



HAL
open science

Hospital discharge data can be used for monitoring procedures and intensive care related to severe maternal morbidity.

Anne A. Chantry, Catherine Deneux-Tharaux, Christine Cans, Anne Ego, Catherine Quantin, Marie-Hélène Bouvier-Colle

► To cite this version:

Anne A. Chantry, Catherine Deneux-Tharaux, Christine Cans, Anne Ego, Catherine Quantin, et al.. Hospital discharge data can be used for monitoring procedures and intensive care related to severe maternal morbidity.. *Journal of Clinical Epidemiology*, 2011, 64 (9), pp.1014-22. 10.1016/j.jclinepi.2010.11.015 . inserm-00574115

HAL Id: inserm-00574115

<https://inserm.hal.science/inserm-00574115v1>

Submitted on 7 Mar 2011

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

Hospital discharge data can be used for monitoring procedures and intensive care related to severe maternal morbidity.

Anne A. Chantry^{1,2}, Catherine Deneux-Tharaux^{1,2}, Christine Cans³, Anne Ego^{1,4}, Catherine Quantin^{5,6}, Marie-Hélène Bouvier-Colle^{1,2} for the GRACE study group*.

¹ INSERM, UMR S953, Epidemiological research on perinatal health and women's and children's health, F-75020, Paris, France.

² UPMC Univ Paris 06, UMR S 953, F-75005, Paris, France.

³ CHRU Grenoble, Public Health Department, F-38000, Grenoble, France.

⁴ CHRU Lille, Medical Evaluation Unit, The Jeanne de Flandre Maternity Hospital, F-59000, Lille, France.

⁵ INSERM, U866, Lipids, nutrition, cancer, F-21000, Dijon, France.

⁶ UB, Univ Bourgogne, F-21000, Dijon, France

***GRACE study group:** G. Bal, G. Beucher, MJ. D'alche Gautier, AS. Ducloy-Bouthors, N. Lamendour, I. Le Fur, V. Tessier, J. Zeitlin.

Corresponding author:

Anne A. CHANTRY

Address: INSERM U953 Hôpital TENON – Bâtiment Recherche – 4 rue de la Chine – 75020
PARIS, France

Telephone: +33 1 56 01 83 69

E-mail: anne.chantry@inserm.fr

1 **Abstract**

2
3 **Objective:** To estimate the accuracy and reliability of the reporting of diagnoses and
4 procedures related to severe acute maternal morbidity in French hospital discharge data.

5
6 **Study design and setting:** The study, conducted in four French tertiary teaching hospitals,
7 covered the years 2006 and 2007 and 30,607 deliveries. We identified severe maternal
8 morbid events – eclampsia, pulmonary embolism, procedures related to postpartum
9 hemorrhages, and intensive care – in administrative hospital discharge data and medical
10 records and compared their recording. Information from medical records was the gold
11 standard. Sensitivity, specificity, positive and negative predictive values of the hospital
12 discharge data for these events were calculated. False positives and false negatives were
13 examined to identify the reasons for misrecorded information.

14
15 **Results:** The positive predictive value of the hospital discharge data was 20% for eclampsia.
16 For procedures related to postpartum hemorrhages, their positive predictive values were
17 high, but sensitivities were lower; however, 95% of recording errors could be corrected. All
18 indicators for intensive care exceeded 98%.

19
20 **Conclusion:** Intensive care and procedures seem reliably reported in the hospital
21 administrative database, which therefore can be used to monitor them. Use these data for
22 monitoring diagnoses will require a greater investment by clinicians in the accuracy of their
23 reporting.

24
25 **Key words:** Severe maternal morbidity - Hospital discharge data – Validity – Sensitivity -
26 Positive predictive value - Medical records.

27 **Running title:** Validity of obstetric hospital discharge data.

28 **Word count:** 200 words.

29 **What is new ?**

30

31 **- Key finding**

32 Intensive care and procedures for postpartum hemorrhages seem reliably and accurately
33 reported in the hospital discharge database.

34

35 **- What this adds to what we know?**

36 Hospital discharge data could be used for monitoring several events related to severe
37 maternal morbidity.

38

39 **- What should change now?**

40 Monitoring diagnoses in hospital discharge databases will require a greater investment by
41 clinicians in the accuracy of their reporting and regular internal quality controls.

42

43 **Introduction**

44

45 Hospital administrative databases are a useful tool for measuring hospital activity [1]. They
46 are employed to define health priorities, assess the costs of providing health care, and
47 optimize the organization of healthcare facilities [2,3]. For some 20 years, these routinely
48 collected data have also been used for research purposes to measure disease incidence
49 [4,5] or procedure frequencies, assess the rate of complications of hospitalizations or surgery
50 [6,7] and identify the determinants of medical conditions [8-10]. The validity of these data
51 depends simultaneously on the reliability of the information recorded and the accuracy of
52 their coding at different stages of processing. Studies to validate hospital administrative data
53 in the United States [11,12], Canada [6], Australia [9,10,13] and Scandinavia [5,14,15] have
54 generally concluded that they can be used, but underline their numerous limitations,
55 including substantial inter-facility variability in coding quality [16-19], better coding for more
56 serious complications and diseases [7,20], and better recording of procedures than
57 diagnoses [16,21,22]. Most reports on the validation of these data come from English-
58 speaking countries. They are relatively sparse in Europe. Such studies in France have
59 covered the fields of oncology [4,10,23,24], intensive care [25] and vascular disease [26], but
60 not obstetrics.

61 Routine childbirth in France takes place within the hospital system. Although no disease is
62 present in most obstetric hospitalizations, a non-negligible but unknown number involve
63 complications of pregnancy, delivery or the postpartum period. Today, changing trends in
64 obstetric practices and in maternal profiles require the development of indicators that can
65 measure and monitor severe maternal morbidity.

66 Hospital databases are a potential tool for estimating the frequency of severe maternal
67 morbidity and following its trends over time because women with such morbidity are always
68 hospitalized and administrative records are supposedly exhaustive, rapidly available and

69 inexpensive to use. However, before this information can be used, its validity must be
70 assessed.

