some. For example, if you or a loved has a heart problem, you will probably be interested in the "Heart Conditions" topic. On the other hand, anyone facing a hospital stay should be interested in the topic "Medical complications of all patients" since it discusses problems that can occur for any hospital patient. With the exception of "Medical care for children" and some information in "Childbirth," all information refers to adult patients.

Within each topic we have information on several different *quality indicators*. A quality indicator is a piece of information, usually a number, that shows how often patients had a particular experience when they received medical care. These experiences reflect a particular aspect of hospital quality. Each health topic is briefly described below, with examples of quality indicators for that topic. To learn about all the indicators we present for each topic, click on the link at the end of the topic description. You can return to this page and pick another topic whenever you like.

- ***Heart conditions:*** This section includes items such as how many patients died while hospitalized for heart attacks, and how often a hospital performs certain heart-related surgeries or procedures. **Click here to see Quality Indicators for Heart Conditions**

- ***Operations for cancer of the esophagus and pancreas:*** This section includes items related to cancer of the esophagus (the tube leading from the throat to the stomach) and the pancreas (a digestive organ). **Click here to see Quality Indicators for Cancer of the Esophagus and Pancreas**

- ***Brain and nervous system:*** This section includes indicators of how many patients died while hospitalized for a stroke, and how often hospitals did an operation to remove blockage in the arteries leading to the brain. **Click here to see Quality Indicators for the Brain and Nervous System**

- ***Childbirth:*** This section includes items such as how often a birth-related injury occurs to either the mother or the infant. **Click here to see Quality Indicators for Childbirth**

- ***Hip replacement and hip fracture:*** This section includes how many patients died in the hospital following hip replacement surgery or a hip fracture. **Click here to see Quality Indicators for Hip Replacement and Hip Fracture**

- ***Other surgeries:*** This section includes how many patients died when getting a repair of an abnormally enlarged artery supplying blood to lower half of the body, and how often the hospital performs this and selected other surgeries. **Click here to see Quality Indicators for Other Surgeries**

- ***Other health conditions:*** This section includes items such as how many patients died while hospitalized for pneumonia, and how often patients died after they came in with heavy bleeding in their stomach or intestines. **Click here to see Quality Indicators for Other Health Conditions**

- ***Medical complications of patients having an operation:*** This section discusses problems or complications patients can face after surgery. Examples are complications from anesthesia, and how often patients were infected following surgery. **Click here to see Quality Indicators for Safety of Patients having Surgery**

- ***Medical complications of all patients:*** This section includes items related to problems or complications that can be experienced by any hospital patient. Examples are how often patients get bed sores and how often patients die after developing a complication that should have been identified and treated. **Click here to see Quality Indicators for Safety of All Patients**

- ***Medical care for children:*** This section includes items such as how often children under the age of 18 have problems breathing after surgery, have a bad reaction to transfused blood or die after heart surgery. **Click here to see Quality Indicators for Children's Medical Care.**

Quality of care for heart conditions

Information is available in the Report about five indicators of quality of care for heart conditions. Definitions of each of the indicators are provided below.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/left)

Select All Indicators

- □ **Death rate for heart attack patients**
  Deaths in the hospital of patients who came in because they had a heart attack (which is called an *acute myocardial infarction*).
- □ **Death rate for patients with congestive heart failure**
  Deaths in the hospital of patients who came in because they had heart failure (which is called *congestive heart failure*).
- □ **Death rate for patient having a coronary artery bypass graft (CABG)**
  Deaths in the hospital following an operation (called a *coronary artery bypass graft*, or *CABG*), which is designed to provide a way around clogged arteries in the heart.
- □ **Death rate for patient having a percutaneous transluminal coronary angioplasty (PTCA)**
  Deaths in the hospital following a procedure (called a *percutaneous transluminal coronary angioplasty*, or *PTCA*) in which clogged arteries of the heart are opened up, and then kept open using wire mesh tubes or "stents."
- □ **Rate of cardiac catheterization procedures on both sides of the heart**
  Many patients undergo a "cardiac catheterization" to learn how well the heart is working. Usually, this is done by putting tubes in the arteries on one side of the heart. This indicator shows how many patients getting this procedure have tubes put into the arteries on both sides of the heart (called a *bi-lateral cardiac catheterization*), which experts believe puts them at greater risk for complications.

Additional information: Number of operations

Information is also available about the number of times coronary artery bypass grafts (CABG) and percutaneous transluminal coronary angioplasties (PTCA) were done at individual hospitals. Research shows that, in general, when hospitals do these operations frequently, they are more likely to have good results. However, experts do not always agree on the minimum number needed to achieve high quality. You will find graphs for these indicators on the same page as he death rate.

Compare Hospital Scores

Compare hospital scores on heart conditions

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names to see detailed results on how each hospital performed.

Death rate is the percent of patients who were treated for a particular illness or had a particular procedure who died while in each hospital during [insert year]. **Rate** is the percent of patients having a particular procedure who had it done in one way rather than another.	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

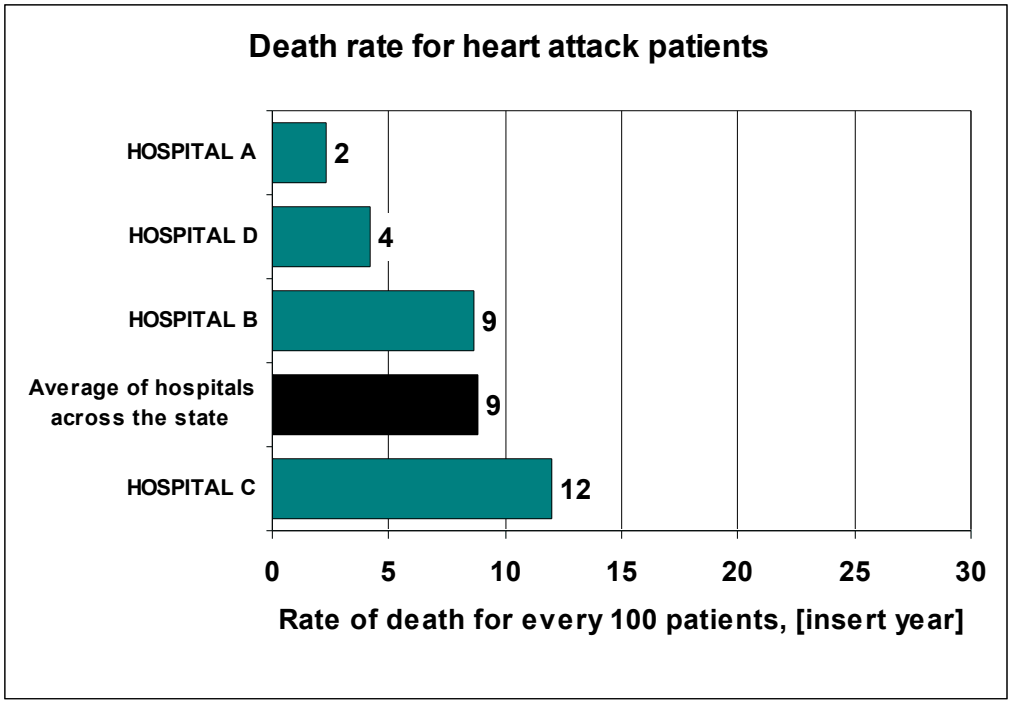
Heart Conditions	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for heart attack patients The average rate of death for hospitals across the state is **9** for every **100** patients.	**Better Than average**	Average	**Worse than average**	**Better than average**
Death rate for patients with congestive heart failure The average rate of death for hospitals across the state is **4** for every **100** patients.	**Better Than average**	**Worse Than average**	Average	**Better than average**
Death rate for patients having CABG (coronary artery bypass graft) The average rate of death for hospitals across the state is **3** for every **100** patients.	Average	**Worse Than average**	Average	**Better than average**
Death rate for patients having PTCA (percutaneous transluminal coronary angioplasty) The average rate of death for hospitals across the state is **10** for every **1,000** patients.	**Better Than average**	**Worse Than average**	**Better Than average**	Average
Rate of patients having cardiac catheterization procedures on both sides of the heart The average rate of death for hospitals	**Better Than average**	**Better Than average**	**Worse Than average**	Average

across the state is <u>7</u> for every **100** patients.				

Death rate for heart attack patients

This graph shows you the percent of patients admitted to each hospital after having a heart attack (called an *acute myocardial infarction*), who died during their hospital stay. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a lower number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



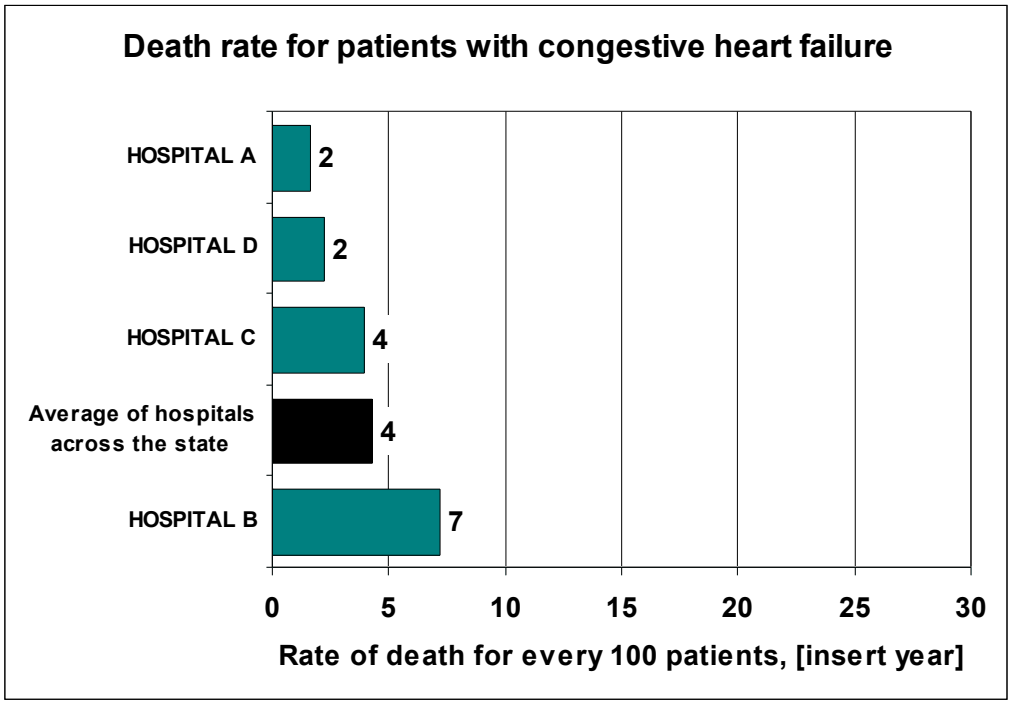
Average of hospitals across the state: The average rate of patients who died after having a heart attack, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate of patients with congestive heart failure

This graph shows you the percent of patients who were admitted to a hospital because they had heart failure (called *congestive heart failure*), who died during their hospital stay. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a lower number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who died after being admitted because they had congestive heart failure in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

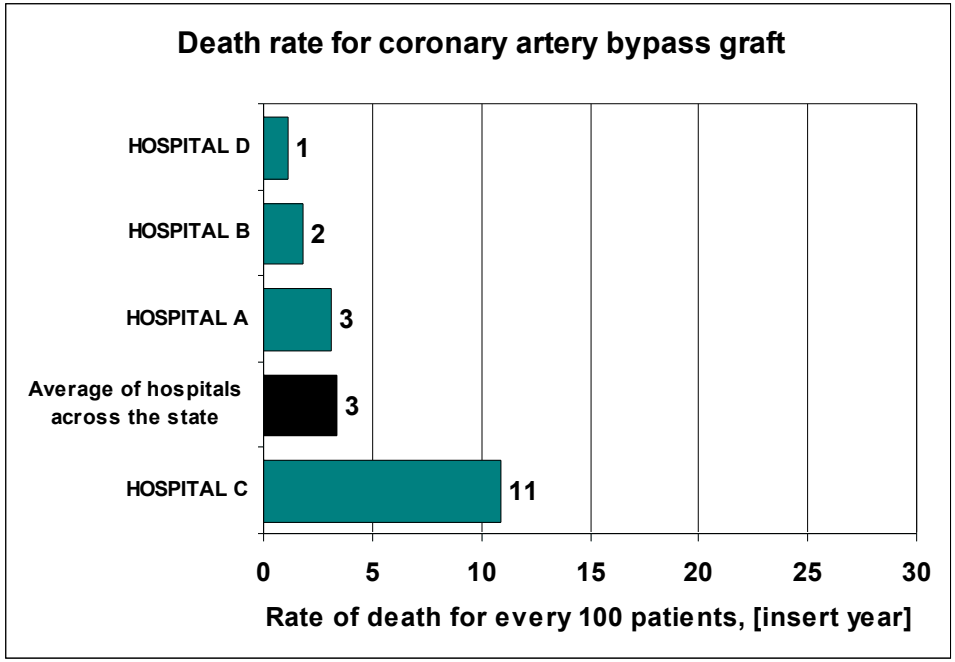
Coronary artery bypass graft (CABG) – death rate and number of operations

The two graphs on this page show you the quality of hospital care related to coronary artery bypass grafts (CABG), a procedure designed to restore the natural flow of blood in the heart. This information is for patients admitted during [insert year].

The graph on the left side of the page shows you how often patients died after they had a CABG. The graph on the right shows you the number of times a hospital performed a CABG. Research shows that, in general, when hospitals do these procedures frequently, they are more likely to have good results. Often, but not always, a hospital that has a higher number of operations (right graph) will have lower death rates (left graph).

Death rate for coronary artery bypass graft

When choosing a hospital, look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.

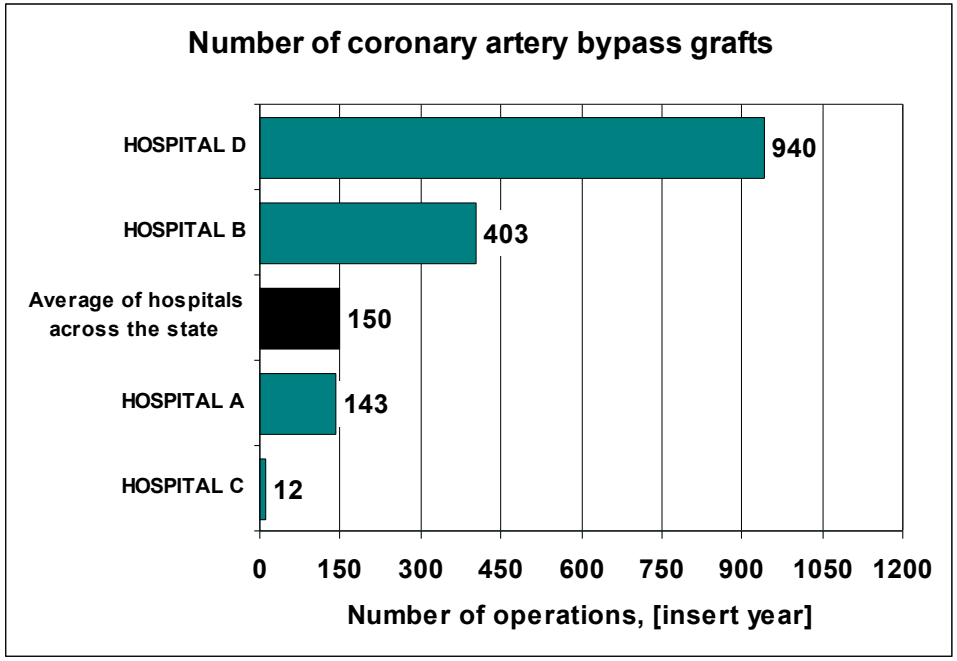


Average of hospitals across the state: The average rate of patients who died after this operation in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Number of coronary artery bypass grafts

When choosing a hospital, look for the hospital that has a **higher** number of operations. A **higher** number is shown by a **longer** bar on the graph below.



Average of hospitals across the state: The average number of operations done by hospitals across your state. This number is included so you have a better idea of what is typical for your state.

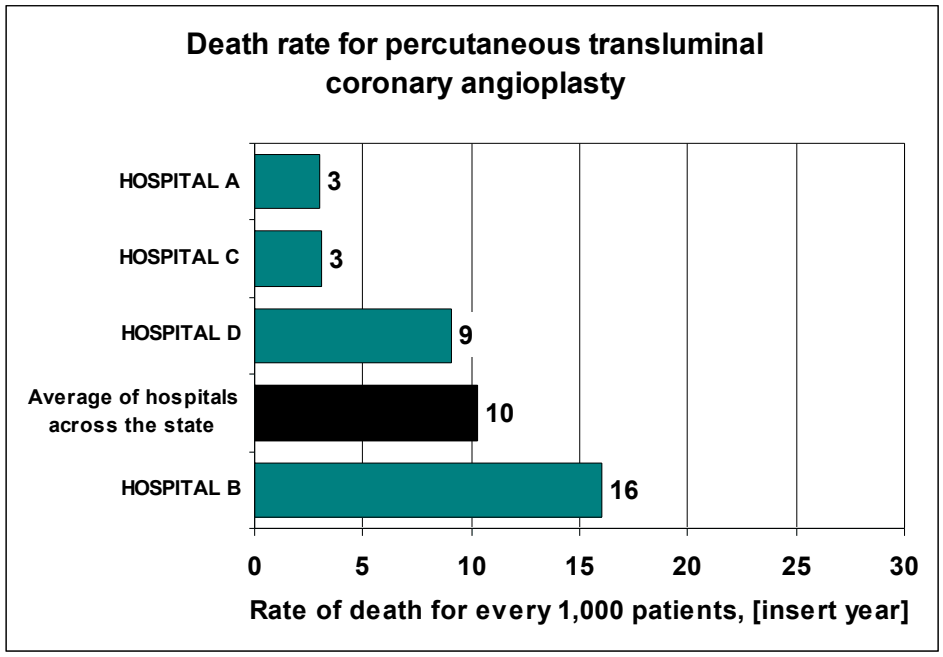
Percutaneous transluminal coronary angioplasty (PTCA) – death rate and number of procedures

The two graphs on this page show you the quality of hospital care related to percutaneous transluminal coronary angioplasty (PTCA), a procedure in which clogged arteries of the heart are opened up, and then kept open using wire mesh tubes or "stents." This information is for patients admitted during [insert year].

The graph on the left side of the page shows you how often patients died after having a PTCA. The graph on the right shows you the number of times a hospital performed this procedure. Research shows that, in general, when hospitals do these procedures frequently, they are more likely to have good results. Often, but not always, a hospital that has a higher number of procedures (right graph) will have lower death rates (left graph).

Death rate for percutaneous transluminal coronary angioplasty

When choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.

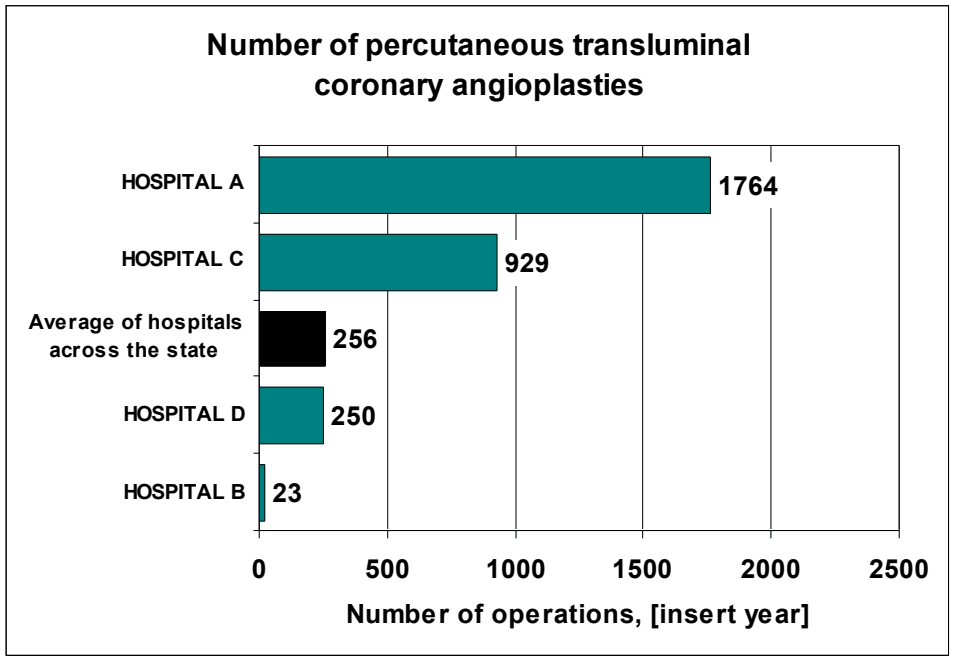


Average of hospitals across the state: The average rate of patients who died after this procedure in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Number of percutaneous transluminal coronary angioplasties

When choosing a hospital, you should look for the hospital that has a **higher** number of operations. A **higher** number is shown by a **longer** bar on the graph below.

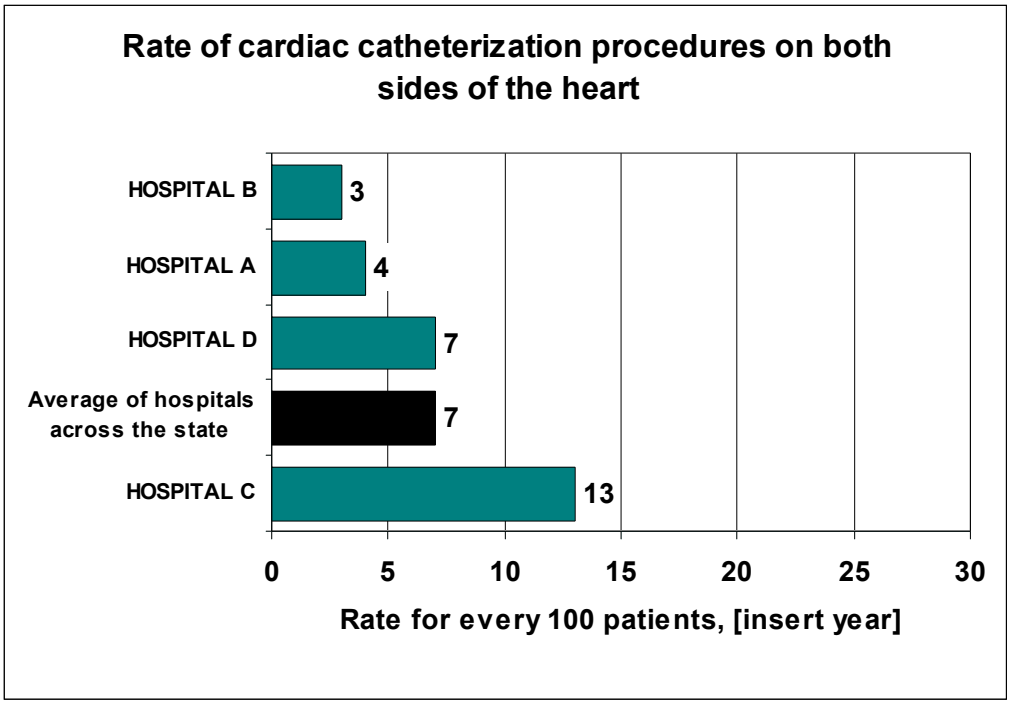


Average of hospitals across the state: The average number of procedures done by hospitals across your state. This number is included so you have a better idea of what is typical for your state.

Rate of cardiac catheterization procedures on both sides of the heart

This graph shows you how often each hospital performs a "cardiac catheterization" to measure how well the heart is working, by putting tubes in the arteries on both sides of the heart rather than on just one side. (This is called a *bi-lateral cardiac catheterization*.) Most experts believe that it is better to put tubes only on one side of the heart (a *uni-lateral catheterization*), so they would look for low scores on this indicator. This information is for patients admitted during [insert year].

When you are choosing a hospital, look for the hospital that has a lower rate of bilateral cardiac catheterization. A **lower** rate is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who had cardiac catheterization procedures on both sides of the heart, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Quality of care for operations for cancer of the esophagus & pancreas

Information is available in the Report about two quality indicators for cancers of the esophagus and the pancreas. Definitions of each of the indicators are provided below.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left)

Select All Indicators

□ **Death rate for operations to remove part or all of the esophagus**
How often patients died in the hospital after an operation to remove part or all of their esophagus (the tube leading from the throat to the stomach). (This is called *esophageal resection*.)

□ **Death rate for operations to remove part or all of the pancreas**
How often patients died in the hospital after an operation to remove part or all of their pancreas (a digestive organ). (This is called *pancreatic resection*.)

Additional information: Number of operations

Information is also available about the number of times these operations were done at individual hospitals. Research shows that, in general, when hospitals do these operations frequently, they are more likely to have good results. However, experts do not always agree on the minimum number needed to achieve high quality.

You will find graphs for these indicators on the same page as the death rate.

Compare Hospital Scores

Compare hospital scores on operations for cancer of the esophagus & pancreas

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names for detailed results on how each hospital performed.

Death rate is the percent of patients who had a particular procedure who died while in each hospital during [insert year].	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

Operations for cancer of the esophagus & pancreas	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for operations to remove part or all of the esophagus The average rate of death for hospitals across the state is **9** for every **1,000** patients.	**Better than average**	**Worse than average**	**Better than average**	Average
Death rate for operations to remove part or all of the pancreas The average rate of death for hospitals across the state is **7** for every **100** patients.	average	**Worse than average**	**Better than average**	Average

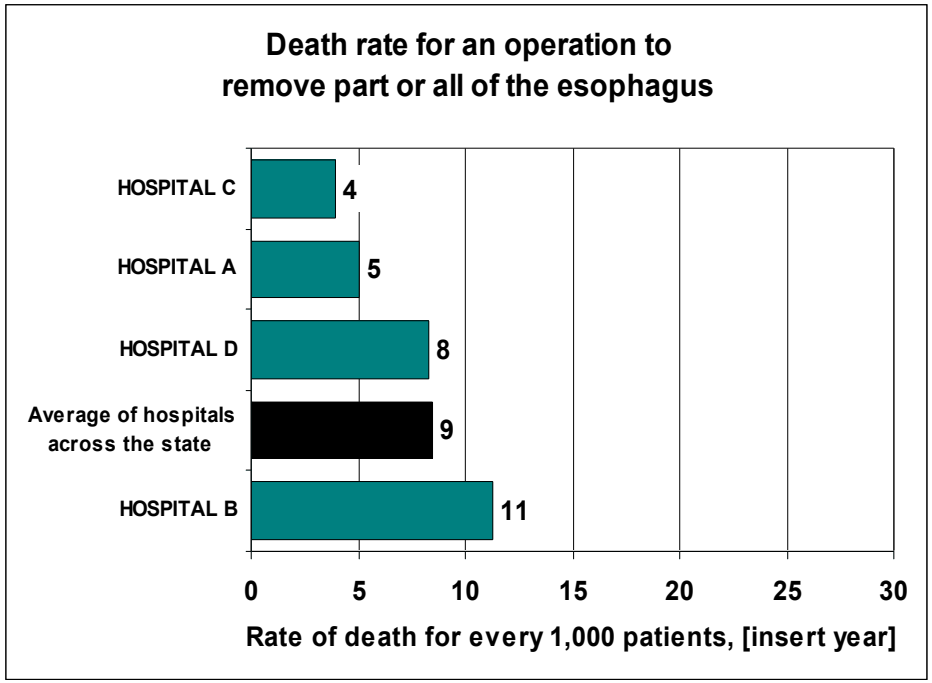
Removal of part or all of the esophagus – death rate and number of operations

The two graphs on this page show you the quality of hospital care for operations to remove part of the esophagus (the tube leading from the throat to the stomach), usually because of cancer. This information is for patients admitted during [insert year].

The graph on the left side of the page shows how often patients died following this operation. The graph on the right side of the page shows the number of times a hospital performed this operation. This is a rare procedure. Research shows that, in general, when hospitals do these procedures frequently, they are more likely to have good results. Often, but not always, a hospital that has a higher number of operations (right graph) will have lower death rates (left graph).

Death rate for operations to remove part or all of the esophagus

When choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



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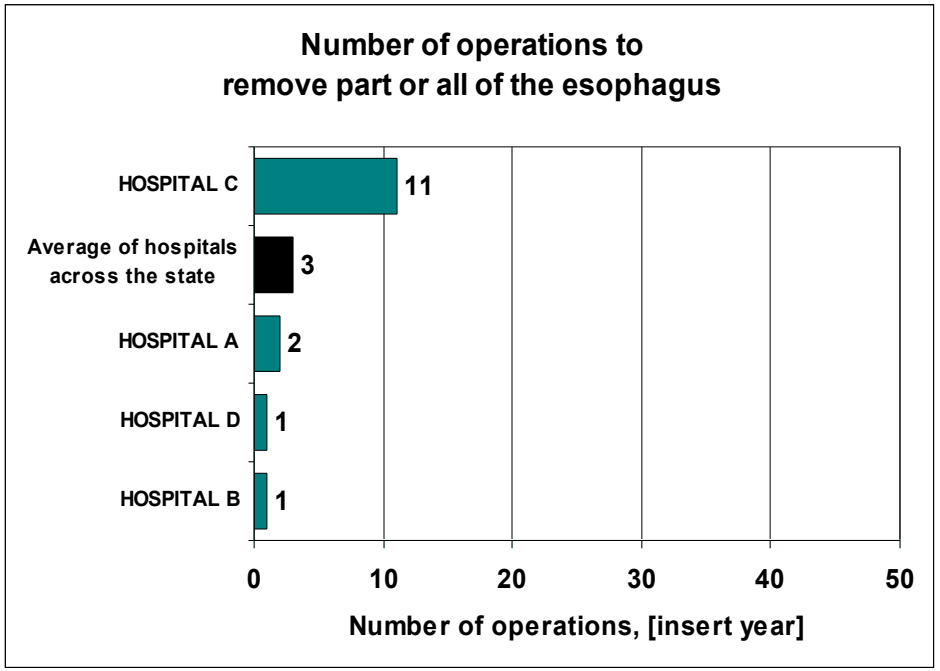
Average of hospitals across the state: The average rate of patients who died following this operation in hospitals across your state. This number is included so you have:

Number of operations to remove part or all of the esophagus

When choosing a hospital, you should look for the hospital that has a **higher** number of operations. A **higher** number is shown by a **longer** bar on the graph below.



Average of hospitals across the state: The average number of operations done by hospitals across your state. This number is included so you have a better idea of what is typical for your state.

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

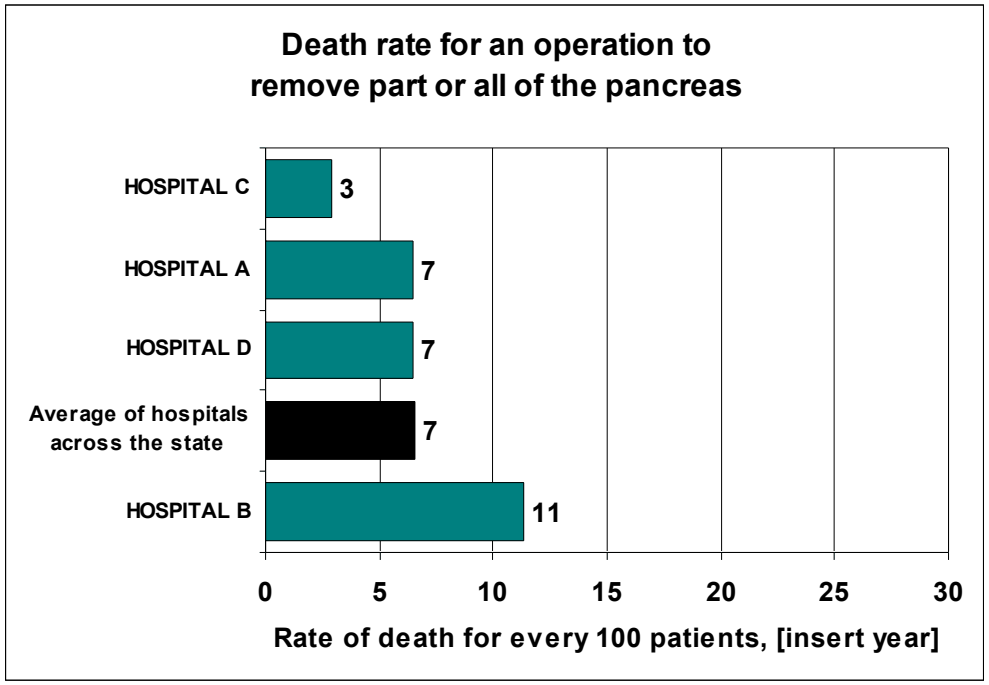
Removal of part of the pancreas – death rate and number of operations

The two graphs on this page show you the quality of hospital care for operations to remove part of the pancreas (a digestive organ), usually because of cancer. This information is for patients admitted during [insert year].

The graph on the left side of the page shows you how often patients died following this surgery. The graph on the right side of the page shows you the number of times a hospital performed this operation. This is a rare procedure. Research shows that, in general, when hospitals do these procedures frequently, they are more likely to have good results. Often, but not always, a hospital that has a higher number of operations (right graph) will have lower death rates (left graph).

Death rate for operations to remove part or all of the pancreas

When choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.

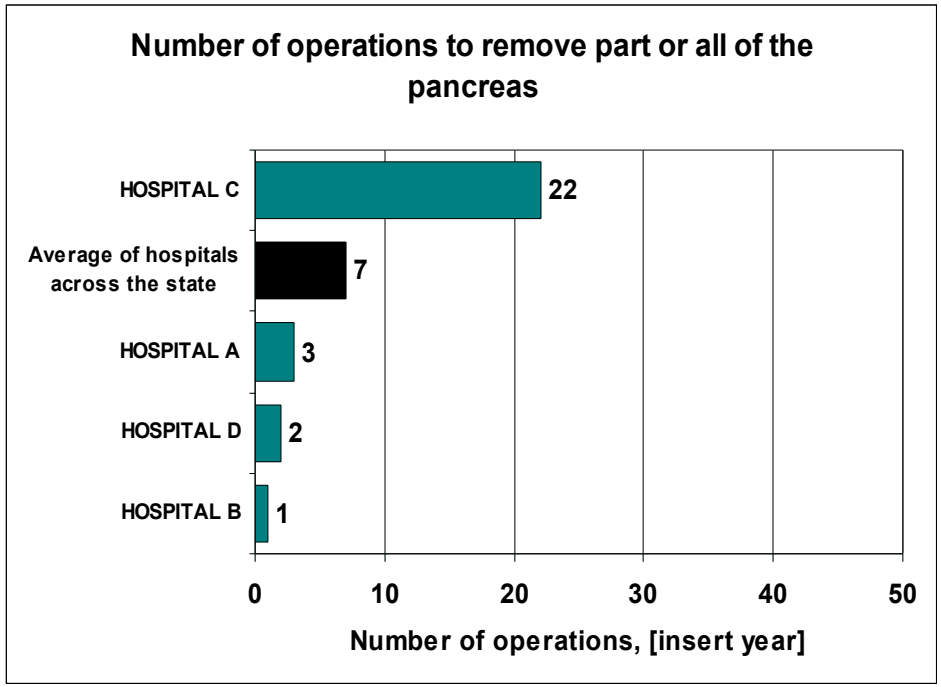


Average of hospitals across the state: The average rate of patients who died following this operation in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.

Number of operations to remove part or all of the pancreas

When choosing a hospital, you should look for the hospital that has a **higher** number of operations. A **higher** number is shown by a **longer** bar on the graph below.



- **Average of hospitals across the state:** The average number of operations done in hospitals across your state. This number is included so you have a better idea of what is typical for your state.

- a basis for comparing individual hospitals' performance.

Quality in care of the brain and nervous system

Information is available in the Report about three indicators related to quality of care for conditions relating to the brain and nervous system. Definitions of each of the indicators are provided below.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left)

Select All Indicators

□ **Death rate for an operation to remove blockage arteries to the brain**
How often patients died in the hospital after an operation to remove blockage in the arteries leading to the brain. (This is called *carotid endarterectomy*).

□ **Death rate for brain surgery**
How often patients died in the hospital following brain surgery. (This is called a *craniotomy*).

□ **Death rate for stroke**
How often patients died in the hospital who came in after having a stroke.

Additional information: Number of operations

Information is also available about the number of times the operation to remove blockage in brain arteries was done at individual hospitals. Research shows that, in general, when hospitals do these operations frequently, they are more likely to have good results. However, experts do not always agree on the minimum number needed to achieve high quality.

You will find a graph for this indicator on the same page as the death rate.

Compare Hospital Scores

Compare hospital scores on the brain and nervous system

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names for detailed results on how each hospital performed.

Death rate is the percent of patients who were treated for a particular illness or had a particular procedure who died while in each hospital during [insert year].	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

Brain and nervous system	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for operation to remove blockage in arteries to the brain The average rate of death for hospitals across the state is **7** for every **1,000** patients.	**Better than average**	**Worse than average**	Average	**Worse than average**
Death rate for brain surgery The average rate of death for hospitals across the state is **6** for every **100** patients.	Average	**Better than average**	**Worse than average**	**Worse than average**
Death rate for stroke The average rate of death for hospitals across the state is **10** for every **100** patients.	**Better than average**	average	**Worse than average**	**Better than average**

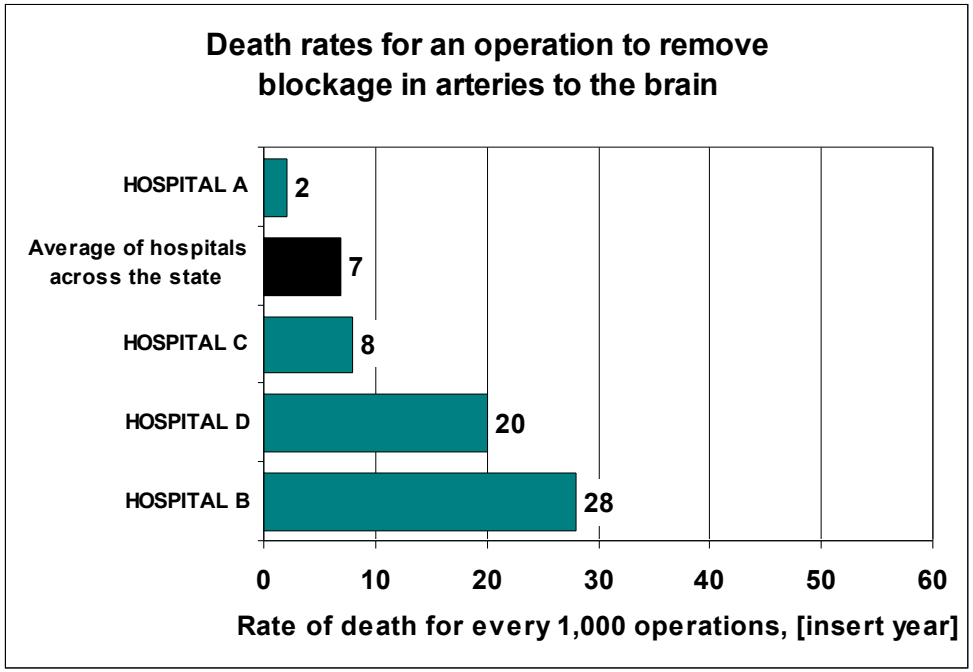
Removal of blockage in arteries to the brain– death rate and number of operations

The two graphs on this page show you the quality of hospital care related to an operation to remove blockage of the arteries leading to the brain, called a *carotid endarterectomy*. This information is for patients admitted during [insert year].

