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Health Care Quality: "Helplessly Hoping"

Jerod M. Loeb, PhD
Executive Vice President
Healthcare Quality Evaluation
The Joint Commission

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- Established in 1951
- Oldest and largest health care accrediting body in the world
  - Nearly 1,000 full-time, part-time, or intermittent employees
- Accredit >19,000 health care organizations and programs in the United States and >400 internationally
- Independent, not-for-profit

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Mission: To *continuously improve* health care for the public, in collaboration with other stakeholders, by *evaluating* health care organizations and *inspiring* them to excel in providing *safe and effective care* of the *highest quality and value*

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The Core Tools of the Accreditor

- Setting and maintaining state-of-the-art ("optimum achievable") standards
- Identifying, implementing and maintaining evidence-based performance measures
- Conducting a rigorous, patient-centered on-site evaluation process
- Rendering evaluative decisions through a rules-based process that assures consistency and fairness
- Promoting transparency

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Let's Go Back In Time……

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America's First Hospital

Benjamin Franklin

Benjamin Rush

Pennsylvania Hospital
First patient admitted in 1752
Collected outcomes data, tabulated by diagnostic groups, as early as 1754

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HOME / LIFESTYLE / HEALTH

The Boston Globe

MASSACHUSETTS GENERAL HOSPITAL AT 200

A great institution rises and, with it, the healing arts

Boston's first general hospital did what it could for the poor; today it brings cutting edge care to the city, and world

By Liz Kowalczyk
Globe Staff / February 26, 2011

E-mail | Print | Reprints | Comments (32) Text size

Mass. General Hospital: Then and Now

Courtesy Mass. General Hospital — David L. Ryan/Globe Staff

Bulfinch Building. — Show only Bulfinch Building then

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1821 2011

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Mass. General Hospital - 1821

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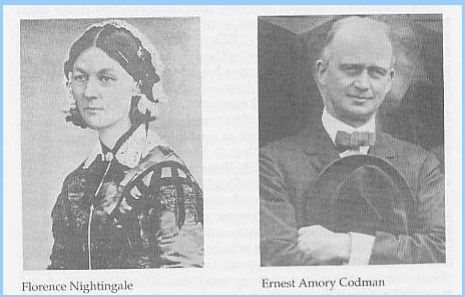
Boston Globe; February 26, 2011

The First Real Performance Measurement Heroes….



Florence Nightingale

Ernest Amory Codman

Table 1.2 Mortality Per Cent. in the Principal Hospitals of England: 1861

	Number of Special Inmates on the 8th April, 1861.	Average Number of Inmates in each Hospital.	Number of Deaths registered in the Year 1861.	Mortality per Cent. on Inmates.
In 106 Principal Hospitals of England	12709	120	7227	56·87
24 London Hospitals	4214	176	3828	90·84
12 Hospitals in Large Towns ...	1870	156	1555	83·16
25 County and Important Provincial Hospitals	2248	90	886	39·41
30 Other Hospitals	1136	38	457	40·23
13 Naval and Military Hospitals ...	3000	231	470	15·67
1 Royal Sea Bathing Infirmary (Margate)	133	133	17	12·78
1 Dane Hill Metropolitan Infirmary (Margate)	108	108	14	12·96

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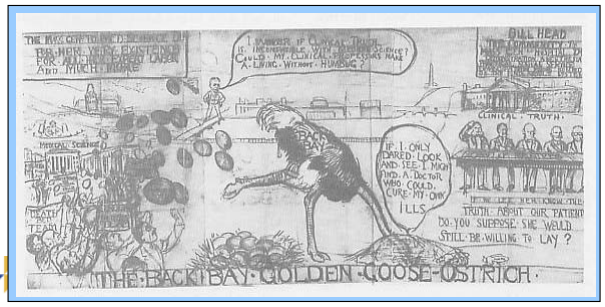
- Everyone wants measurement
- No one wants to be measured



CARTOON BY PHYSICIAN MAKES STIR

Medical Society Is Divided Over Action

A cartoon of an ostrich, representing the Back Bay population, laying "golden eggs" for the "Back Bay medical ring," which was sprung on the members of the Suffolk District Medical Society at its January meeting by Dr. Ernest Amory Codman, a prominent Beacon street physician and surgeon, has stirred the medical profession of Boston as has no other sensation in medical circles in years.

Headline in the *Boston Post* from January 18, 1915, detailing the reaction to Codman's cartoon and the meeting at the Boston Medical Library (Courtesy Bill Mallon, M.D. Collection)

What Codman Proposed In His "End Results Hypothesis"

- Detailed system of patient records, including post-discharge follow-up
- Identification of the "best" and "worst" surgeons
- Patient access to results of treatment and inter-hospital comparisons
- Codman said "…nobody is responsible for examining the results of treatment at hospitals, and the reason is money….in other words, the medical staff are not paid and therefore cannot be held accountable…."

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Knickerbocker Press
Albany, New York
September 1923

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The Diffusion of Innovation

"It takes 50 years to get a wrong idea out of medicine, and 100 years to get a right one into medicine"

J. N. Blau
Lancet 1998; 351:376

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How Many Years To Change Practice And Behavior???

