

# Healthgrades Patient Safety Ratings and Excellence Awards

Healthgrades publishes patient safety ratings and patient safety excellence awards yearly

## Patient Safety Ratings Methodology

- 1** Healthgrades uses MedPAR data to find the number of preventable complications that occurred at all eligible short-term acute care hospitals over the course of three fiscal years (for the 2018 ratings, this included data from fiscal years 2014-2016)
- 2** Focusing on 14 potentially preventable events (from AHRQ's patient safety indicators), Healthgrades uses multiple linear regression models to predict the number of patient safety incidents expected at any given hospital based on the hospital's patient mix.  

One indicator, 'Foreign Object Left During Surgery,' has zero predicted incidents (PSI) as it is classified by AHRQ as a "never event"—an event that should never occur at a hospital.
- 3** Healthgrades compares the predicted number of safety incidents at every hospital with the actual number of events to receive a z-score for each indicator. The hospital's performance for each metric is then grouped as "better," "same as," or "worse" than expected.

### Data Sources

- Inpatient data from the Medicare Provider Analysis and Review (MedPAR), which is purchased from CMS<sup>1</sup>
- Agency for Healthcare Research and Quality's (AHRQ's) Patient Safety Indicators Technical Specifications, version 5 Enhanced

Note: Hospitals only receive a rating on a given safety indicator if they had at least 15 patients in the past three years or five patients in the most recent year who were eligible to be evaluated for indicator (i.e., were at risk of a safety incident due to their condition or procedure)

## Patient Safety Excellence Awards Designation Criteria

To be eligible for Healthgrades' Patient Safety Excellence Award, a hospital must be in the top 80% for clinical quality as measured by a volume-weighted z-score across all conditions and procedures that Healthgrades measures (in their separate quality evaluation). In addition, eligible hospitals must not have any occurrences of the PSI 'Foreign Object Left During Surgery.' The hospital must also have data—with at least 15 patients evaluated across three years and five patients in the most recent year—for at least seven of the eight "core PSIs" (designated in the chart below.)

To designate the Award recipients, Healthgrades creates a composite patient safety score by averaging the z-scores for the 13 PSIs and weighting them by the total number of patients evaluated for each PSI. Hospitals in the top 10% of this weighted score receive the Patient Safety Excellence Award.

In 2018, Healthgrades awarded 458 hospitals its Patient Safety Excellence Award. Healthgrades determined these winning hospitals after analyzing 247,676 potentially preventable patient events and estimated that 126,342 of these events could have been avoided if all hospitals performed similarly to the award recipients.

1) Centers for Medicare and Medicaid.

Sources: "[Patient Safety Ratings Patient Safety Excellence Award 2018 Methodology](#)," healthgrades.com. Web. 15 May 2018.

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## Patient Safety Indicators and National Observed Rate

AHRQ Patient Safety Indicator	Healthgrades Report Category	National observed rate (per 1,000) <sup>1</sup>
Death Rate Among Surgical Inpatients with Serious Treatable Complications	Death following a serious complication after surgery	118.62
Death Rate in Low-Mortality Diagnosis Related Groups (DRGs)	Death in procedures where mortality is usually very low	.32
Pressure Ulcer Rate*	Pressure sores or bed sores acquired in the hospital	.5
Iatrogenic Pneumothorax Rate*	Collapsed lung due to a procedure or surgery in or around the chest	.34
Central Venous Catheter-Related Bloodstream Infection Rate*	Catheter-related bloodstream infections acquired at the hospital	.21
Postoperative Hip Fracture Rate*	Hip fracture following surgery	.04
Postoperative Hemorrhage or Hematoma Rate	Excessive bruising or bleeding as a consequence of a procedure or surgery	5.11
Postoperative Physiologic and Metabolic Derangement Rate	Electrolyte and fluid imbalance following surgery	.69
Postoperative Respiratory Failure Rate	Respiratory failure following surgery	10.05
Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate*	Deep blood clots in the lungs or legs following surgery	4.99
Postoperative Sepsis Rate*	Bloodstream infection following surgery	9.61
Postoperative Wound Dehiscence Rate*	Breakdown of abdominal incision site	1.86
Accidental Puncture or Laceration Rate*	Accidental cut, puncture, perforation or hemorrhage during medical care	1.89
Retained Surgical Item or Unretrieved Device Fragment Count	Foreign objects left in body during a surgery or procedure (reported as number of events)	None <sup>2</sup>

\*Core PSIs used to determine eligibility for the 2018 Patient Safety Excellence Awards

1) National average rate per 1,000 Medicare patients according to Version 5.0 of AHRQ's patient safety indicators. While version 6.0 has been released, the 2018 Healthgrades ratings relied on the technical specifications of this earlier version.

2) This indicator is not analyzed as this is a "never event" which should never occur at hospitals

Sources: [Patient Safety Ratings Patient Safety Excellence Award 2018 Methodology](#), healthgrades.com, Web, 15 May 2018, [Patient Safety Indicators v5.0 Benchmark Data Tables](#), ahrq.gov, Web, 15 May 2018.