The graph on the left side of the page shows you how often patients died after having this operation. The graph on the right shows you the number of times a hospital performed this operation. Research shows that, in general, when hospitals do these procedures frequently, they are more likely to have good results. Often, but not always, a hospital that has a higher number of operations (right graph) will have lower death rates (left graph).

Death rate for an operation to remove blockage in arteries to the brain

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.

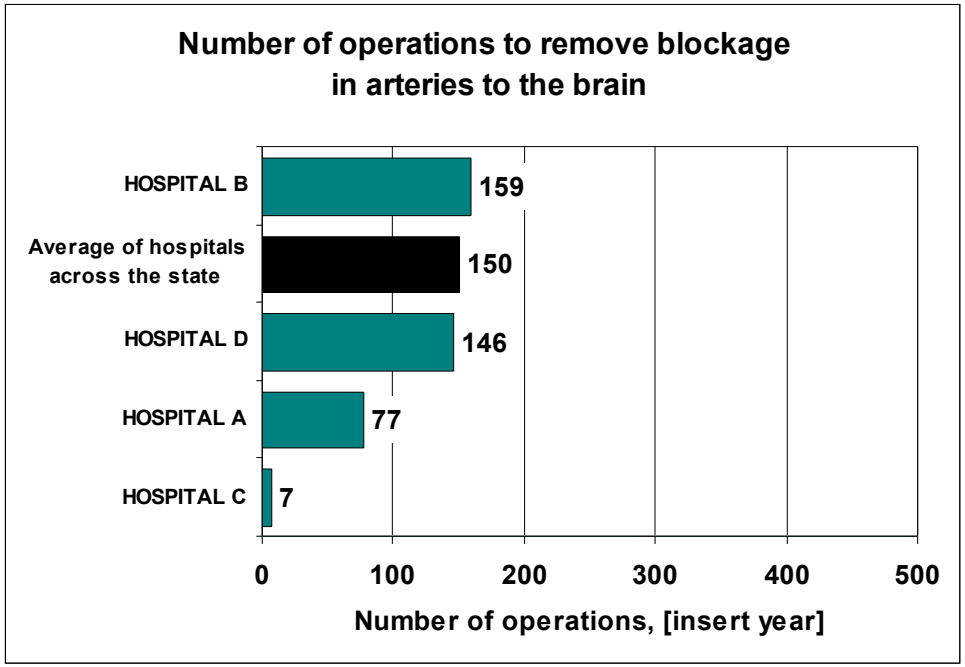


Average of hospitals across the state: The average rate of patients who died following this operation in hospitals across your state This number is included so you have:

- a better idea of what is typical for your state.

Number of operations to remove blockage in arteries to the brain

When you are choosing a hospital, you should look for the hospital that has a **higher** number of operations. A **higher** number is shown by a **longer** bar on the graph below.



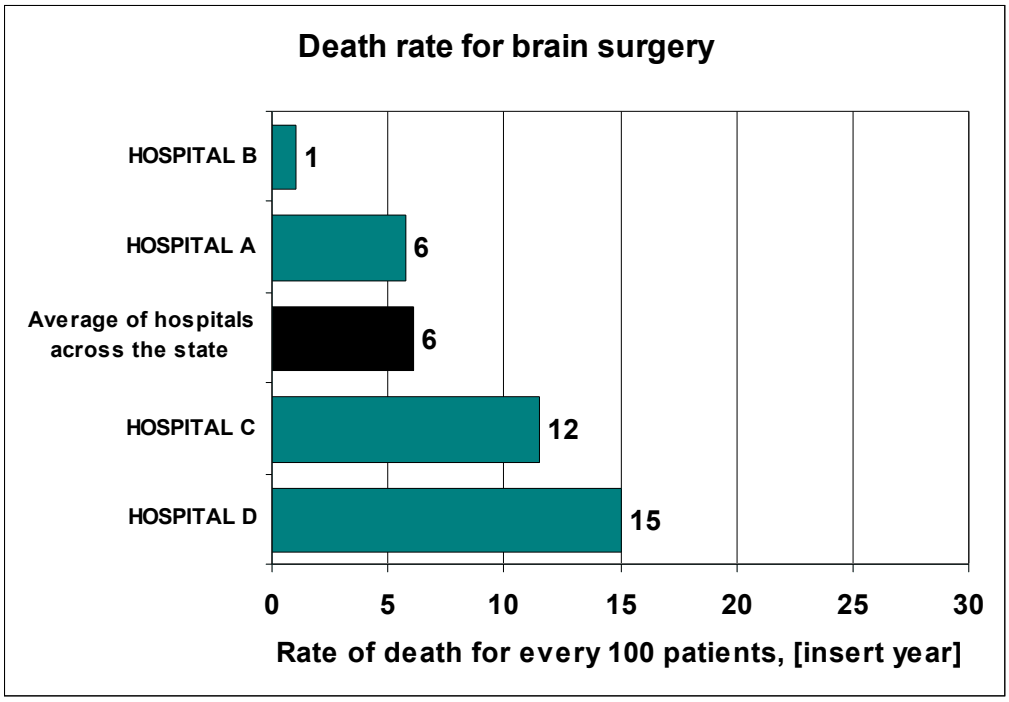
Average of hospitals across the state: The average number of operations performed in hospitals across your state. This number is included so you have a better idea of what is typical for your state.

- a basis for comparing individual hospitals' performance.

Death rate for brain surgery

This graph shows you the percent of patients who died after brain surgery (called a *craniotomy*). This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths for this operation. A **lower** number is shown by a **shorter** bar on the graph below.



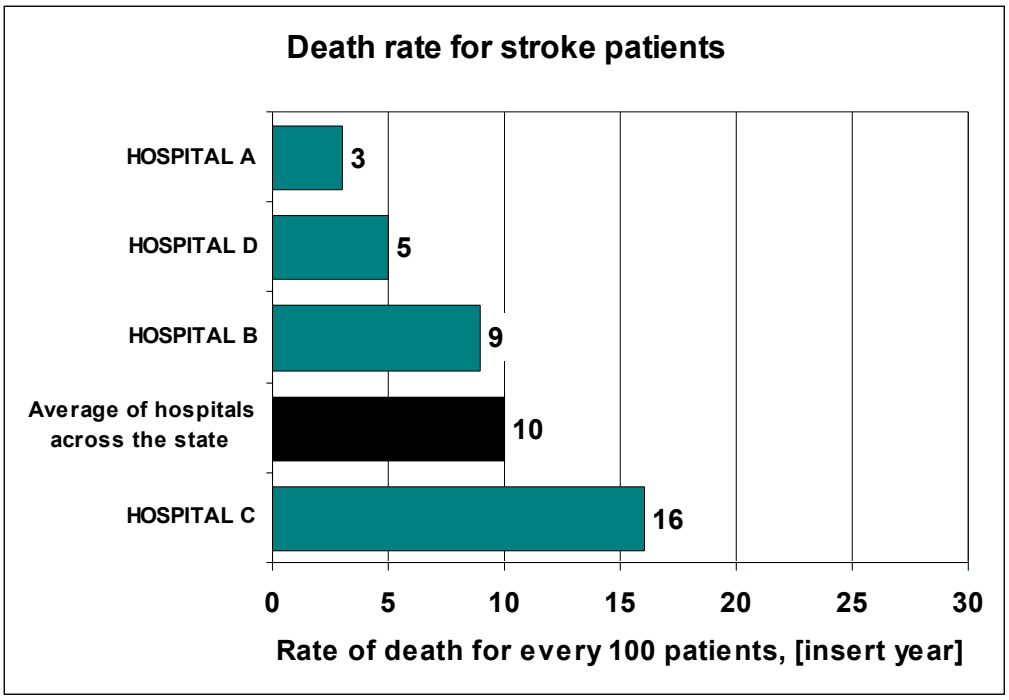
Average of hospitals across the state: The average rate of patients who died in the hospital after brain surgery, across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for stroke patients

This graph shows you the percent of patients who died after being admitted to the hospital because they had a stroke. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who died after being admitted because they had a stroke, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Quality of childbirth

Information is available in the Report about four indicators of childbirth quality and safety. Definitions of each of the indicators are provided below.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left)

Select All Indicators

☐ **Rate of birth injury or infection to newborn**
How often a newborn infant experiences a problem during the birth process (labor or delivery) such as a broken collarbone, an infection, or a head injury.

☐ **Rate of obstetric tearing – vaginal delivery with medical instruments**
How often a woman experiences a tear (trauma) to her perineum – the area between her vagina and rectum – while giving birth, when a health care provider is helping to deliver her baby using a forceps or other medical instrument. Such tears are often preventable.

☐ **Rate of obstetric tearing – vaginal delivery without medical instruments**
How often a woman experiences a tear (trauma) to her perineum – the area between her vagina and rectum – while giving birth. Such tears, which can happen even when medical instruments are not used, are often preventable.

☐ **Rate of obstetric tearing – Cesarean delivery**
How often a woman experiences a tear (trauma) in her perineum – the area between her vagina and rectum – or to any of the birth-related organs inside her body, during a Cesarean (surgical) delivery of a baby. Such tears are often preventable.

Compare Hospital Scores

Utilization rates for Cesarean section and vaginal birth after Cesarean (VBAC)

Information is also available about the proportion of deliveries in a hospital that are performed by Cesarean section, which involves surgery, and the proportion of deliveries in which a woman who previously had a Cesarean section give birth normally (vaginally). **These are not quality indicators**, but if you are interested in learning about these rates, **Click here for Utilization Rates.**

Compare hospital scores on childbirth

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names for detailed results on how each hospital performed.

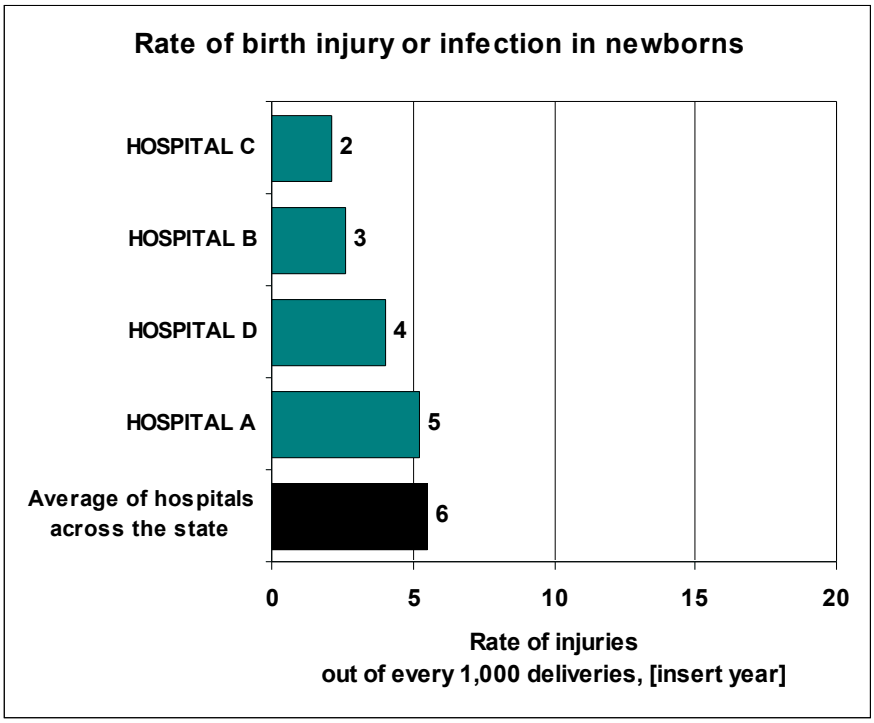
Rate is the percent of mothers or babies who experienced a particular problem during childbirth during [insert year].	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

Childbirth	Hospital A	Hospital B	Hospital C	Hospital D
Rate of birth injury or infection in newborns The average rate for hospitals across the state is **6** for every **1,000** patients.	Average	**Better than average**	**Better than average**	**Better than average**
Rate of obstetric tearing, vaginal delivery, without instruments The average rate for hospitals across the state is **46** for every **1,000** patients.	**Worse than Average**	Average	**Better than average**	Average
Rate of obstetric tearing, vaginal delivery, with instruments The average rate for hospitals across the state is **191** for every **1,000** patients.	**Worse than Average**	Average	**Better than average**	**Better than average**
Rate of obstetric tearing, Cesarean section The average rate for hospitals across the state is **4** for every **1,000** patients.	**Better than average**	**Better than average**	Average	Average

Rate of birth injury or infection in newborns

This graph shows you the percent of newborn babies who experienced an injury or other problem during the birth process (labor or delivery) such as a broken collarbone or head injury. This information is for newborns delivered in hospitals in [insert year].

When choosing a hospital, look for the hospital that has lower numbers for this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



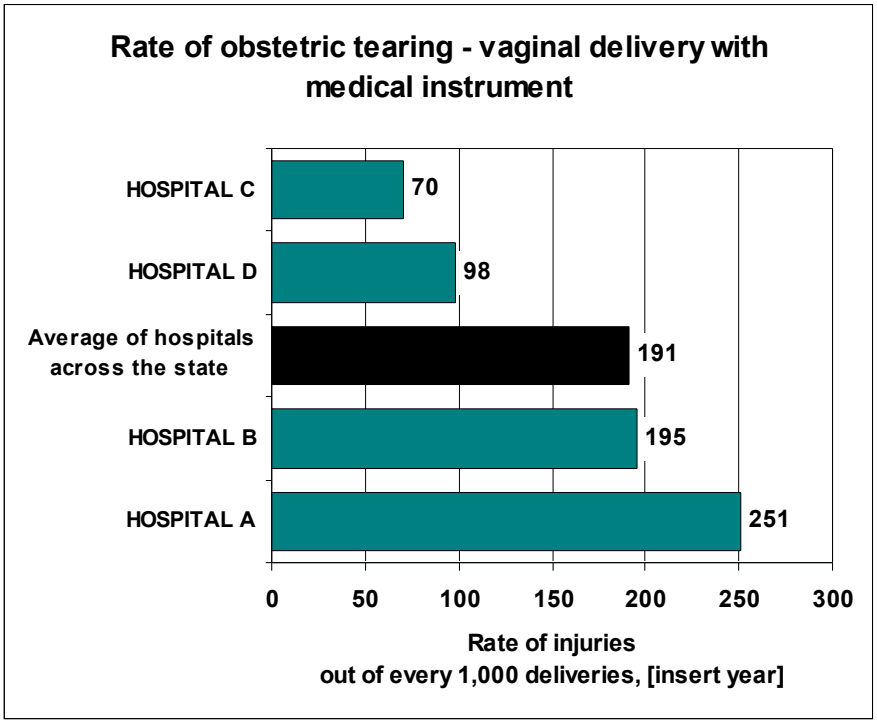
Average of hospitals across the state: The average rate of birth injuries or infections in newborns in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of obstetric tearing - vaginal delivery with medical instrument

This graph shows you the percent of women who experienced a tear in their pelvic area or pelvic organ (*obstetric trauma*) while giving birth, when a health care provider was helping to deliver the baby using a forceps or other medical instrument. This information is for patients admitted to a hospital in [insert year].

When choosing a hospital, you should look for the hospital that has lower numbers for this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



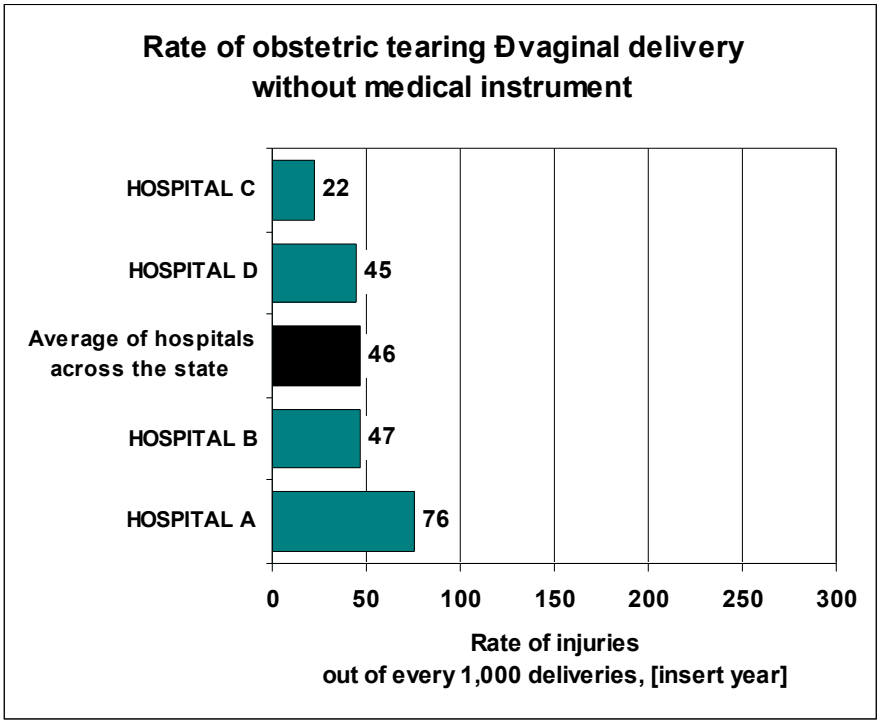
Average of hospitals across the state: The average rate of obstetric tearing, in vaginal deliveries using medical instruments, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of obstetric tearing – vaginal delivery without medical instrument

This graph shows you the percent of women who experienced a tear in their pelvic area or pelvic organ (*obstetric trauma*) while giving birth, even though no forceps or other medical instruments were used. This information is for patients admitted to a hospital in 2004.

When choosing a hospital, you should look for a hospital that has lower numbers on this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



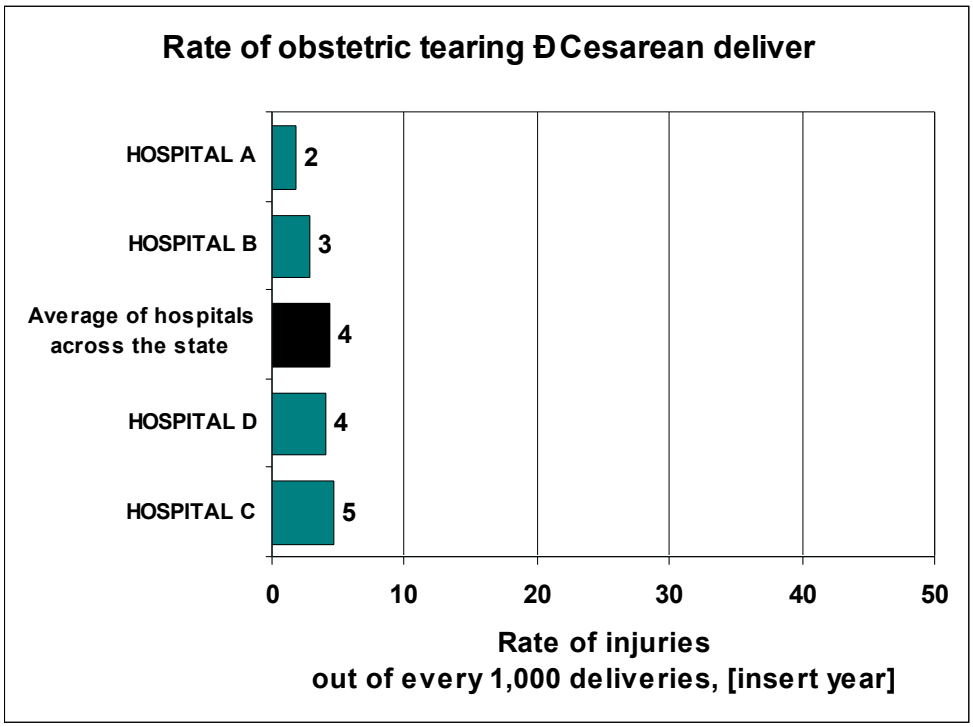
Average of hospitals across the state: The average rate of obstetric tearing, in vaginal deliveries without using medical instruments, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of obstetric tearing – Cesarean delivery

This graph shows you the percent of women who experienced a tear in their pelvic area or any of the birth-related organs inside her body (*obstetric trauma*), during a Cesarean (surgical) delivery of a baby.

When choosing a hospital, you should look for a hospital that has lower numbers for this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of obstetric tearing during Cesarean deliveries, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Additional information on childbirth:

Utilization rates* for Cesarean section

The following information relates to Cesarean section (childbirth involving an operation). These are not indicators of quality, since health experts don't know which utilization rates are better or worse for these procedures. However, if a woman has a strong preference either for having or avoiding a Cesarean section, and her doctor confirms that her preference is safe for her, these utilization rates may provide some useful information.

*The **utilization rate** is the number of times a hospital did a particular medical procedure during [insert year].

Please check the box next to each utilization rate you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left)

Select All Utilization Rates

☐ **Utilization rate for Cesarean section delivery**
How often babies in the hospital are delivered using Cesarean section, which involves an operation, instead of by normal/vaginal delivery.

☐ **Utilization rate for Cesarean section delivery, first birth**
How often babies in the hospital are delivered using Cesarean section, which involves an operation, instead of by normal/vaginal delivery – where this is the mother's first birth.

☐ **Rate of vaginal birth after Cesarean (VBAC) among women at low risk of needing a Cesarean section**
How often babies in the hospital are delivered normally – meaning with a vaginal birth – when the mother previously delivered by Cesarean section (involving an operation), and she is not facing a high risk of needing another Cesarean for other medical reasons.

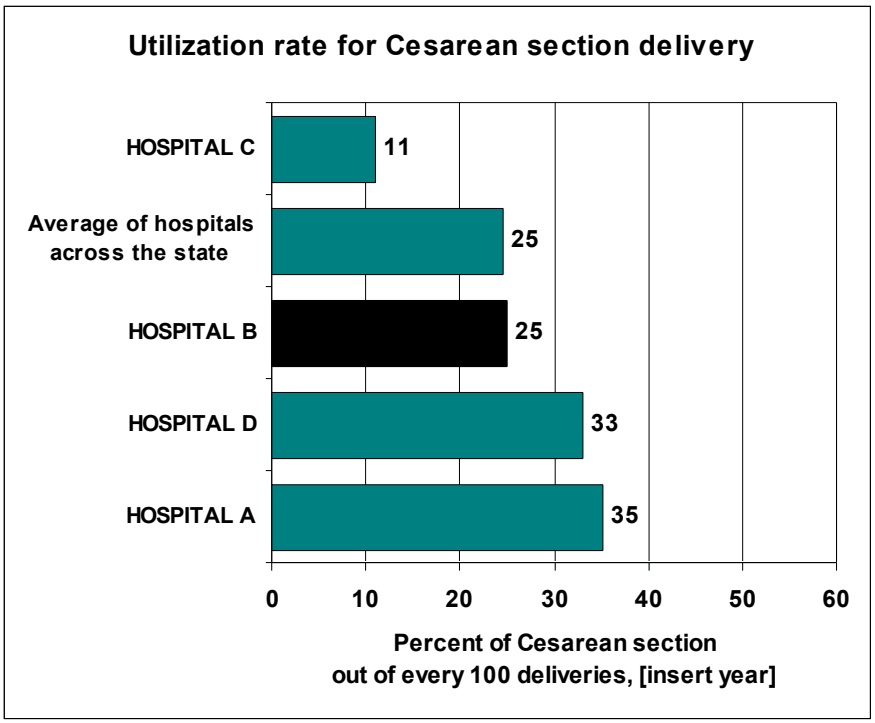
☐ **Rate of vaginal birth after Cesarean (VBAC), all**
How often babies in the hospital are delivered normally – meaning with a vaginal birth – where the mother has previously delivered by Cesarean section (involving an operation). The difference between this indicator and the one above it is that this one counts <u>all</u> VBACs, no matter how much the mother was at risk of needing another Cesarean.

Note to sponsor: Choose only one of the two VBAC rates to report, not both.

Compare Utilization Rates

Utilization rate for Cesarean section delivery

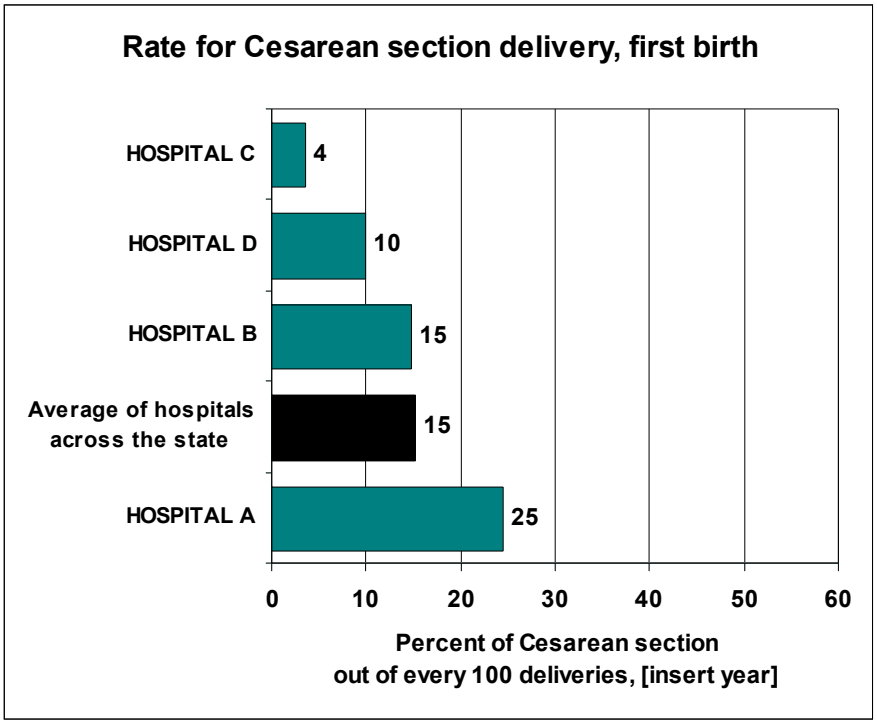
This graph shows you the percent of babies in each hospital who were delivered using Cesarean section, which involves an operation, instead of by normal (vaginal) delivery. This information is for patients admitted to a hospital during [insert year].



Average of hospitals across the state: The average rate of babies delivered using Cesarean section across your state. This number is included so you have a better idea of what is typical for your state.

Rate for Cesarean section delivery, first birth

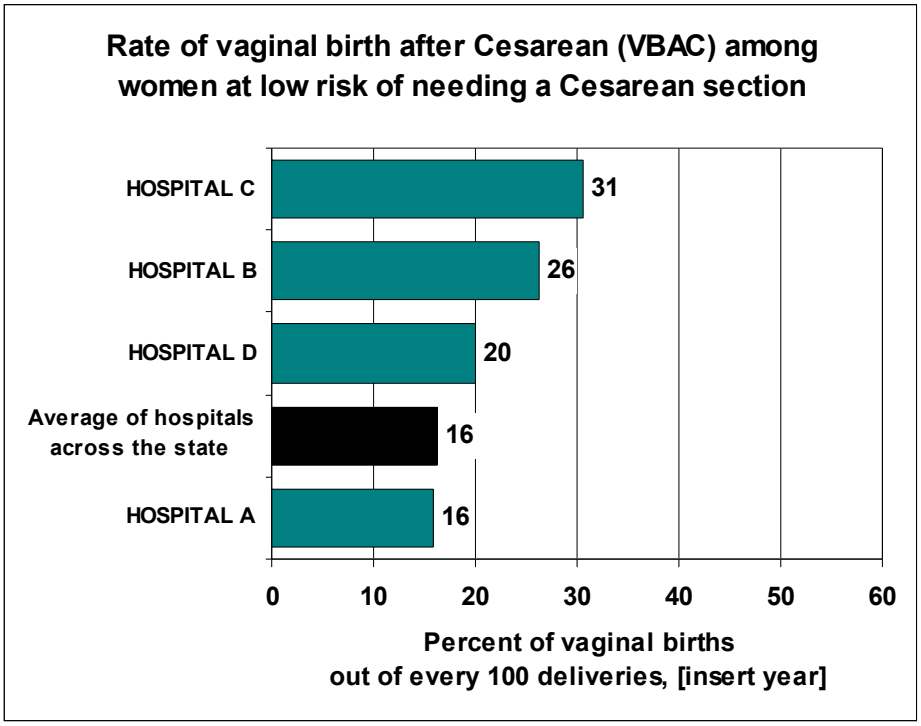
This graph shows you the percent of babies in each hospital delivered using Cesarean section, which involves an operation, instead of by normal (vaginal) delivery – where this is the mother's first (primary) birth. This information is for patients admitted to a hospital during [insert year].



Average of hospitals across the state: The average number of babies delivered by Cesarean section, where this is the mother's first birth, across your state. This number is included so you have a better idea of what is typical for your state.

Rate of vaginal birth after Cesarean (VBAC) among women at low risk of needing a Cesarean section

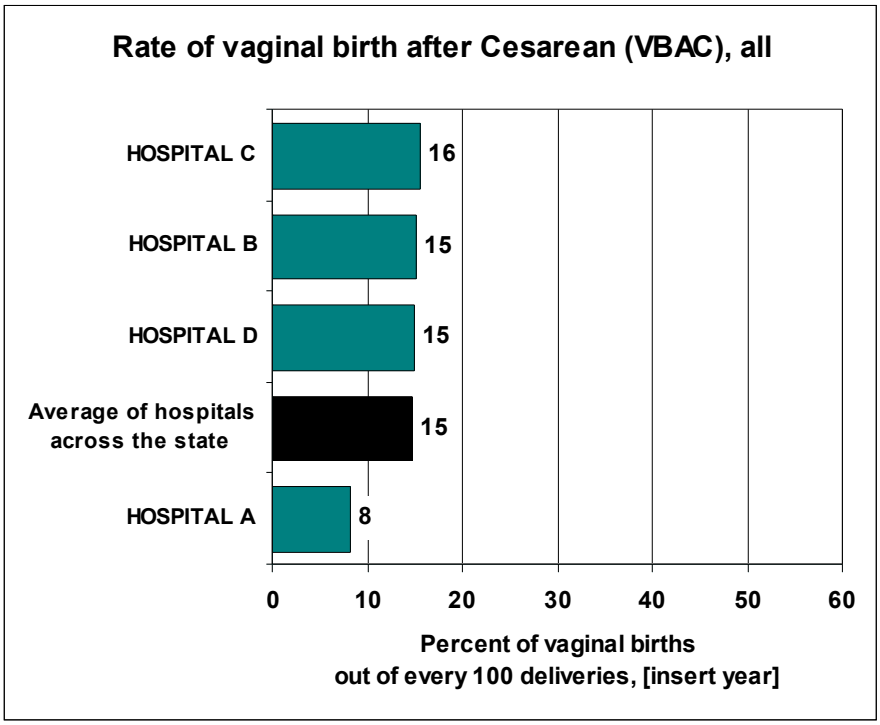
This graph shows you the percent of babies in each hospital who were delivered normally – meaning with a vaginal birth – when the mother delivered an earlier baby by Cesarean section (involving an operation), and she is not facing a high risk of needing another Cesarean for other reasons. This information is for patients admitted to a hospital during [insert year].



Average of hospitals across the state: The average rate of uncomplicated vaginal births after a Cesarean section, across your state. This number is included so you have a better idea of what is typical for your state.

Rate of vaginal birth after Cesarean (VBAC), all

This graph shows you the percent of babies who were delivered normally – meaning with a vaginal birth – where the mother previously delivered by Cesarean section (involving an operation). The difference between this indicator and the previous one is that this one counts all VBACs, even those where a complication occurred during childbirth. This information is for patients admitted to a hospital during [insert year].



Average of hospitals across the state: The average rate of vaginal births after a Cesarean section, across your state. This number is included so you have a better idea of what is typical for your state.

Quality of care for hip replacement and hip fracture

Information is available in the Report about two indicators for care for hip replacement and hip fracture. Definitions of each of the indicators are provided below.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left)

Select All Indicators

□ **Death rate for patients with a broken hip**
How often patients died in the hospital who came in with a broken hip (hip fracture).

□ **Death rate for hip replacement surgery**
How often patients died in the hospital after an operation to replace a bad hip.

Compare Hospital Scores

Compare hospital scores for hip replacement and hip fracture

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names for detailed results on how each hospital performed.

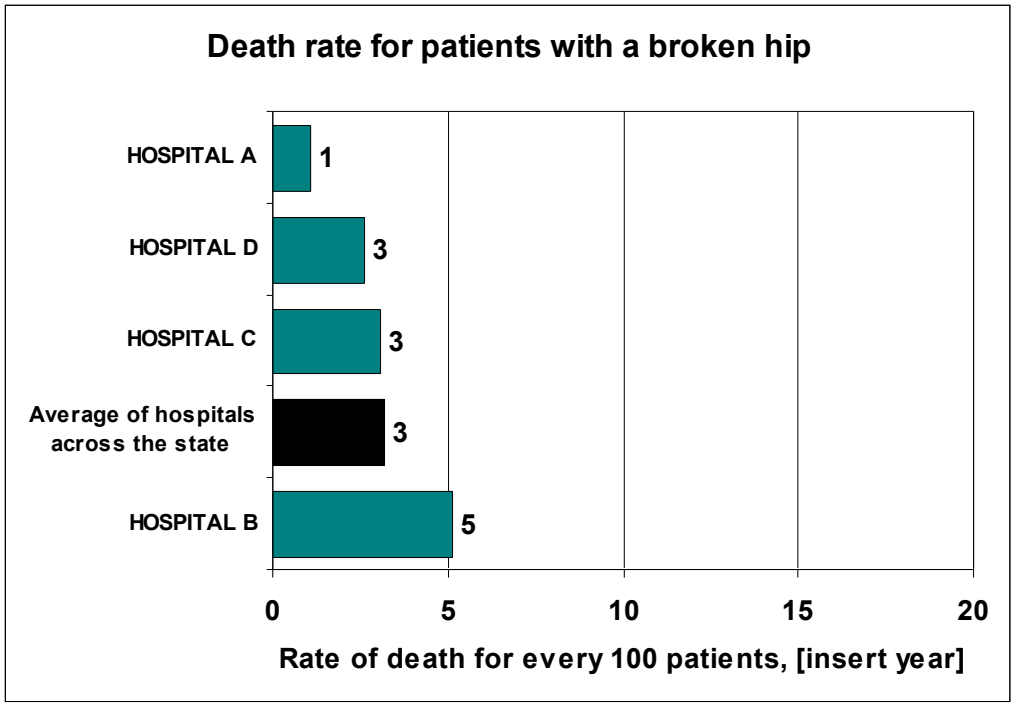
Death rate is the percent of patients who were treated for a particular illness or had a particular procedure who died while in each hospital during [insert year].	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

Hip replacement and hip fracture	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for patients with a broken hip The average rate of death for hospitals across the state is **3** for every **100** patients.	**Better than average**	**Worse than average**	average	average
Death rate for hip replacement surgery The average rate of death for hospitals across the state is **3** for every **1,000** patients.	**Better than average**	**Worse than average**	average	average

Death rate for patients with a broken hip

This graph shows you the percent of patients who died in the hospital, who came in with a broken hip (hip fracture). This information is for patients admitted during [insert year].

Deaths due to a broken hip are very rare. When choosing a hospital, you should look for the hospital with a **lower** number for this condition. A **lower** number is shown by a **shorter** bar on the graph below.



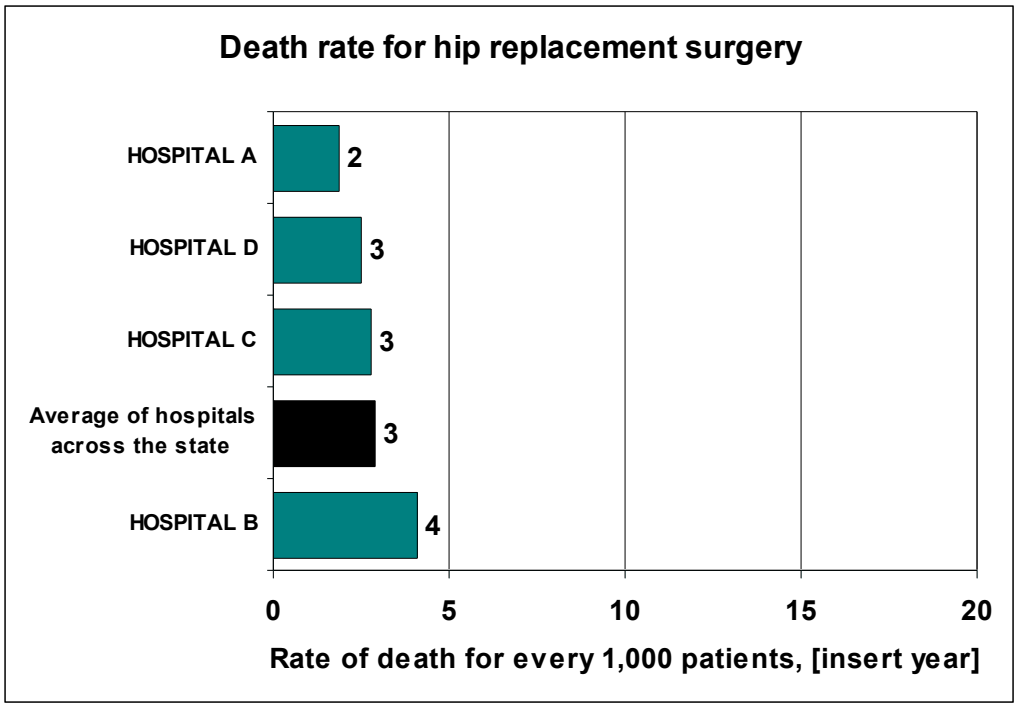
Average of hospitals across the state: The average rate of patients who died after being admitted with a broken hip, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for hip replacement surgery

This graph shows you the percent of patients who died after surgery to replace a bad hip. This is a fairly common operation that is not usually complicated. Death rates should be extremely low. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who died in the hospital after hip replacement surgery, across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Quality of care for other surgeries

Information is available in the Report about three indicators of quality related to other surgical procedures. Definitions of each of the indicators are provided below.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/left)

Select All Indicators

□ **Death rate for surgical repair of an aortic aneurysm**
How often patients died in the hospital after an operation (called an *abdominal aortic aneurysm repair*) to repair an enlarged blood vessel supplying blood to the lower half of the body.

□ **Rate of gallbladder removal using minimally-invasive (laparoscopic) surgery**
How often a hospital did an operation to remove a patient's gallbladder using a "laparoscopic" approach. (This is called a *laparoscopic cholecystectomy*.) This approach involves less cutting and is considered a better choice where possible, since it results in fewer complications and a faster and less painful recovery.

□ **Rate of healthy appendix removal in the elderly**
How often a healthy appendix was removed from an elderly person in the hospital, during an operation for another medical problem. (This is called an *incidental appendectomy*). Health experts believe this should be avoided, but some surgeons still do it.

Additional information: Number of operations
Information is also available about the number of times operations to repair an enlarged blood vessel supplying blood to the lower half of the body were done at individual hospitals. Research shows that, in general, when hospitals do these operations frequently, they are more likely to have good results. However, experts do not always agree on the minimum number needed to achieve high quality.

You will find a graph for this indicator on the same page as the death rate.

Compare Hospital Scores

Compare hospital scores for other surgeries

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names for detailed results on how each hospital performed.

