Hospital Peer Groups, Reliability, and Stabilization: Shrinking to the Right Mean

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Presentation to the Federal Committee on Statistical Methodology
Washington, DC
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Agenda

- Including Peer Groups in Hospital Comparisons
  - Rationale
  - Technical Approaches

- Empirical Example

- Challenges and Next Steps
Stabilizing the Quality Indicators

- Hospital Risk-Adjusted Rates (RARs) are often unstable
  - Small sample sizes
  - Rare events

- Smoothing stabilizes RARs by using information from the entire sample of hospitals
Including hospital characteristics to create peer groups is controversial
- Influences hospital ranking (Austin et al. 2004)
- Changes the interpretation (Romano 2004)

Volume is the most common characteristic considered
- Strong empirical volume-outcome relationship for mortality (Silber et al. 2010)

The ultimate choice of peer group
- Needs conceptual and empirical backing
- Depends on the outcome of interest
- Should be precise
Hospital characteristics can enter risk- or reliability-adjustment models (or both)

- **Risk-Adjustment Model**
  - Peer group fixed effects, and/or

- **Reliability-Adjustment Model**
  - One-part or unified: Smooth to peer group rates
    - Peer group random effects
    - With or without risk adjustment for hospital-level factors
  - Two-part shrinkage model: Standardize to peer group rate
    - Estimate reliability as signal-to-noise ratio
    - Smooth to the peer group target
Illustrative Example

- **Aim**: Incorporate peer group targets into the AHRQ QI model

- **Peer grouping**: Teaching vs. Non-Teaching Affiliation

- **Measure**: PSI 12 (Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate)

- **Approach**:
  - Base case: Current QI methodology
  - Alternative: Two-part approach smoothing to teaching peer group target rates

- **Evaluation criteria**:
  - Change in reliability (signal variance/total variance)
  - Correlation of hospital ranking across approaches
  - Proportion of hospitals moving above/below national average
Methods

- Calculate reliability weights and shrinkage targets for two scenarios:
  - Base Case ("Overall")
  - Alternative ("Peer Group")

- Reliability weights vary for each approach
  - Recalculate signal and noise

- Changes in smoothed rate estimates is therefore a function of
  - The new shrinkage target
  - The change in reliability weight
Descriptive Statistics: PSI 12 (DVT/PE)

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Non-Teaching</th>
<th>Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals (n)</td>
<td>1,264</td>
<td>944</td>
<td>320</td>
</tr>
<tr>
<td>Denominator (mean)</td>
<td>4,605</td>
<td>3,056</td>
<td>9,177</td>
</tr>
<tr>
<td>Observed Rate</td>
<td>5.81</td>
<td>4.80</td>
<td>6.81</td>
</tr>
<tr>
<td>Expected Rate</td>
<td>5.81</td>
<td>5.52</td>
<td>6.11</td>
</tr>
<tr>
<td>Risk-Adjusted Rate</td>
<td>5.81</td>
<td>5.06</td>
<td>6.48</td>
</tr>
</tbody>
</table>

- Rates have units per 1,000 discharges
- Random sample of hospitals from 12 states with Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SIDs), 2009 and 2010*

* We would like to thank the HCUP Partners from the following states: AR, AZ, CA, FL, IA, KY, MA, MD, NE, NJ, NY, WA ([http://www.hcup-us.ahrq.gov/partners.jsp](http://www.hcup-us.ahrq.gov/partners.jsp))
Smoothed Rate Distribution

PSI-12 Smoothed Rate Distribution

Smoothed Rate (per 1,000 Discharges)

Overall, Non-Teaching
Peer, Non-Teaching
Overall, Teaching
Peer, Teaching
- Teaching hospitals: 18% move above national average
- Non-teaching hospitals: 15% move below national average
Summary

- Using peer group targets changes ranking of smoothed rates
  - Teaching: 18% move above national average
  - Non-teaching: 15% move below national average
  - Rank sum correlation of 0.91

- Peer grouping changes the variability in PSI 12 distribution through reliability weights
  - Teaching: Increased variability
  - Non-teaching: Decreased variability
Challenges and Limitations

Practical, Conceptual, and Technical Questions Remain

- What happens for hospitals on the boundary?
  - For example: volume, disproportionate share percentages, or nurse staffing ratios

- What about more precise subgroups?
  - Major versus minor teaching status
  - Subdividing non-teaching hospitals further

- What happens for small peer groups (e.g., two hospitals)?

- How do we handle hospitals missing peer group information?
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References


- Romano, P.S. Peer group benchmarks are not appropriate for health care quality report cards. *American Heart Journal*, 148(6); 2004.

Appendix: Estimating Noise

By the law of total variance:

\[
\text{Var}(\epsilon_h) = E \{ \text{Var} (RAR_h - \theta_h|\theta_h) \} + \text{Var} \{ E (RAR_h - \theta_h|\theta_h) \}
\]

\[
= E \{ \text{Var} (RAR_h|\theta_h) \} + E \{ \text{Var} (\theta_h|\theta_h) \} + \text{Var} \{ E (RAR_h - \theta_h|\theta_h) \}
\]

The last two terms drop out.

\[
\text{Var}(\epsilon_h) = E \{ \text{Var} (RAR_h|\theta_h) \}
\]

\[
= E \left\{ \text{Var} \left( \frac{\bar{Y} \cdot O_h}{E_h} \right) \right\}
\]

\[
\hat{o}_h^2 = \left( \frac{\bar{Y}}{n_h \cdot E_h} \right)^2 \sum_{i \in A_h} \hat{Y}_i \left( 1 - \hat{Y}_i \right)
\]
Appendix: Estimating Signal

Signal variance is the total variance $\text{Var}(RAR_h)$ minus the noise variance $\text{Var}(\varepsilon_h)$. Note that:

$$E \left\{ (RAR_h - \mu)^2 - \hat{\sigma}_h^2 \right\} = \text{Var} (\theta_h)$$

Using this relation we have that:

$$\text{Var}(\theta_h) = \text{Var}(RAR_h) - E(\hat{\sigma}_h^2)$$

$$\hat{\tau}^2 = \frac{1}{H-1} \sum_h \left\{ (RAR_h - \overline{RAR})^2 - \hat{\sigma}_h^2 \right\}$$
Appendix: Estimating Reliability

We have assumed a simple linear regression which has a known solution found using the least-squares estimate or the maximum likelihood estimate: (MLE)

\[ \theta_h - \mu = \lambda_h \cdot (RAR_h - \mu) + \omega_h \]

The MLE is given by:

\[ \hat{\lambda}_h = \frac{Cov(\theta_h, RAR_h)}{Var(RAR_h)} = \frac{Var(\theta_h)}{Var(\theta_h) + Var(\epsilon_h)} = \frac{\tau^2}{\tau^2 + \sigma_h^2} \]

Use the relation \( RAR_h = \theta_h + \epsilon_h \) to get the numerator result that \( Cov(\theta_h, RAR_h) = Var(\theta_h) \).
Future Considerations

- Multilevel random effects
  - Cross-classification of groups

- Incorporating peer groups (or different peer groups) into the risk-adjustment model

- Exploring the impact of historical priors, or priors defined outside the analytic population

- Application to patient safety indicators
  - Lower event rates
  - No consistent relationship with characteristics
Conclusions

- Whether to shrink to peer group means depends on:
  - Empirical evidence
  - Conceptual background
  - Precise peer group classification
  - Desired interpretation or use