71 Several studies in Australia and in the USA sought to validate hospital discharge data for
72 numerous obstetrical complications (as many as 50) [13], or on the contrary, have
73 concentrated on only one or two [20,27,28]. Because there is no consensual definition for
74 severe maternal morbidity, we focused on the severe maternal morbid events (SMME) that
75 are the most frequent causes of maternal mortality [29-31].

76 Our objective was to study the validity of French hospital discharge data from the
77 Programme of Medicalization of Information System (PMSI) for some SMME. More
78 specifically, our aim was to evaluate whether the SMME were transcribed in the PMSI as
79 they were described in the medical records.

80

81 **Material & methods**

82

83 *PMSI*

84 Inspired by the American DRG (diagnosis-related groups) model [2], the PMSI was
85 established in France in 1991 [3] and extended in 1997 to all French healthcare facilities [32].
86 Initially designed to analyze hospital activity and contribute to the strategic elaboration of
87 facility plans, it has become an instrument of financial management. Since 2008, each
88 hospital's budget has depended on the medical activity described in this PMSI [33], which
89 compiles discharge abstracts for every admission. Information in these abstracts is
90 anonymous and covers both administrative (age, sex, geographic code of residence, year,
91 month and type of admission, year, month, and type of discharge, facility status) and medical
92 data. Diagnoses identified during the admission are coded according to the 10th edition of
93 the International Classification of Diseases (ICD10). The condition occasioning the greatest
94 use of resources during the hospitalization is recorded as the main diagnosis, with other
95 diseases listed as associated diagnoses [34]. All procedures performed during the
96 hospitalization are coded according to the French Common Classification of Medical

97 Procedures (CCAM). PMSI rules are national and imposed by the government. Each facility
98 produces its own anonymous standardized data, which are then compiled at the national
99 level. Our validation study was conducted on this PMSI database.

100

101 *Selection of the study population*

102 First, PMSI abstracts from the four study hospitals (Caen, Cochin [AP-HP, Paris], Grenoble
103 and Lille, university hospitals) were extracted from the national database. Then, we selected
104 hospitalizations of women of reproductive age (14 to 50), with at least one code related to
105 pregnancy, delivery, or the postpartum period, and who were discharged from 1 January
106 2006 through 31 December 2007 (Figure 1). Women who did not give birth in one of the
107 study hospitals were excluded because the content of their medical records was incomplete.

108

109 *Selection of hospitalizations*

110 Within the selected PMSI database (= 64,061 abstracts), we identified abstracts including at
111 least one of the following SMME: diagnosis of eclampsia; diagnosis of pulmonary embolism;
112 one of the following procedures for treating postpartum hemorrhages: uterine artery
113 embolization, uterine artery ligation, uterine vascular pedicle ligation, or hysterectomy; or
114 finally, intensive care. In the PMSI, the intensive care variable is defined by admission to
115 intensive care unit and/or a simplified acute physiology score (SAPS II) ≥ 15 associated with
116 at least one specific procedure. The hospitalizations were selected from the PMSI by
117 searching for specific codes for each of these SMME (figure 1) which occurred during the
118 whole maternal risk period as defined by the WHO (pregnancy, delivery and post-partum).
119 When several abstracts described the same event for the same woman, the event was
120 counted only once.

121

122 *Validation of the PMSI recorded data*

123 The medical record was considered to be the gold standard. The term or name of each of the
124 SMME under study was used to search for it in the medical records.

125 The SMME identification in the medical records was made possible by querying an additional
126 database: the database of computerized medical records available in all four centers. For
127 2006-2007, 30,614 deliveries were recorded in this database. In centers 1 and 3, the medical
128 records and computerized medical records were combined. In centers 2 and 4, the
129 computerized records consisted of a complementary database where information was
130 entered daily by clinicians during hospitalization. SMME were identified in the computerized
131 databases by searching for their terms.

132 This computerized medical records database has been linked with the database extracted
133 from the PMSI using the following variables: patient's age, month and type of admission to
134 hospital, month and type of discharge, length of stay and geographic code of residence.

135 The cases selected from the PMSI were compared with the data from the matching medical
136 records. This comparison involved a simple reading of the source medical record with all its
137 components: discharge letters (to referring and primary care physicians), nursing records,
138 hospital and surgical reports. Specifically, we did not interpret any examinations or judge any
139 diagnoses. The SMME we sought was either specifically mentioned in the record or it was
140 not.

141 The true positives were the SMME identified simultaneously in the PMSI abstracts and in the
142 corresponding medical records. Inversely, false positives were events recorded in the PMSI
143 that did not exist as such in the patients' records.

144 False negatives were the SMME experienced by patients and listed in their medical records,
145 but not reported in the PMSI. On the contrary, true negatives corresponded to all the
146 situations in which no SMME was listed in either the patient's record or the PMSI abstract.

147 The causes of both false positives and false negatives were further analyzed by reading the
148 complete medical chart and examining all the codes of the hospital discharge abstract.

149

150 The National Data Protection Authority (Commission Nationale de l'Informatique et des
151 Libertés) approved the study (n° 1004749).

152

153 *Statistical analyses*

154 To estimate the accuracy and reliability of the PMSI database for the SMME studied, we
155 analyzed sensitivity, specificity, positive predictive value (PPV), and negative predictive value
156 (NPV) of the PMSI data relative to the source medical records.

157 Sensitivity was the probability that PMSI data correctly identified a woman with a SMME;
158 specificity was the probability that PMSI data correctly identified a woman with no SMME.

159 The PPV corresponded to the probability that a woman had a SMME given that SMME was
160 also coded in the PMSI. The NPV, on the other hand, was the probability that a woman had
161 not a SMME given SMME was also not coded in the PMSI.

162 Cohen kappa scores were calculated to assess the degree of agreement between the two
163 databases, taking random agreement into account. The Kappa score proposes a neutral
164 description of the agreement between the two data sources for each event, without
165 attributing more importance to the database serving as a reference for the other analyses.