Death rate is the percent of patients who had a particular procedure who died while in each hospital during [insert year]. **Rate** is the percent of patients having a particular kind of surgery during [insert year], who were operated on using one approach to the surgery rather than another.	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

Other Surgeries	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for surgical repair of an aortic aneurysm The average rate of death for hospitals across the state is **10** for every **100** patients.	**Better than average**	Average	Average	**Better than average**
Rate of gallbladder removal using minimally-invasive (laparoscopic), surgery The average rate for hospitals across the state is **76** for every **100** patients.	**Better than average**	**Better than average**	**Worse than average**	**Worse than average**
Rate of healthy appendix removal in the elderly The average rate for hospitals across the state is **2** for every **100** patients.	**Better than average**	**Worse than average**	Average	**Worse than average**

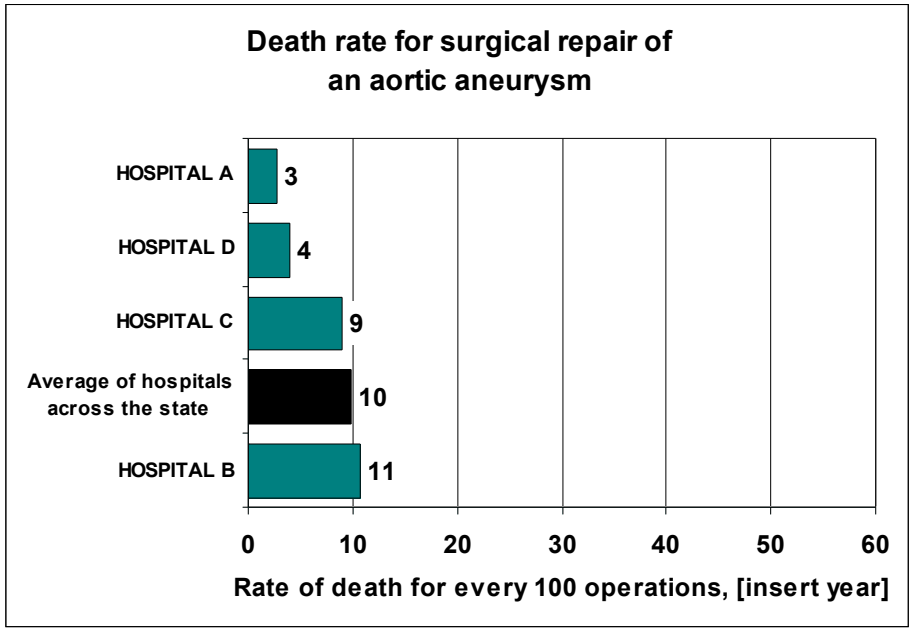
Surgical repair of an aortic aneurysm – death rate and number of operations

The two graphs on this page show you the quality of hospital care related to the surgical repair of an enlarged artery or vein supplying blood to the lower half of the body. This is sometimes called an *abdominal aortic aneurysm repair.* This information is for patients admitted during [insert year].

The graph on the left side of the page shows you how often patients died after having this operation. The graph on the right shows you the number of times a hospital performed this operation. This procedure is somewhat rare. Research shows that, in general, when hospitals do these procedures frequently, they are more likely to have good results. Often, but not always, a hospital that has a higher number of operations (right graph) will have lower death rates (left graph).

Death rate for surgical repair of an aortic aneurysm

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.

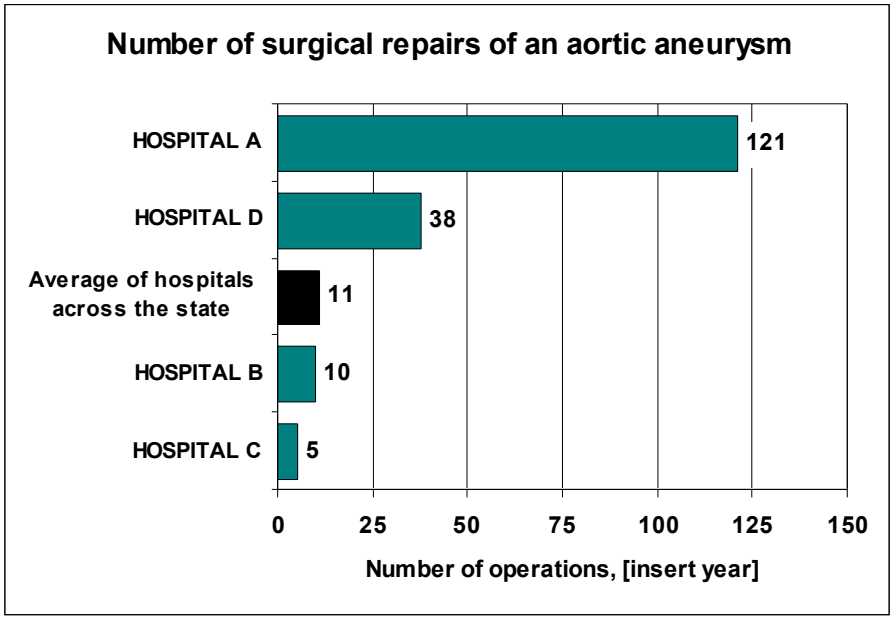


Average of hospitals across the state: The average number of deaths following this operation in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Number of surgical repairs of an aortic aneurysm

When you are choosing a hospital, you should look for the hospital that has a **higher** number of operations. A **higher** number is shown by a **longer** bar on the graph below.

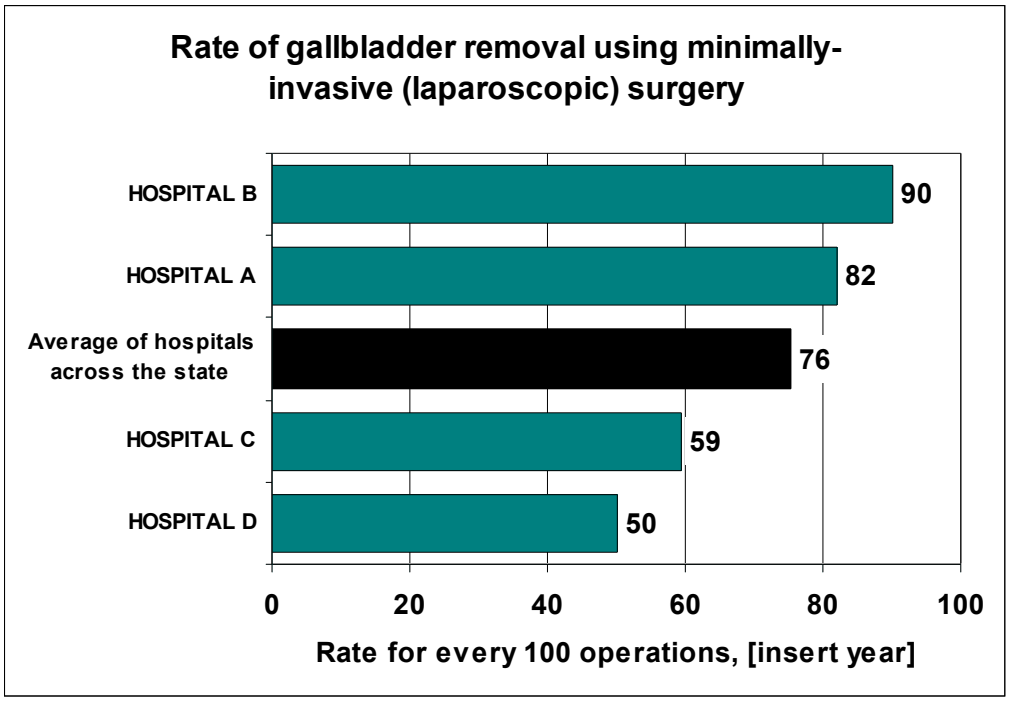


Average of hospitals across the state: The average number of operations performed in hospitals across your state. This number is included so you have a better idea of what is typical for your state.

Rate of gallbladder removal using minimally-invasive (laparoscopic) surgery

This graph shows you the number of times a hospital did an operation to remove a patient's gallbladder, using a "laparoscopic" approach. (This is called a *laparoscopic cholecystectomy.)* This information is for patients admitted during [insert year].

A laparoscopic approach involves smaller incisions and a quicker healing time. Most experts believe that if at all possible, the laparoscopic approach is better for the patient. Therefore, when choosing a hospital, you should look for the hospital with a **higher** number for this indicator. A **higher** number is shown by a **longer** bar on the graph below.



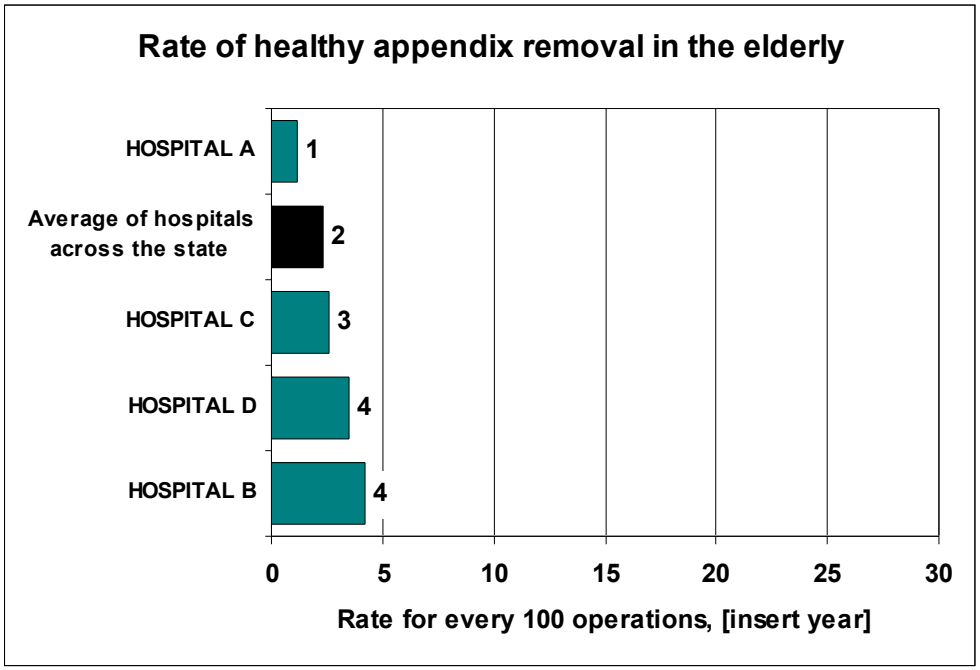
Average of hospitals across the state: The average number of gallbladder removals done using laparoscopy, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of healthy appendix removal in the elderly

This graph shows you the number of times a hospital removed a healthy appendix from an elderly person, during an operation for another medical problem (called an *incidental appendectomy*). This information is for patients admitted during [insert year].

A healthy appendix is removed when an adult is having some other kind of abdominal surgery, to prevent future problems with the appendix or to make sure the appendix is not a source of abdominal pain. However, this additional procedure is <u>not</u> recommended for people aged 65 and older. Therefore, when choosing a hospital, you should look for the hospital with a **<u>lower</u>** number for this indicator. A **<u>lower</u>** number is shown by a **<u>shorter</u>** bar on the graph below.



Average of hospitals across the state: The average number of healthy appendix removals in the elderly done in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Quality of care for other health conditions

Information is available in the Report about two quality indicators for other health conditions. Definitions of each indicator are provided below.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left)

Select All Indicators

☐ **Death rate for pneumonia**
Deaths in the hospital of patients who came in with pneumonia.

☐ **Death rate for patients with GI (gastrointestinal) bleeding**
How often patients died after they came in with heavy bleeding in their stomach or intestines (called *gastrointestinal bleeding*).

Compare Hospital Scores

Compare hospital scores on other health conditions

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names for detailed results on how each hospital performed.

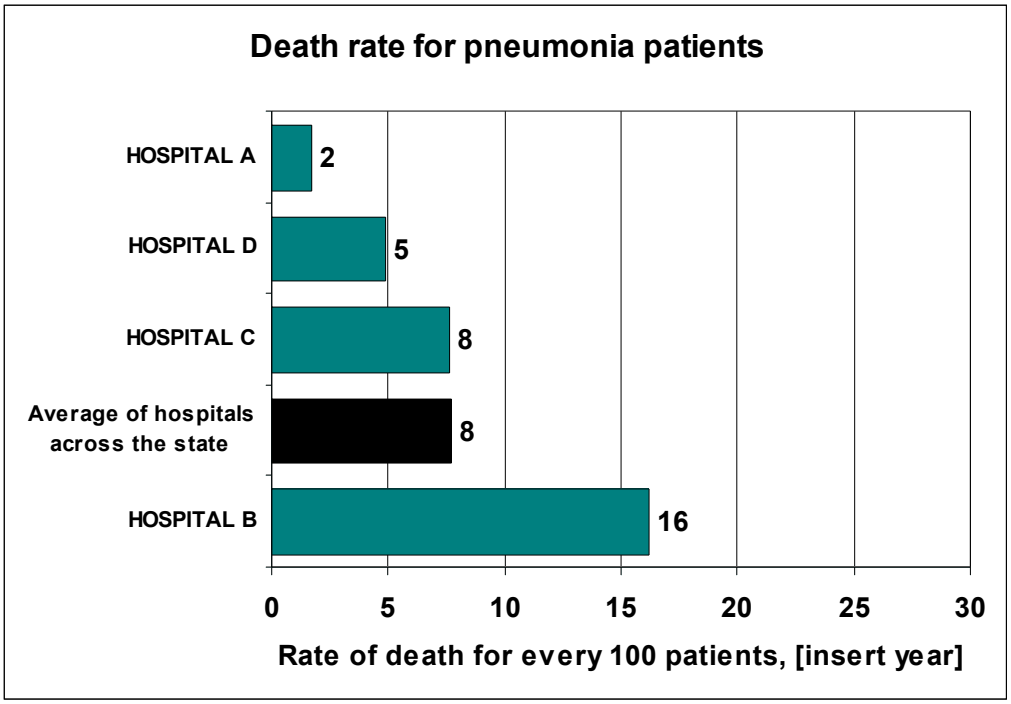
Death rate is the percent of patients who were treated for a particular illness who died while in each hospital during [insert year].	A hospital's score is calculated in comparison to the average of hospitals across the state. **Average** is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

Other Health Conditions	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for pneumonia patients The average rate of death for hospitals across the state is **8** for every **100** patients.	**Better than average**	**Worse than average**	Average	**Better than average**
Death rate for patients with GI (gastrointestinal) bleeding The average rate of death for hospitals across the state is **3** for every **100** patients.	Average	**Better than average**	**Worse than average**	**Worse than average**

Death rate for pneumonia patients

This graph shows you the percent of patients admitted to a hospital because they had pneumonia, who died during their hospital stay. This information is for patients who were admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** number for this condition. A **lower** number is shown by a **shorter** bar on the graph below.



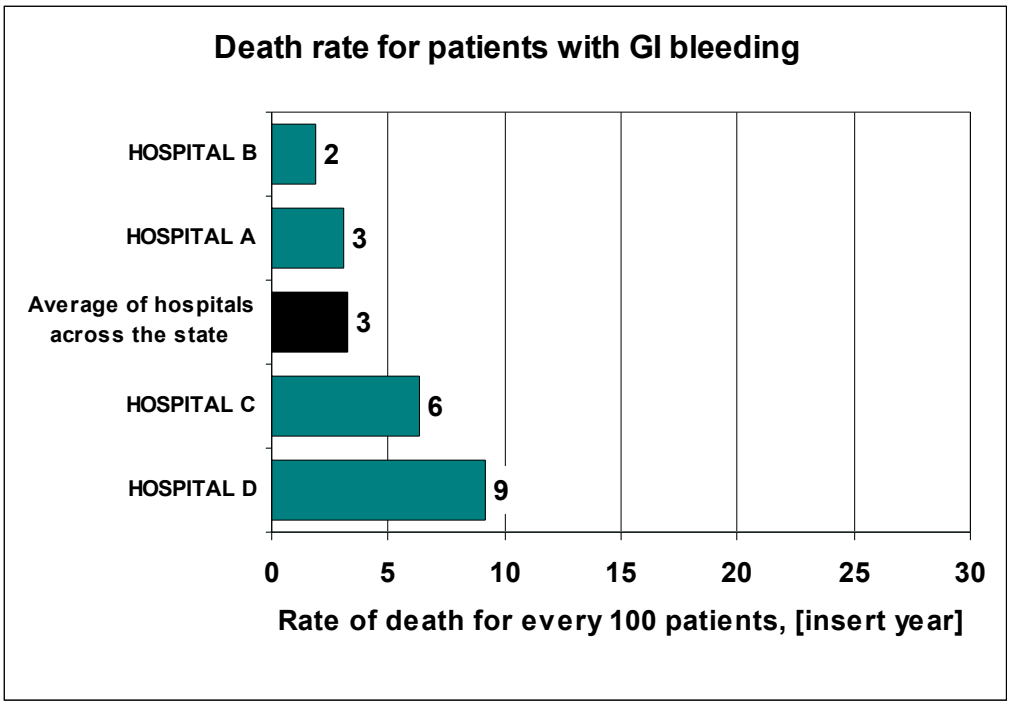
Average of hospitals across the state: The average rate of patients with pneumonia who died in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for patients with GI bleeding

This graph shows you the percent of patients who died after being admitted to the hospital because of bleeding into their stomach or intestines (which is called *gastrointestinal, or GI, bleeding*). This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate of deaths for this condition. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who died after being admitted with GI bleeding, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Medical complications for patients having operations

This Report includes ten indicators showing how often patients experienced a complication or problem as a result of having an operation. These complications can be serious, even fatal. Each of them can be prevented if steps are taken to make care safer. Definitions of each indicator are provided below.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left)

Select All Indicators

☐ **Rate of complications of anesthesia**
How often patients experienced problems as a result of having anesthesia, i.e. being "put to sleep" before having an operation or procedure.

☐ **Rate of hip fracture after an operation**
How often hospital patients broke a hip bone from a fall following any kind of operation.

☐ **Rate of too much bleeding or blood clots after an operation**
How often patients bled too much (called *hemorrhaging*) or developed a large blood clot after an operation (which is called a *hematoma*).

☐ **Rate of abnormal changes in body functions after an operation**
How often hospital patients experienced problems with blood sugar control (if they have diabetes) or kidney failure (if they did not have previous kidney trouble) after having an operation (these problems are called *postoperative physiologic and metabolic derangements)*.

☐ **Rate of breathing failure after an operation**
How often patients became unable to breathe on their own following an operation, and needed a ventilator (a machine that helps someone breathe), at least temporarily. (This is called *postoperative respiratory failure*.)

☐ **Rate of blood clots in the lung or a large vein, after an operation**
How often hospital patients developed a blood clot that ends up in the lungs (which is called a *pulmonary embolism*) or in a large vein (which is called *deep vein thrombosis*), after an operation.

☐ **Rate of bloodstream infection following an operation**
How often hospital patients got a serious bloodstream infection following an operation (which is called *postoperative sepsis*).

☐ **Rate of splitting open of a surgical wound after an operation on the stomach or pelvis**
How often a surgical wound in the stomach or pelvic area split open after an operation. (This is called *postoperative wound dehiscence in abdominopelvic surgical patients*.)

☐ **Rate of surgical instrument or tool accidentally left in a patient's body**
How often a surgical instrument or tool (called a *foreign body*), such as a scalpel or a sponge, was accidentally left in a patient's body during an operation.

☐ **Rate of patients having air leaking out of their lung**

How often air leaks out of the patient's lung because someone accidentally punctured during a medical procedure or operation (a complication called *iatrogenic pneumothorax)*.

Compare Hospital Scores

Compare hospital scores on medical complications for patients having operations

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names for detailed results on how each hospital performed.

Rate is the percent of surgical patients who experienced a particular problem following their operation during [insert year].	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

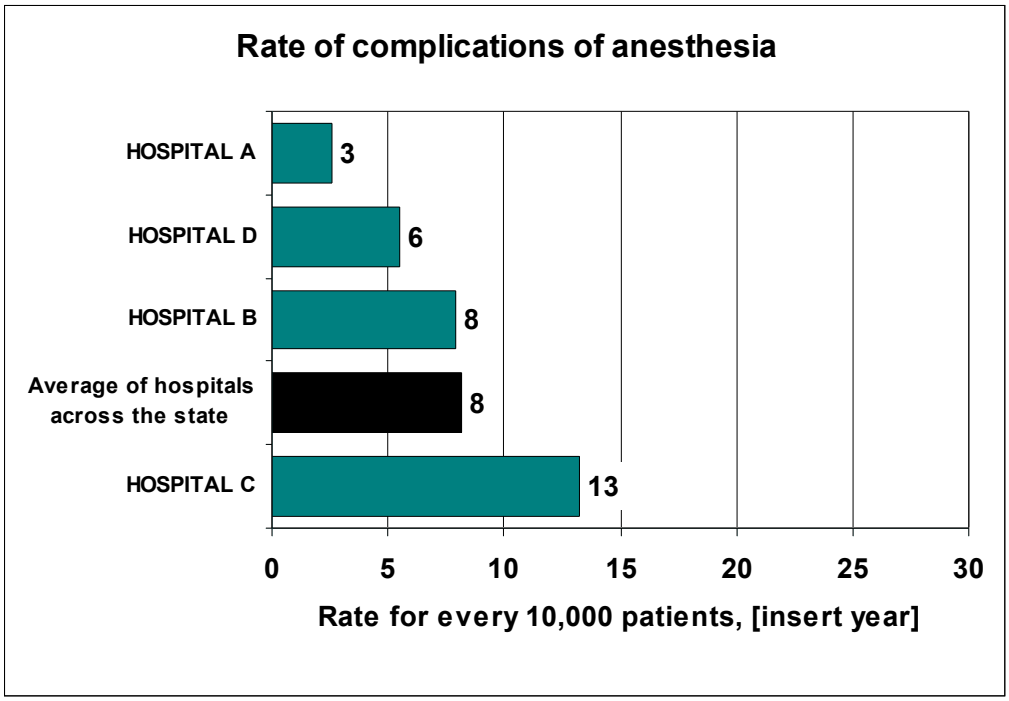
Medical Complications for Patients Having Operations	Hospital A	Hospital B	Hospital C	Hospital D
Rate of complications of anesthesia The average rate for hospitals across the state is **8** for every **10,000** patients.	**Better than average**	Average	**Worse than average**	**Better than average**
Rate of hip fracture after an operation The average rate for hospitals across the state is **3** for every **10,000** patients.	**Better than average**	**Worse than average**	Average	Average
Rate of too much bleeding or blood clots after an operation The average rate for hospitals across the state is **2** for every **1,000** patients.	**Better than average**	**Worse than average**	Average	Average
Rate of abnormal changes in body function after an operation The average rate for hospitals across the state is **10** for every **10,000** patients.	**Better than average**	**Better than average**	Average	**Better than average**
Rate of breathing failure after an	**Worse than average**	Average	**Worse than average**	**Better than average**

operation The average rate for hospitals across the state is **9** for every **1,000** patients.				
Rate of blood clots in the lung or large vein, after an operation The average rate for hospitals across the state is **10** for every **1,000** patients.	Average	Average	Average	**Better than average**
Rate of bloodstream infection following an operation The average rate for hospitals across the state is **11** for every **1,000** patients.	**Better than average**	**Worse than average**	**Better than average**	**Worse than average**
Rate of splitting open of a surgical wound after an operation on the stomach or pelvic area The average rate for hospitals across the state is **11** for every **10,000** patients.	**Better than average**	**Worse than average**	**Better than average**	Average
Rate of surgical instrument or tool accidentally left in a patient's body The average rate for hospitals across the state is **3** for every **100,000** patients.	**Better than average**	**Better than average**	**Worse than average**	**Better than average**
Rate of patients having air leaking out of the lung The average rate for hospitals across the state is **9** for every **10,000** patients.	**Better than average**	**Worse than average**	Average	**Better than average**

Rate of complications of anesthesia

This graph shows you the percent of patients who experienced problems as a result of having anesthesia, meaning being "put to sleep" before having an operation or medical procedure. This information is for patients admitted during [insert year]. **Please note: this is a very rare event.**

When choosing a hospital, you should look for the hospital that has a **lower** rate of complications from anesthesia. A **lower** number is shown by a **shorter** bar on the graph below.



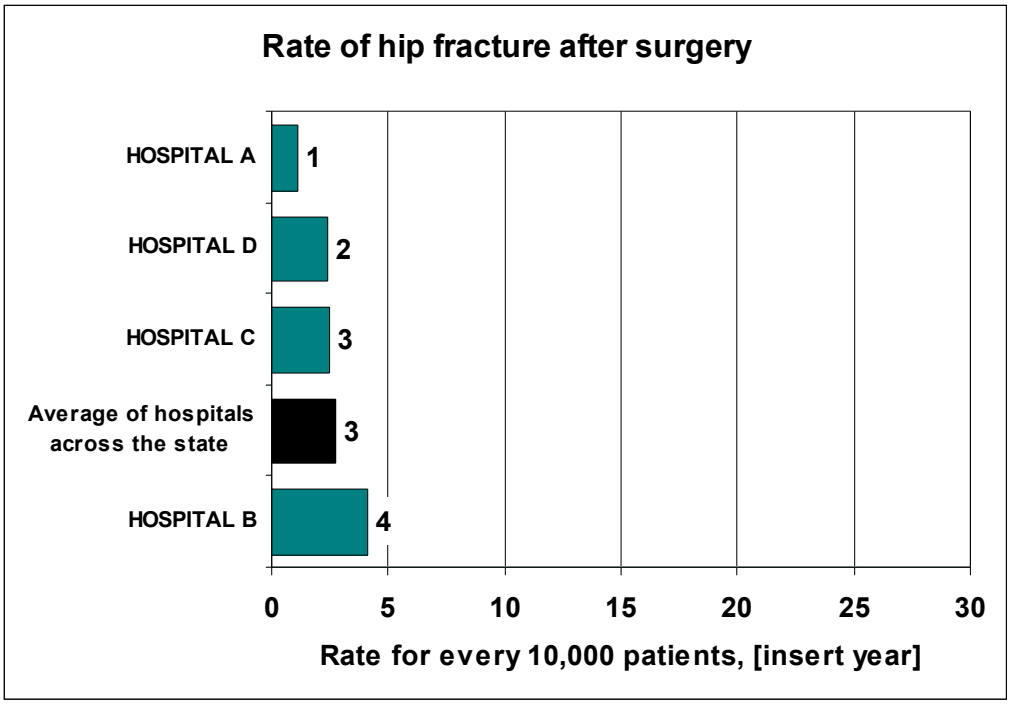
Average of hospitals across the state: The average rate of complications from anesthesia of patients in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of hip fracture after an operation

This graph shows you the percent of patients who broke a hip from a fall following any kind of operation. A fall can happen for different reasons, such as being given too much pain medication, or having too little supervision when trying to walk after an operation. Or, it may just happen. This information is for patients admitted during [insert year]. **Please note that this is a very rare event.**

When choosing a hospital, you should look for the hospital that has a **lower** rate of postoperative hip fractures. A **lower** number is shown by a **shorter** bar on the graph below.



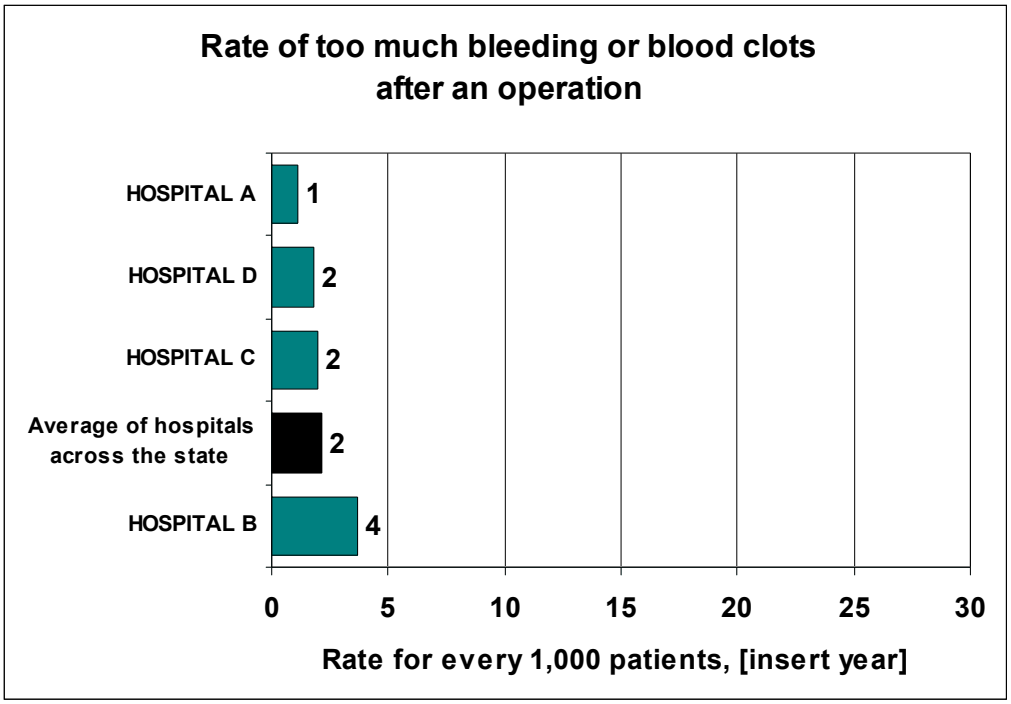
Average of hospitals across the state: The average rate of patients with hip fractures after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of too much bleeding or blood clots after an operation

This graph shows you how often patients bled too much (called *hemorrhaging*) or developed a large blood clot (called a *hematoma*) after an operation. All of these complications involved another operation to stop the bleeding or remove the blood clots. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** rate is shown by a **shorter** bar on the graph below.



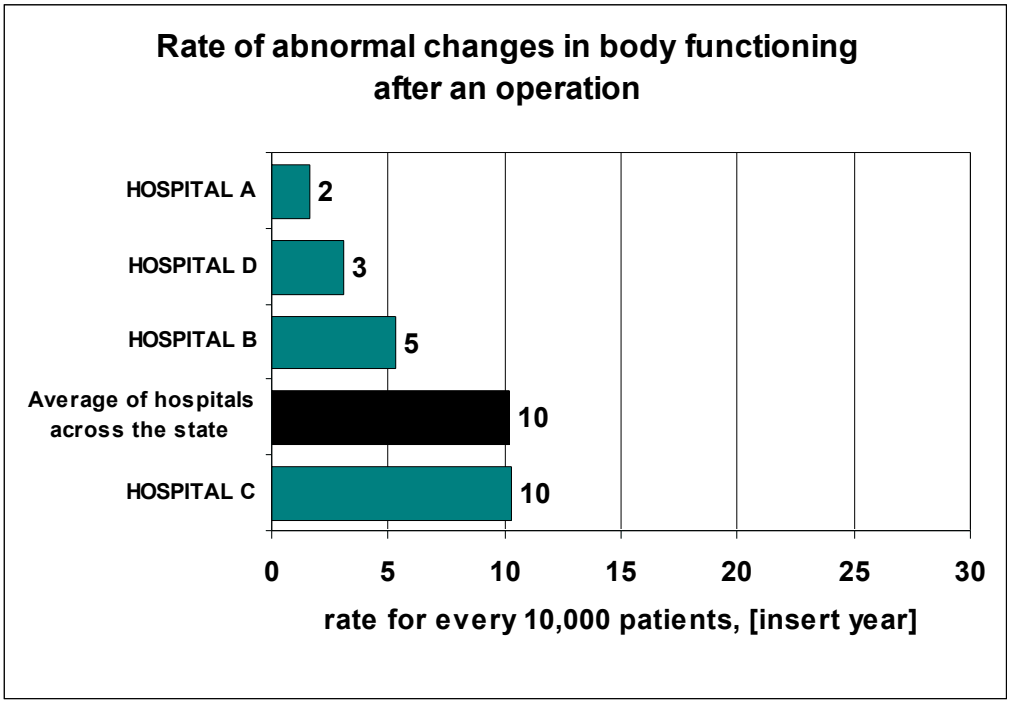
Average of hospitals across the state: The average rate of patients who had too much bleeding, or blood clots after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of abnormal changes in body functioning after an operation

This graph shows you the percent of patients who experienced problems with blood sugar control (if they have diabetes) or kidney failure (if they did not have previous kidney trouble) after having an operation (these complications are called *postoperative physiologic and metabolic derangements)* This information is for patients admitted during [insert year]. **Please note that this is a very rare event.**

When you are choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



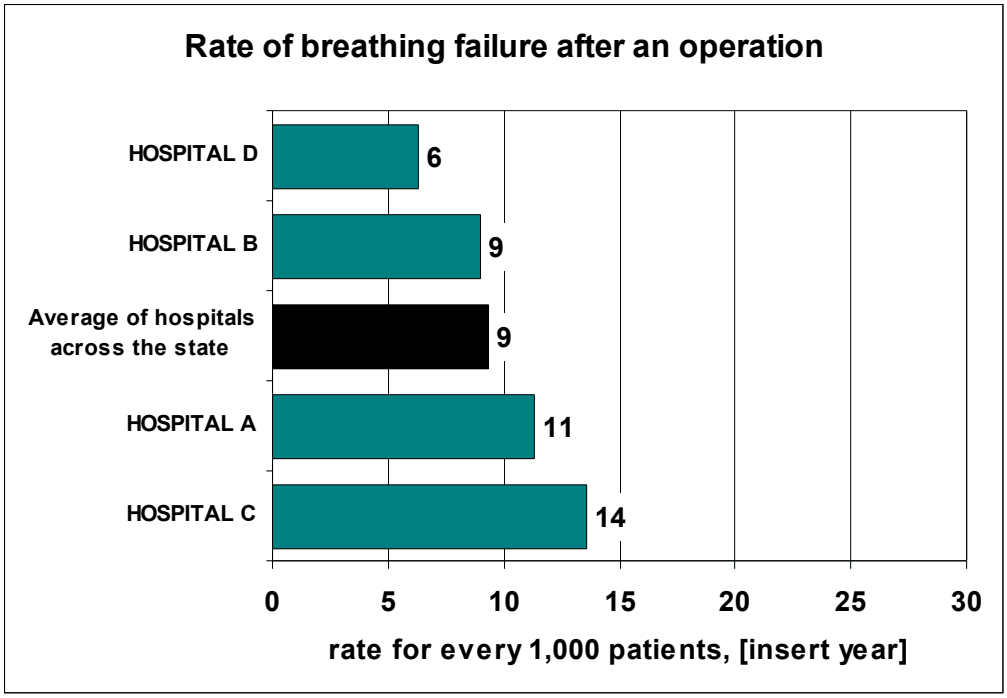
Average of hospitals across the state: The average rate of patients with abnormal changes in body functioning, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of breathing failure after an operation

This graph shows you the percent of patients who became unable to breathe on their own following an operation, and who needed a ventilator, which is a machine that helps someone breathe, at least temporarily (which is called *postoperative respiratory failure*). This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



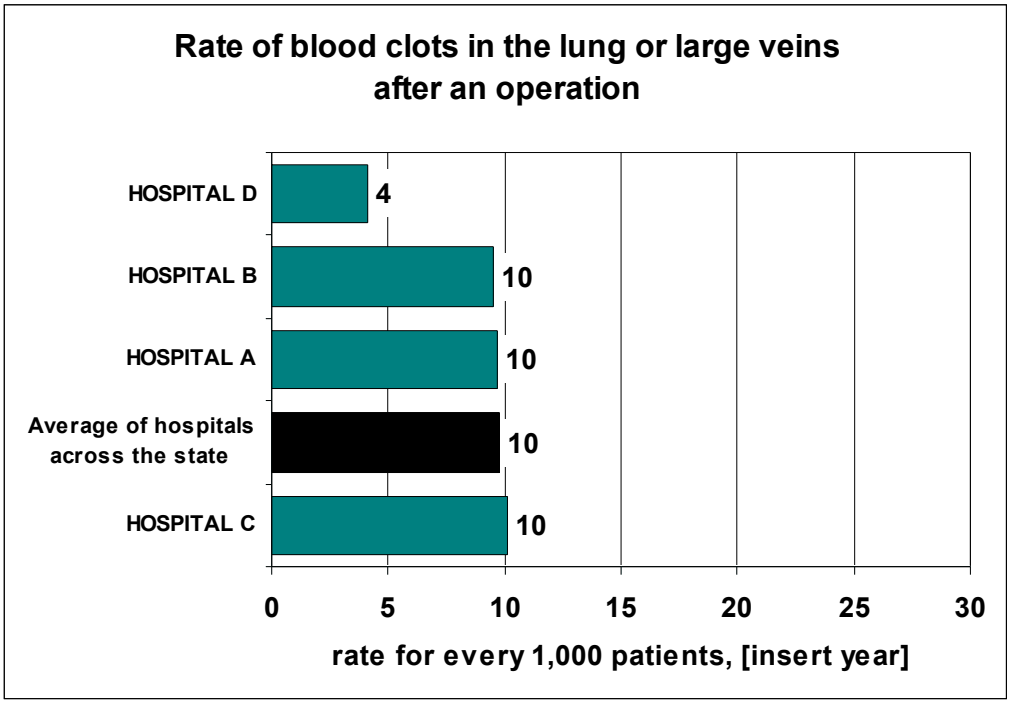
Average of hospitals across the state: The average rate of patients with breathing failure after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of blood clots in the lung or large veins after an operation

This graph shows you the percent of patients who developed a blood clot in the lungs (which is called a *pulmonary embolism*) or in a large vein (which is called *deep vein thrombosis*) following an operation. This information is for patients admitted during [insert year].

These clots can be life-threatening. When you are choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



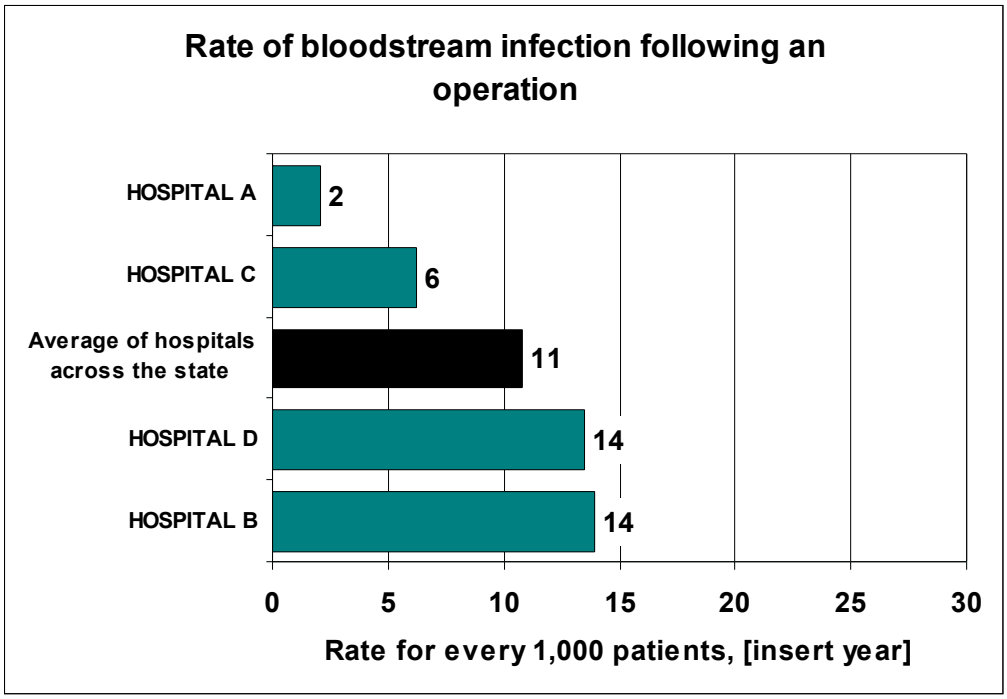
Average of hospitals across the state: The average rate of patients with blood clots in the lung or large veins after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of bloodstream infection following an operation

This graph shows you the percent of patients who got a bloodstream infection following an operation (which is called *postoperative sepsis*). This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



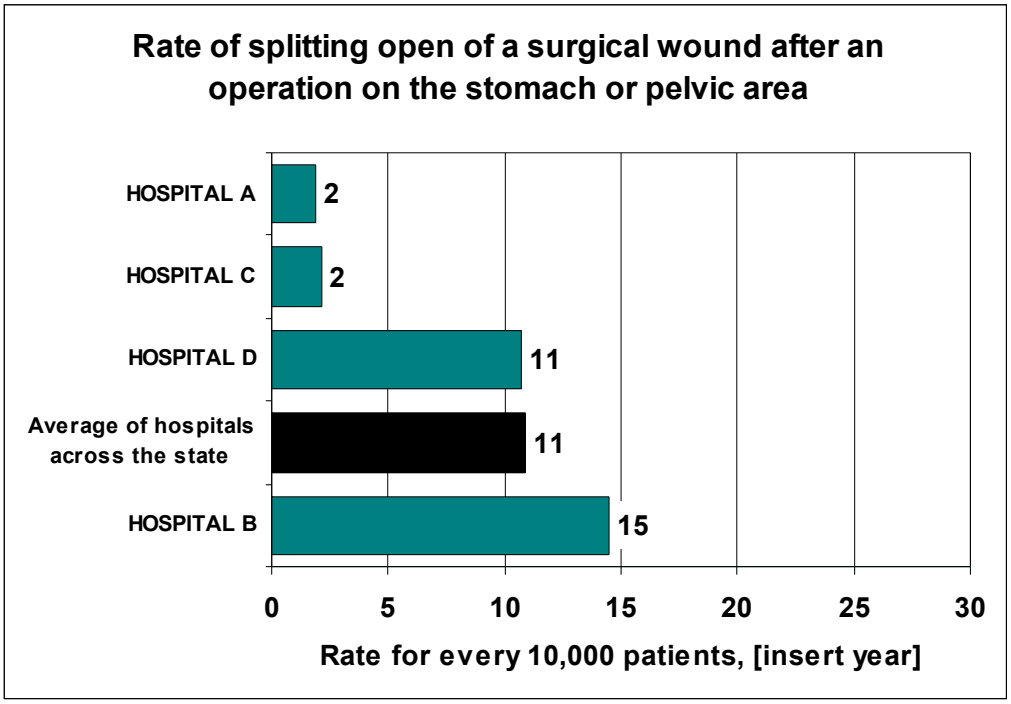
Average of hospitals across the state: The average rate of patients with bloodstream infections following an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of splitting open of a surgical wound after an operation on the stomach or pelvic area

This graph shows you the percent of patients having an operation in their stomach or pelvic area whose wound split open after an operation (which is called *postoperative wound dehiscence*). All of these complications were treated with another major operation to fix the wound. This information is for patients admitted during [insert year]. **Please note that this is a very rare event**.

When choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



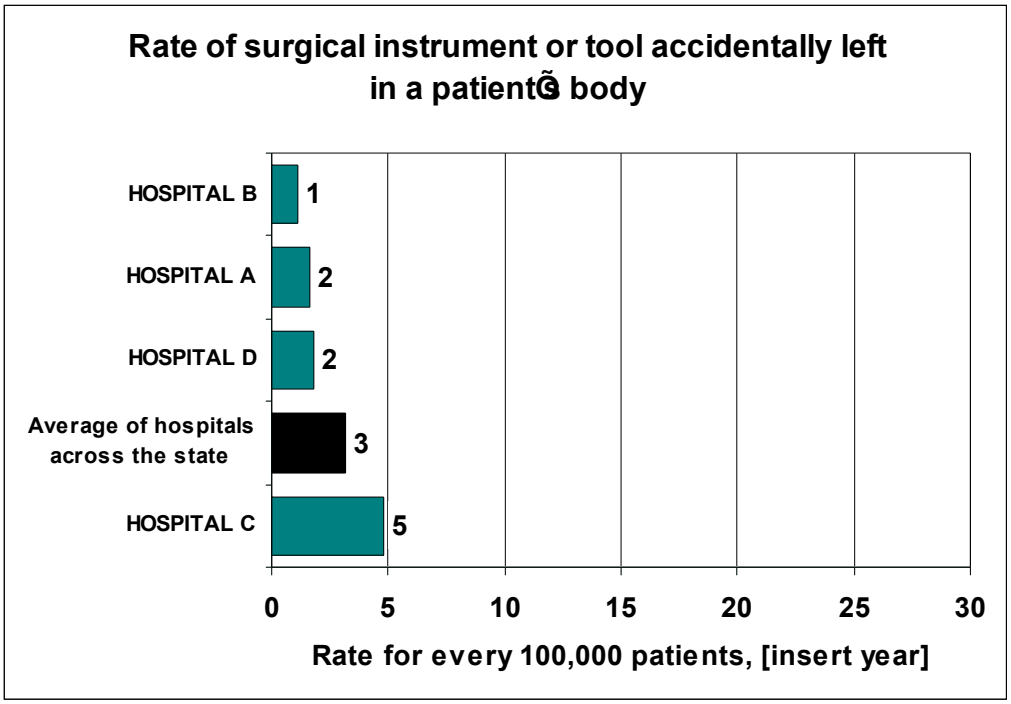
Average of hospitals across the state: The average rate of patients with splitting open of a surgical wound after an operation on the stomach or pelvis splitting, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of surgical instrument or tool accidentally left in a patient's body

This graph shows you how often a surgical instrument or tool (called a *foreign body*), such as a scalpel or sponge, was accidentally left in a patient's body after an operation. This information is for patients admitted during [insert year]. **Please note: this is a very rare event.**

Even though a patient may not feel anything, having a surgical instrument or tool left behind can cause infection or cuts and be very dangerous. When choosing a hospital, you should look for the hospital that has **lower** rates for this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



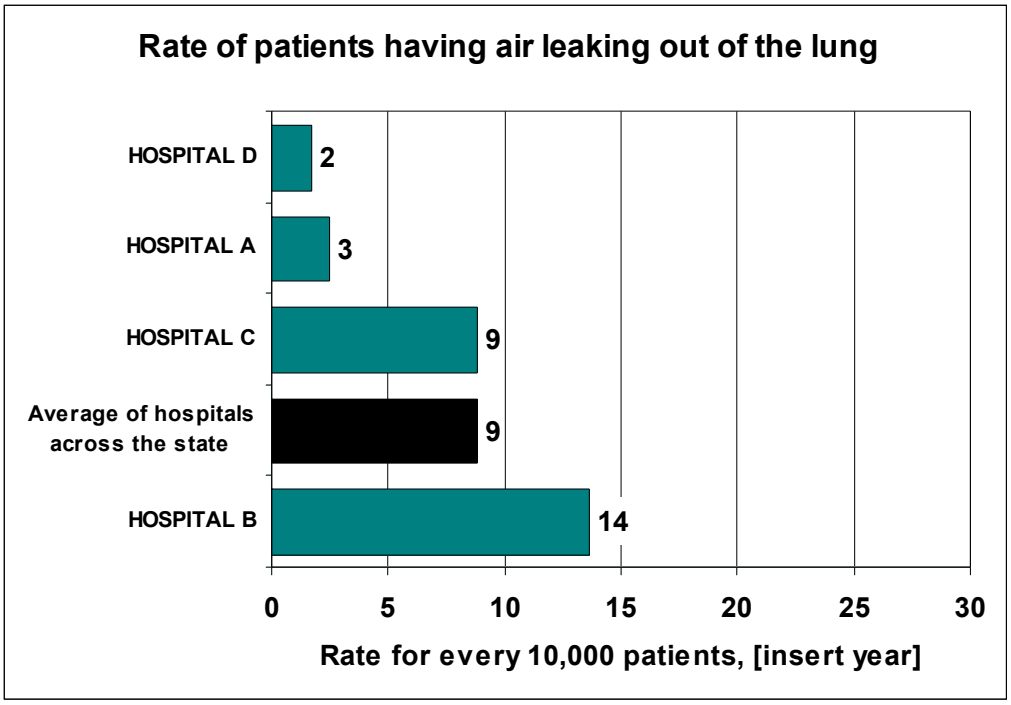
Average of hospitals across the state: The average rate at which surgical tools were accidentally left in a patient's body, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of patients having air leaking out of the lung

This graph shows you how often air leaks out of the lung because someone accidentally punctured it as a result of a medical procedure (called *iatrogenic pneumothorax*). Iatrogenic pneumothorax sometimes requires putting a tube into a patient's chest to remove the extra air. This information is for patients who were admitted during [insert year]. **Please note that this is a very rare event**.

When choosing a hospital, look for the hospital that has a **lower** rate for this complication. A **lower** rate is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients with this complication in hospitals across your state. This number is included so you have:

- a better idea of what is normal for your state.
- a basis for comparing individual hospitals' performance.

Medical complications in the hospital, for adult patients

This Report includes nine indicators showing how often **adult** hospital patients experienced a medical complication or problem during a hospital stay. These complications can be serious, even fatal. Each of them can be potentially prevented if steps are taken to make care safer.

Please check the box next to each indicator you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left)

Select All Indicators

☐ **Death rate from failure to identify and treat a serious complication**
How often patients died after developing a complication that should have been identified quickly and treated (called *failure to rescue*).

☐ **Death rate for patients with health problems that rarely result in death**
How often patients died in the hospital when they had been admitted for a health problem that rarely results in death. (This is called *death in low mortality DRGs,* i.e. **d**iagnosis-**r**elated **g**roups.)

☐ **Rate of infections due to medical care**
How often patients got certain types of infections as a result of the care they received in the hospital.

☐ **Rate of patients with bed sores**
How often patients developed a bed sore (called a *decubitus ulcer*), which is a sore or wound on the skin. This can occur because people are lying in one position for too long.

☐ **Rate of blood transfusion reaction**
How often patients in the hospital had a reaction because they received the wrong type of blood. (This is called a *transfusion reaction*).

☐ **Rate of accidental cuts and tears**
How often patients were accidentally cut, making an unnecessary or dangerous hole or tear in an organ of the body (called an *accidental puncture and laceration*), while receiving medical care in the hospital.

Compare Hospital Scores

Compare hospital scores on medical complications, for adult patients

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the indicator names for detailed results on how each hospital performed.

Death rate is the percent of patients who were treated for a particular illness or had a particular procedure who died while in each hospital during [insert year]. **Rate** is the percent of patients who experienced a particular problem while in the hospital during [insert year].	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

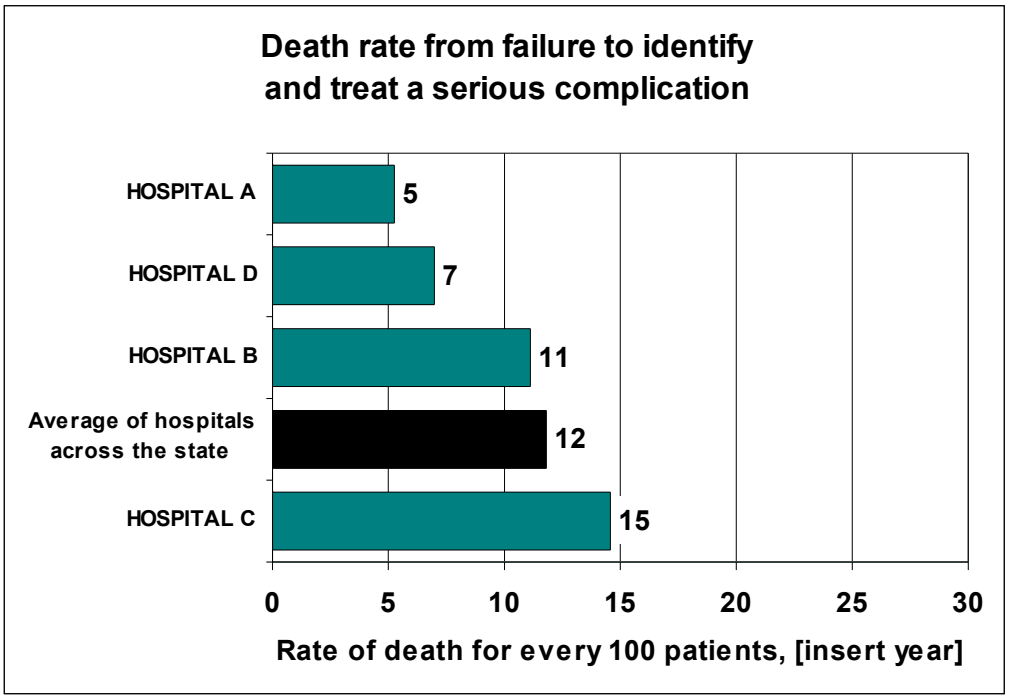
Medical complications, for adult patients	Hospital A	Hospital B	Hospital C	Hospital D
Death rate from failure to identify and treat a serious complication The average rate of death for hospitals across the state is **12** for every **100** patients.	**Better than average**	Average	**Worse than average**	**Better than average**
Death rate for patients with health problems that rarely result in death The average rate of death for hospitals across the state is **2** for every **1,000** patients.	**Better than average**	**Worse than average**	**Worse than average**	**Worse than average**
Rate of patients with bed sores The average rate for hospitals across the state is **3** for every **100** patients.	**Better than average**	Average	**Worse than average**	**Better than average**
Rate of infections due to medical care The average rate for hospitals across the state is **3** for every **1,000** patients.	**Better than average**	**Worse than average**	Average	**Better than average**
Rate of blood transfusion reaction The average rate for hospitals across the state is **5** for every **1,000,000** patients.	**Better than average**	**Better than average**	Average	**Worse than average**
Rate of accidental cuts and tears The average rate for hospitals across the	Average	**Better than average**	**Worse than average**	Average

state is **3** for every **1,000** patients.				

Death rate from failure to identify and treat a serious complication

This graph shows you the percent of patients who died because they developed a complication that should have been identified quickly and treated by hospital staff (which is called *failure to rescue*). This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has **lower** death rates for this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



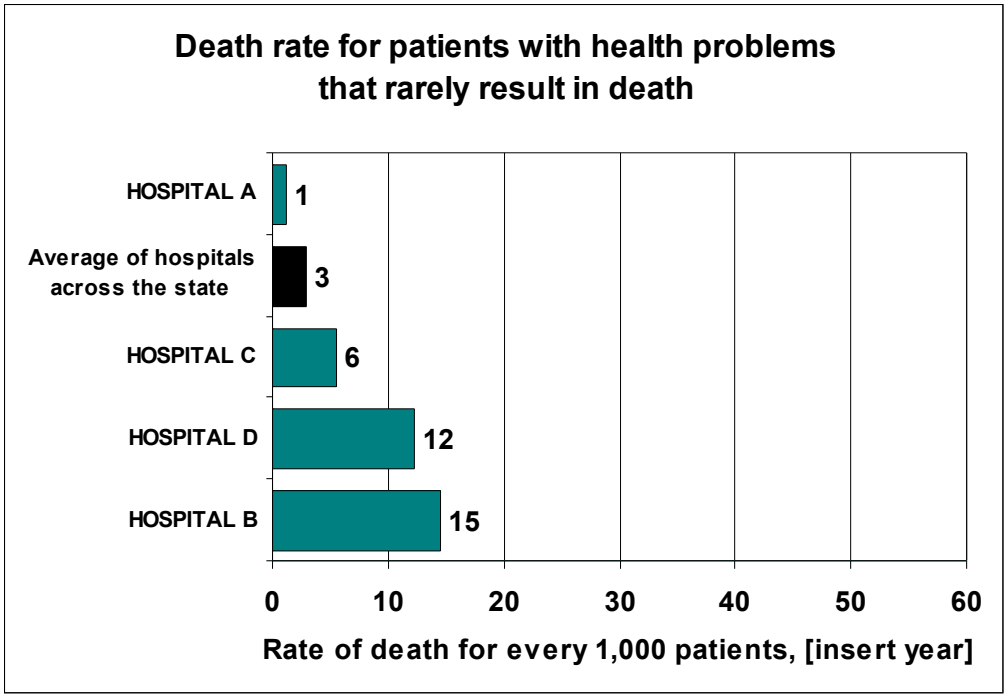
Average of hospitals across the state: The average rate of patients who died from failure to identify and treat a serious complication, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for patients with health problems that rarely result in death

This graph shows you how often patients died in the hospital when they were admitted for a health problem or condition that rarely results in death. (This is called *death in low mortality DRGs*.) This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate of deaths for this indicator. A **lower** rate is shown by a **shorter** bar on the graph below.



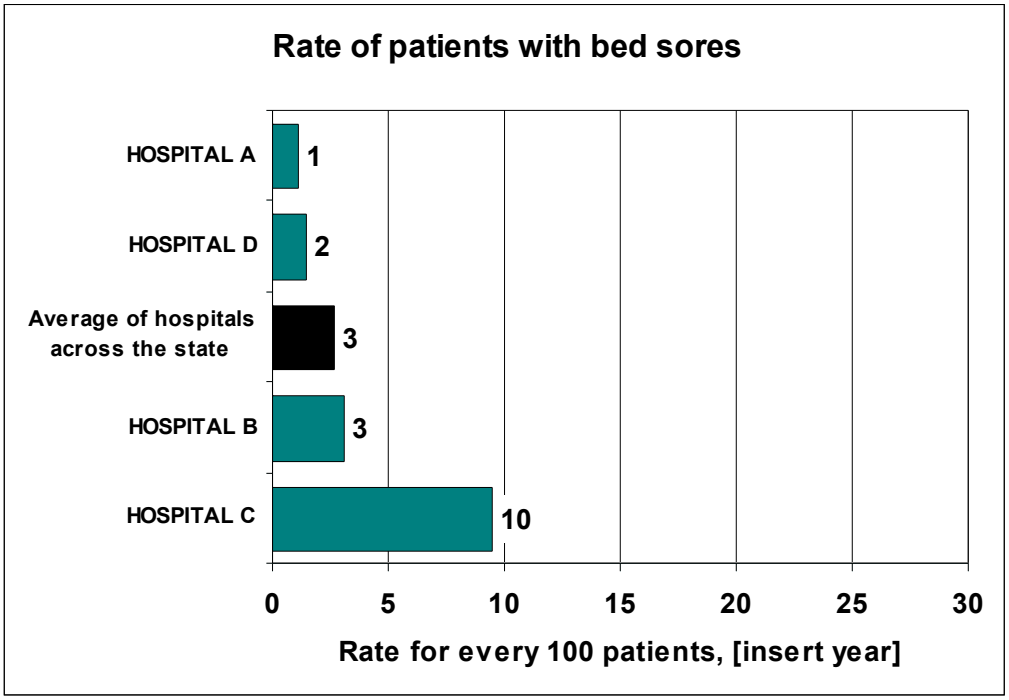
Average of hospitals across the state: The average rate of deaths for patients admitted to the hospital with health problems that rarely result in death in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of patients with bed sores

This graph shows you the percent of patients who developed bed sores, which are sores or wounds on the skin (called a *decubitus ulcer*), during their hospital stay. Usually this happens when patients are lying in one position for too long and can often be prevented. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



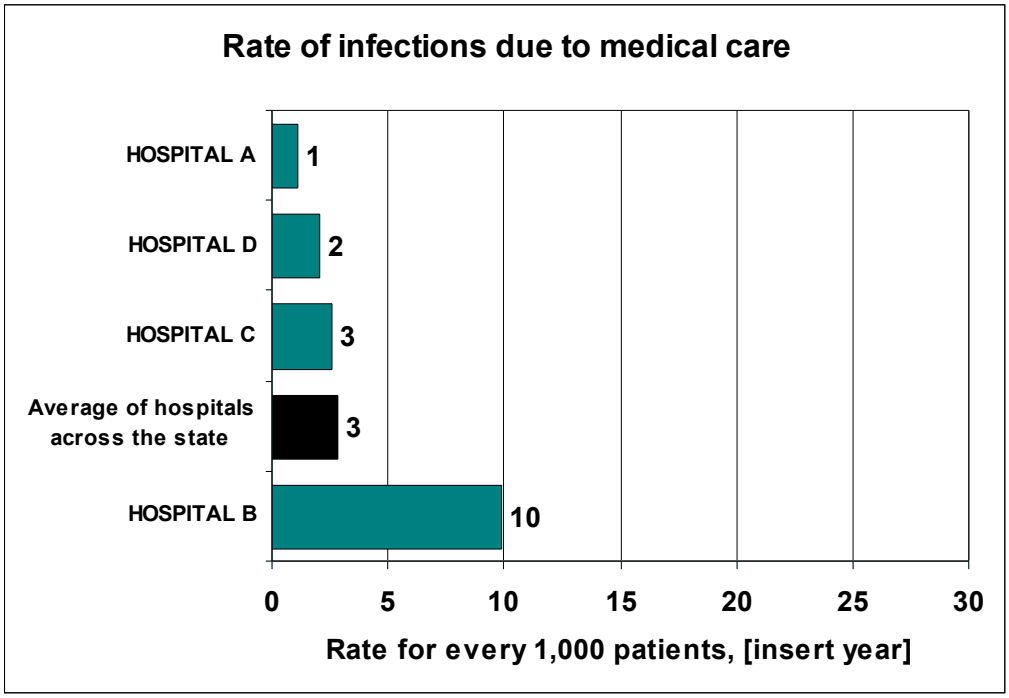
Average of hospitals across the state: The average rate of patients with bed sores in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of infections due to medical care

This graph shows you the percent of patients who got certain types of infections as a result of care they received while in the hospital. These include infections related to intravenous tubes and fluids, treatment of kidney failure, transfusions, and other types of shots. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this topic. A **lower** number is shown by a **shorter** bar on the graph below.



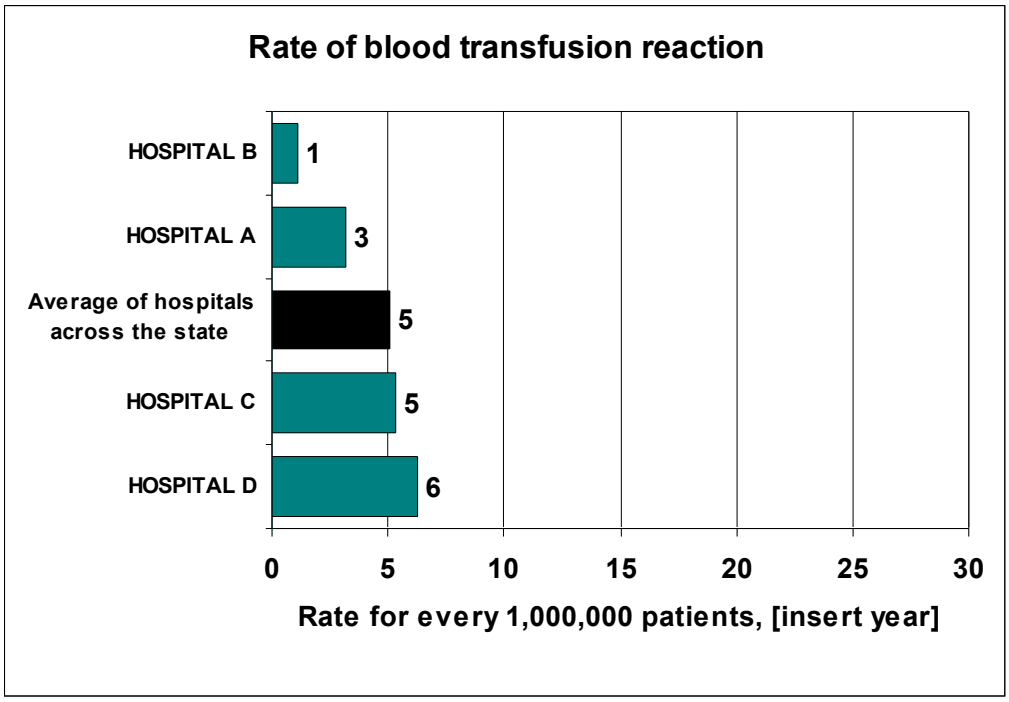
Average of hospitals across the state: The average rate of patients with certain types of infections due to medical care, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of blood transfusion reaction

This graph shows you the percent of patients who had a reaction because they received the wrong type of blood (which is called a *transfusion reaction*). This situation can largely be avoided if the blood is tested correctly beforehand and the right blood is given to the right patient. This information is for patients admitted during [insert year]. **Please note this is a very rare event.**

A blood transfusion reaction can be very serious. When choosing a hospital, you should look for the hospital that has **lower** rates for this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



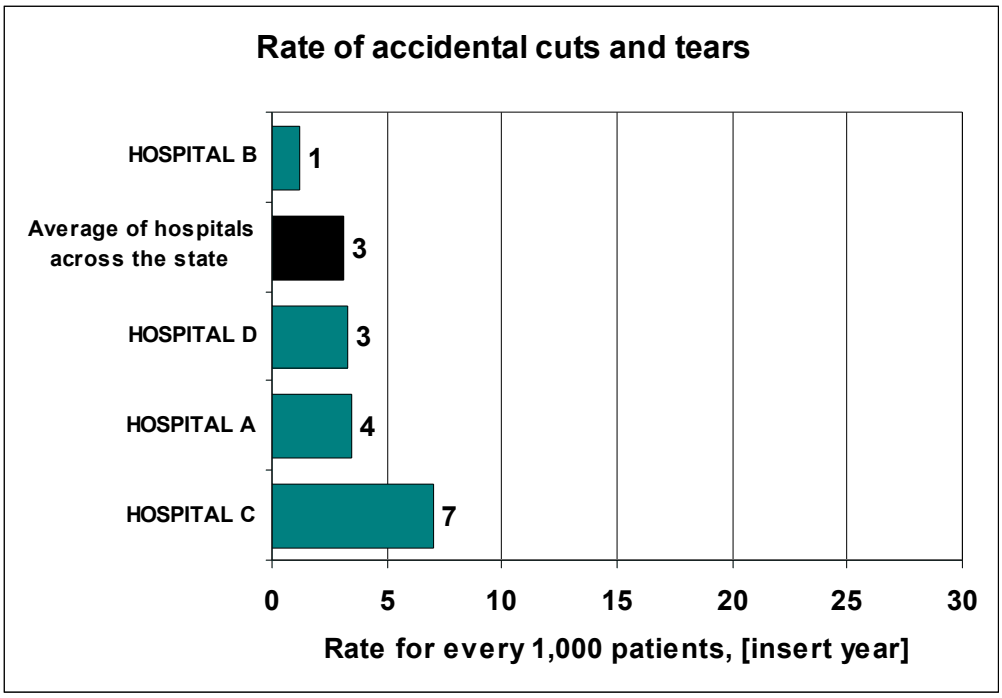
Average of hospitals across the state: The average rate of patients who had a blood transfusion reaction, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of accidental cuts and tears

This graph shows you the percent of patients who were accidentally cut or injured, making a hole or tear in an organ of the body, while receiving medical care (which is called *accidental puncture and laceration*). This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who had accidental cuts and tears, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Quality of medical care, for children

Information is available in the Report about eight indicators of the quality of care for **children** in the hospital. The information does **not** cover what happens to anyone over the age of 18. Definitions of each of the indicators are provided below.

Please check the box next to each topic you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/ left).

Select All Indicators

☐ **Rate of breathing failure among children after an operation**
How often children became unable to breathe on their own following an operation, and needed a ventilator (a machine that helps someone breathe), at least temporarily (which is called *postoperative respiratory failure*.)

☐ **Rate of splitting open of a surgical wound among children after an operation on the stomach or pelvis**
How often a surgical wound in the stomach or pelvic area of a child split open after an operation (which is called *postoperative wound dehiscence in abdominopelvic surgical patients*.)

☐ **Rate of too much bleeding or blood clots after an operation, among children**
How often children bled too much (called *hemorrhaging*), or developed a large blood clot (called a *hematoma*) after an operation.

☐ **Rate of bed sores in hospitalized children**
How often children in the hospital developed a bed sore (called a *decubitus ulcer*), which is a sore or wound on the skin. This can occur because children are lying in one position for too long.

☐ **Rate of blood transfusion reaction in hospitalized children**
How often children in the hospital had a reaction because they received the wrong type of blood (which is called a *transfusion reaction*).

☐ **Rate of surgical instrument or tool accidentally left in a child's body**
How often a surgical instrument or tool (called a *foreign body*), such as a scalpel or a sponge, was accidentally left in a child's body during an operation.

☐ **Rate of children other than newborns having air leaking out of their lung**
How often air leaked out of a child's lung because someone accidentally punctured it as a result of a medical procedure (which is called *iatrogenic pneumothorax)*. This rate is for children other than newborns.

☐ **Death rate of children having heart operations**
How often children died in the hospital following heart operations.

Additional information: Number of operations
Information is also available about the number of times heart operations on children were done at individual hospitals. Research shows that, in general, when hospitals do these operations frequently, they are more likely to have good results. However, experts do not always agree on the minimum number needed to achieve high quality.

You will find a graph for this indicator on the same page as the death rate.

Compare Hospital Scores

Compare hospital scores on medical care for children

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on any of the indicators to see details on how each hospital performed on that particular indicator.

Rate is the percent of children who experienced a particular medical problem as a result of the care they received in each hospital during [insert year]. **Death rate** is the percent of children who had a particular procedure and who died while in each hospital during [insert year].	**A hospital's score is calculated in comparison to the average of hospitals across the state.** Average is about the same as the average of hospitals across the state. **Better than average** is better than the average of hospitals across the state. **Worse than average** is worse than the average of hospitals across the state.

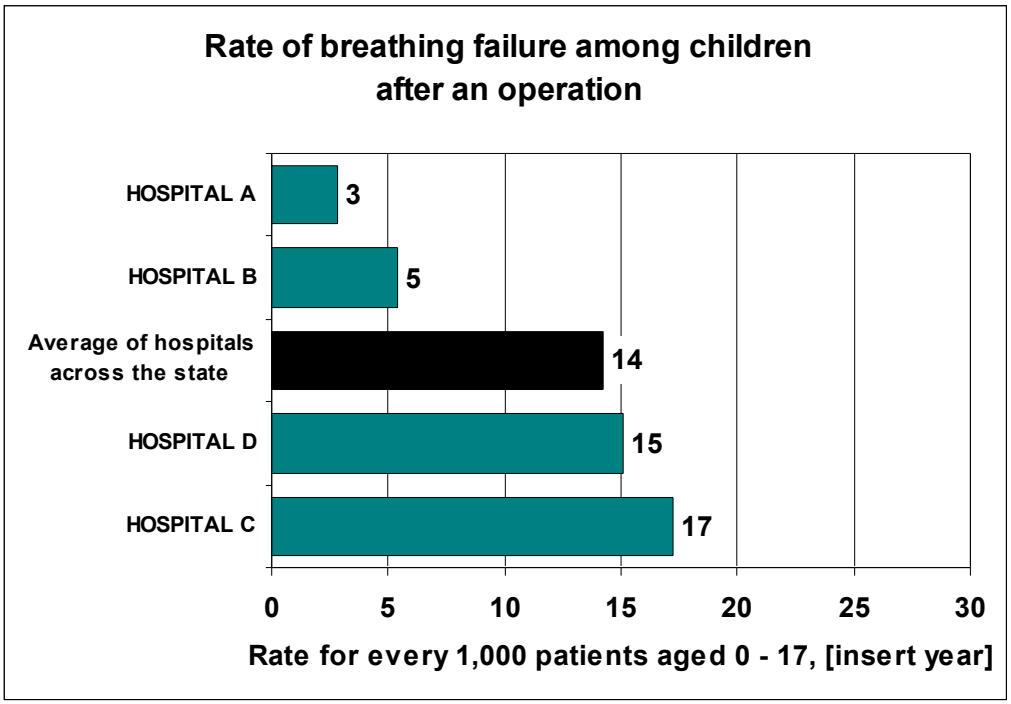
Medical care for children	Hospital A	Hospital B	Hospital C	Hospital D
Rate of breathing failure in children following an operation The average rate for hospitals across the state is **14** for every **1,000** child patients.	**Better than average**	**Better than average**	**Worse than average**	**Worse than average**
Rate of splitting open of a surgical wound after an operation on the stomach or pelvis of a child The average rate for hospitals across the state is **8** for every **10,000** child patients.	**Worse than average**	**Better than average**	Average	**Better than average**
Rate of too much bleeding or blood clots in children following an operation The average rate for hospitals across the state is **2** for every **1,000** child patients	**Better than average**	**Worse than average**	Average	Average
Rate of bed sores in hospitalized children The average rate for hospitals across the state is **3** for every **1,000** child patients	**Better than average**	**Worse than average**	Average	**Better than average**

Medical care for children	Hospital A	Hospital B	Hospital C	Hospital D
Rate of blood transfusion reaction in hospitalized children The average rate for hospitals across the state is **2** for every **1,000,000** child patients	**Worse than average**	**Better than average**	Average	**Better than average**
Rate of surgical instrument or tool accidentally left in child's body The average rate for hospitals across the state is **3** for every **100,000** child patients	**Worse than average**	Average	**Worse than average**	**Better than average**
Rate of children having air leaking out of their lung The average rate for hospitals across the state is **2** for every **10,000** child patients	**Better than average**	Average	**Worse than average**	**Better than average**
Death rate for children having heart operations The average rate of death for hospitals across the state is **5** for every **100** child patients.	**Better than average**	**Better than average**	**Worse than average**	**Better than average**

Rate of breathing failure among children after an operation

This graph shows you how often children having any kind of operation became unable to breathe on their own right afterwards, and needed a ventilator, which is a machine that helps someone breathe, at least temporarily (a complication that is called *postoperative respiratory failure*). This information is for patients under 18 admitted during [insert year].

When choosing a hospital, you should look for the hospital that has **lower** rates for this topic. A **lower** number is shown by a **shorter** bar on the graph below.



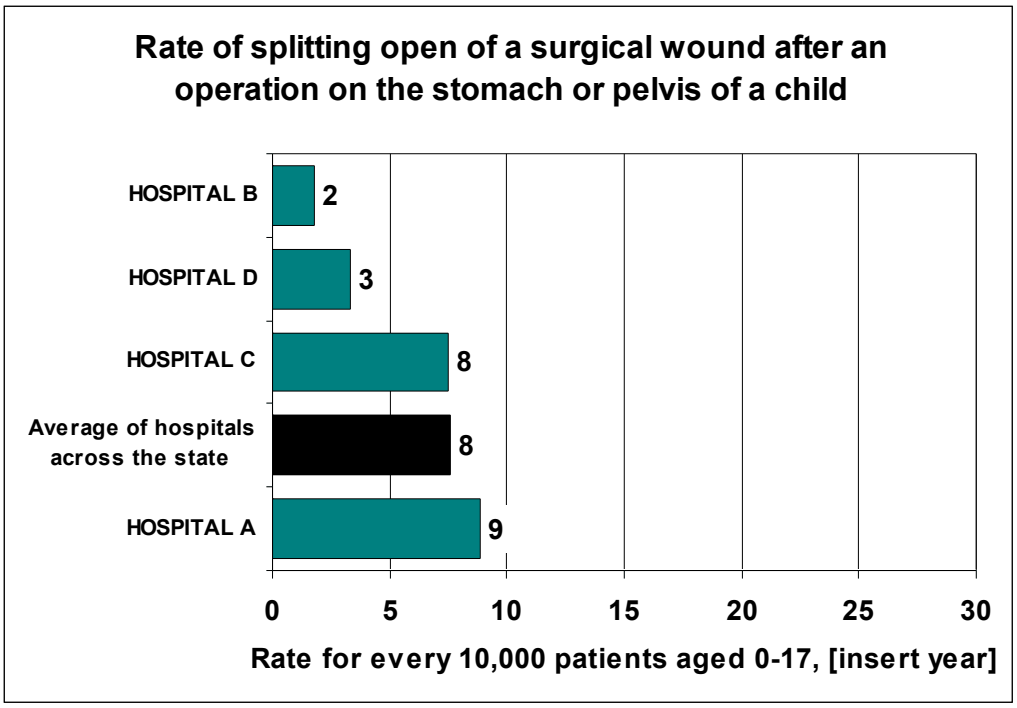
Average of hospitals across the state: The average rate of children with breathing failure after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of splitting open of a surgical wound after an operation on the stomach or pelvic area among children

This graph shows you the percent of children having an operation in their stomach or pelvic area whose wound split open after an operation (which is called *postoperative wound dehiscence*). All of these complications were treated with another major operation to fix the wound. This information is for patients admitted during [insert year]. **Please note that this is a very rare event.**

When choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



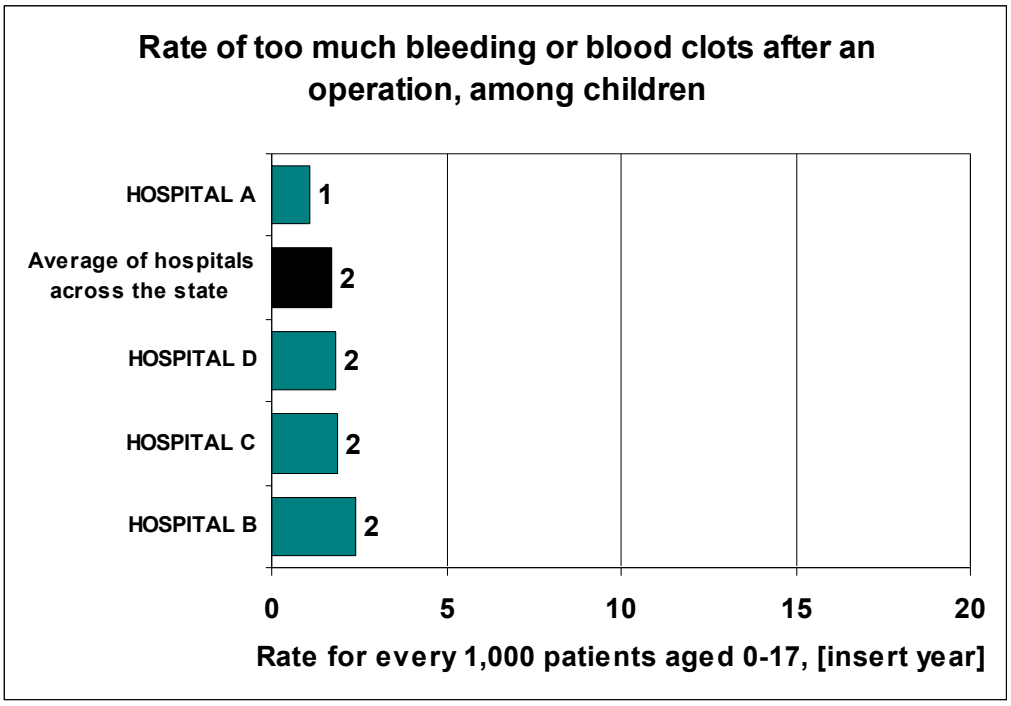
Average of hospitals across the state: The average rate of children who had surgical wounds in the stomach or pelvis split open after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of too much bleeding or blood clots after an operation, among children

This graph shows you how often children bled too much (called *hemorrhaging*) or developed a large blood clot (called *hematoma*) after an operation. All of these complications involved another operation to stop the bleeding or remove the blood clots. This information is for patients under 18 admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** rate is shown by a **shorter** bar on the graph below.