166 Excellent agreement was defined as a score greater than 0.80, substantial from 0.80 to 0.60,
167 moderate from 0.59 to 0.40, and poor below 0.40 [35]. Confidence intervals (CI) were
168 determined with a type I risk of 5%.

169

170 **Results**

171

172 For 2006-2007, among the 64,061 PMSI abstracts, 1,022 abstracts identified an SMME.

173 After the study of duplicates, 403 single SMME were identified in the PMSI.

174 In the PMSI, the three most frequent SMME were, in decreasing order: intensive care,
175 eclampsia, and embolizations (Table 1). Comparison with the content of the corresponding
176 medical files validated 314 SMME of the 403 identified in the PMSI. After validation, the order
177 of frequency was modified, and eclampsia moved from the second most frequent event in the
178 PMSI to the least frequent.

179

180 Considering the study population of 30,614 women who delivered during the study period,
181 the analysis of the false positives and false negatives in the PMSI showed three distinct
182 situations: a high proportion of false positives for diagnoses, false negatives for procedures,
183 and few false positives or negatives for intensive care (Table 1).

184 The rate of false positives was 80% for eclampsia. Analysis of the medical records failed to
185 validate 67 of the 84 cases of eclampsia identified in the PMSI. Similarly, 36% of the
186 pulmonary embolisms, that is, 11 of 31 recorded in the PMSI, were not confirmed in the
187 medical records.

188 There was only one case of false positive for postpartum hemorrhage procedures, for 1 of
189 the 34 ligations mentioned in the PMSI. However, the proportion of false negatives for
190 procedures was 44% for embolizations and 25% for hysterectomies and ligations. Overall, 56
191 embolizations, 8 hysterectomies and 11 ligations were not identified in the PMSI.

192 The PMSI and the medical records listed the same number of cases receiving intensive care,
193 although there were three false positives and three false negatives.

194 For seven SMME identified in the PMSI, the corresponding computerized file was empty, and
195 the accuracy of the information could not be checked. Consequently, these cases could not
196 be classified as either true or false positive, and their status is described as “uncertain”
197 (Table 1). This concerned five eclampsia and two embolisations.

198
199 The analysis of the content of medical records showed that the false positives for eclampsia
200 in the PMSI corresponded to less severe situations, such as preeclampsia, isolated
201 gestational hypertension or isolated proteinuria. The study of the PMSI false negatives for
202 procedures found that 95% of them (71/75) were due to inappropriate coding of procedures
203 for postpartum hemorrhage management that were mentioned in the PMSI but with codes
204 not specific to the postpartum period. For example, medical records reported emergency
205 hysterectomies for massive postpartum hemorrhage, whereas the corresponding PMSI
206 abstract coded for a planned hysterectomy in a non-obstetric context (CCAM code JFKA015
207 instead of JNFA001). Another frequent error was miscoding of embolization of uterine

208 arteries for postpartum hemorrhage as embolization conducted as a preoperative phase for
209 oncologic surgery, outside of pregnancy.

210

211 Table 2 presents the values of the indicators calculated for the PMSI, with the medical
212 records as the reference, by type of SMME.

213 Because the PMSI had numerous false positive errors for eclampsia, its PPV for this disease
214 was low, only 20%. Its PPV for pulmonary embolism was 65%. On the contrary, the PMSI
215 was highly sensitive for these diagnoses, respectively, 85% and 83%. Inversely, the PPVs of
216 the PMSI for procedures were very high, ranging from 97% to 100%, although values for
217 sensitivities ranged from 56% to 75%, reflecting the false negative errors found in the
218 preceding analysis. We considered these false negatives for procedures rectifiable since the
219 context of pregnancy/delivery could be identified through other codes contained in the PMSI
220 abstracts. In consequence, we secondarily considered these records as true positive cases
221 of SMME in PMSI, and recalculated revised estimates for the validity indices (Table 2). The
222 revised sensitivities of the PMSI exceeded 95% for embolizations as for ligations, and
223 reached 100% for hysterectomies.

224 For intensive care, the sensitivity, specificity, PPV and NPV of the PMSI all exceeded 98%
225 and the kappa score was close to 1.

226 Sensitivity analyses were conducted to evaluate the impact on the calculated indicators of
227 the seven PMSI SMME cases for which the accuracy of information could not be checked in
228 the medical records, and showed similar results.

229

230 The results by center point out two particular situations (Table 3). In centers 1 and 2, the
231 sensitivity, specificity, PPV and NPV of the PMSI data were greater than 80% for identifying
232 SMME. On the other hand, SMME were recorded less accurately in centers 3 and 4. In
233 center 3 where most of the mis-coding errors for embolizations were found, the sensitivity of
234 the PMSI data greatly improved after correction of these codes. In center 4, the sensitivity of
235 the PMSI data also improved after correction of procedures codes not specific to the

236 obstetrical context, but its 57% PPV reflected the large number of false positives found for
237 cases of eclampsia in this facility.

238

239 **Discussion**

240

241 This validation study of French hospital discharge database for severe maternal morbidity
242 shows a various quality of data according to the types of event and centers. The PMSI
243 appears to overreport diagnoses, although procedures are reported correctly on the whole.
244 PMSI reporting of intensive care is very reliable. Two hospitals correctly transcribed their
245 SMME data in hospital discharge abstracts, whereas two others require improvements: one
246 for false negatives, the other because of false positives.

247

248 Our study has several limitations. First, there is no consensual definition of severe maternal
249 morbidity. Our selected SMME do not cover all types of maternal morbidity, but they do cover
250 those that are the most frequent causes of maternal deaths [29-31]. In addition, our
251 combination of events makes it possible to analyze the validity of various types of hospital
252 data, namely diagnoses, procedures and management codes.