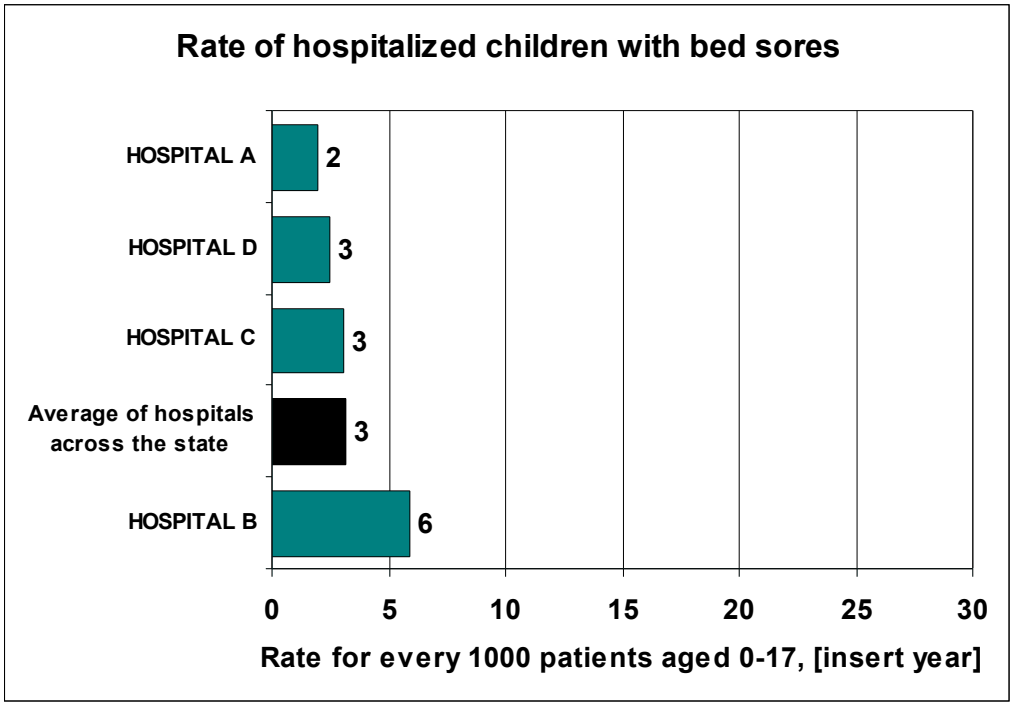
Average of hospitals across the state: The average rate of children with too much bleeding or blood clots in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance

Rate of hospitalized children with bed sores

This graph shows you how often children in the hospital developed a bed sore (which is called a *decubitus ulcer*), which is a sore or wound on the skin. This can occur because children are lying in one position for too long. This information is for patients under 18 admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



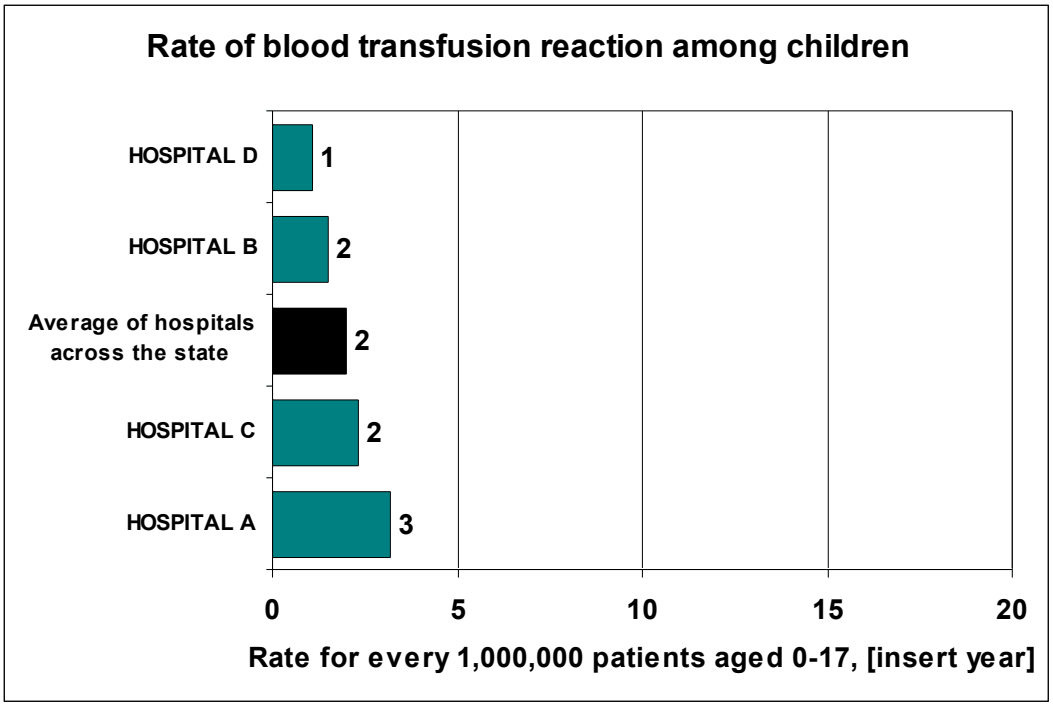
Average of hospitals across the state: The average rate of children with bed sores in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance

Rate of blood transfusion reaction among children

This graph shows you how often children in the hospital had a reaction because they received the wrong type of blood. (This is called a *transfusion reaction*.) This situation can largely be avoided if the blood is tested correctly and the right blood is given to the right patient. A blood transfusion reaction can be very serious. This information is for patients under 18 admitted during [insert year]. **Please note this is a very rare event.**

When choosing a hospital, you should look for the hospital that has **lower** rates for this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



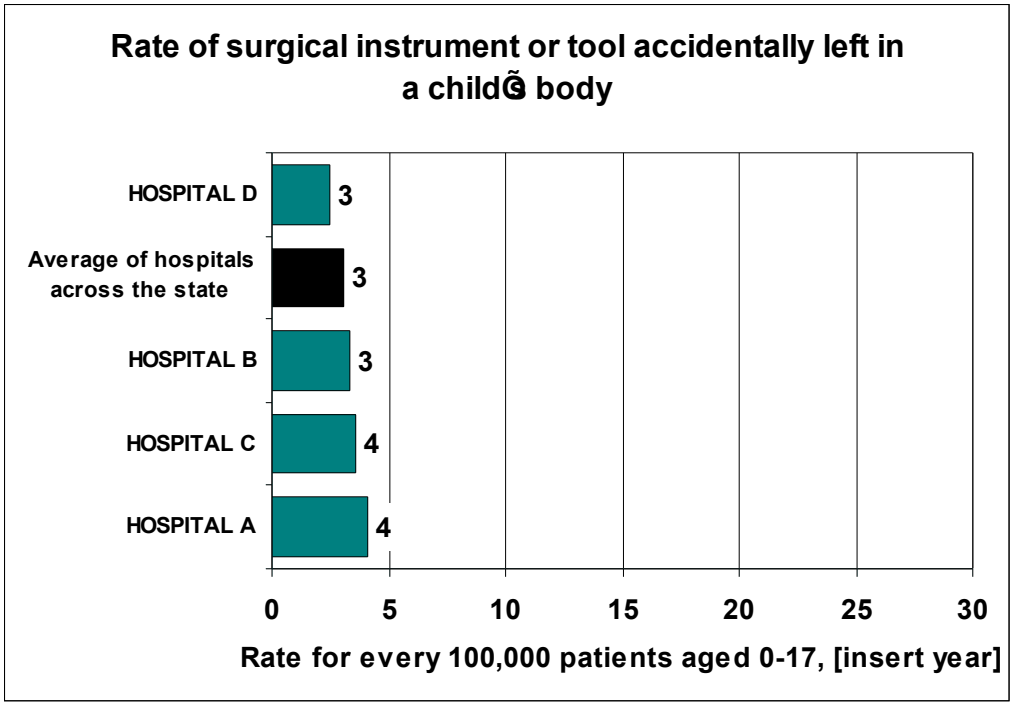
Average of hospitals across the state: The average rate of children who had a blood transfusion reaction, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of surgical instrument or tool accidentally left in a child's body

This graph shows you how often a surgical instrument or tool (called a *foreign body*), such as a scalpel or a sponge, was accidentally left in a child's body during an operation. This information is for patients under 18 admitted during [insert year]. **Please note: this is a very rare event.**

Having a surgical instrument or tool left behind can cause infection or cuts and be very dangerous. When choosing a hospital, you should look for the hospital that has **lower** rates for this indicator. A **lower** number is shown by a **shorter** bar on the graph below.



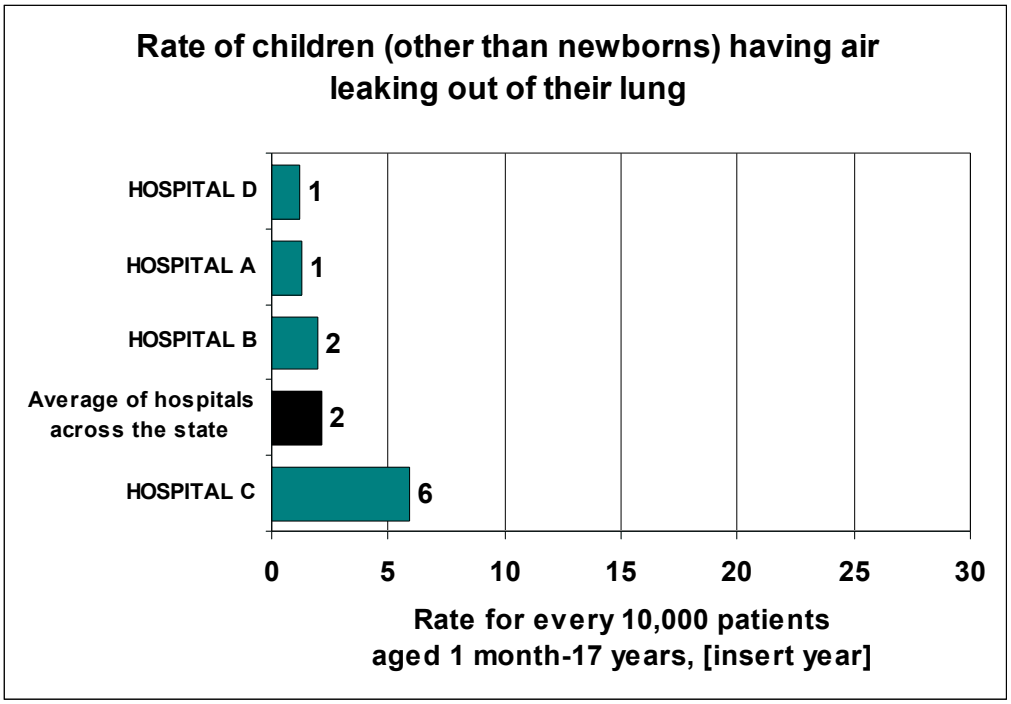
Average of hospitals across the state: The average rate at which surgical tools were accidentally left in a child's body, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of children (other than newborns) having air leaking out of their lung

This graph shows you how often air leaks out of a child's lung because someone accidentally punctured it during a medical procedure (a complication which is called *iatrogenic pneumothorax*). Iatrogenic pneumothorax sometimes requires putting a tube into a child's chest to remove the extra air. This information is for patients under 18, other than newborns, who were admitted during [insert year]. **Please note that this is a very rare event.**

When choosing a hospital, look for the hospital that has a **lower** rate for this complication. A **lower** rate is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients with this complication in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

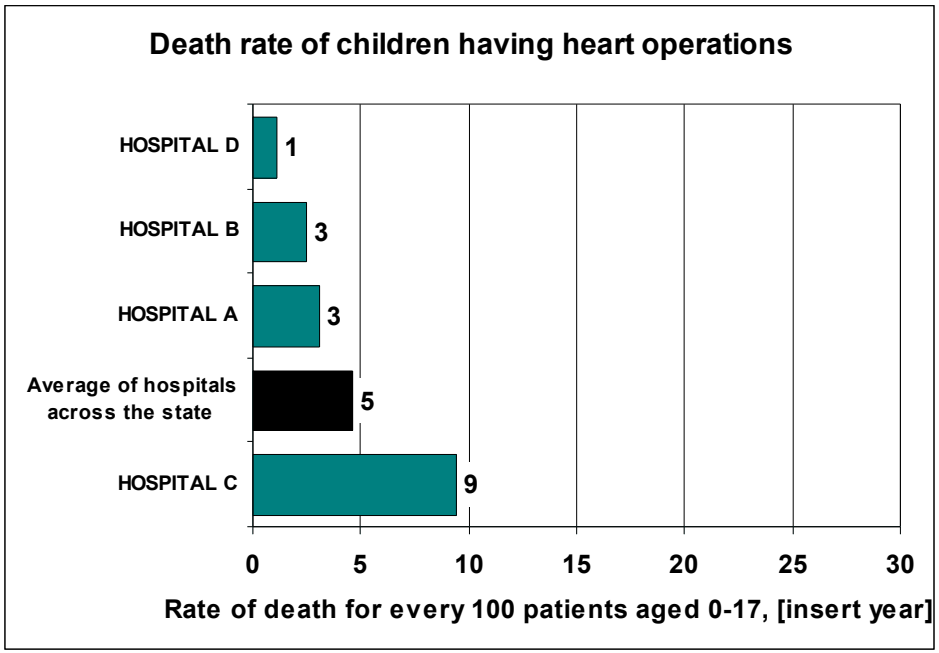
Heart operations performed on children – Death rate and number of operations

The two graphs on this page show you the quality of hospital care related to heart operations performed on children. This information is for patients under 18 admitted during [insert year].

The graph on the left side of the page shows you how often children died following this operation. The graph on the right shows the number of times a hospital performed this operation. Research shows that, in general, when hospitals do these procedures frequently, they are more likely to have good results. Often, but not always, a hospital that has a higher number of operations (right graph) will have lower death rates (left graph).

Death rate of children having heart operations

When choosing a hospital, look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.

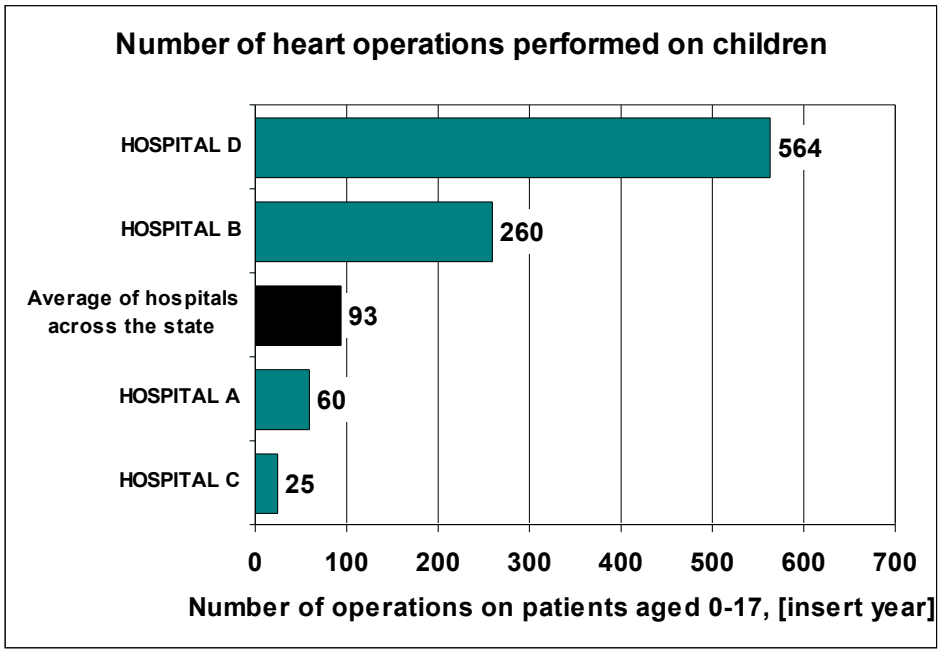


Average of hospitals across the state: The average number of deaths in children following this operation in the hospitals across the state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Number of heart operations performed on children

When choosing a hospital, look for the hospital that has a **higher** number of operations. A **higher** number is shown by a **longer** bar on the graph below.



Average of hospitals across the state: The average number of operations performed on children in hospitals across the state. This number is included so you have a better idea of what is typical for your state.

How should you use the Report?

How can this information help you? First and foremost, if you or someone you care about expects to be admitted to a hospital in the near future, you can use this information to **help you choose a hospital**. The information can help you **rule out certain hospitals** because the information indicates they do not perform well. It can help you **find a hospital that is especially good** at treating the conditions you face, or especially good at avoiding complications. The report can also help you **make a final choice** between two or three hospitals with good reputations.

The best way to use this particular report is also to **look for patterns in the scores**. Some hospitals may do very well across the board; others may do well in some areas and not in others; still others may really show problems in a wide range of areas. Look carefully for these patterns. At the same time, if there is a particular surgery, or medical condition, or complication that is of particular concern to you, you will want to give more weight to information related to those concerns.

Several factors go into making a hospital choice. For example, you may have to **use the specific hospitals in the "network" of your health plan.** If you have to go to a hospital in the network whose scores in this report are troubling to you, **bring the information to your doctor** to discuss it. You may want to ask your doctor to be especially vigilant to ensure that certain problems that are worrying you are avoided.

Second, you can only be admitted to a hospital by a doctor, and doctors typically have "admitting privileges," the right to admit patients, at one or a few hospitals. So when you choose a doctor, and especially **when you choose a specialist, you may actually be choosing a hospital** at the same time. So when your regular doctor refers you to a specialist, ask the question "Where can this specialist admit patients?" Then, **before committing yourself to a particular specialist, check out their hospital** in this report. Again, if the information troubles you, bring it back to your doctor and see if you can be referred to a specialist who practices at a hospital that performs well on the topics that are important to you.

Remember, it's your life, and your health. Most physicians and hospitals are happy to talk with patients about information from reliable sources, and they care about your preferences. You certainly have the right to raise issues with them and get answers to your questions.

A few things to keep in mind as you use the Report

This Report is a starting point for looking at the quality of care at a particular hospital. The overall scores and specific topic results are not the final word. There are a few things to keep in mind when looking at this report.

- **Neither the summary scores nor the specific topics cover all health conditions or surgeries.**

  As new information becomes available, this report may be updated.

- **The Report doesn't address all aspects of quality.**

  For example, this report does not include information on what patients say about their care in the hospital, or information on whether hospitals consistently follow steps known to lead to better results. Information like this is available for many American hospitals on a federal government website called Hospital Compare. **Click here to go to the Hospital Compare website.**

  The Report also does not include information on the specific services provided by a hospital. That information is best obtained directly from the hospital itself. **Click here for a list of hospitals included in this Report and how to contact them.**

- **Don't presume that because a hospital does well (or poorly) in one area of health care, that it will do well (or poorly) in all areas.**

  Hospitals can have strengths and weaknesses in providing different types of care. For example, there are many different kinds of cancers, each of which is treated differently. A hospital that has good scores on surgery involving cancer of the pancreas may not do so well with a different type of cancer.

- **In some cases, the specific topics track serious failures in a hospital's performance which happen only once in a great while.**

  You have to be careful when comparing hospitals on these very rare events. The numbers are so small that it is hard to know when a difference means something or just happens by chance. An example would be a reaction to a blood transfusion, which happens in only a handful of cases out of a million people each year.

- **Don't give too much weight to small differences between hospitals.**

  Even on more common events, be careful not to give too much weight to small differences. If in one hospital, 25 people out of a thousand had too much bleeding after surgery, and in another hospital, 26 people out of a thousand did, that's a really small difference and you shouldn't worry about it.

- **Some differences in scores may reflect the age of patients or how sick patients are rather than the care provided by the hospital.**

  Hospitals vary in quality, but they also vary in terms of their patients. Their patients can be differ in terms of their age, or in terms of how sick they are.

  If one hospital takes care of people who happen to be older, or sicker, that hospital's patients are more likely to die or have certain complications, no matter how good the hospital is.

  We want to show you differences that relate to how hospitals actually perform, rather than differences that relate to how old or sick their patients are. So to the extent possible, the information in this Report takes account of differences between hospitals in the age of their patients, and how sick they are. The scores in this report have been calculated to try to take account of these differences. For details about how the scores in this report were developed, **Click here for Technical Details about the Quality Information in this Report**

Hospital Quality: What is it? Where can I find learn more about it?

Quality in health care, including in hospitals, can be described as "doing the right thing, at the right time, in the right way -- and having the best possible results."

The Institute of Medicine recently stated that high quality health care is:

- ***Effective:*** Treatment uses scientific knowledge and medical experience to increase the chances of getting the best results, and decrease the chance of getting bad results, including death.
- ***Safe:*** Treatment does not result in medical complications or cause harm to the patient that can be prevented.
- ***Patient-centered:*** Doctors, nurses, and other medical staff treat patients with respect, dignity and compassion, and are responsive to patients' needs, values, and preferences.
- ***Timely:*** Patients get the care they need without harmful delays.
- ***Efficient:*** Treatment does not waste doctors' or patients' time or money.
- ***Equitable:*** The same level of care is available to everyone, including men, women and children of all cultures, incomes, education level, social status or any other characteristic.

Where to learn more about Hospital Quality

The information in this Report deals with the first two aspects of hospital quality described above – effective care and safe care. If you are interested in other aspects of quality care, here are some resources that can help. We also list websites with materials to help you think through the process of choosing a hospital.

Hospital Compare – Department of Health and Human Services

- *Hospital Compare* is a website with quality information on almost all hospitals in the US. Current information includes measures of timely and effective care for three conditions: heart attack, heart failure and pneumonia. There is also a measure of safe care, the surgical infection prevention rate.

  In the next year or so, the website will add two kinds of new information: information similar to this report about death rates for patients admitted for different operations and medical conditions, and information about patients' experiences in hospitals, such as how well doctors and nurses communicate with patients and how responsive hospital staff are to patient needs. Go to **www.hospitalcompare.hhs.gov**.
  In addition, the *Hospital Compare* website provides a *Hospital Checklist* that you can use to think through a range of issues to consider in choosing a hospital. Go to **http://www.hospitalcompare.hhs.gov/Hospital/Static/About-HospChecklist.asp**

Agency for Healthcare Research & Quality (AHRQ)

- *Quick Checks for Quality: Choosing Quality Health Care*, an information sheet by AHRQ, from **http://www.ahrq.gov/consumer/quick.htm**.

- AHRQ's *Your Guide to Choosing Quality Health Care*, from **http://www.ahrq.gov/consumer/qnt**

- *Be an Active Health Care Consumer* (**http://www.ahrq.gov/path/beactive.htm**), an AHRQ web page that includes a list of quality tools and information for people who want to take an active role in their health care. Among the resources is a booklet, ***Guide to Health Care Quality: How to Know it When You See It***

To contact AHRQ by mail write to:
Agency for Healthcare Research and Quality
Office of Communications and Knowledge Transfer
540 Gaither Road, Suite 2000
Rockville, MD 20850.

To reach them by phone, call (301) 427-1364

Joint Commission on the Accreditation of Healthcare Organizations

This organization (JCAHO) is the primary group that reviews and accredits hospitals in the United States.

- *Quality Check* (**http://www.qualitycheck.org/consumer/searchQCR.aspx**), a site of the Joint Commission on the Accreditation of Healthcare Organizations, on which you can look up hospitals that meet this organization's patient safety and quality standards.

To reach JCAHO with a general question, call 630-792-5000.

To order JCAHO publications, call 877-223-6866

If you have concerns and complaints about your care

If you have a complaint about the quality of the medical care you or a loved one received at a hospital, first contact the hospital's patient advocate. You can usually reach the patient advocate through the hospital's telephone operator.

If you still need help, there are two agencies in every state that work on hospital quality.

- *The Quality Improvement Organization or QIO.* This is the organization to contact if you are not satisfied after calling the hospital's patient advocate.
- *The State Survey Agency.* This is the organization to call if you have other complaints about a health care facility.

The phone numbers for the State Survey Agency and the Quality Improvement Organization in your state can be found at **www.medicare.gov/Contacts/Home.asp.** Additional information about hospitals may be found on websites of these state agencies.

You can also contact the Complaint Hotline at the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
Phone: 1-800-994-6610
E-mail: complaint@jointcommission.org.

Technical details about the quality information in this Report

The quality indicator scores in this report are based on standardized information that all hospitals in our state are required to submit to (insert name of state agency). Hospitals have to demonstrate that the information they provide is accurate and complete. The (agency) actually calculates the scores, not the hospitals.

The specific indicators in this report were developed by the Agency for Healthcare Research and Quality (AHRQ), and are called the AHRQ Quality Indicators. AHRQ is a federal government agency whose mission is to improve the quality and safety of health care in the United States.

AHRQ saw a need for a set of hospital quality indicators that could be collected easily, based on information that was gathered in exactly the same way from hospital to hospital. Dozens of experts in health services research, internal medicine and pediatrics, statistics, and health care quality measurement worked together to develop and test these indicators to make sure they were medically meaningful, accurate and reliable. The indicators are regularly reviewed and updated. **Click here for detailed information about the AHRQ Quality Indicators**

AHRQ has developed several kinds of indicators. The ones in this Report include what are called Inpatient Quality Indicators, Patient Safety Indicators, and Pediatric Quality Indicators. Both of these sets of indicators relate primarily to the *results* of hospital care for patients.

Click here for detailed information about the AHRQ Inpatient Quality Indicators

Click here for detailed information about the AHRQ Patient Safety Indicators

Click here for detailed information about the AHRQ Pediatric Quality Indicators

How we analyzed the data and calculated scores

In this section of the website, the sponsor should present information about the methods they used in analyzing the data and calculating scores. For example, this is the place to explain how some hospitals were identified as being "better" or "worse" than average, additional details about risk-adjustment methods, and whether or not the data were smoothed, or combined for several years.

III. HOSPITAL QUALITY MODEL REPORT: COMPOSITES

SPONSOR HOME PAGE

This page would be the normal home page of whatever group is releasing the report in a particular state or community. The group might be, for example, the State Health Department. The page would have a direct link to the ***Report Home Page****. We are thinking about using the following language to introduce the Report. Note that throughout this document we will refer to the entire template as "the Report" but it is presumed that the name of the report will be chosen by the sponsor.*

Announcing!

(sponsor name) is proud to introduce a new tool to help the people and hospitals of (insert location) learn about and improve the quality of health care in our (community/state). The Report provides information that lets you compare how well our hospitals perform when they take care of patients with a wide range of health problems.

Whether you are choosing a hospital for yourself or a loved one, or just want to see where a particular hospital performs well and how it might improve its care, take advantage of this new resource. **Go to Report Home Page** *Note: this can be a "tab" on the website in addition to having a link here*

National experts in medicine and hospital quality, led by the federal government's lead agency for health care quality, provided the building blocks for this tool. They identified the most readily available information that can give an accurate picture of the quality and safety of care at different hospitals. **Click here to get Technical Details about the Quality Information in the Report** *Note: this can be a "tab" on the website in addition to having a link here*

They also asked people like you if this was information they would like to have, and their answer was "yes!"

We hope you find this tool valuable. If you have questions, or want to share your feedback on the tool, please email us at (insert email address or provide link to feedback form).

Report on Hospital Quality in [*community/state*]

Quality in health care, including in hospitals, can be described as "doing the right thing, at the right time, in the right way -- and having the best possible results."

This report provides information on how well all the hospitals in [*community/state*] care for patients with a wide range of health problems. It can:

- help you choose a hospital for yourself,
- provide useful information for your loved ones if they need hospital care,
- encourage hospitals to improve their quality, and
- help everyone learn more about hospital quality.

Why should you look at this information?

Don't people get good care in any hospital their doctor recommends? Here are the facts:

- All hospitals do not provide the same quality of care. Some hospitals are better than others.
- A particular hospital might do a very good job on some health problems and not such a good job on other health problems.
- Whenever anyone goes to the hospital, they risk getting a new health problem while getting medical care for an existing problem. Hospitals vary in how well they protect patients from these risks.
- Your doctor, or the specialist or surgeon he or she recommends, may be highly skilled, but hospital quality also depends on how well all the hospital staff, such as the nurses, take care of you, and on how well the hospital is organized.

Given those facts, our goal is to give you information you can use to increase your chances of getting the best possible hospital care when you need it.

What Information is available in the Report?

There are two types of information provided in this Report:

- how often patients had medical complications while in the hospital, and
- how often patients died while in the hospital for certain health conditions and operations

This information is provided about [X] hospitals. By looking at this information, you will be able to compare which hospitals have the **fewest number of deaths and complications**.

There are many ways to judge hospital quality. We are reporting this information because experience shows it is accurate, easily available for most hospitals from their administrative records, and of interest to members of the public.

Click here to start comparing hospitals' results

Step One: Choose one or more hospitals to compare

We have information on how well (insert number) hospitals performed.

Sponsors: This is where you set up a search function through which users will be able to enter information, such as a zip code or city/state, and then view a list of hospitals in your area that are included in the report.

Click here to go to Step Two: Select which scores you want to see

Step Two: Select overall scores

Each of these overall scores reflects a hospital's performance on a number of more specific topics listed below. Once you view the results for the overall score, you can then choose to see the results for these more specific topics. All of the information refers to adult patients, with the exception of "Overall score for medical complications for children."

Please check the boxes next to each overall score you want to see.
You can return to this page and pick another overall score to look at whenever you like, using the tabs on the (top/left).

Select All of the Overall Scores

☐ **Overall score for hospital patients having operations.** This score is based on how often patients died after having the following operations:

- CABG (Coronary artery bypass graft)
- PTCA (Percutaneous transluminal coronary angioplasty)
- Operation to remove part or all of the esophagus
- Operation to remove part or all of the pancreas
- Operation to remove blockage in arteries to the brain
- Brain surgery
- Hip replacement surgery
- Surgical repair of an aortic aneurysm

☐ **Overall score for hospital patients admitted with particular health conditions.** This score is based on how often patients died after being admitted to the hospital for the following health conditions:

- Heart Attack
- Congestive heart failure
- Pneumonia
- Stroke
- Broken hip (hip fracture)
- GI (stomach or intestinal) bleeding

☐ **Overall score for medical complications, for adults.** This score is based on how often adult patients experience the following twelve complications, either after an operation or as a result of other care provided in the hospital:

- Bed sores
- Leaking air from the lung because it was accidentally punctured during a medical procedure
- Infections due to medical care
- Hip fracture after an operation
- Too much bleeding or clots after an operation
- Abnormal changes in body function after an operation
- Breathing failure after an operation
- Blood clots in the lung or large vein after an operation
- Bloodstream infection following an operation

- Splitting open of a surgical wound after an operation on the stomach or pelvic area
- Accidental cuts and tears

☐ **Overall score for medical complications, for children.** This score is based on how often children under the age of 18 experienced the following seven complications in the hospital, either after an operation or as a result of other care provided by the hospital:

- Bed sores
- Leaking air from the lung because it was accidentally punctured during a medical procedure
- Infections due to medical care
- Too much bleeding or blood clots after an operation
- Breathing failure after an operation
- Bloodstream infection following an operation
- Splitting open of a surgical wound after an operation on the stomach or pelvic area
- Accidental cuts and tears

Compare Hospital Scores

Compare the Results of Hospital's Overall Scores

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the overall score name to see detailed results of how each hospital performed.

Each hospital's score is compared to the average scores of hospitals across the state.

Average is about the same as the average score of hospitals across the state.

Better than average is better than the average score of hospitals across the state.

Worse than average is worse than the average score of hospitals across the state.

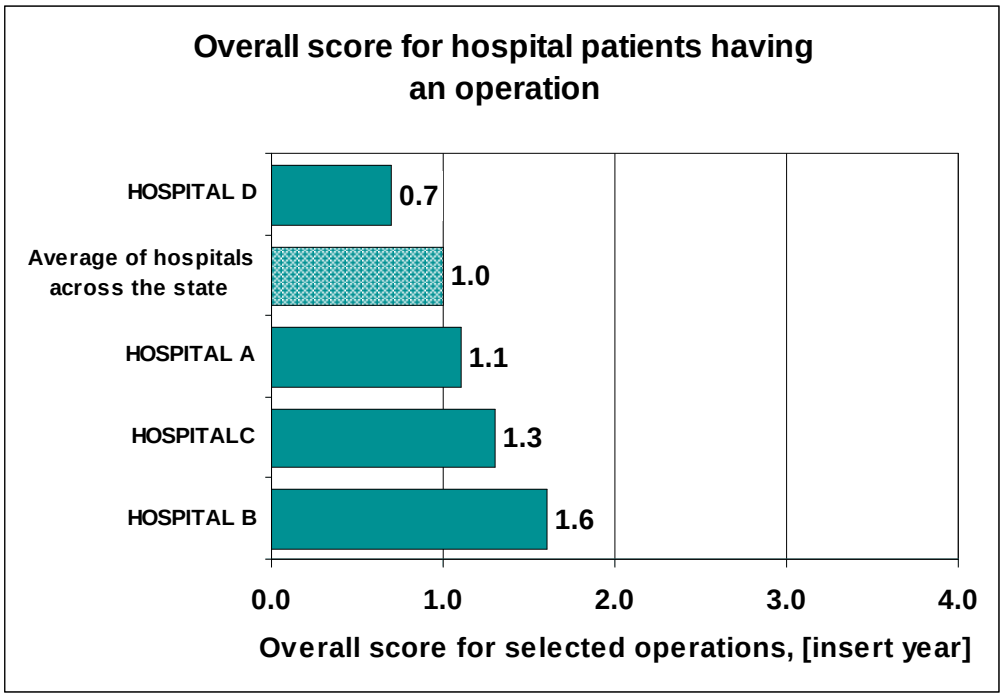
Overall Scores	Hospital A	Hospital B	Hospital C	Hospital D
Overall score for hospital patients having operations	Average	Worse than average	Worse than average	Better than average
Overall score for hospital patients admitted with particular health conditions	Better than average	Better than average	Worse than average	Better than average
Overall score for medical complications for adults	Better than average	Worse than average	Average	Average
Overall score for medical complications for children	Worse than average	Worse than average	Better than average	Better than average

Overall score for hospital patients having operations

This graph shows overall scores based on how often patients died in each hospital after having the following eight different operations:

- CABG (Coronary artery bypass graft)
- PTCA (Percutaneous transluminal coronary angioplasty)
- Operation to remove part or all of the esophagus
- Operation to remove part or all of the pancreas
- Operation to remove blockage in arteries to the brain
- Brain surgery
- Hip replacement surgery
- Surgical repair of an aortic aneurysm

When choosing a hospital, you should look for the hospital that has a **lower** score. A lower score is shown by a **shorter** bar on the graph below. In particular, look for a score that is **1.0 or less.** This information is for patients admitted during [insert year].



Average of hospitals across the state: The average score for hospital patients having operations in the hospitals across your state. This number is included so you have a better idea of what is typical for your state.

What do these scores mean?

Even in the best hospital, some patients will die after having each of these operations. The scores in this report are calculated by comparing the number of deaths expected in a particular hospital, (based on how many operations they do and how old and sick their patients are) and how many patients actually died. An overall score of 2.0 means that twice as many patients died as expected. An overall score of .5 means that half as many patients died as expected.

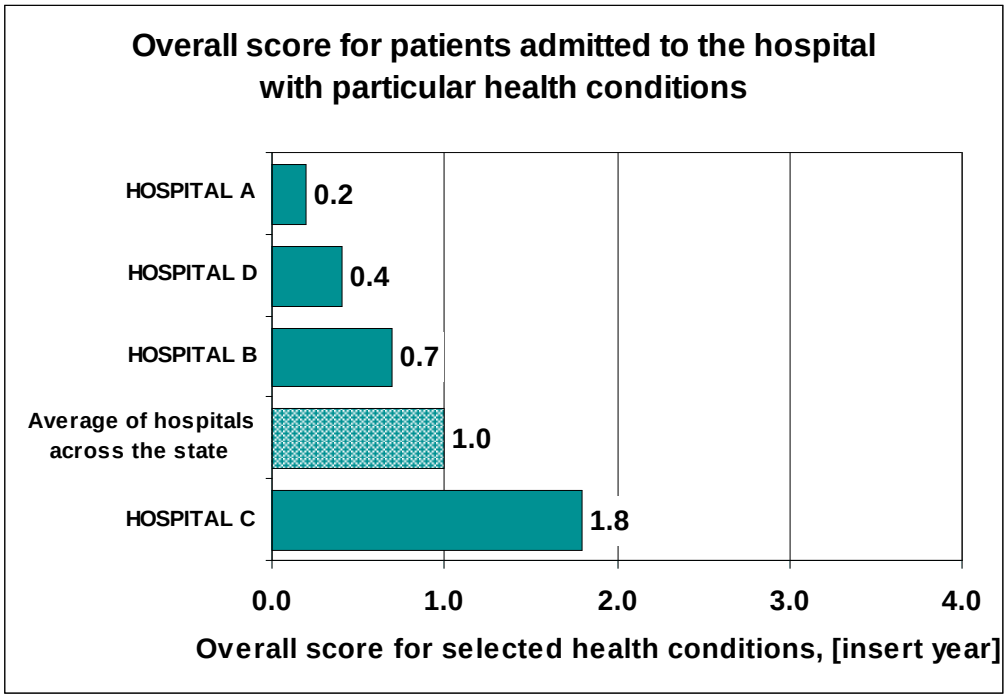
Click here to see results for each of the specific operations listed above

Overall score for hospital patients admitted with particular health conditions

This score is based on how often patients died in the hospital after being admitted with particular health conditions. These patients did not have an operation. This score is based on the results for the following six health conditions:

- Heart attack
- Congestive heart failure
- Pneumonia
- Stroke
- Broken hip (hip fracture)
- GI (stomach or intestinal) bleeding

When choosing a hospital, you should look for the hospital that has a **lower** score. A lower score is shown by a **shorter** bar on the graph below. In particular, look for a score that is **1.0 or less.** This information is for patients admitted during [insert year].



Average of hospitals across the state: The average score for patients admitted to the hospital with particular health conditions in the hospitals across your state. This number is included so you have a better idea of what is typical for your state.

What do these scores mean?

Even in the best hospital, some patients will die after having each of these operations. The scores in this report are calculated by comparing the number of deaths expected in a particular hospital, (based on the number of operations they do or patients they see and how old and sick their patients are) and how many patients actually died. An overall score of 2.0 means that twice as many patients died as expected. An overall score of .5 means that half as many patients died as expected.