253 The type of hospitals selected might have resulted in selection bias. All are tertiary teaching
254 hospitals, chosen because they treat the most severe cases of maternal morbidity in their
255 regions. Even though SMME are, obviously, not exclusive to these tertiary hospitals, this type
256 of facility, which concentrates SMME, remains best for an initial study of PMSI validity related
257 to severe maternal morbidity, given the low expected frequency of these events. Hsia *et al.*
258 showed in a different context and field that data from small non-university hospitals are not
259 reliable [11]. Inversely, Iezzoni *et al.* argued that level III hospitals, because they handle
260 more complex cases, face greater difficulties in coding and may thus make more frequent
261 errors [17]. In the obstetric field, Lydon-Rochelle *et al.* [36] found that type II maternity units
262 (average size and able to care for moderately serious situations) have the most reliable

263 hospital discharge databases. Di Giuseppe *et al.* found no difference in data validity
264 according to hospital size in a study of 20 maternity units [37].

265 The number of centers included in our study is small, and each has its own organization
266 regarding collection and coding of hospital discharge data. Despite the national rules for
267 treatment of these medical data, the quality of their PMSI differed. In our study, it is not the
268 PMSI data processing system that seems inappropriate for dealing with severe maternal
269 morbidity, but rather the rigor and quality of its application within each facility. This limitation
270 prevents us from generalizing our results to the national level. However, this issue is less
271 relevant for intensive care because the great majority of intensive care units are located in
272 teaching hospitals; moreover, the intensive care variable is less error-prone due to its
273 particular coding rules.

274 Our objective was to study the validity of the PMSI database for some SMME. More
275 specifically, our aim was to know how accurately the PMSI database reflected diagnoses
276 made and procedures performed by the team in charge of the case. In that context, we did
277 not reinterpret a posteriori the whole medical information like other authors did [6-
278 14,16,17,22,27,38-40], but we evaluated whether the SMME were transcribed in the PMSI as
279 they were described in the medical records. Therefore, our study is based on the comparison
280 of existing records, and the gold standard is represented by the diagnoses which justified
281 and generated a specific management. In a different perspective, a study assessing the
282 accuracy of diagnoses recorded in a series of randomly selected source medical files, by
283 using a blinded recoding by experts would provide complementary information.

284
285 The use of computerized medical files was required to search easily and inexpensively for
286 SMME that were described in records but not reported in the PMSI (false negatives). In half
287 of the centers (n°1 and 3), these computerized medical files were the actual entire and only
288 medical record. The search for false negatives in the PMSI was thus possible and even easy.
289 In the other two centers (n°2 and 4), the computerized medical files were a supplementary
290 document, completed bit by bit by the clinicians during the course of the hospitalization, and

291 verified daily by midwives specifically assigned to this function. They might therefore be
292 considered a relevant source for false negatives searching. Our method therefore simplified
293 the study of false negatives and allowed us to estimate the validity of PMSI coding for the
294 SMME in a large sample of more than 30,000 deliveries. Nonetheless, it is possible that
295 some SMME were not entered in the source medical record or in the computerized files.
296 These false negatives may not have been identified, their number may have been
297 underestimated, and consequently the sensitivities overestimated. It would have been
298 possible to randomly sample hospitalizations to estimate the false negative rate in the
299 medical records. Because SMME are rare events, however, to be valid, this method would
300 have had to include a very large sample. The cost/benefit ratio of such a study appeared
301 quite negative to us, and we did not chose this option.

302 However, in the two centers with complementary computerized medical files, midwives daily
303 verify all the information reported in the computerized medical records, thereby minimizing
304 the risk of errors and oversights. In addition, according to Altman, serious events are seldom
305 forgotten during coding [41]. Thus, although this bias should be borne in mind, it is likely to
306 remain marginal.

307
308 The analyses of the diagnoses in the PMSI show that their coding validity is poor. The
309 numerous false positives indicate that diagnoses are overreported in the discharge abstracts.
310 The low PPV of the PMSI for eclampsia — 20.2% — means that in this database, most so-
311 called eclampsia cases are not. Detailed examination showed that these cases were instead
312 severe preeclampsia or HELLP syndrome. Such coding errors are not unusual. Other
313 authors have found PPVs for eclampsia in hospital databases ranging from 23.5% in an
314 Australian multicenter study [13,39] to 41.7% for single-center study in Chicago [28], and
315 50% for a statewide validation in Washington [36].

316 Several factors may explain the overreporting or upcoding of diagnoses in hospital
317 databases. First, the large variety of participants of diverse skill levels involved in coding
318 leads to heterogeneity in the quality of the medical information [15,18,36,40,42,43]. Second,

319 the most serious cases, which involved the mobilization of the entire medical team, may be
320 overcoded to indicate the seriousness of situation [39,40,44,45]. Finally, the payment system
321 based on severity of diagnosis is a strong incentive to overcoding, that is, it increases
322 remuneration for the hospital [11,43,46,47]. Our study confirmed these hypotheses for
323 eclampsia and pulmonary embolisms. Coding at all four hospitals was routinely performed by
324 employees with widely heterogeneous skill levels and with little or no training in this quite
325 particular task: nurses, midwives, interns, residents, and sometimes even secretaries or
326 students. Also in all centers, the cases of severe preeclampsia or deep venous thrombosis
327 overcoded as eclampsia or pulmonary embolism corresponded to cases with prolonged
328 hospitalizations or severe illness that required major and expensive treatment.

329

330 On the other hand, the high positive predictive value of the PMSI data for procedures
331 indicates that these are not overreported. Analysis of the procedures does not show false
332 positives but rather some false negatives, indicating moderate underreporting of their true
333 number in the PMSI. The sensitivity of the PMSI for the procedures therefore varies. It is
334 relatively elevated for hysterectomies and ligations (close to 75%), but lower (56%) for
335 embolizations. An Australian multicenter study on the validity of administrative databases
336 found a sensitivity of 28.3% for hysterectomy data in the context of postpartum hemorrhage
337 and attributed this result to specific coding errors [13,20]. The quality of reporting is better in
338 our study, but the same type of errors is still present. These errors, first mentioned in the
339 1990s [12,42-44] and reported still today [20,22], are the consequence of using a
340 classification that is ever more specific and increasingly complicated. Coding becomes
341 extremely time-consuming, thus inciting physicians to record procedures in the hospital
342 databases with the code they use most often, even though perfectly appropriate codes exist
343 for the specific situation. A similar problem is seen with the use of the "thesaurus", a
344 summary of codes of procedures performed regularly in the department, which facilitates
345 coding, but does not describe rare and severe situations correctly [22,42]. Demlo [44,45]

346 predicted this type of problem at the implementation of the system of health-related
347 administrative databases in the United States in the early 1980s.