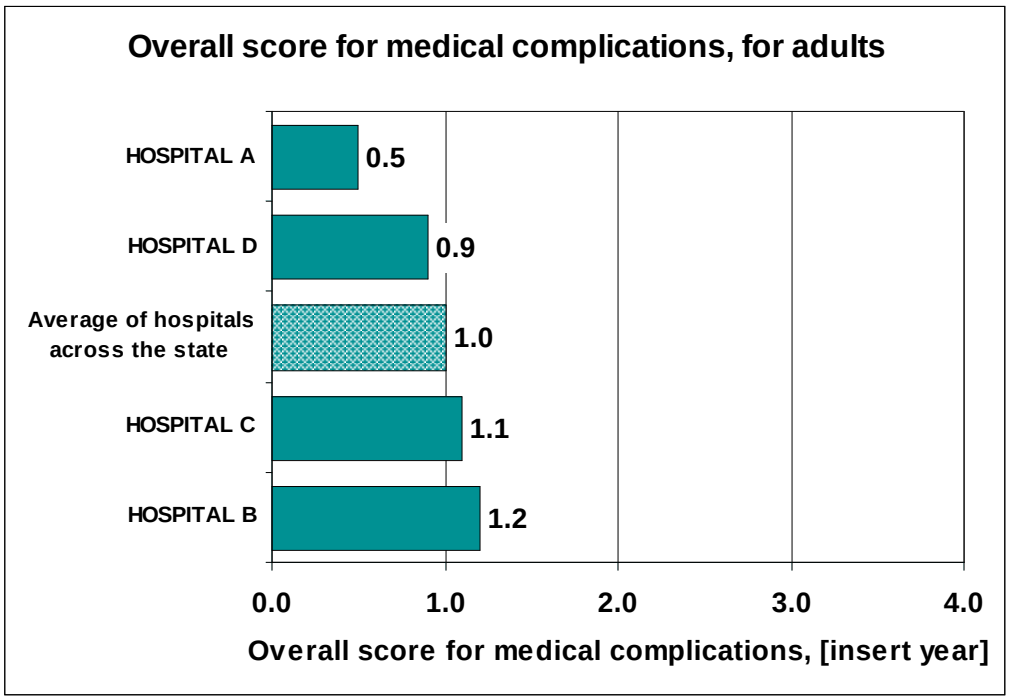
Click here to see results for each of the specific operations listed above

Overall score for medical complications, for adults

This score is based on how often adult patients experienced the following eleven complications, either after an operation or as a result of other care provided in the hospital:

- Bed sores
- Leaking air from the lung because it was accidentally punctured during a medical procedure
- Infections due to medical care
- Hip fracture after an operation
- Too much bleeding or blood clots after an operation
- Abnormal changes in body function after an operation
- Breathing failure after an operation
- Blood clots in the lung or large vein, after an operation
- Infection following an operation
- Splitting open of a surgical wound after an operation on the stomach or pelvic area
- Accidental cuts and tears

When choosing a hospital, you should look for the hospital that has a **lower** score. A lower score is shown by a **shorter** bar on the graph below. In particular, look for a score that is **1.0 or less.** This information is for patients admitted during [insert year].



Average of hospitals across the state: The average score for medical complications in adult patients in the hospitals across your state. This number is included so you have a better idea of what is typical for your state.

What do these scores mean?

Even in the best hospital, some patients will experience complications either after an operation or as a result of other care. The scores in this report are calculated by comparing the number of complications expected in a particular hospital (based on the number of operations they do or patients they see and how old and sick their patients are) and how many patients actually experienced complications. An overall score of 2.0 means that twice as many patients

experienced complications as expected. An overall score of 0.5 means that half as many patients experience complications as expected.

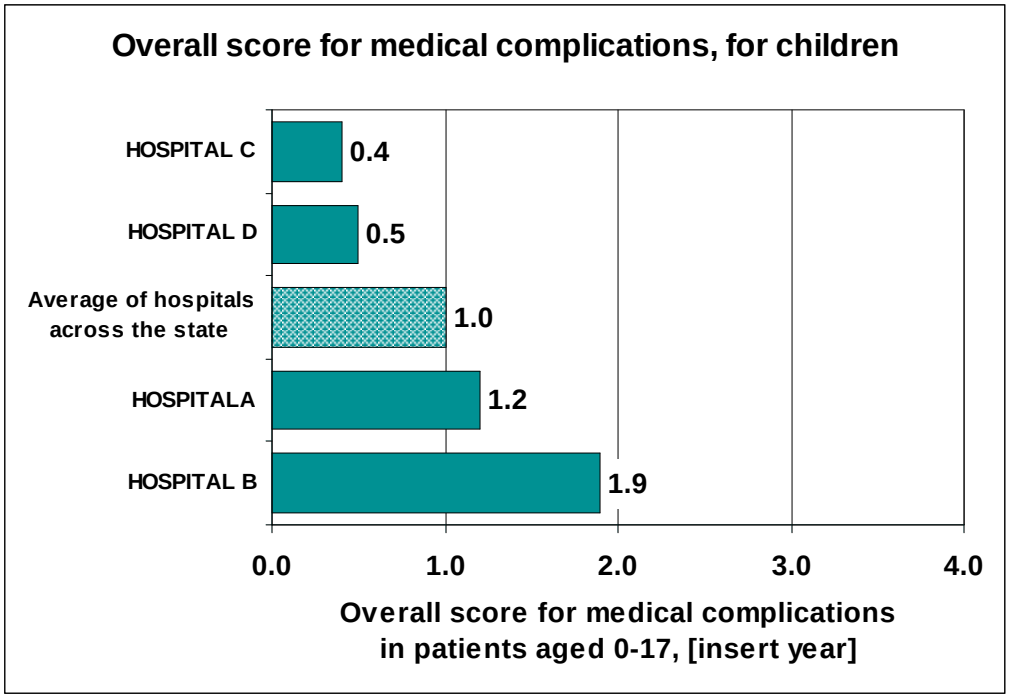
Click here to see results for each of the specific complications listed above

Overall score for medical complications, for children

This score is based on how often children under 18 experienced the following eight complications, either after an operation or as a result of other care provided in the hospital:

- Bed sores
- Complication in which air leaks out of a lung because someone accidentally punctured it during a medical procedure, in children under 18 except newborns
- Infections due to medical care
- Too much bleeding or clots after an operation
- Breathing failure after an operation
- Infection following an operation
- Splitting open of a surgical wound after an operation on the stomach or pelvic area
- Accidental cuts and tears

When choosing a hospital, you should look for the hospital that has a **lower** score. A lower score is shown by a **shorter** bar on the graph below. In particular, look for a score that is **1.0 or less.** This information is for patients admitted during [insert year].



Average of hospitals across the state: The average score for medical complications in child patients in the hospitals across your state. This number is included so you have a better idea of what is typical for your state.

What do these scores mean?

Even in the best hospital, some patients will experience complications either after an operation or as a result of other care. The scores in this report are calculated by comparing the number of complications expected in a particular hospital (based on the number of operations they do or patients they see and how old and sick their patients are) and how many patients actually experienced complications. An overall score of 2.0 means that twice as many patients

experienced complications as expected. An overall score of 0.5 means that half as many patients experience complications as expected.

Click here to see results for each of the specific complications listed above

Specific topics about patients having an operation

Information is available in the Report about the death rates of hospital patients who have eight different kinds of operation.

Please check the box next to each topic you care about.
You can return to this page and pick another topic whenever you like, using the tabs on the (top/left).

Select All

☐ **Death rate for coronary artery bypass graft (CABG)**
How often patients died in the hospital after an operation (called a *coronary artery bypass graft*, or CABG), which is designed to provide a way around clogged arteries in the heart.

☐ **Death rate for percutaneous transluminal coronary angioplasty (PTCA)**
How often patients died in the hospital after a procedure (called a *percutaneous transluminal coronary angioplasty*, or PTCA) in which clogged arteries of the heart are opened up, and then kept open using wire mesh tubes or "stents."

☐ **Death rate for operations to remove part or all of the esophagus**
How often patients died in the hospital after an operation (called an *esophageal resection*) to remove part or all of their esophagus, which is the tube leading from the throat to the stomach.

☐ **Death rate for operations to remove part or all of the pancreas**
How often patients died in the hospital after an operation (called a *pancreatic resection*) to remove part or all of their pancreas, which is a digestive organ.

☐ **Death rate for operations to remove blockage in arteries to the brain**
How often patients died in the hospital after an operation (called a *carotid endarterectomy*) to remove blockage in the arteries leading to the brain.

☐ **Death rate for brain surgery**
How often patients died in the hospital following brain surgery (called a *craniotomy*).

☐ **Death rate for hip replacement surgery**
How often patients died in the hospital after an operation to replace a bad hip.

☐ **Death rate for surgical repair of an aortic aneurysm**
How often patients died in the hospital after an operation (called an *abdominal aortic aneurysm repair*) to repair an enlarged blood vessel supplying blood to the lower half of the body

Compare Hospital Scores

Compare Hospital Scores for Patients Having an Operation

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the topic name to see detailed results of how each hospital performed.

Death rate is the percent of patients who had a particular operation who died while in each hospital during [insert year].	**Each hospital's rate is compared to the average rate of hospitals across the state.** The state average is provided beneath the name of the individual topic. Average is about the same as the average rate of hospitals across the state. **Better than average** is better than the average rate of hospitals across the state. **Worse than average** is worse than the average rate of hospitals across the state..

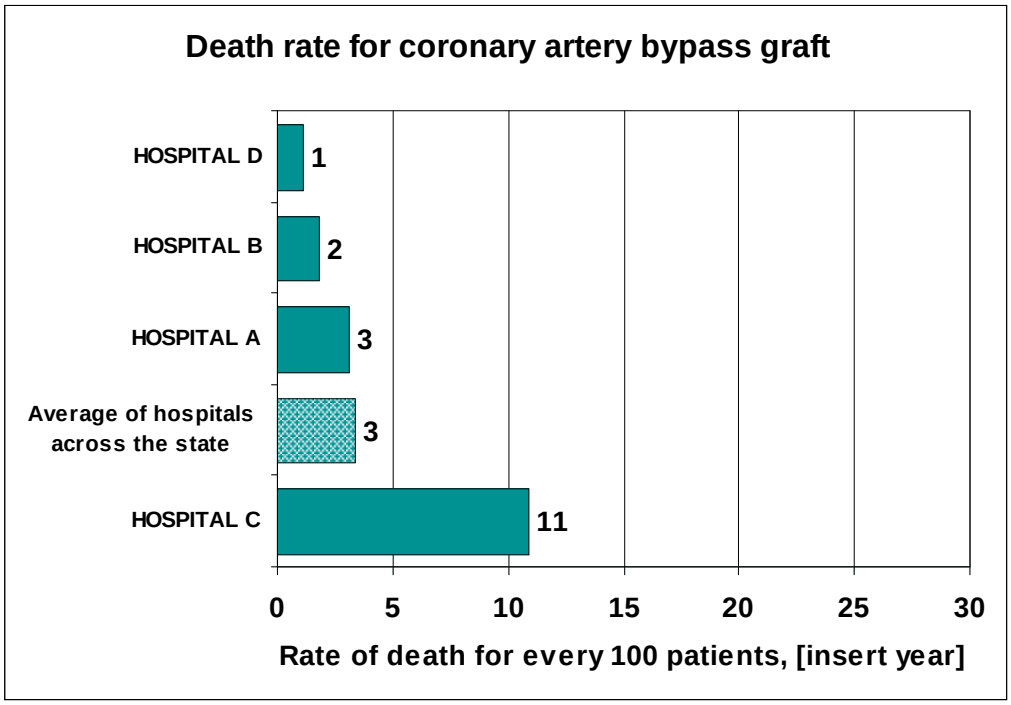
Operations	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for CABG (coronary artery bypass graft) The average rate of death for hospitals across the state is **3** for every **100** operations.	Average	**Better than average**	**Worse Than average**	**Better than average**
Death rate for PTCA (percutaneous transluminal coronary angioplasty) The average rate of death for hospitals across the state is **10** for every **1,000** operations.	**Better than average**	**Worse than average**	**Better than average**	**Better than average**
Death rate for operations to remove part or all of the esophagus The average rate of death for hospitals across the state is **3** for every **100** operations.	**Better than average**	**Worse than average**	**Better than average**	**Better than average**
Death rate for operations to remove part or all of the pancreas The average rate of death for hospitals across the state is **7** for every **100** operations.	Average	**Worse than average**	**Better than average**	**Better than average**
Death rate for operations to remove blockage in arteries to the brain The average rate of death for hospitals across the state is **7** for every **1,000** operations.	**Better than average**	**Worse than average**	**Worse Than average**	**Worse than average**

Operations	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for brain surgery The average rate of death for hospitals across the state is **6** for every **100** operations.	Average	**Better than average**	**Worse than average**	**Worse than average**
Death rate for hip replacement surgery The average rate of death for hospitals across the state is **3** for every **1,000** operations.	**Better than average**	**Worse than average**	**Worse Than average**	**Better than average**
Death rate for surgical repair of an aortic aneurysm The average rate of death for hospitals across the state is **10** for every **100** operations.	**Better than average**	**Worse than average**	**Better than average**	**Better than average**

Death rate for coronary artery bypass graft (CABG)

This graph shows you the percent of patients who died following an operation called a coronary artery bypass graft, or CABG - designed to restore the natural flow of blood in the heart. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



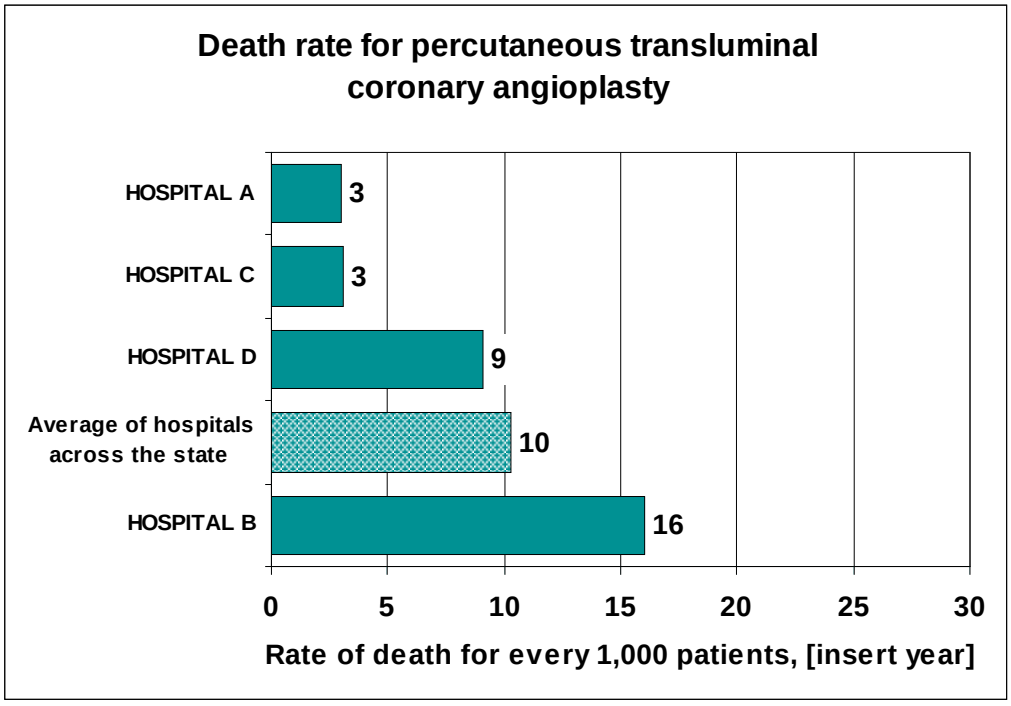
Average of hospitals across the state: The average rate of patients who died following this operation in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for percutaneous transluminal coronary angioplasty (PTCA)

This graph shows you the percent of patients who died following a procedure called a percutaneous transluminal coronary angioplasty, or PTCA, in which clogged arteries of the heart are opened up, and then kept open using wire mesh tubes or "stents." This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



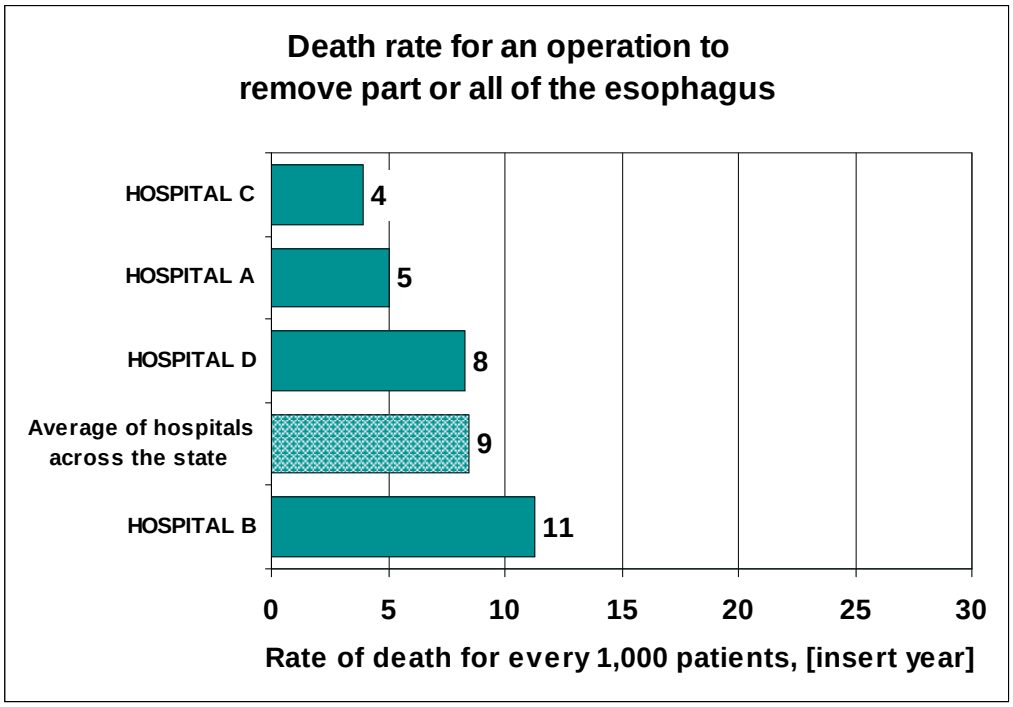
Average of hospitals across the state: The average rate of patients who died after this procedure in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for an operation to remove part or all of the esophagus

This graph shows you the percent of patients who died following an operation (called an *esophageal resection*) to remove part or all of their esophagus, which is the tube leading from the throat to the stomach. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



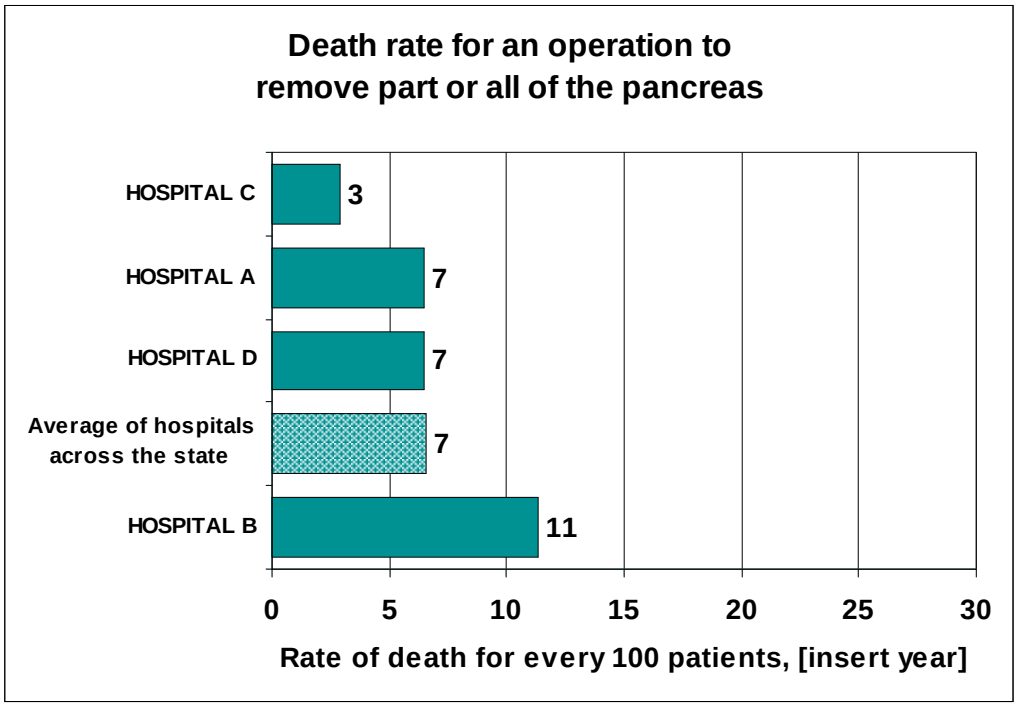
Average of hospitals across the state: The average rate of patients who died in the hospital following an operation to remove part or all of the esophagus, across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for an operation to remove part or all of the pancreas

This graph shows you the percent of patients who died following an operation (called a *pancreatic resection*) to remove part or all of their pancreas, which is a digestive organ. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



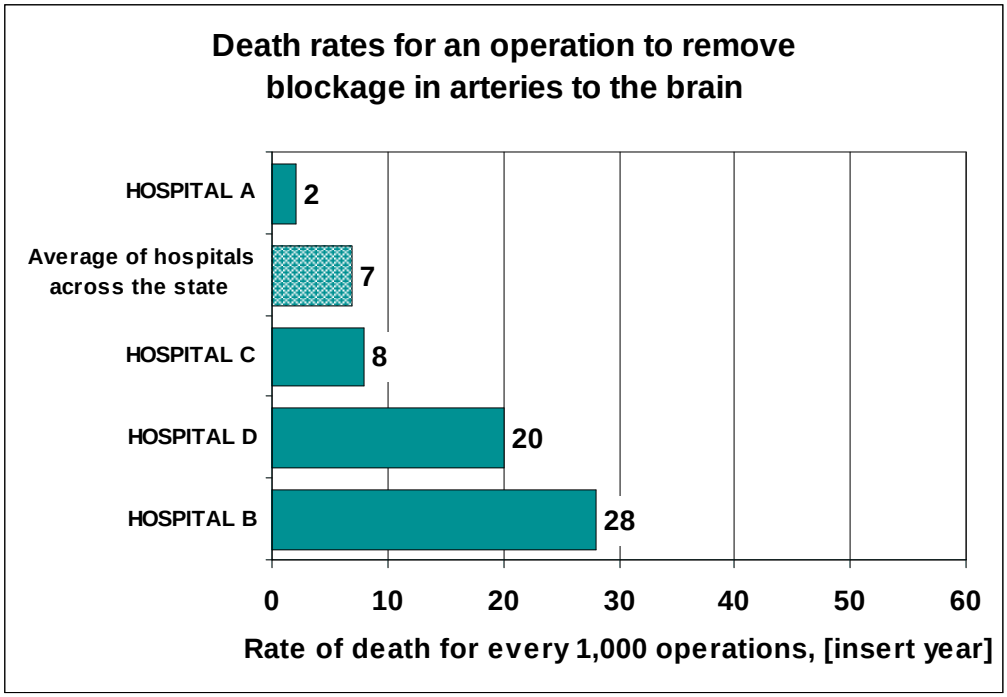
Average of hospitals across the state: The average rate of patients who died in the hospital following an operation to remove part or all of the pancreas, across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for an operation to remove blockage in arteries to the brain

This graph shows you the percent of patients who died after an operation (called a *carotid endarterectomy*) to remove blockage in the arteries leading to the brain. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



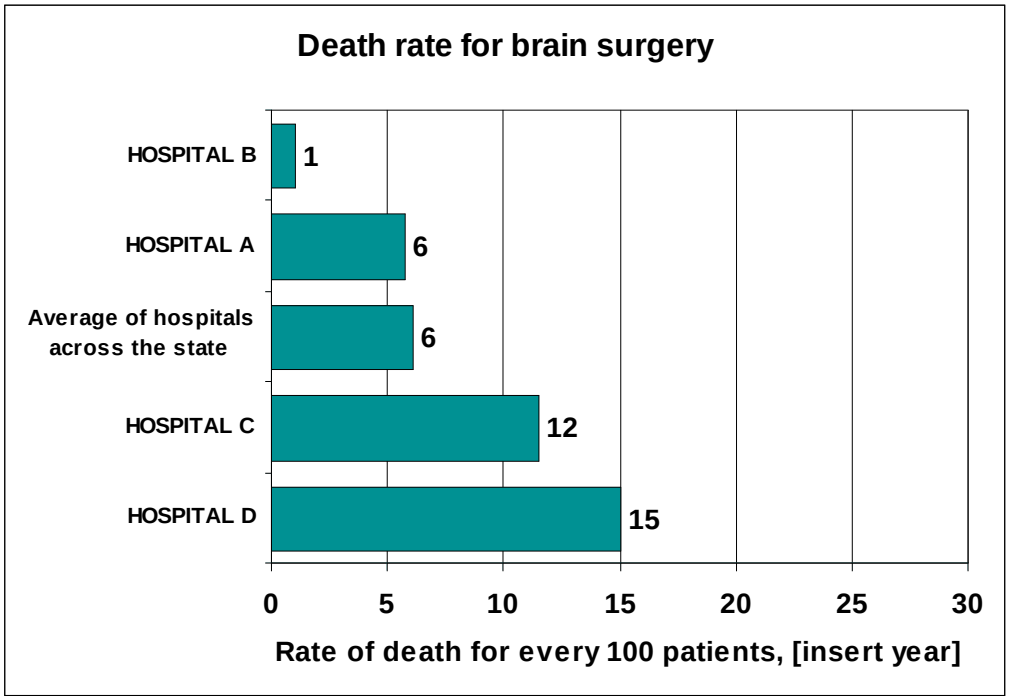
Average of hospitals across the state: The average rate of patients who died after this operation in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for brain surgery

This graph shows you the percent of patients who died after brain surgery (called a *craniotomy*). This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths for this operation. A **lower** number is shown by a **shorter** bar on the graph below.



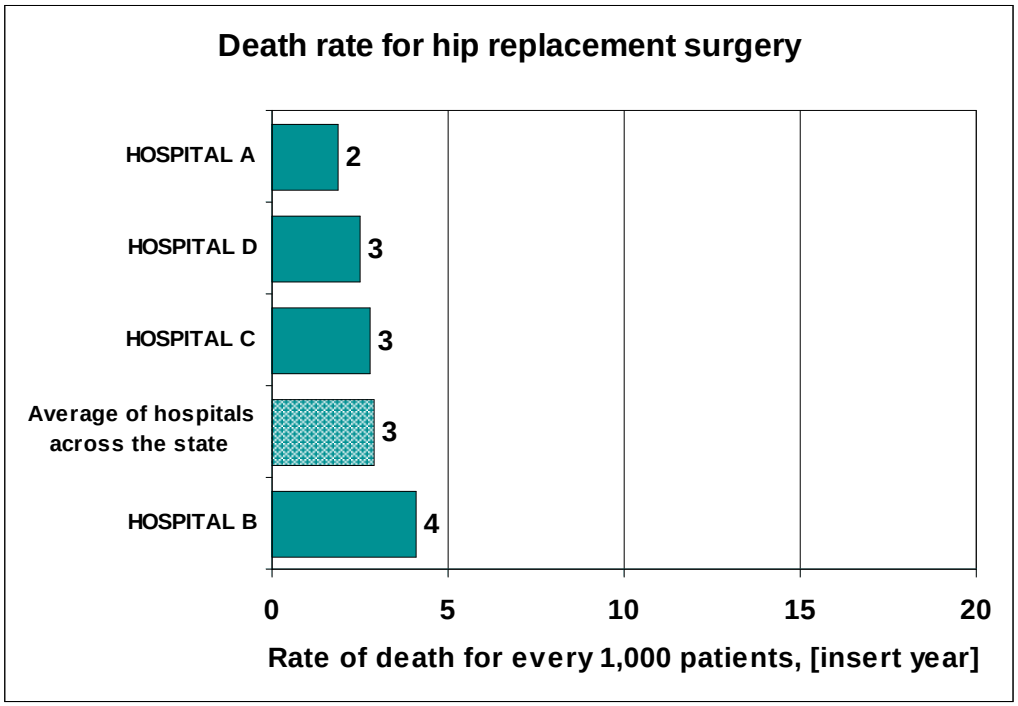
Average of hospitals across the state: The average rate of patients who died in the hospital after brain surgery, across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for hip replacement surgery

This graph shows you the percent of patients who died after surgery to replace a bad hip. This is a fairly common operation that is not usually complicated. Death rates should be extremely low. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



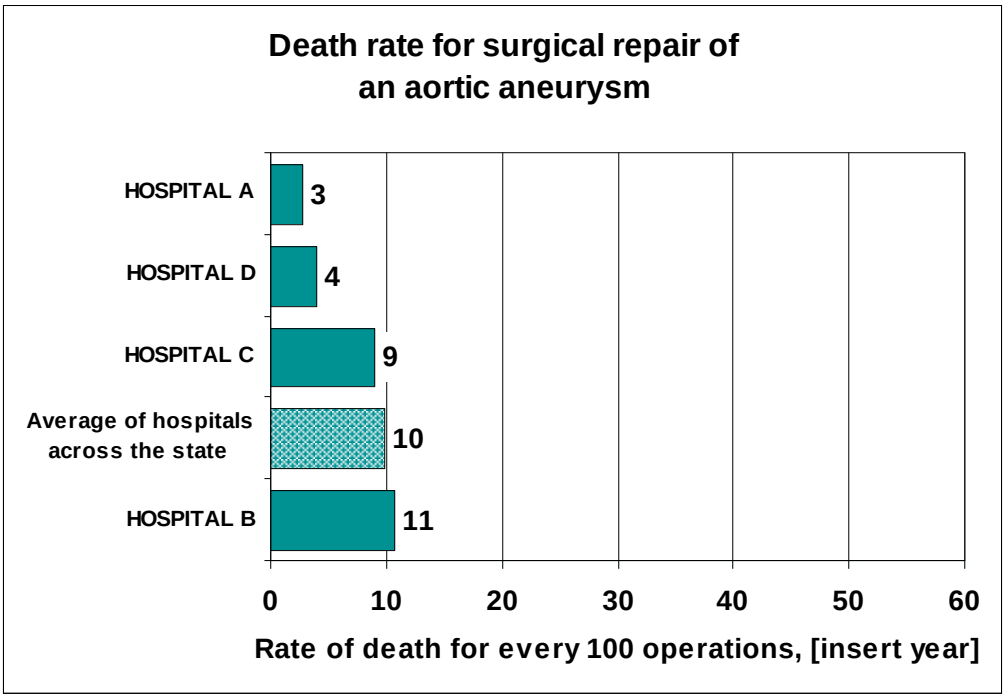
Average of hospitals across the state: The average rate of patients who died in the hospital after hip replacement surgery, across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for surgical repair of an aortic aneurysm

This graph shows you the percent of patients in the hospital who died following an operation to repair an enlarged artery supplying blood to the lower half of the body (called an *abdominal aortic aneurysm repair*). This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who died in the hospital after surgical repair of an aortic aneurysm, across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Specific topics for hospital patients with particular health conditions

Information is available in the Report about the death rates of hospital patients who were hospitalized for six different health problems.

Please check the box next to each topic you care about.

You can return to this page and pick another topic whenever you like, using the tabs on the (top/left).

Select All

☐ **Death rate for heart attack patients**
Deaths in the hospital of patients who came in because they had a heart attack (which is called an *acute myocardial infarction*).

☐ **Death rate for patients with congestive heart failure**
Deaths in the hospital of patients who came in because they had heart failure (which is called *congestive hearth failure*).

☐ **Death rate for pneumonia patients**
Deaths in the hospital of patients who came in because they had pneumonia.

☐ **Death rate for stroke patients**
Deaths in the hospital of patients who came in because they had stroke.

☐ **Death rate for patients with a broken hip**
Deaths in the hospital of patients who came in because they had a broken hip.

☐ **Death rate for patients with GI (gastrointestinal) bleeding**
Deaths in the hospital of patients who came in because they had heavy bleeding into their stomach or intestines (which is called *gastrointestinal bleeding*).

Compare Hospital Scores

Compare hospital scores for particular health conditions

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the topic name to see detailed results on how each hospital performed.

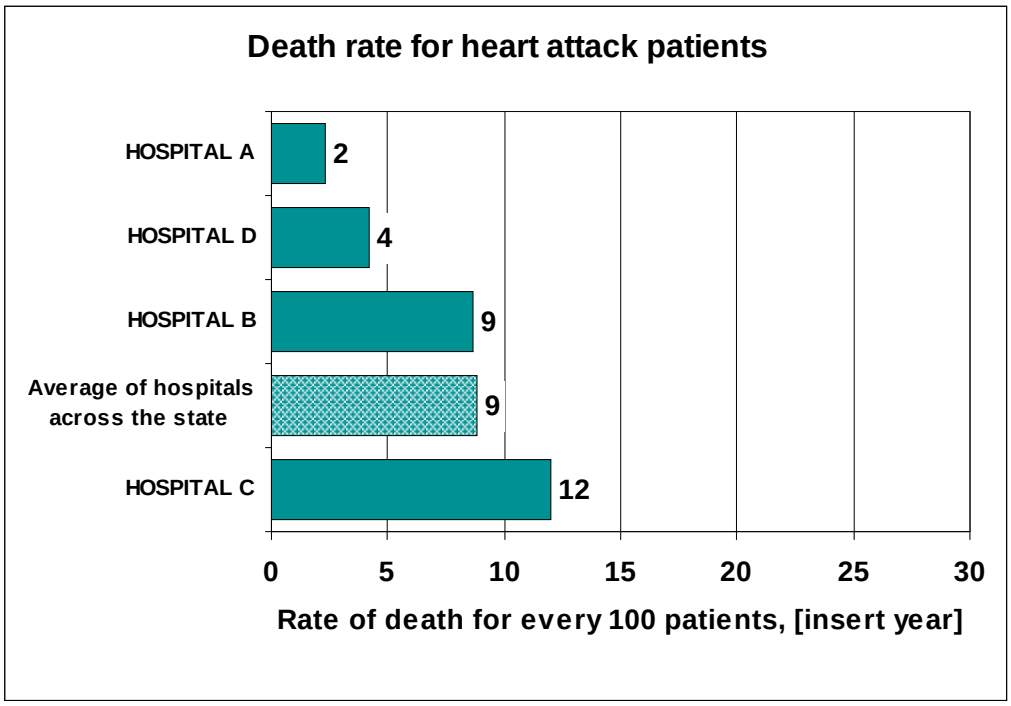
Death rate is the percent of patients who were treated for a particular illness who died while in each hospital during [insert year].	**Each hospital's rate is compared to the average rate of hospitals across the state.** The state average is provided beneath the name of the individual topic. Average is about the same as the average rate of hospitals across the state. **Better than average** is better than the average rate of hospitals across the state. **Worse than average** is worse than the average rate of hospitals across the state.

Health Conditions	Hospital A	Hospital B	Hospital C	Hospital D
Death rate for heart attack patients The average rate of death for hospitals across the state is **9** for every **100** patients.	**Better Than average**	Average	**Worse than average**	**Better than average**
Death rate for patients with congestive heart failure The average rate of death for hospitals across the state is **4** for every **100** patients.	**Better Than average**	**Worse Than average**	Average	**Better than average**
Death rate for pneumonia patients The average rate of death for hospitals across the state is **8** for every **100** patients.	**Better than average**	**Worse than average**	Average	**Better than average**
Death rate for stroke patients The average rate of death for hospitals across the state is **10** for every **100** patients.	**Better than average**	Average	**Worse than average**	**Better than average**
Death rate for patients with a broken hip The average rate of death for hospitals across the state is **3** for every **100** patients.	**Better than average**	**Worse than average**	Average	Average
Death rate for patients with GI (gastrointestinal) bleeding The average rate of death for hospitals across the state is **3** for every **100** patients.	Average	**Better than average**	**Worse than average**	**Worse than average**

Death rate for heart attack patients

This graph shows you the percent of patients admitted to each hospital because they had a heart attack (called an *acute myocardial infarction*), who died during their hospital stay. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



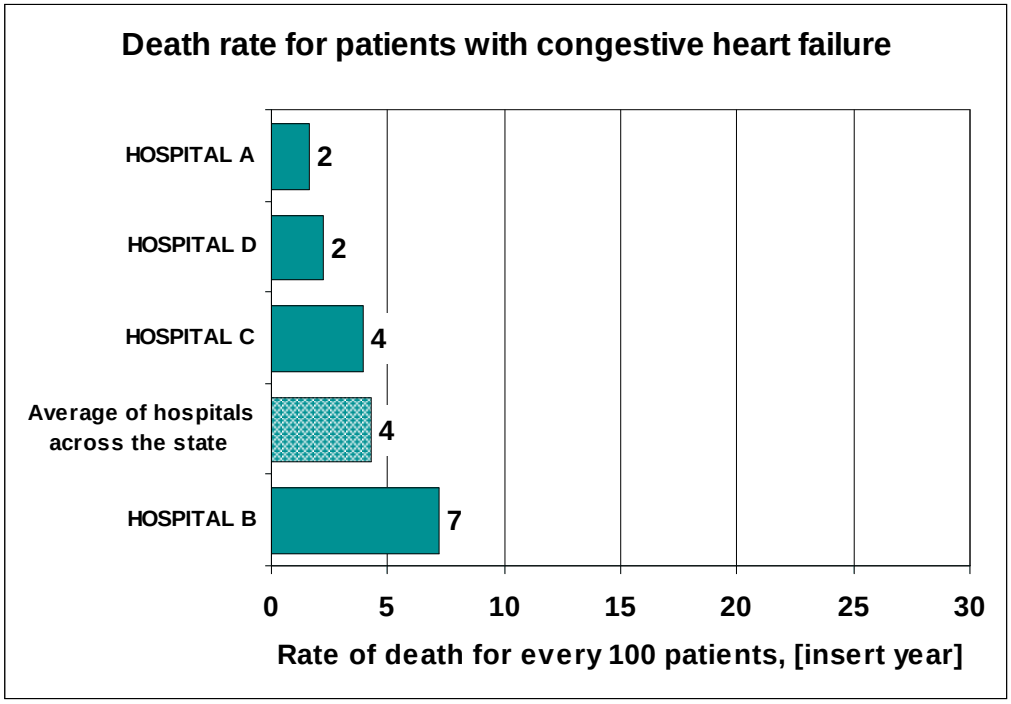
Average of hospitals across the state: The average rate of patients who died in the hospital after having a heart attack, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate of patients with congestive heart failure

This graph shows you the percent of patients who were admitted to a hospital because they had heart failure (called *congestive heart failure*), who died during their hospital stay. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



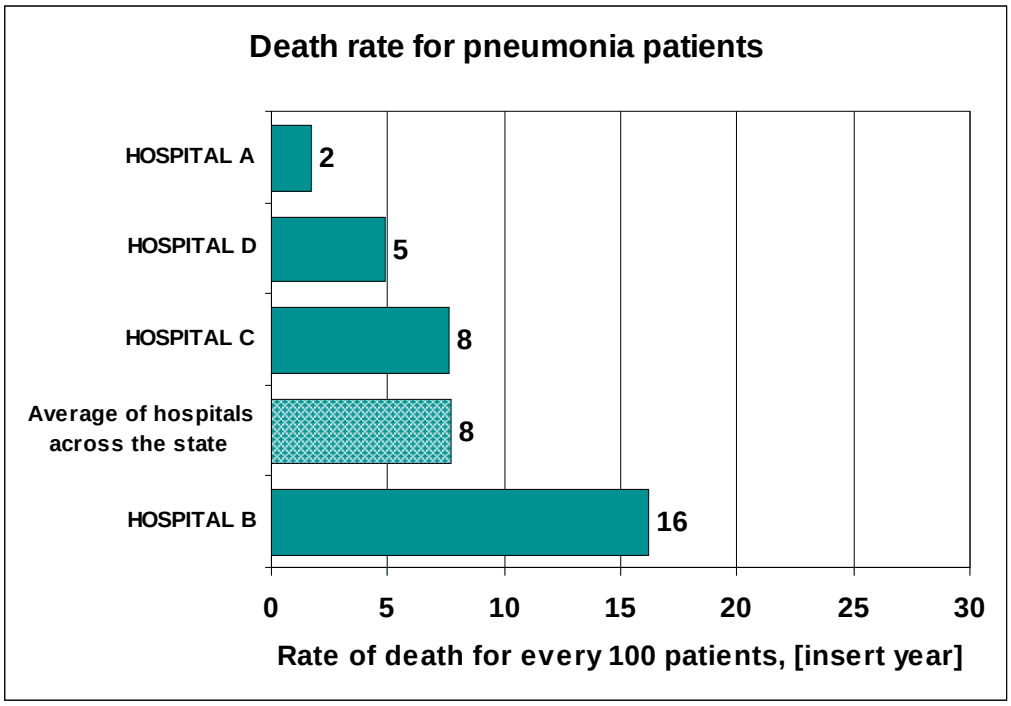
Average of hospitals across the state: The average rate of patients who died after being admitted because they had heart failure in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for pneumonia patients

This graph shows you the percent of patients admitted to a hospital because they had pneumonia, who died during their hospital stay. This information is for patients who were admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** number for this condition. A **lower** number is shown by a **shorter** bar on the graph below.