348 In our study, most of these false negatives could be easily identified because the hospital
349 discharge summaries with the non-specific procedure code also contained codes indicating
350 the context of pregnancy/delivery. In consequence, such a correction could be introduced in
351 routine. Overall, the high PPV and sensitivity of the PMSI for most of the procedures studied
352 indicates that their coding is relatively valid and that errors are rectifiable. In these conditions,
353 it appears acceptable to us to monitor their frequencies from the PMSI.

354
355 Our findings are consistent with those from international studies that validated similar types
356 of databases. In obstetrics as in other field, the coding in hospital databases is more reliable
357 for procedures than for diagnoses [16,19-22,38]. This research appears to us to be an
358 essential prerequisite to any use of administrative databases. Nonetheless, because they are
359 easy to access, they are regularly used in hospital departments for research purposes,
360 without validation. Erroneous data leading to biased results, incorrect conclusions and thus
361 flawed proposals cannot improve either quality of care or patient health. Like Pollock and
362 Hadfield [10,48], we hope that other teams across the world will make an effort to validate
363 their hospital administrative data, especially in the field of severe maternal morbidity, to
364 facilitate comparisons between countries.

365
366 An original aspect of our study is to have sought to validate the coding for intensive care in
367 hospital data. Their sensitivity, specificity, PPV and NPV in the PMSI are very high (>98%).
368 Related PMSI data are both accurate and reliable. In obstetrics, such intensive care can
369 therefore be used as a marker of the severity of maternal morbidity, and our results are the
370 first to show its validity.

371
372 Our study is one of the first to estimate the validity of hospital administrative databases in
373 Europe [15,19,26]. Although the only moderate validity of the hospital data means that

374 research cannot be based exclusively on them, it appears likely that the system in France will
375 improve. Because the reimbursement of medical services is directly correlated with PMSI
376 data, the national health insurance fund is multiplying external audits to identify coding errors
377 and overcoding. Facilities where abuses are identified will be required to reimburse
378 payments for unjustified services. The increase in these external quality controls, in addition
379 to the internal controls organized by the hospitals, should surely lead to improvements in
380 data quality.

381

382 **Conclusion**

383 Hospital discharge data can be used for monitoring the frequencies of procedures for
384 postpartum hemorrhages and intensive care related to severe maternal morbidity. The
385 utilization of PMSI data about diagnoses will require a greater investment by clinicians in the
386 accuracy of their reporting and regular internal quality controls.

387

388

389 **Count of words** : 4,013 words.

390

391

392 **Acknowledgments**

393 This study was funded by the IReSP (French Research Institute of Public Health) and Anne
394 Chantry was supported by a doctoral grant from the French Ministry of Research. The
395 authors thank all the members of the Grace study group and Annick Blondel, Maïté Mériaux,
396 Julie Tort for their participation.

397

398

399

400 **Titles of figure and tables:**

401

402 - **Figure 1** - Algorithm for selection of the PMSI abstracts

403 - **Table 1** - Severe maternal morbid events (SMME) identified in the PMSI database and in
404 the medical records, 4 centers, 2006-2007: number, false positives and false negatives *.
405 - **Table 2** - Validity of the PMSI data for severe maternal morbid events (SMME): kappa
406 score, sensitivity, specificity, positive predictive value (PPV) and negative predictive value
407 (NPV) *.
408 - **Table 3** - Validity of the PMSI data for severe maternal morbid events (SMME), per center:
409 sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) *.
410

411 **References**

412

- 413 1. MINISTERE DE LA SANTE. Décret n°94-666 du 27 juillet 1994 relatif aux systèmes
414 d'information médicale et à l'analyse de l'activité des établissements de santé publics
415 et privés. In, Journal Officiel de la République Française, n°180 du 5 août 1994.
416 Paris; 1994:11395
- 417 2. Fetter RB, Shin Y, Freeman JL, Averill RF, Thompson JD. Case mix definition by
418 diagnosis-related groups. *Med Care* 1980;18:iii, 1-53
- 419 3. MINISTERE DE LA SANTE. Loi n°94-748 du 31 Juillet 1991 portant réforme
420 hospitalière. In, Journal Officiel de la République Française, n° 179 du 2 août 1991.
421 Paris; 1991:10255
- 422 4. Couris CM, Polazzi S, Olive F, et al. Breast cancer incidence using administrative
423 data: correction with sensitivity and specificity. *J Clin Epidemiol* 2009;62:660-666
- 424 5. Mahonen M, Salomaa V, Keskimaki I, et al. The feasibility of combining data from
425 routine Hospital Discharge and Causes-of-Death Registers for epidemiological
426 studies on stroke. *Eur J Epidemiol* 2000;16:815-817
- 427 6. Quan H, Parsons GA, Ghali WA. Assessing accuracy of diagnosis-type indicators for
428 flagging complications in administrative data. *J Clin Epidemiol* 2004;57:366-372
- 429 7. Quan H, Parsons GA, Ghali WA. Validity of procedure codes in International
430 Classification of Diseases, 9th revision, clinical modification administrative data. *Med*
431 *Care* 2004;42:801-809
- 432 8. Humphries KH, Rankin JM, Carere RG, et al. Co-morbidity data in outcomes
433 research: are clinical data derived from administrative databases a reliable alternative
434 to chart review? *J Clin Epidemiol* 2000;53:343-349
- 435 9. Taylor LK, Travis S, Pym M, Olive E, Henderson-Smart DJ. How useful are hospital
436 morbidity data for monitoring conditions occurring in the perinatal period? *Aust N Z J*
437 *Obstet Gynaecol* 2005;45:36-41

- 438 10. Hadfield RM, Lain SJ, Cameron CA, et al. The prevalence of maternal medical
439 conditions during pregnancy and a validation of their reporting in hospital discharge
440 data. *Aust N Z J Obstet Gynaecol* 2008;48:78-82
- 441 11. Hsia DC, Krushat WM, Fagan AB, Tebbutt JA, Kusserow RP. Accuracy of diagnostic
442 coding for Medicare patients under the prospective-payment system. *N Engl J Med*
443 1988;318:352-355
- 444 12. Lloyd SS, Rissing JP. Physician and coding errors in patient records. *JAMA*
445 1985;254:1330-1336
- 446 13. Roberts CL, Cameron CA, Bell JC, Algert CS, Morris JM. Measuring maternal
447 morbidity in routinely collected health data: development and validation of a maternal
448 morbidity outcome indicator. *Med Care* 2008;46:786-794
- 449 14. Klemmensen AK, Olsen SF, Osterdal ML, Tabor A. Validity of preeclampsia-related
450 diagnoses recorded in a national hospital registry and in a postpartum interview of the
451 women. *Am J Epidemiol* 2007;166:117-124
- 452 15. Klemmensen AK, Olsen SF, Wengel CM, Tabor A. Diagnostic criteria and reporting
453 procedures for pre-eclampsia: a national survey among obstetrical departments in
454 Denmark. *Eur J Obstet Gynecol Reprod Biol* 2005;123:41-45
- 455 16. Fisher ES, Whaley FS, Krushat WM, et al. The accuracy of Medicare's hospital claims
456 data: progress has been made, but problems remain. *Am J Public Health*
457 1992;82:243-248
- 458 17. Iezzoni LI, Burnside S, Sickles L, et al. Coding of acute myocardial infarction. Clinical
459 and policy implications. *Ann Intern Med* 1988;109:745-751
- 460 18. Smulian JC, Ananth CV, Hanley ML, et al. New Jersey's electronic birth certificate
461 program: variations in data sources. *Am J Public Health* 2001;91:814-816
- 462 19. Calle JE, Saturno PJ, Parra P, et al. Quality of the information contained in the
463 minimum basic data set: results from an evaluation in eight hospitals. *Eur J Epidemiol*
464 2000;16:1073-1080

- 465 20. Lain SJ, Roberts CL, Hadfield RM, Bell JC, Morris JM. How accurate is the reporting
466 of obstetric haemorrhage in hospital discharge data? A validation study. *Aust N Z J*
467 *Obstet Gynaecol* 2008;48:481-484
- 468 21. Campbell SE, Campbell MK, Grimshaw JM, Walker AE. A systematic review of
469 discharge coding accuracy. *J Public Health Med* 2001;23:205-211
- 470 22. Yasmeen S, Romano PS, Schembri ME, Keyzer JM, Gilbert WM. Accuracy of
471 obstetric diagnoses and procedures in hospital discharge data. *Am J Obstet Gynecol*
472 2006;194:992-1001
- 473 23. Carre N, Uhry Z, Velten M, et al. [Predictive value and sensibility of hospital discharge
474 system (PMSI) compared to cancer registries for thyroid cancer (1999-2000)]. *Rev*
475 *Epidemiol Sante Publique* 2006;54:367-376
- 476 24. Remontet L, Mitton N, Couris CM, et al. Is it possible to estimate the incidence of
477 breast cancer from medico-administrative databases? *Eur J Epidemiol* 2008;23:681-
478 688
- 479 25. Misset B, Nakache D, Vesin A, et al. Reliability of diagnostic coding in intensive care
480 patients. *Crit Care* 2008;12:R95
- 481 26. Casez P, Labarere J, Sevestre MA, et al. ICD-10 hospital discharge diagnosis codes
482 were sensitive for identifying pulmonary embolism but not deep vein thrombosis. *J*
483 *Clin Epidemiol* 2010;63:790-97
- 484 27. Romano PS, Yasmeen S, Schembri ME, Keyzer JM, Gilbert WM. Coding of perineal
485 lacerations and other complications of obstetric care in hospital discharge data.
486 *Obstet Gynecol* 2005;106:717-725
- 487 28. Geller SE, Ahmed S, Brown ML, et al. International Classification of Diseases-9th
488 revision coding for preeclampsia: how accurate is it? *Am J Obstet Gynecol*
489 2004;190:1629-1633; discussion 1633-1624
- 490 29. Bouvier-Colle MH, Salanave B, Ancel PY, et al. Obstetric patients treated in intensive
491 care units and maternal mortality. Regional Teams for the Survey. *Eur J Obstet*
492 *Gynecol Reprod Biol* 1996;65:121-125

- 493 30. National Committee of the experts on maternal mortality. Report of the national
494 committee of the experts on maternal mortality, 1995-2001. In. Paris: INSERM - INVS;
495 2006
- 496 31. National Committee of the experts on maternal mortality. Report of the national
497 committee of the experts on maternal mortality, 2001-2006. In. Paris: INSERM - INVS;
498 2010
- 499 32. MINISTERE DE LA SANTE. Arrêté du 22 juillet 1996 relatif au recueil et au traitement
500 des données d'activité médicale. In, Journal Officiel de la République Française,
501 n°173 du 26 juillet 1996. Paris; 1996:11308
- 502 33. MINISTERE DE LA SANTE. Loi n°2003-1199 du 18 décembre 2003 de financement
503 de la sécurité sociale pour 2004. In, Journal Officiel de la République Française,
504 n°293 du 19 décembre 2003. Paris; 2003
- 505 34. MINISTERE DE LA SANTE. Circulaire n° 119 du 4 octobre 1985 relative à la mise en
506 place dans les établissements hospitaliers des résumés de sortie standardisés
507 (RSS). In, Bulletin officiel du ministère chargé de la santé n° 90/2 bis Paris; 1989:29-
508 71
- 509 35. Landis JR, Koch GG. The measurement of observer agreement for categorical data.
510 Biometrics 1977;33:159-174
- 511 36. Lydon-Rochelle MT, Holt VL, Cardenas V, et al. The reporting of pre-existing
512 maternal medical conditions and complications of pregnancy on birth certificates and
513 in hospital discharge data. Am J Obstet Gynecol 2005;193:125-134
- 514 37. DiGiuseppe DL, Aron DC, Ranbom L, Harper DL, Rosenthal GE. Reliability of birth
515 certificate data: a multi-hospital comparison to medical records information. Matern
516 Child Health J 2002;6:169-179
- 517 38. Thornton C, Makris A, Ogle R, Hennessy A. Generic obstetric database systems are
518 unreliable for reporting the hypertensive disorders of pregnancy. Aust N Z J Obstet
519 Gynaecol 2004;44:505-509