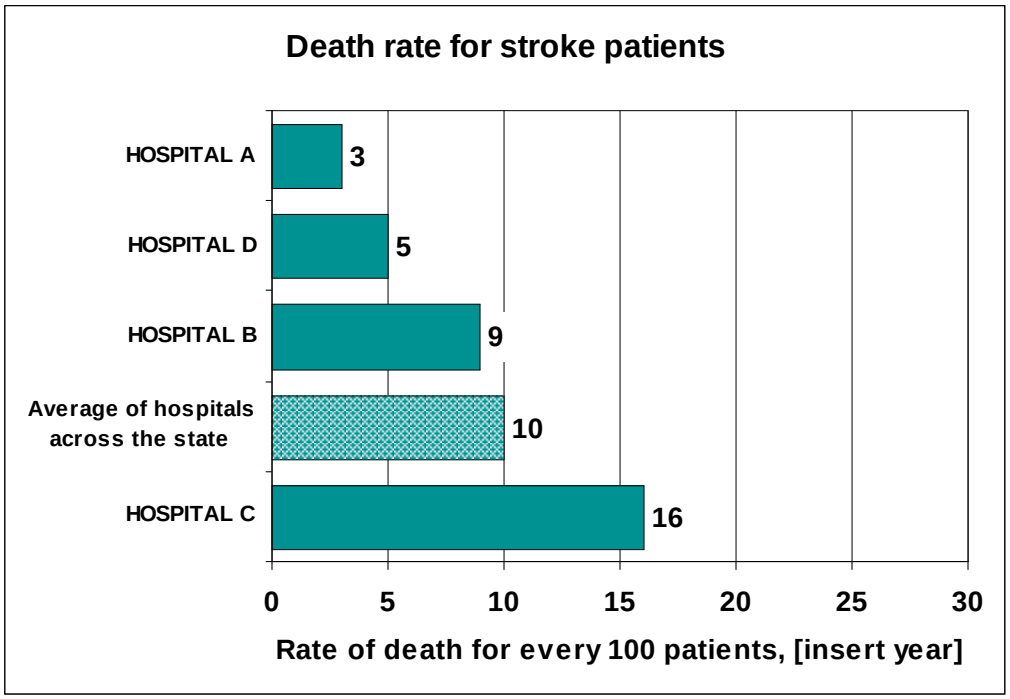
Average of hospitals across the state: The average rate of patients with pneumonia who died in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for stroke patients

This graph shows you the percent of patients who died after being admitted to the hospital because they had a stroke. This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has a **lower** number of deaths. A **lower** number is shown by a **shorter** bar on the graph below.



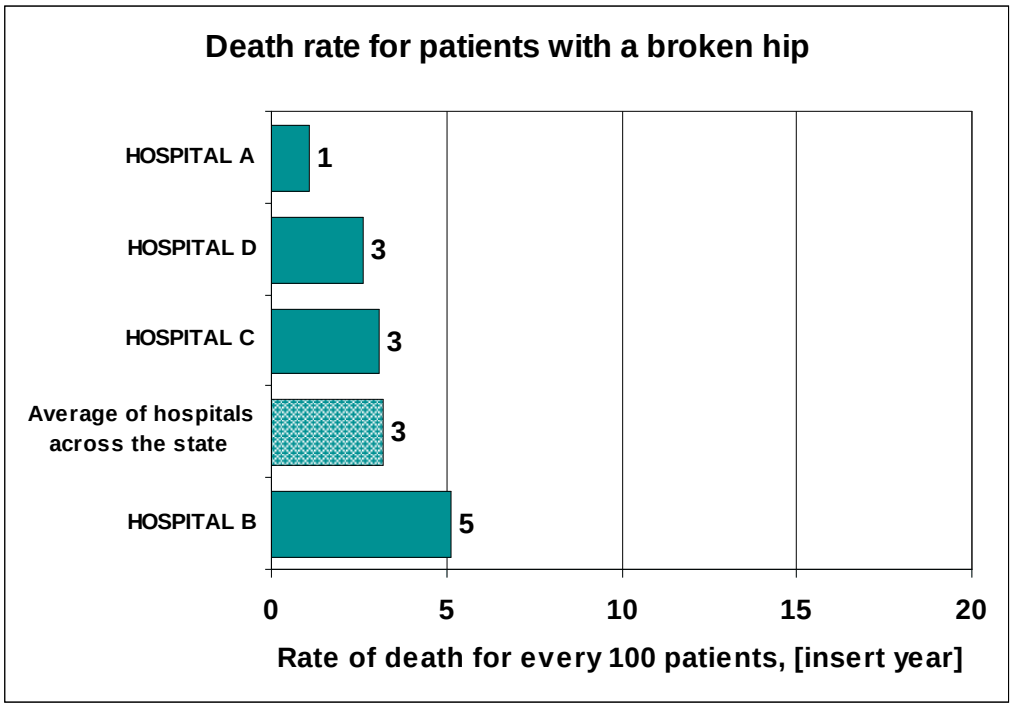
Average of hospitals across the state: The average rate of patients who died after being admitted because they had a stroke, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for patients with a broken hip

This graph shows you the percent of patients who died in the hospital, who came in with a broken hip (hip fracture). This information is for patients admitted during [insert year].

Deaths due to a broken hip are very rare. When choosing a hospital, you should look for the hospital with a **lower** number for this condition. A **lower** number is shown by a **shorter** bar on the graph below.



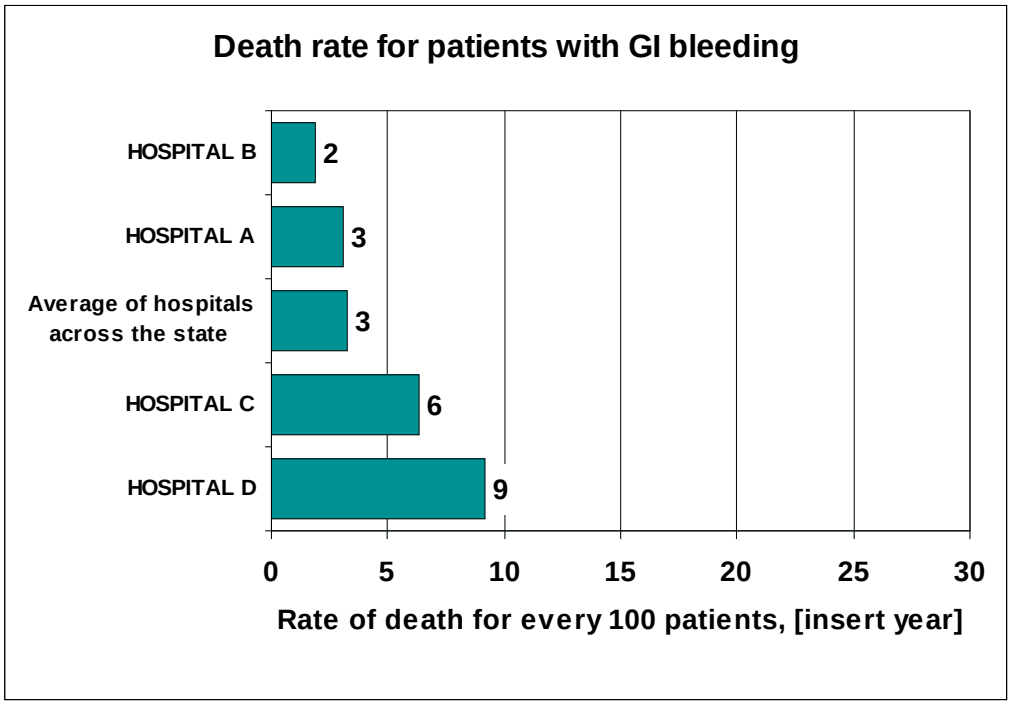
Average of hospitals across the state: The average rate of patients who died after being admitted with a broken hip, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Death rate for patients with GI bleeding

This graph shows you the percent of patients who died after being admitted to the hospital because of bleeding into their stomach or intestines (which is called *gastrointestinal, or GI, bleeding*). This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate of deaths for this condition. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who died after being admitted with GI bleeding, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Specific topics for medical complications, for adults

Information is available in the Report about 11 topics that show how often **adult** hospital patients experienced serious health problems as a result of their stay. These complications can be serious, even fatal. Each of them can often be potentially prevented if steps are taken to make care safer.

Please check the box next to each topic you care about.
You can return to this page and pick another topic whenever you like, using the tabs on the (top/left).

Select All

☐ **Rate of patients with bed sores**
How often patients developed a bed sore (called a *decubitus ulcer*), which is a sore or wound on the skin. This can occur because people are lying in one position for too long.

☐ **Rate of patients having air leaking out of their lung**
How often air leaks out of the patient's lung because someone accidentally punctured it as a result of a medical procedure or operation (a complication which is called *iatrogenic pneumothorax)*.

☐ **Rate of infections due to medical care**
How often patients got certain types of infections as a result of the care they received in the hospital.

☐ **Rate of hip fracture after an operation**
How often hospital patients broke a hip bone from a fall following any kind of operation.

☐ **Rate of too much bleeding or blood clots after an operation**
How often patients bled too much (called *hemorrhaging*) or developed a large blood clot after an operation (which is called a *hematoma*).

☐ **Rate of abnormal changes in body functions after an operation**
How often hospital patients experienced problems with blood sugar control (if they have diabetes) or kidney failure (if they did not have previous kidney trouble) after having an operation (these problems are called *postoperative physiologic and metabolic derangements)*.

☐ **Rate of breathing failure after an operation**
How often patients became unable to breathe on their own following an operation, and needed a ventilator, which is a machine that helps someone breathe, at least temporarily (which is called *postoperative respiratory failure*).

☐ **Rate of blood clots in the lung or a large vein after an operation**
How often hospital patients developed a blood clot in the lungs (which is called a *pulmonary embolism*) or in a large vein (which is called *deep vein thrombosis*), after an operation.

☐ **Rate of bloodstream infection following an operation**
How often hospital patients got a serious bloodstream infection following an operation (which is called *postoperative sepsis*).

☐ **Rate of splitting open of a surgical wound after an operation on the stomach or pelvis**
How often a surgical wound in the stomach or pelvic area split open after an operation (which is called *postoperative wound dehiscence*).

☐ **Rate of accidental cuts and tears**
How often a patient is accidentally cut or injured, making a hole or tear in an organ of the body, while receiving medical care (which is called *accidental puncture and laceration*).

Compare Hospital Scores

Compare hospital scores for medical complications, for adults

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the topics that are most important to you, or on as many items as possible.

Click on the topic name to see detailed results of how each hospital performed.

Rate is the percent of patients who experienced a particular problem during their hospital stay during [insert year]. **Death rate** is the percent of patients who died while in each hospital during [insert year] as a result of a serious complication that could have been prevented.	**Each hospital's rate is compared to the average rate of hospitals across the state.** This state average is provided beneath the name of the individual topic. Average is about the same as the average rate of hospitals across the state. **Better than average** is better than the average rate of hospitals across the state. **Worse than average** is worse than the average rate of hospitals across the state.

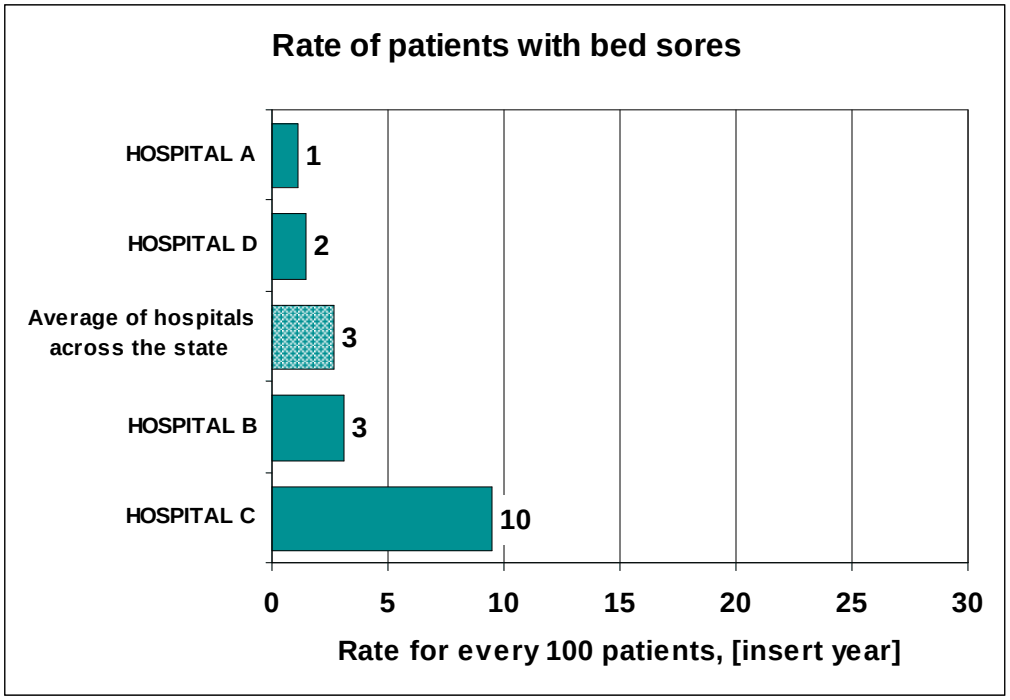
Medical Complications, Adults	Hospital A	Hospital B	Hospital C	Hospital D
Rate of patients with bed sores The average rate for hospitals across the state is **3** for every **100** patients.	**Better than average**	Average	**Worse than average**	**Better than average**
Rate of patients having air leaking out of the lung The average rate for hospitals across the state is **9** for every **10,000** patients.	Average	**Better than average**	**Worse than average**	**Worse than average**
Rate of infections due to medical care The average rate for hospitals across the state is **3** for every **1,000** patients.	**Better than average**	**Worse than average**	**Better than average**	**Better than average**
Rate of hip fracture after an operation The average rate for hospitals across the state is **3** for every **10,000** patients.	**Better than average**	**Worse than average**	Average	Average
Rate of too much bleeding or blood clots after an operation The average rate for hospitals across the state is **2** for every **1,000** patients.	**Better than average**	**Worse than average**	Average	Average

Medical Complications, Adults	Hospital A	Hospital B	Hospital C	Hospital D
Rate of abnormal changes in body function after an operation The average rate for hospitals across the state is **10** for every **10,000** patients.	**Better than average**	**Better than average**	Average	**Better than average**
Rate of breathing failure after an operation The average rate for hospitals across the state is **9** for every **1,000** patients.	**Worse than average**	Average	**Worse than average**	**Better than average**
Rate of blood clots in the lung or large vein after an operation The average rate for hospitals across the state is **10** for every **1,000** patients.	Average	Average	Average	**Better than average**
Rate of bloodstream infection following an operation The average rate for hospitals across the state is **11** for every **1,000** patients.	**Better than average**	**Worse than average**	**Better than average**	**Worse than average**
Rate of splitting open of a surgical wound after an operation on the stomach or pelvic area The average rate for hospitals across the state is **11** for every **10,000** patients.	**Better than average**	**Worse than average**	**Better than average**	Average
Rate of accidental cuts and tears The average rate for hospitals across the state is **3** for every **1,000** patients.	Average	**Better than average**	**Worse than average**	Average

Rate of patients with bed sores

This graph shows you the percent of patients who developed bed sores, which are sores or wounds on the skin (called a *decubitus ulcer*), during their hospital stay. Usually this happens when patients are lying in one position for too long and can often be prevented. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



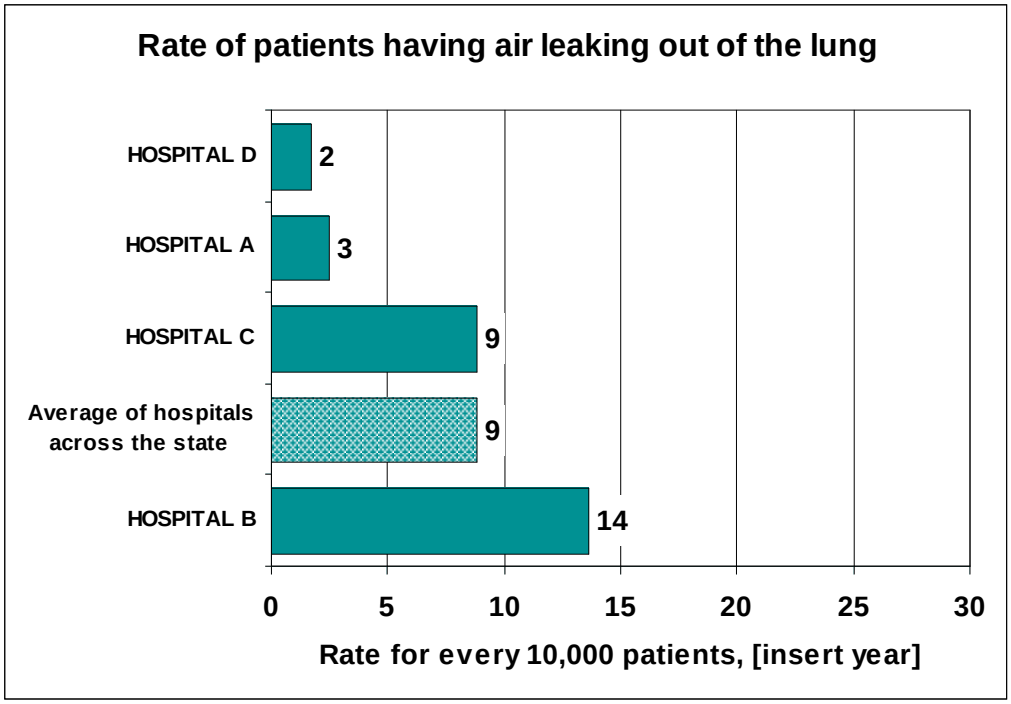
Average of hospitals across the state: The average rate of patients with bed sores in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of patients having air leaking out of the lung

This graph shows you how often air leaks out of the lung because someone accidentally punctured it as a result of a medical procedure (called *iatrogenic pneumothorax*). Iatrogenic pneumothorax sometimes requires putting a tube into a patient's chest to remove the extra air. This information is for patients who were admitted during [insert year]. **Please note that this is a very rare event**.

When choosing a hospital, look for the hospital that has a **lower** rate for this complication. A **lower** rate is shown by a **shorter** bar on the graph below.



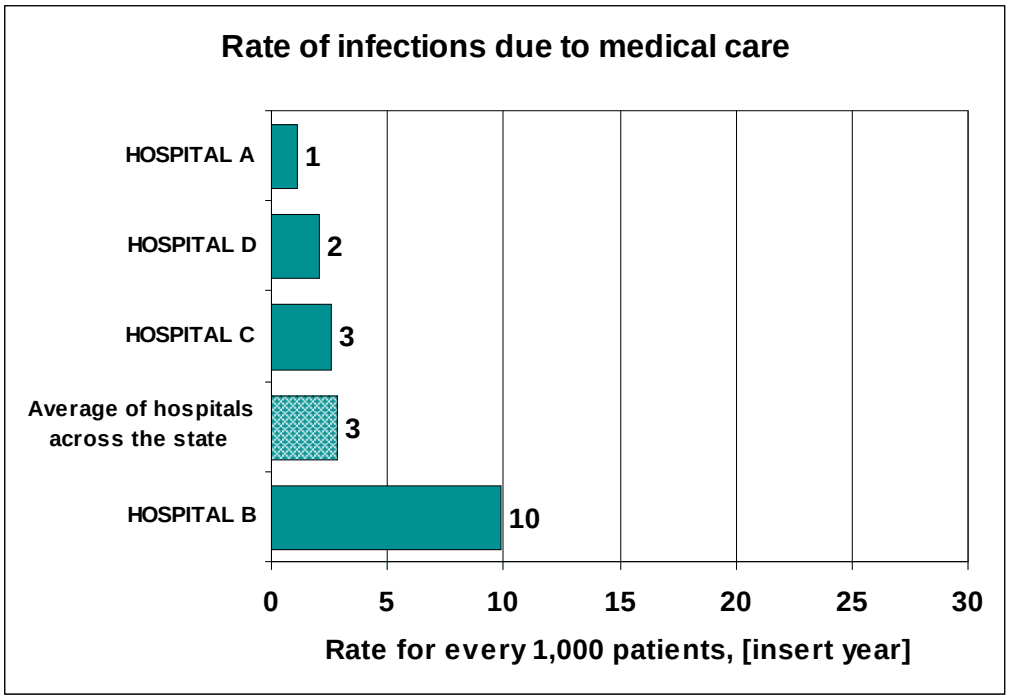
Average of hospitals across the state: The average rate of patients with this complication in hospitals across your state. This number is included so you have:

- a better idea of what is normal for your state.
- a standard to compare the other hospitals to.

Rate of infections due to medical care

This graph shows you the percent of patients who got certain types of infections as a result of care they received while in the hospital. These include infections related to intravenous tubes and fluids, treatment of kidney failure, transfusions, and other types of shots. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this topic. A **lower** number is shown by a **shorter** bar on the graph below.



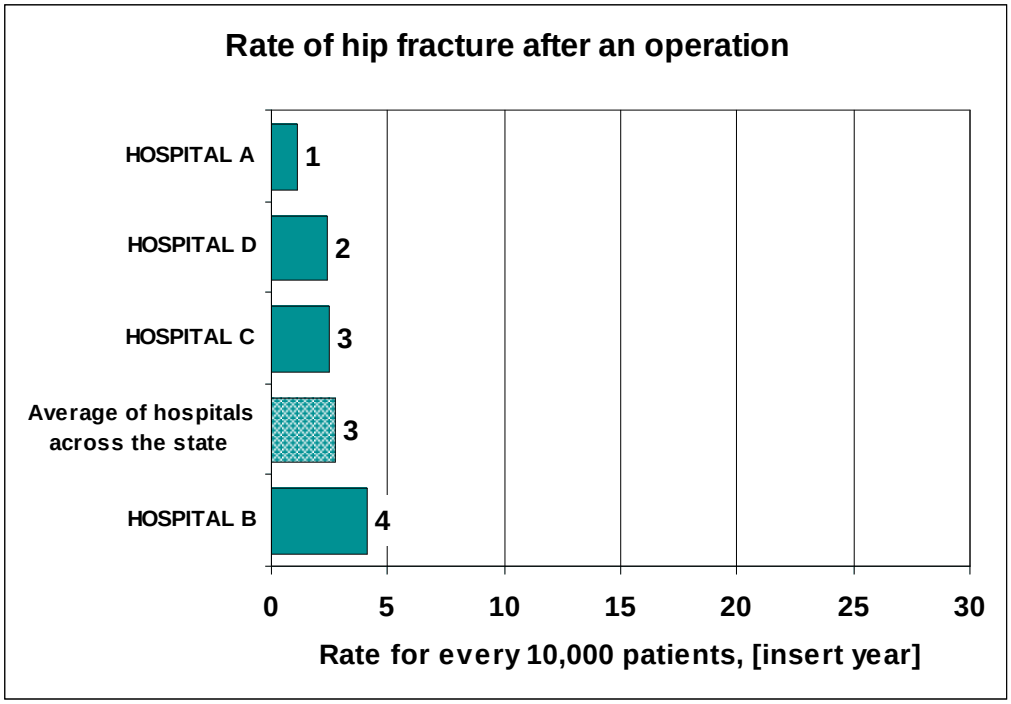
Average of hospitals across the state: The average rate of patients with certain types of infections due to medical care, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of hip fracture after an operation

This graph shows you the percent of patients who broke a hip from a fall following any kind of operation. A fall can happen for different reasons, such as being given too much pain medication, or having too little supervision when trying to walk after an operation. Or, it may just happen. This information is for patients admitted during [insert year]. **Please note that this is a very rare event**.

When choosing a hospital, you should look for the hospital that has a **lower** rate of postoperative hip fractures. A **lower** number is shown by a **shorter** bar on the graph below.



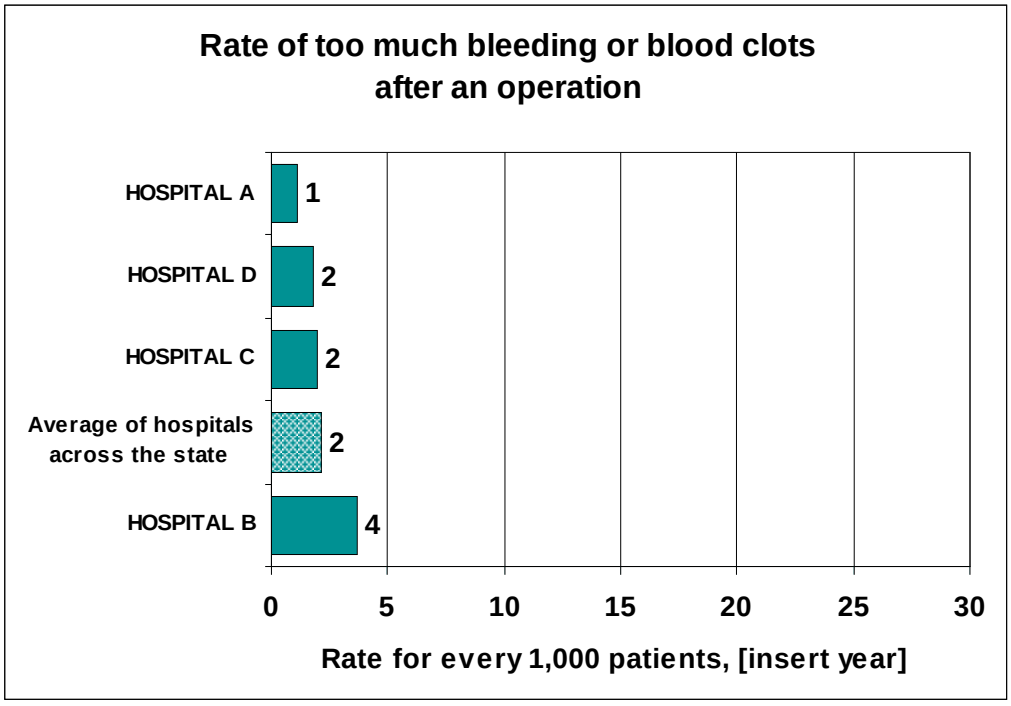
Average of hospitals across the state: The average rate of patients with hip fractures after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of too much bleeding or blood clots after an operation

This graph shows you how often patients bled too much (called *hemorrhaging*) or developed a large blood clot (called a *hematoma*) after an operation. All of these complications involved another operation to stop the bleeding or remove the blood clots. This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** rate is shown by a **shorter** bar on the graph below.



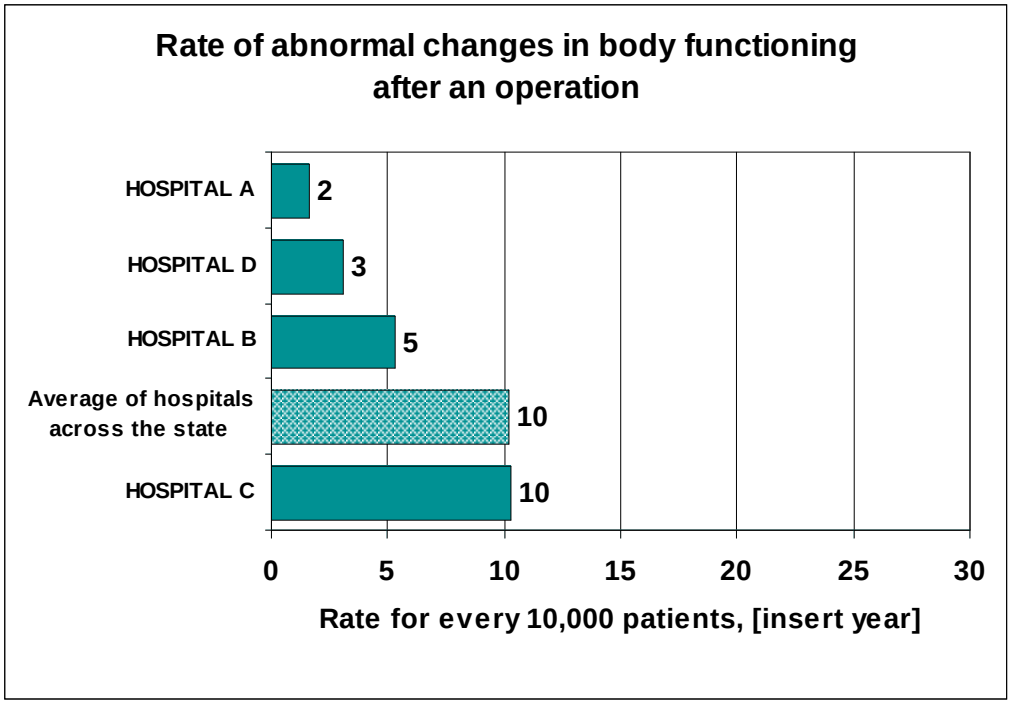
Average of hospitals across the state: The average rate of patients who had too much bleeding, or blood clots after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of abnormal changes in body functioning after an operation

This graph shows you the percent of patients who experienced problems with blood sugar control (if they have diabetes) or kidney failure (if they did not have previous kidney trouble) after having an operation (these complications are called *postoperative physiologic and metabolic derangements).* This information is for patients admitted during [insert year]. **Please note that this is a very rare event**.

When you are choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



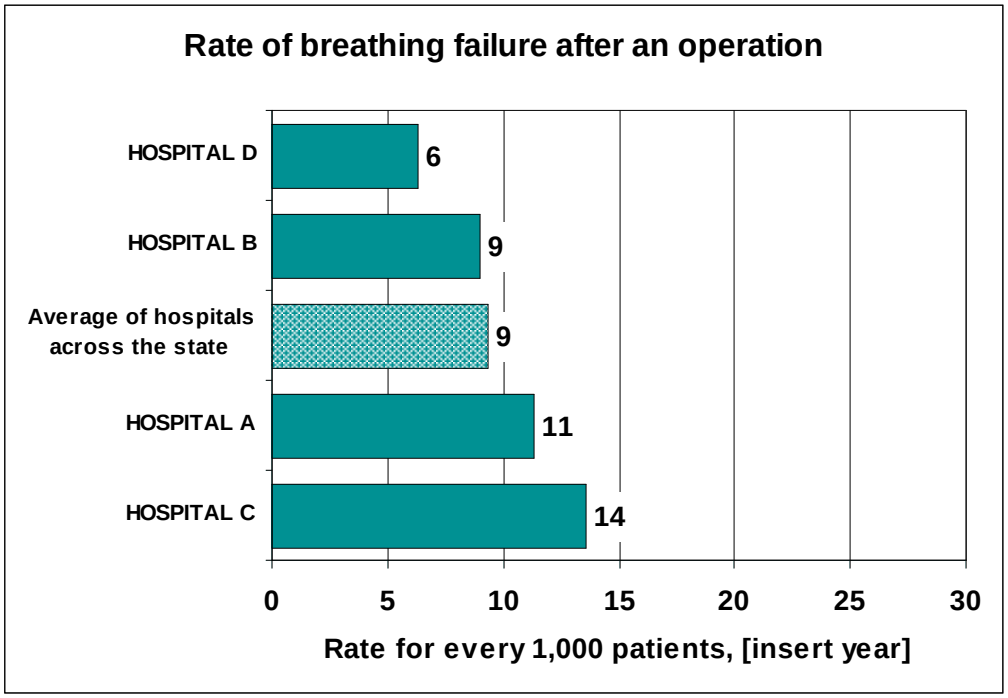
Average of hospitals across the state: The average rate of patients with abnormal changes in body functioning, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of breathing failure after an operation

This graph shows you the percent of patients who became unable to breathe on their own following an operation, and who needed a ventilator, which is a machine that helps someone breathe, at least temporarily (which is called *postoperative respiratory failure*). This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



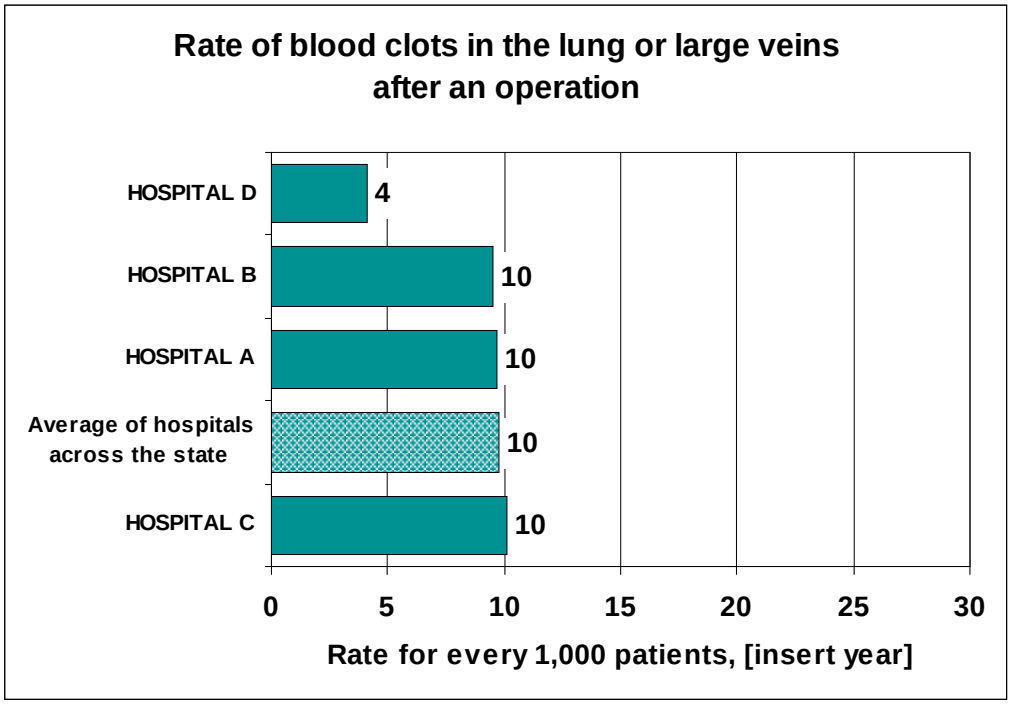
Average of hospitals across the state: The average rate of patients with breathing failure after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of blood clots in the lung or large veins after an operation

This graph shows you the percent of patients who developed a blood clot in the lungs (which is called a *pulmonary embolism*) or in a large vein (which is called *deep vein thrombosis*) following an operation. This information is for patients admitted during [insert year].

These clots can be life-threatening. When you are choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



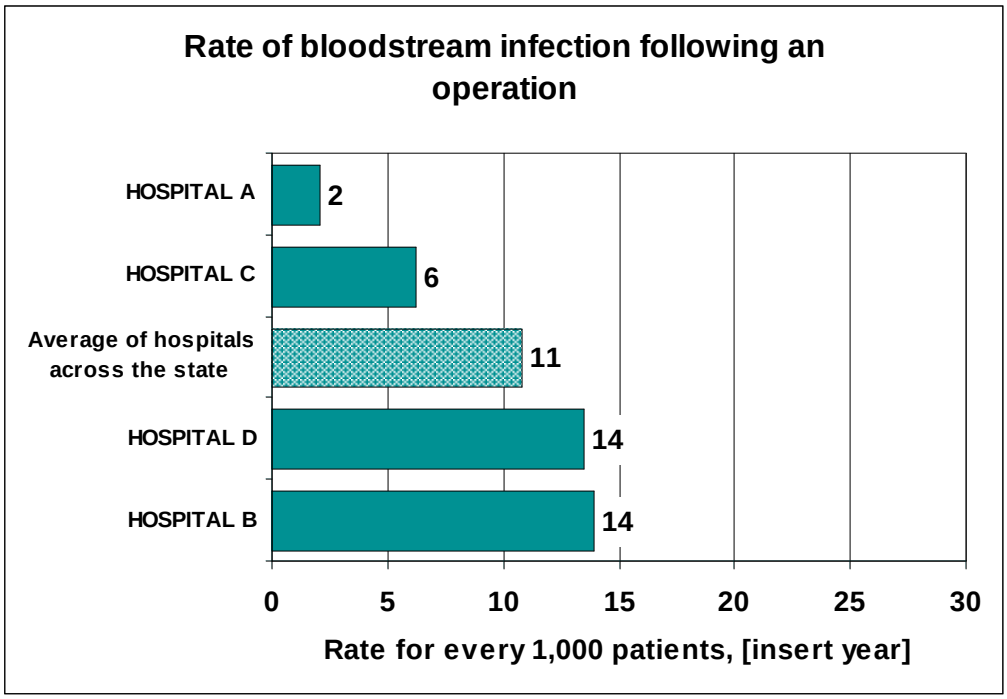
Average of hospitals across the state: The average rate of patients with blood clots in the lung or large veins after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of bloodstream infection following an operation

This graph shows you the percent of patients who got a bloodstream infection following an operation (which is called *postoperative sepsis*). This information is for patients admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



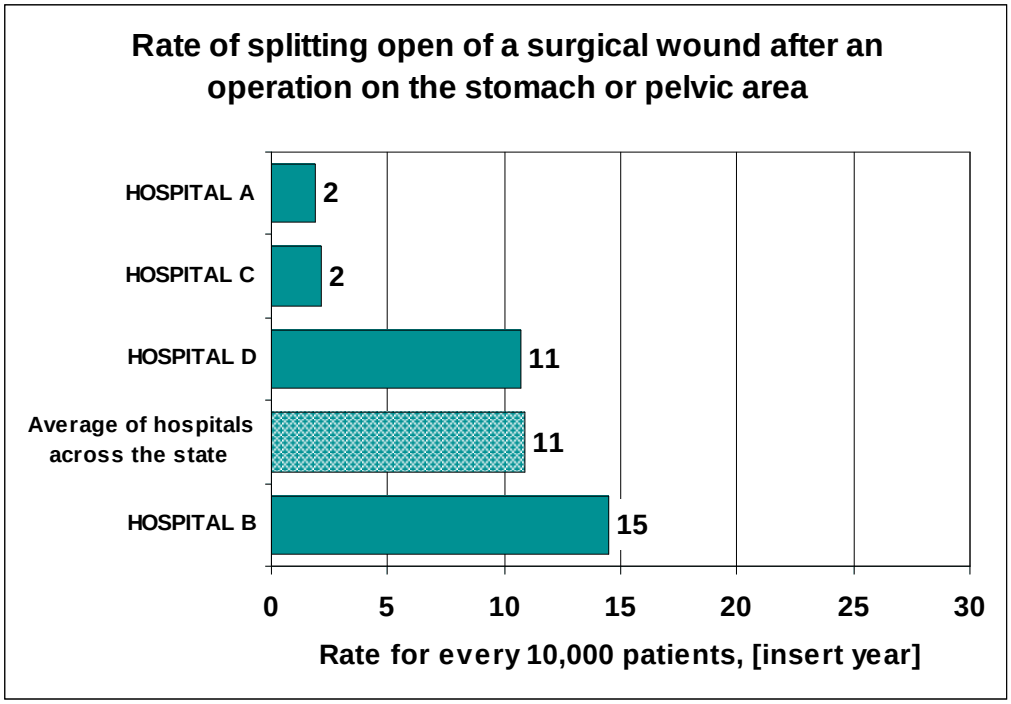
Average of hospitals across the state: The average rate of patients with bloodstream infections following an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of splitting open of a surgical wound after an operation on the stomach or pelvic area

This graph shows you the percent of patients having an operation in their stomach or pelvic area whose wound split open after an operation (which is called *postoperative wound dehiscence*). All of these complications were treated with another major operation to fix the wound. This information is for patients admitted during [insert year]. **Please note that this is a very rare event**.

When choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



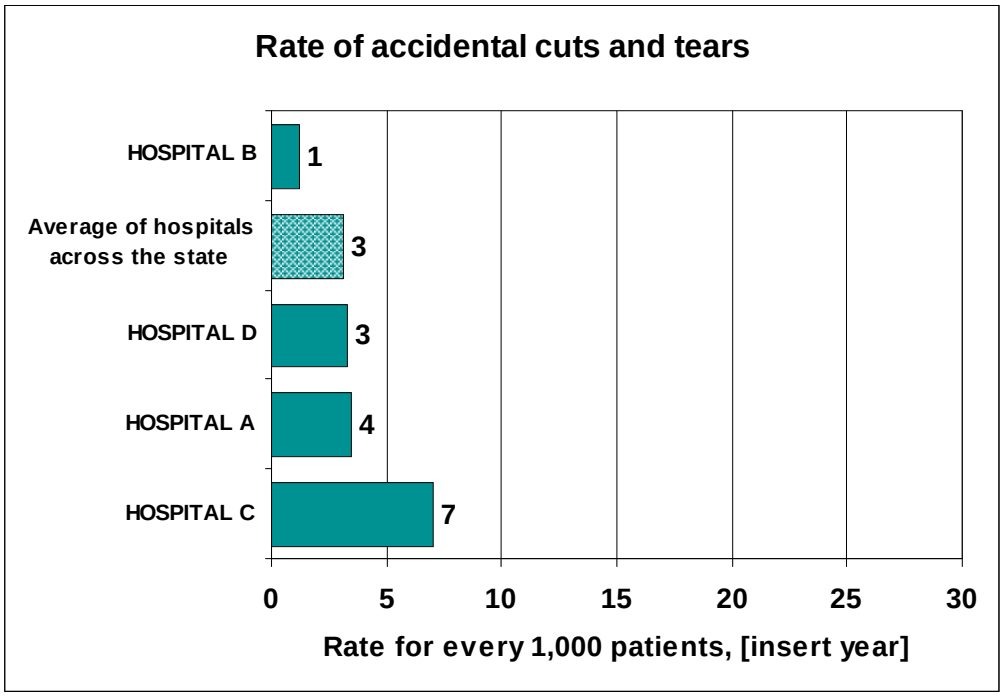
Average of hospitals across the state: The average rate of patients with splitting open of a surgical wound after an operation on the stomach or pelvis splitting, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of accidental cuts and tears

This graph shows you the percent of patients who were accidentally cut or injured, making a hole or tear in an organ of the body, while receiving medical care (which is called *accidental puncture and laceration*). This information is for patients admitted during [insert year].

When choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of patients who had accidental cuts and tears, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Specific topics of medical complications, for children

Information is available in the Report about the seven topics that show how often **children** under 18 in the hospital experienced complications as a result of their stay. These complications can be serious, even fatal. They can be potentially prevented if steps are taken to make care safer. Definitions of each of these seven topics are provided below.

Please check the box next to each topic you care about.
You can return to this page and pick another overall score whenever you like, using the tabs on the (top/left)

.

Select All

☐ **Rate of bed sores in hospitalized children**
How often children in the hospital under 18 developed a bed sore (which is called a *decubitus ulcer*), which is a sore or wound on the skin. This can occur because people are lying in one position for too long.

☐ **Rate of children (other than newborns) having air leaking out of their lung**
How often air leaks out of the lung because someone accidentally punctured it as a result of a medical procedure or operation (which is called *iatrogenic pneumothorax*). This rate is for children other than newborns.

☐ **Rate of infections due to medical care**
How often children under 18 got certain types of infections as a result of the care they received in the hospital.

☐ **Rate of too much bleeding, or bruises or clots after an operation**
How often children under 18 bled too much, either within their body or outside their body (called *hemorrhaging*), or developed a large blood clot after an operation (which is called a *hematoma*).

☐ **Rate of breathing failure after an operation**
How often children under 18 became unable to breathe on their own following an operation, and needed a ventilator, which is a machine that helps someone breathe, at least temporarily (which is called *postoperative respiratory failure*).

☐ **Rate of bloodstream infection following an operation**
How often children under 18 got a serious bloodstream infection following an operation (which is called *postoperative sepsis*).

☐ **Rate of splitting open of a surgical wound after an operation on the stomach or pelvis**
How often children under 18 had a surgical wound in the stomach or pelvic area split open after an operation (which is called *postoperative wound dehiscence*).

☐ **Rate of accidental cuts and tears**

How often children under 18 were accidentally cut, making a hole or tear in an organ of the body, while receiving medical care (which is called *accidental puncture and laceration*).

Compare Hospital Scores

Compare hospital scores for medical complications, for children

When you are choosing a hospital, you should look for the hospital that does **Better than average** on the
topics that are most important to you, or on as many items as possible.

Click on the topic name to see detail results of how each hospital performed.

Rate is the percent of patients who experienced a particular problem during their hospital stay during [insert year]. **Death rate** is the percent of patients who died while in each hospital during [insert year] as a result of a serious complication that could have been prevented.	**Each hospital's rate is compared to the average rate of hospitals across the state.** This state average is provided beneath the name of the individual topic. Average is about the same as the average rate of hospitals across the state. **Better than average** is better than the average rate of hospitals across the state. **Worse than average** is worse than the average rate of hospitals across the state.

Medical Complications, Children	Hospital A	Hospital B	Hospital C	Hospital D
Rate of bed sores in hospitalized children The average rate for hospitals across the state is **3** for every **1,000** child patients	**Better than average**	**Worse than average**	Average	**Better than average**
Rate of children having air leaking out of their lung The average rate for hospitals across the state is **2** for every **10,000** child patients.	**Better than average**	Average	**Worse than average**	**Better than average**
Rate of infections in children due to medical care The average rate for hospitals across the state is **3** for every **1,000** child patients	Average	**Better than average**	**Worse than average**	Average
Rate of too much bleeding or blood clots in children following an operation The average rate for hospitals across the state is **2** for every **1,000** child patients	**Better than average**	**Worse than average**	Average	Average
Rate of breathing failure in children following an operation The average rate for hospitals across the state is **14** for every **1,000** child patients	**Better than average**	**Better than average**	**Worse than average**	**Worse than average**
Rate of bloodstream infection in children following an operation	Average	**Better than average**	Average	**Worse than average**

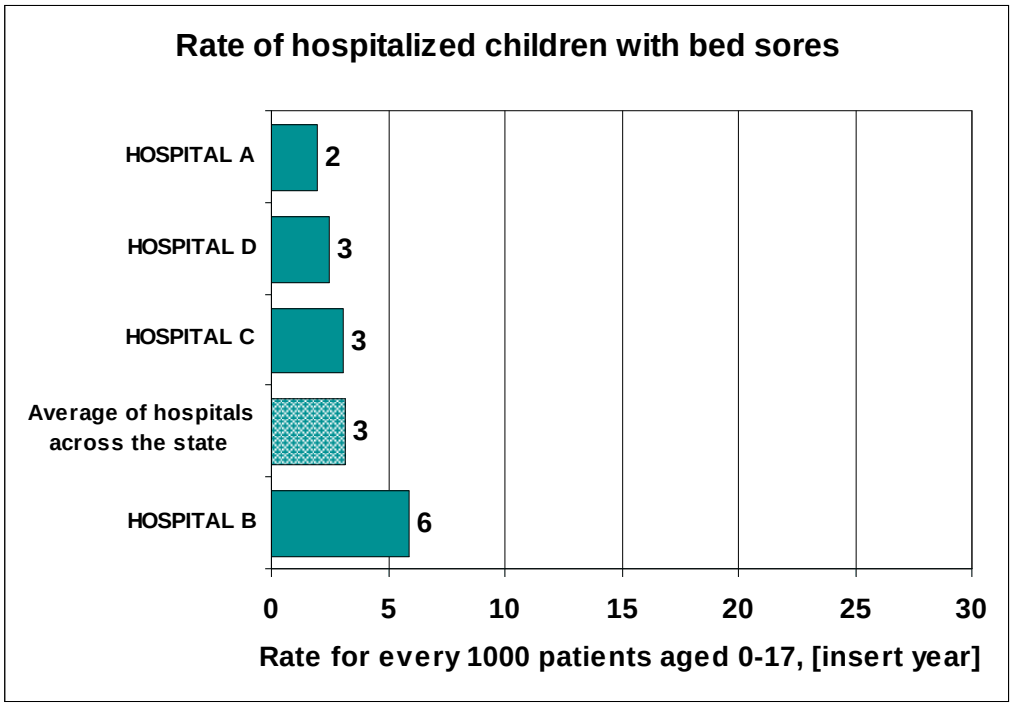
The average rate for hospitals across the state is **9** for every **1,000** child patients.				

Rate of splitting open of a surgical wound after an operation on the stomach or pelvic area among children The average rate for hospitals across the state is **10** for every **10,000** child patients.	**Better than average**	**Worse than average**	**Better than average**	**Better than average**
Rate of accidental cuts and tears in hospitalized children The average rate for hospitals across the state is **2** for every **1,000** child patients.	Average	**Better than average**	**Worse than average**	Average

Rate of hospitalized children with bed sores

This graph shows you how often children in the hospital developed a bed sore (which is called a *decubitus ulcer*), which is a sore or wound on the skin. This can occur because children are lying in one position for too long. This information is for patients under 18 admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



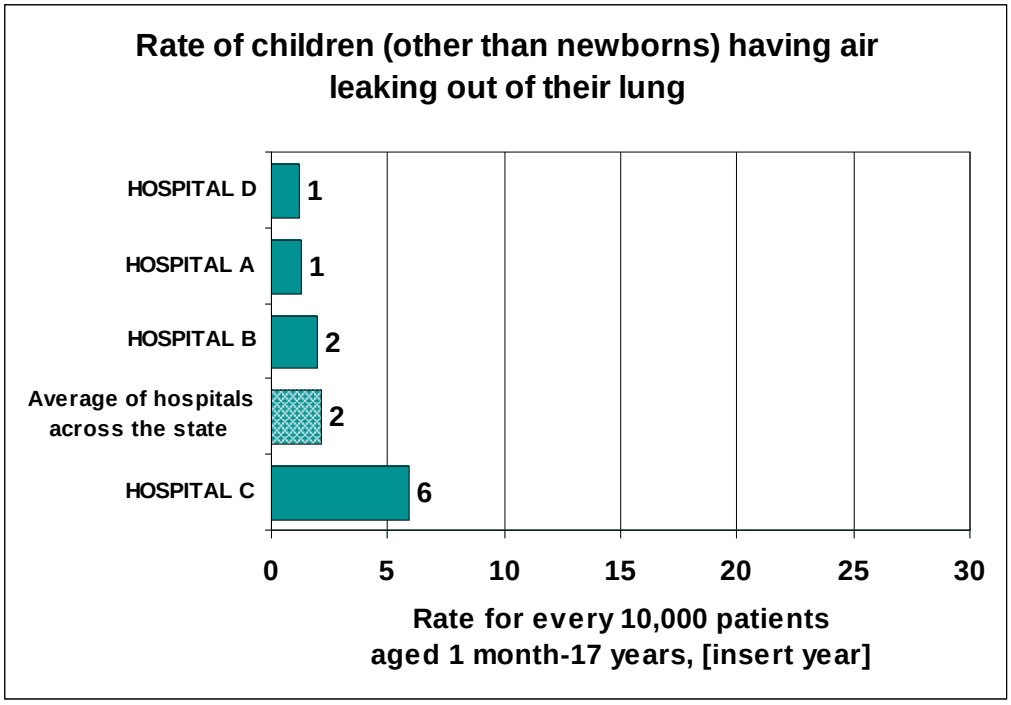
Average of hospitals across the state: The average rate of children with bed sores in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of children (other than newborns) having air leaking out of their lung

This graph shows you how often air leaks out of a child's lung because someone accidentally punctured it during a medical procedure (a complication which is called *iatrogenic pneumothorax*). Iatrogenic pneumothorax sometimes requires putting a tube into a child's chest to remove the extra air. This information is for patients under 18, other than newborns, who were admitted during [insert year]. **Please note that this is a very rare event**.

When choosing a hospital, look for the hospital that has a **lower** rate for this complication. A **lower** rate is shown by a **shorter** bar on the graph below.



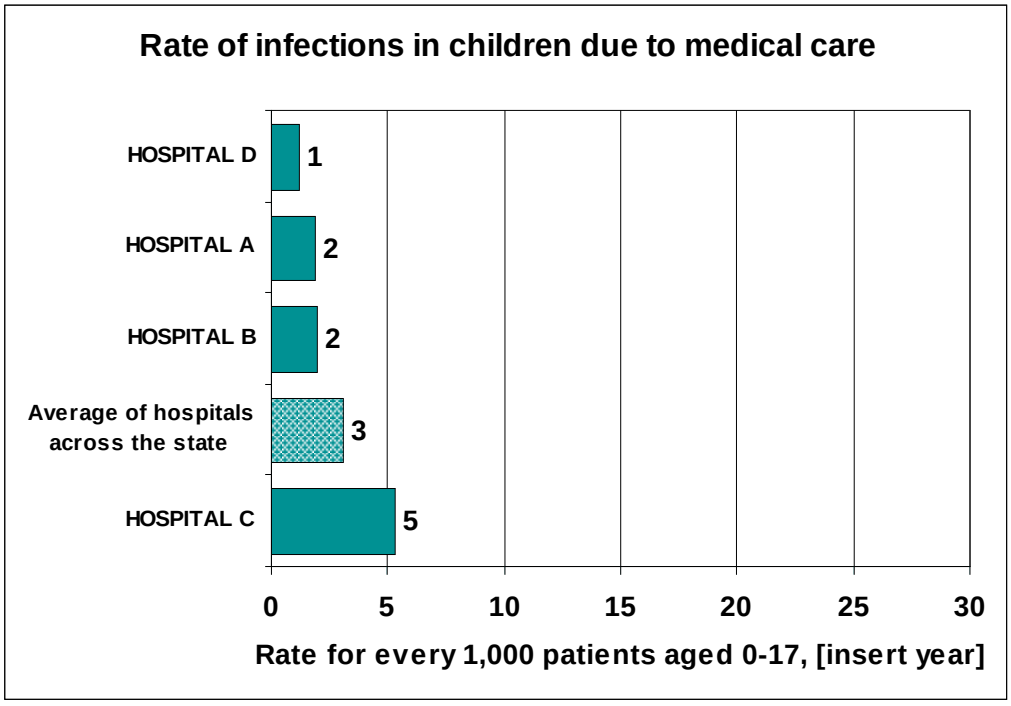
Average of hospitals across the state: The average rate of children with this complication in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of infections in children due to medical care

How often children under 18 got certain types of infections as a result of the care they received in the hospital. These include infections related to intravenous tubes and fluids, treatment of kidney failure, transfusions, and other types of shots. This information is for patients under 18 admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



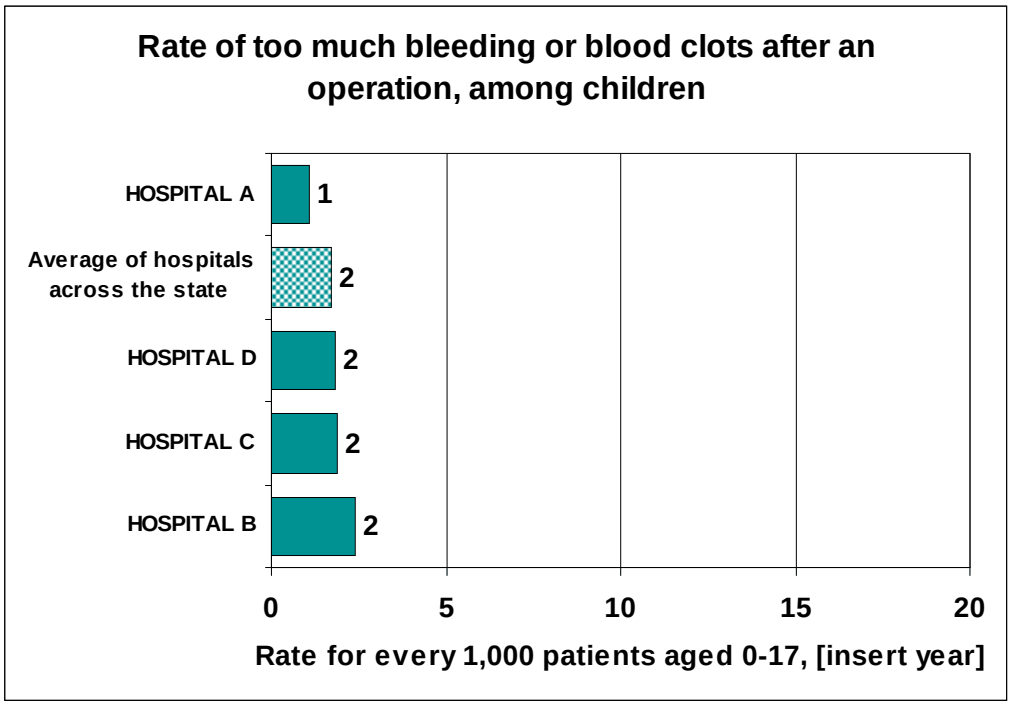
Average of hospitals across the state: The average rate of children with infections due to medical care in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of too much bleeding or blood clots after an operation, among children

This graph shows you how often children bled too much (called *hemorrhaging*) or developed a large blood clot (called *hematoma*) after an operation. All of these complications involved another operation to stop the bleeding or remove the blood clots. This information is for patients under 18 admitted during [insert year].

When choosing a hospital, you should look for the hospital that has a **lower** rate for this complication. A **lower** rate is shown by a **shorter** bar on the graph below.



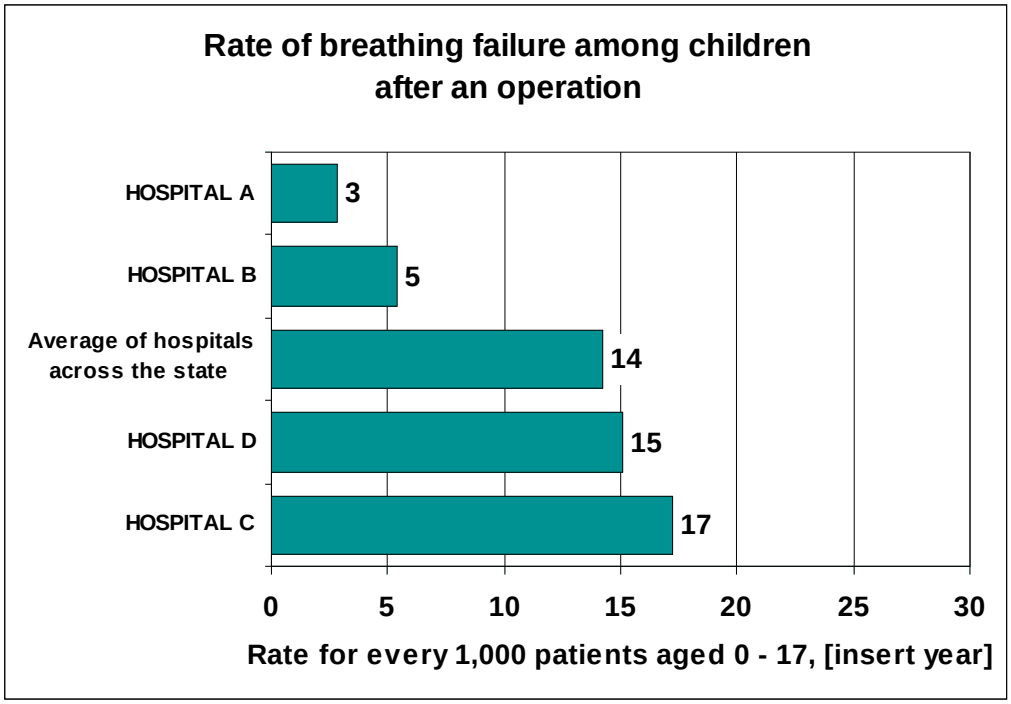
Average of hospitals across the state: The average rate of children with too much bleeding or blood clots in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of breathing failure among children after an operation

This graph shows you how often children having any kind of operation became unable to breathe on their own right afterwards, and needed a ventilator, which is a machine that helps someone breathe, at least temporarily (a complication that is called *postoperative respiratory failure*). This information is for patients under 18 admitted during [insert year].

When choosing a hospital, you should look for the hospital that has **lower** rates for this topic. A **lower** number is shown by a **shorter** bar on the graph below.



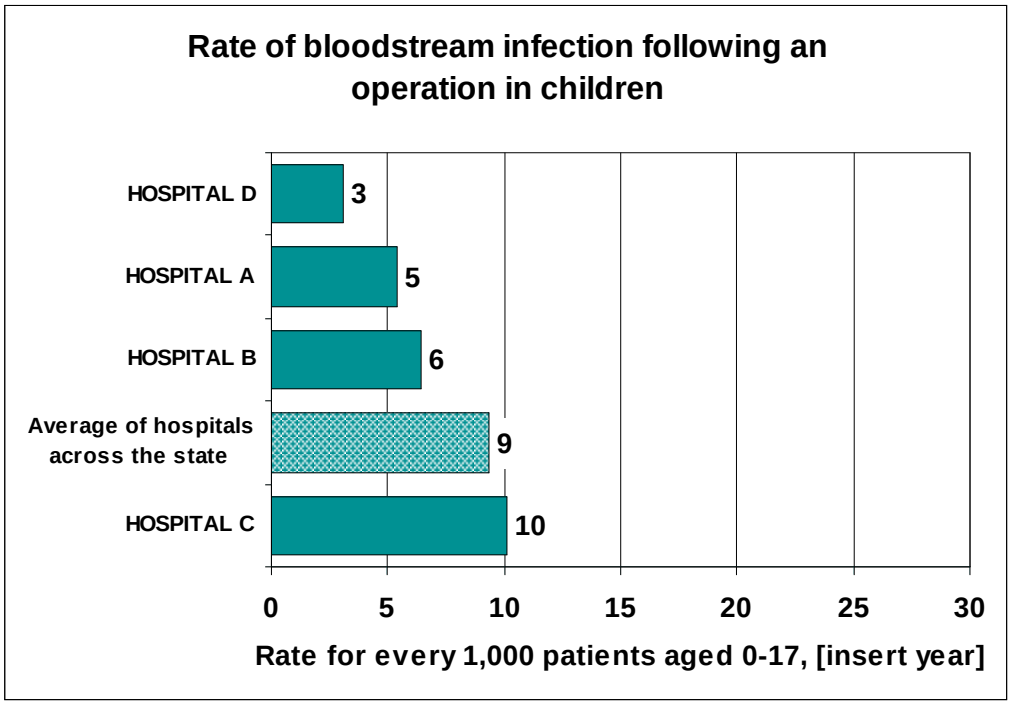
Average of hospitals across the state: The average rate of children with breathing failure after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of bloodstream infection among children following an operation

This graph shows you how often children got a bloodstream infection following an operation (which is called *postoperative sepsis*). This information is for patients under 18 admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



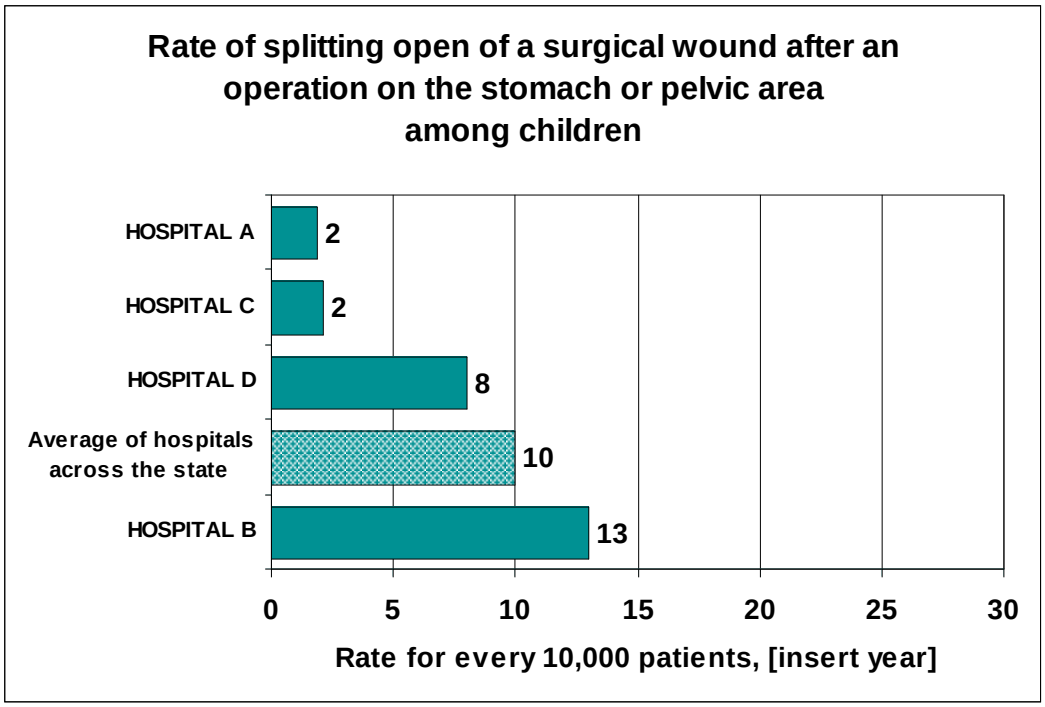
Average of hospitals across the state: The average rate of children with bloodstream infections following an operation in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of splitting open of a surgical wound after an operation on the stomach or pelvic area among children

This graph shows you the percent of children having an operation in their stomach or pelvic area whose wound split open after an operation (which is called *postoperative wound dehiscence*). All of these complications were treated with another major operation to fix the wound. This information is for patients admitted during [insert year]. **Please note that this is a very rare event**.

When choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



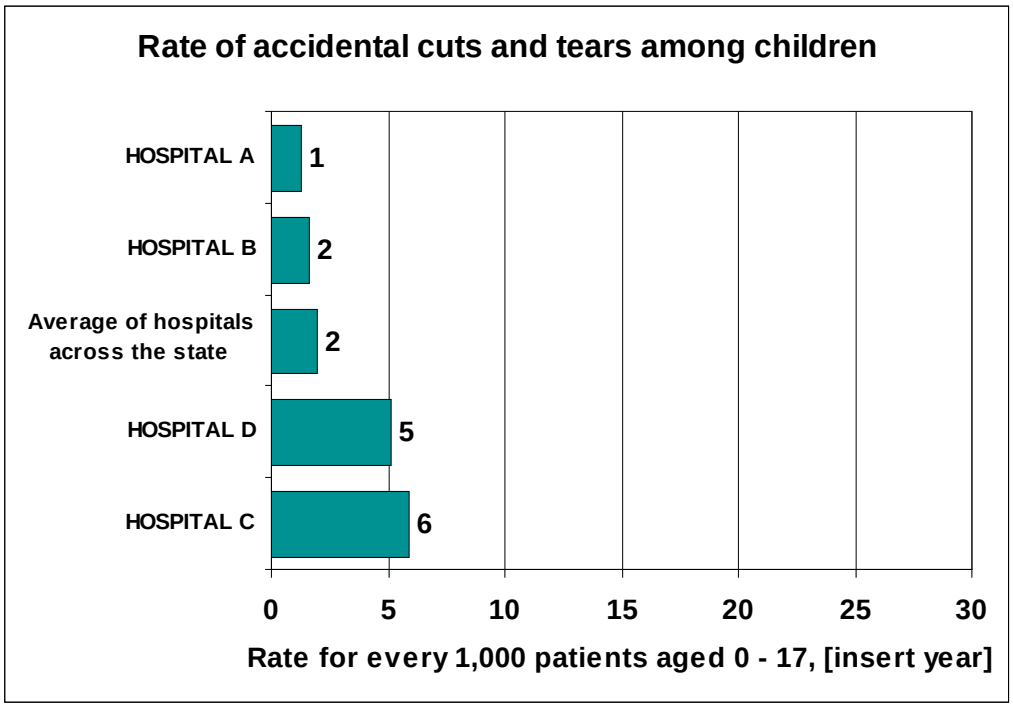
Average of hospitals across the state: The average rate of children who had surgical wounds in the stomach or pelvis split open after an operation, in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

Rate of accidental cuts and tears among children

This graph shows you how often a child under 18 was accidentally cut, making a hole or tear in an organ of the body, while receiving medical care (which is called *accidental puncture and laceration*). This information is for patients under 18 admitted during [insert year].

When you are choosing a hospital, you should look for the hospital that has **lower** rates for this complication. A **lower** number is shown by a **shorter** bar on the graph below.



Average of hospitals across the state: The average rate of children with accidental cuts and tears in hospitals across your state. This number is included so you have:

- a better idea of what is typical for your state.
- a basis for comparing individual hospitals' performance.

How should you use the Report?

How can this information help you? First and foremost, if you or someone you care about expects to be admitted to a hospital in the near future, you can use this information to **help you choose a hospital**. The information can help you **rule out certain hospitals** because the information indicates they do not perform well. It can help you **find a hospital that is especially good** at treating the conditions you face, or especially good at avoiding complications. The report can also help you **make a final choice** between two or three hospitals with good reputations.

The best way to use this particular report is also to **look for patterns in the scores**. Some hospitals may do very well across the board; others may do well in some areas and not in others; still others may really show problems in a wide range of areas. Look carefully for these patterns. At the same time, if there is a particular operation, or medical condition, or complication that is of particular concern to you, you will want to give more weight to information related to those concerns.

Several factors go into making a hospital choice. For example, you may have to **use the specific hospitals in the "network" of your health plan.** If you have to go to a hospital in the network whose scores in this report are troubling to you, **bring the information to your doctor** to discuss it. You may want to ask your doctor to be especially vigilant to ensure that certain problems that are worrying you are avoided.

Second, you can only be admitted to a hospital by a doctor, and doctors typically have "admitting privileges," the right to admit patients, at one or a few hospitals. So when you choose a doctor, and especially **when you choose a specialist, you may actually be choosing a hospital** at the same time. So when your regular doctor refers you to a specialist, ask the question "Where can this specialist admit patients?" Then, **before committing yourself to a particular specialist, check out their hospital** in this report. Again, if the information troubles you, bring it back to your doctor and see if you can be referred to a specialist who practices at a hospital that performs well on the topics that are important to you.

Remember, it's your life, and your health. Most physicians and hospitals are happy to talk with patients about information from reliable sources, and they care about your preferences. You certainly have the right to raise issues with them and get answers to your questions.

A few things to keep in mind as you use the Report

This Report is a starting point for looking at the quality of care at a particular hospital. The overall scores and specific topic results are not the final word. There are a few things to keep in mind when looking at this report.

- **Neither the summary scores nor the specific topics cover all health conditions or surgeries.**

  As new information becomes available, this report may be updated.

- **The Report doesn't address all aspects of quality.**

  For example, this report does not include information on what patients say about their care in the hospital, or information on whether hospitals consistently follow steps known to lead to better results. Information like this is available for many American hospitals on a federal government website called Hospital Compare. **Click here to go to the Hospital Compare website.**

  The Report also does not include information on the specific services provided by a hospital. That information is best obtained directly from the hospital itself. **Click here for a list of hospitals included in this Report and how to contact them.**

- **Don't presume that because a hospital does well (or poorly) in one area of health care, that it will do well (or poorly) in all areas.**

  Hospitals can have strengths and weaknesses in providing different types of care. For example, there are many different kinds of cancers, each of which is treated differently. A hospital that has good scores on operations involving cancer of the pancreas may not do so well with a different type of cancer.

- **In some cases, the specific topics track serious failures in a hospital's performance which happen only once in a great while.**

  You have to be careful when comparing hospitals on these very rare events. The numbers are so small that it is hard to know when a difference means something or just happens by chance. An example would be a bad reaction to a blood transfusion, which happens in only a handful of cases out of a million people each year.

- **Don’t give too much weight to small differences between hospitals.**

  Even on more common events, be careful not to give too much weight to small differences. If in one hospital, 25 people out of a thousand had too much bleeding after an operation, and in another hospital, 26 people out of a thousand did, that’s a really small difference and you shouldn’t worry about it.

- **Some differences in scores may reflect the age of patients or how sick patients are rather than the care provided by the hospital.**

  Hospitals vary in quality, but they also vary in terms of their patients. Their patients can differ in terms of their age**,** or in terms of how sick they are.
  If one hospital takes care of people who happen to be older, or sicker, that hospital’s patients are more likely to die or have certain complications, no matter how good the hospital is.

  We want to show you differences that relate to how hospitals actually perform, rather than differences that relate to how old or sick their patients are. So to the extent possible, the information in this Report takes account of differences between hospitals in the age of their patients, and how sick they are. The scores in this report have been calculated to try to take account of these differences. For details about how the scores in this report were developed, **Click here for Technical Details about the Quality Information in this Report**

Hospital Quality: What is it? Where can I find learn more about it?

Quality in health care, including in hospitals, can be described as "doing the right thing, at the right time, in the right way -- and having the best possible results."

The Institute of Medicine recently stated that high quality health care is:

- ***Effective:*** Treatment uses scientific knowledge and medical experience to increase the chances of getting the best results, and decrease the chance of getting bad results, including death.
- ***Safe:*** Treatment does not result in medical complications or cause harm to the patient that can be prevented.
- ***Patient-centered:*** Doctors, nurses, and other medical staff treat patients with respect, dignity and compassion, and are responsive to patients' needs, values, and preferences.
- ***Timely:*** Patients get the care they need without harmful delays.
- ***Efficient:*** Treatment does not waste doctors' or patients' time or money.
- ***Equitable:*** The same level of care is available to everyone, including men, women and children of all cultures, incomes, education level, social status or any other characteristic.

Where to learn more about Hospital Quality

The information in this Report deals with the first two aspects of hospital quality described above – effective care and safe care. If you are interested in other aspects of quality care, here are some resources that can help. We also list websites with materials to help you think through the process of choosing a hospital.

Hospital Compare – Department of Health and Human Services

- *Hospital Compare* is a website with quality information on almost all hospitals in the US. Current information includes measures of timely and effective care for three conditions: heart attack, heart failure and pneumonia. There is also a measure of safe care, the surgical infection prevention rate.

  In the next year or so, the website will add two kinds of new information: information similar to this report about death rates for patients admitted for different operations and medical conditions, and information about patients' experiences in hospitals, such as how well doctors and nurses communicate with patients and how responsive hospital staff are to patient needs. Go to **www.hospitalcompare.hhs.gov**.
  In addition, the *Hospital Compare* website provides a *Hospital Checklist* that you can use to think through a range of issues to consider in choosing a hospital. Go to **http://www.hospitalcompare.hhs.gov/Hospital/Static/About-HospChecklist.asp**

Agency for Healthcare Research & Quality (AHRQ)

- *Quick Checks for Quality: Choosing Quality Health Care*, an information sheet by AHRQ, from **http://www.ahrq.gov/consumer/quick.htm**.

- AHRQ's *Your Guide to Choosing Quality Health Care*, from **http://www.ahrq.gov/consumer/qnt**

- *Be an Active Health Care Consumer* (**http://www.ahrq.gov/path/beactive.htm**), an AHRQ web page that includes a list of quality tools and information for people who want to take an active role in their health care. Among the resources is a booklet, ***Guide to Health Care Quality: How to Know it When You See It***

To contact AHRQ by mail write to:
Agency for Healthcare Research and Quality
Office of Communications and Knowledge Transfer
540 Gaither Road, Suite 2000
Rockville, MD 20850.

To reach them by phone, call (301) 427-1364

Joint Commission on the Accreditation of Healthcare Organizations

This organization (JCAHO) is the primary group that reviews and accredits hospitals in the United States.

- *Quality Check* (**http://www.qualitycheck.org/consumer/searchQCR.aspx**), a site of the Joint Commission on the Accreditation of Healthcare Organizations, on which you can look up hospitals that meet this organization's patient safety and quality standards.

To reach JCAHO with a general question, call 630-792-5000.

To order JCAHO publications, call 877-223-6866

If you have concerns and complaints about your care

If you have a complaint about the quality of the medical care you or a loved one received at a hospital, first contact the hospital's patient advocate. You can usually reach the patient advocate through the hospital's telephone operator.

If you still need help, there are two agencies in every state that work on hospital quality.

- *The Quality Improvement Organization or QIO.* This is the organization to contact if you are not satisfied after calling the hospital's patient advocate.
- *The State Survey Agency.* This is the organization to call if you have other complaints about a health care facility.

The phone numbers for the State Survey Agency and the Quality Improvement Organization in your state can be found at **www.medicare.gov/Contacts/Home.asp** Additional information about hospitals may be found on websites of these state agencies.

You can also contact the Complaint Hotline at the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
Phone: 1-800-994-6610
E-mail: complaint@jointcommission.org.

Technical details about the quality information in this Report

The scores in this report are based on standardized information that all hospitals in our state are required to submit to (insert name of state agency). Hospitals have to demonstrate that the information they provide is accurate and complete. The (agency) actually calculates the scores, not the hospitals.

The specific topics in this report were developed by the Agency for Healthcare Research and Quality (AHRQ), and are called the AHRQ Quality Indicators. AHRQ is a federal government agency whose mission is to improve the quality and safety of health care in the United States.

AHRQ saw a need for a set of hospital quality indicators that could be collected easily, based on information that was gathered in exactly the same way from hospital to hospital. Dozens of experts in health services research, internal medicine and pediatrics, statistics, and health care quality measurement worked together to develop and test these indicators to make sure they were medically meaningful, accurate and reliable. The indicators are regularly reviewed and updated.
Click here for detailed information about the AHRQ Quality Indicators

AHRQ has developed several kinds of indicators. They have also developed the overall scores that combine information from several indicators. The information in this Report is based on what are called Inpatient Quality Indicators, Patient Safety Indicators, and Pediatric Quality Indicators. Both these sets of indicators relate primarily to the *results* of hospital care for patients.

Click here for detailed information about the AHRQ Inpatient Quality Indicators

Click here for detailed information about the AHRQ Patient Safety Indicators

Click here for detailed information about the AHRQ Pediatric Quality Indicators

How we analyzed the data and calculated scores

In this section of the website, the sponsor should present information about the methods they used in analyzing the data and calculating scores. For example, this is the place to explain how some hospitals were identified as being "better" or "worse" than average, additional details about risk-adjustment methods, and whether or not the data were smoothed, or combined for several years.

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