- 520 39. Roberts CL, Bell JC, Ford JB, et al. The accuracy of reporting of the hypertensive
521 disorders of pregnancy in population health data. *Hypertens Pregnancy* 2008;27:285-
522 297
- 523 40. Lydon-Rochelle MT, Holt VL, Nelson JC, et al. Accuracy of reporting maternal in-
524 hospital diagnoses and intrapartum procedures in Washington State linked birth
525 records. *Paediatr Perinat Epidemiol* 2005;19:460-471
- 526 41. Altman D, Bland JM. Confidence intervals illuminate absence of evidence. *BMJ*
527 2004;328:1016-1017
- 528 42. Dussaucy A, Viel JF, Mulin B, Euvrard J. [The framework Prospective Payment
529 Information Systems: bias, sources of errors and consequences]. *Rev Epidemiol*
530 *Sante Publique* 1994;42:345-358
- 531 43. Lombrail P, Minvielle E, Kohler F, et al. [Coding problems in medical information in
532 the framework of the medicalization of the hospital information system]. *Rev*
533 *Epidemiol Sante Publique* 1991;39:285-295
- 534 44. Demlo LK, Campbell PM. Improving hospital discharge data: lessons from the
535 National Hospital Discharge Survey. *Med Care* 1981;19:1030-1040
- 536 45. Demlo LK, Campbell PM, Brown SS. Reliability of information abstracted from
537 patients' medical records. *Med Care* 1978;16:995-1005
- 538 46. Geoffroy-Perez B, Imbernon E, Gilg Soit Ilg A, Goldberg M. [Comparison of the
539 French DRG based information system (PMSI) with the National Mesothelioma
540 Surveillance Program database]. *Rev Epidemiol Sante Publique* 2006;54:475-483
- 541 47. Lombrail P, Minvielle E, Comar L, Gottot S. [Prospective Payment Information
542 Systems and epidemiology: a difficult link to establish]. *Rev Epidemiol Sante Publique*
543 1994;42:334-344
- 544 48. Pollock W, Sullivan E, Nelson S, King J. Capacity to monitor severe maternal
545 morbidity in Australia. *Aust N Z J Obstet Gynaecol* 2008;48:17-25
- 546
547
548

549

550

Figure 1- Algorithm for the selection of the PMSI abstracts

551

552

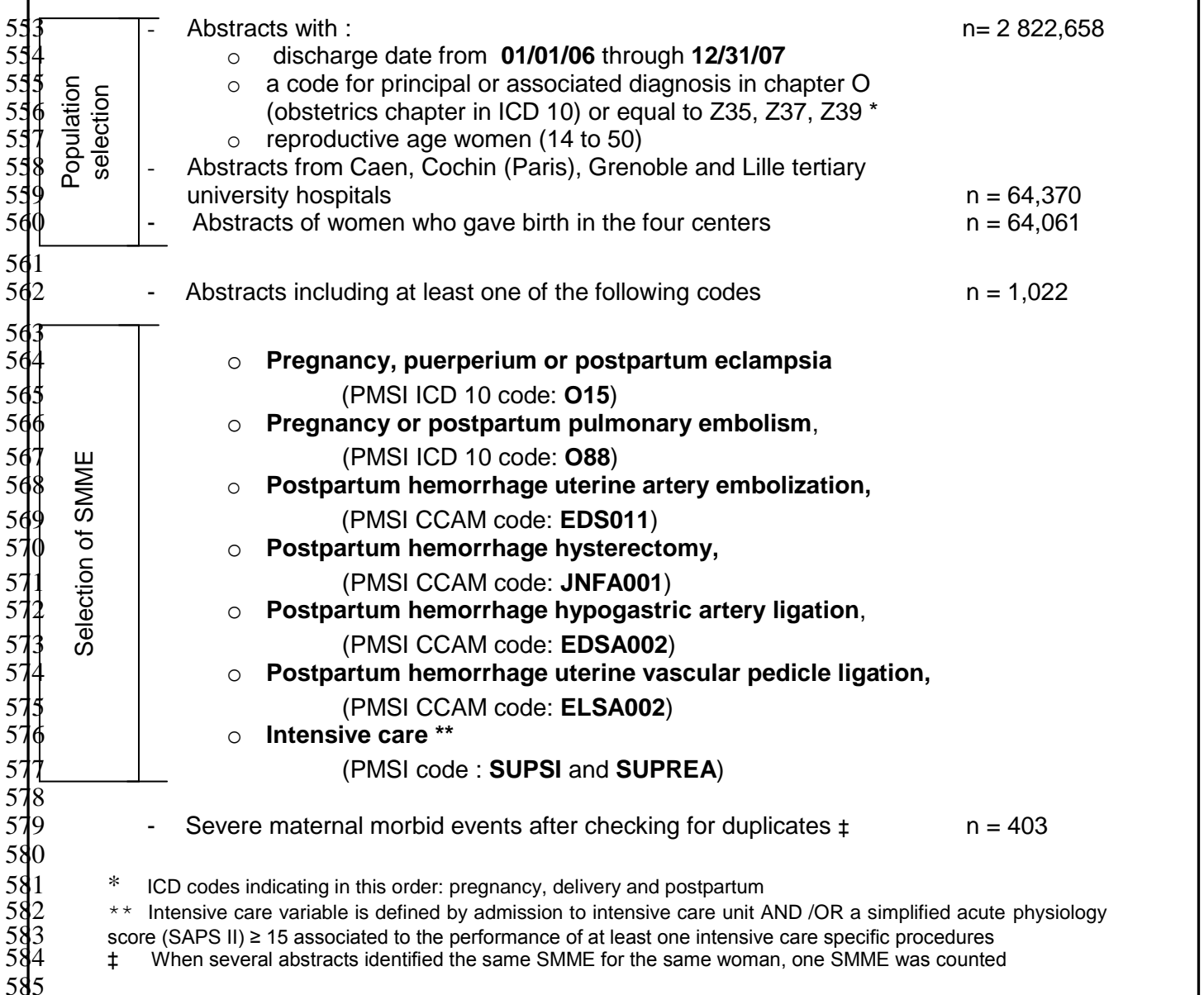


Table 1 - Severe maternal morbid events (SMME) identified in the PMSI database and in the medical records, 4 centers, 2006-2007 : number, false positives and false negatives *.

	Single SMME identified in PMSI	SMME in medical records	SMME identified in PMSI and validated in medical records	False- positives	False- negatives	Uncertain status
	n (%)	n (%)	n (%)	n	n	n
Total	403 (100%)	399 (100%)	314 (100%)	82	85	7
Eclampsia	89 (22)	20 (5)	17 (5)	67	3	5
Pulmonary embolism	33 (8)	24 (6)	20 (6)	11	4	2
Uterine artery embolization	72 (18)	128 (32)	72 (23)	0	56	-
Hysterectomy	23 (6)	31 (8)	23 (7)	0	8	-
Uterine artery and pedicle ligation	34 (8)	44 (11)	33 (11)	1	11	-
Intensive care	152 (38)	152 (38)	149 (48)	3	3	-

* on the basis of 30,614 deliveries, medical record as reference.

Table 2 - Validity of the PMSI data for severe maternal morbid events (SMME): kappa score, sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) *.

	Kappa	Sensitivity % [95% CI]	Specificity % [95% CI]	PPV % [95% CI]	NPV % [95% CI]
Eclampsia	0,33	85,0 [69,3-100,0]	99,7 [99,6-99,8]	20,2 [11,6-28,8]	99,9 [99,9-100,0]
Pulmonary embolism	0,73	83,3 [68,4-98,2]	99,9 [99,9-100,0]	64,5 [47,6-81,3]	99,9 [99,9-100,0]
Embolization	0,72	56,2 [47,6-64,5]	100,0 -	100,0 -	99,8 [99,7-99,8]
<i>revised results **</i>	0,98	95,3 [91,6-98,9]	100,0 -	100,0 -	99,9 [99,8-100,0]
Hysterectomy	0,85	74,2 [58,8-89,6]	100,0 -	100,0 -	99,9 [99,9-100,0]
<i>revised results **</i>	1	100,0 -	100,0 -	100,0 -	100,0 -
Ligation	0,84	75,0 [62,2-87,8]	99,9 [99,9-100,0]	97,6 [92,4-100,0]	99,9 [99,9-100,0]
<i>revised results **</i>	96,5	95,5 [89,4-100,0]	99,9 [99,8-100,0]	97,7 [93,2-100,0]	99,9 [99,8-100,0]
Intensive care	0,99	98,0 [95,8-100,0]	99,9 [99,9-100,0]	98,0 [95,8-100,0]	99,9 [99,9-100,0]

* 4 centers, 2006-2007, on the basis of 30,607 deliveries, medical record as reference.

** : revised results after correction of procedure codes not specific to the obstetrical context

Table 3 - Validity of the PMSI data for severe maternal morbid events (SMME) per center: sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) *.

	Deliveries n	Single SMME in PMSI n	Sensitivity	Specificity	PPV	NPV
			%	%	%	%
			[95% CI]	[95% CI]	[95% CI]	[95% CI]
All centers	30 607	396	78,7 [74,6-82,7]	99,7 [99,6-99,8]	79,3 [75,3-83,3]	99,7 [99,6-99,8]
<i>revised results *</i>		465	96,7 [94,9-98,4]	99,7 [99,6-99,8]	83,0 [79,6-86,4]	99,9 [99,9-100,0]
Center 1	6555	74	97,3 [93,6-100,0]	99,9 [99,8-99,9]	97,3 [93,6-100,0]	99,9 [99,8-99,9]
<i>revised results *</i>		74	97,3 [93,6-100,0]	99,9 [99,8-99,9]	97,3 [93,6-100,0]	99,9 [99,8-99,9]
Center 2	10 486	126	84,4 [78,4-90,4]	99,9 [99,8-100,0]	94,4 [90,4-98,4]	99,8 [99,7-99,9]
<i>revised results *</i>		141	95,0 [91,4-98,6]	99,9 [99,8-100,0]	95,0 [91,4-98,6]	99,9 [99,8-100,0]
Center 3	3970	38	51,5 [39,4-63,6]	99,9 [99,8-100,0]	89,4 [79,6-99,2]	99,2 [98,9-99,5]
<i>revised results *</i>		70	97,0 [92,9-100,0]	99,9 [99,8-100,0]	94,2 [88,7-99,7]	99,9 [99,8-100,0]
Center 4	9596	158	75,4 [67,6-83,2]	99,3 [99,1-99,5]	57,4 [49,6-65,2]	99,7 [99,6-99,8]
<i>revised results *</i>		181	98,3 [95,9-100,0]	99,3 [99,1-99,5]	63,5 [56,5-70,5]	100,0 -

* 4 centers, 2006-2007, on the basis of 30,607 deliveries, medical record as reference.

** : revised results after correction of procedure codes not specific to the obstetrical context