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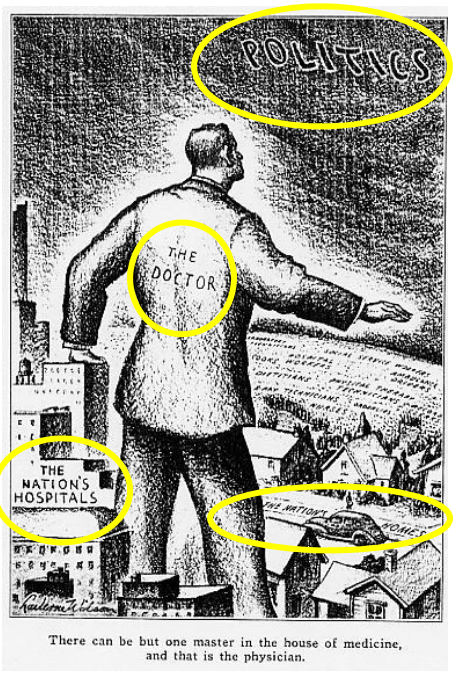

There can be but one master in the house of medicine, and that is the physician.

1938 or 2011?

JAMA,111 (4)
July 23, 1938
Page 327

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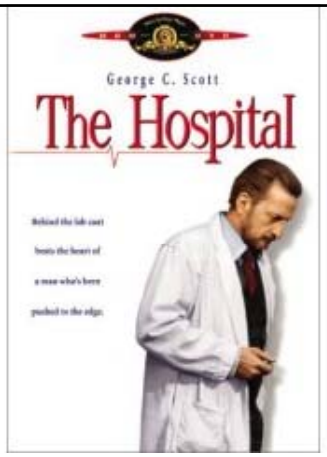

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And The Evolution Continues….

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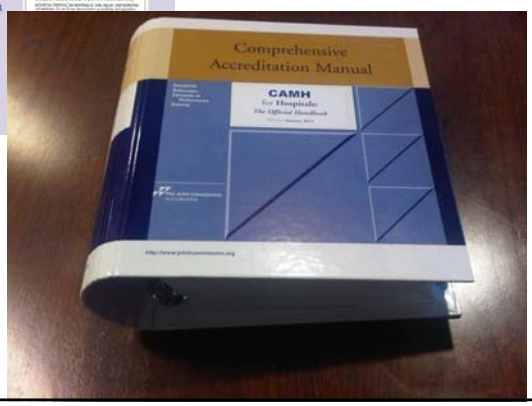
First Hospital Standards

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff.
2. That membership upon the staff be restricted to physicians and surgeons who are full graduates of medicine, legally licensed, competent and worthy in character.
3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital.
4. That accurate and complete records be written for all patients and filed in an accessible manner in the hospital — a complete case record being one which includes identification data.
5. That diagnostic and therapeutic facilities under competent supervision be available for the study, diagnosis, and treatment of patients.

– American College of Surgeons, 1917



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And What About Performance Measurement? A Very Crowded (And Growing) Field!

The Performance Measurement Train
Has Left The Station

Some Are Already On The Train:
Others Are Still Waiting At The Station

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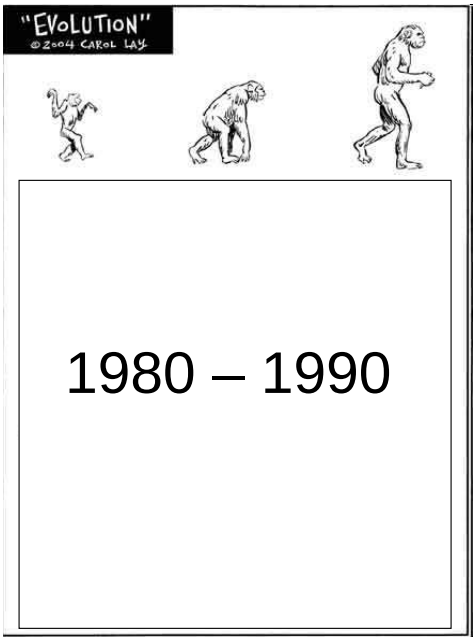
Performance Measurement



1980 – 1990

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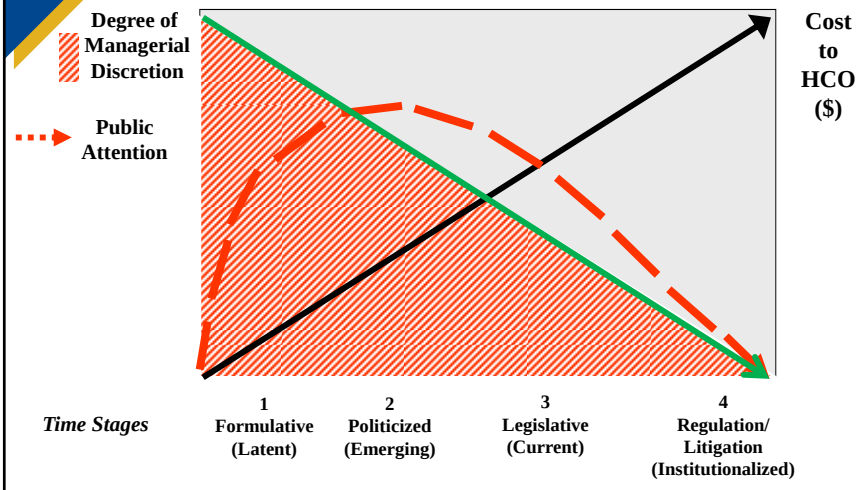
Performance Measurement (Issue Life Cycle)



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Only 1 doctor in 3

receives any data about performance.

◤Audet AJ, Doyt MM, Shamasdin J, et al. *Physicians' Views on Quality of Care: Findings from the Commonwealth Fund National Survey of Physicians and Quality of Care.* New York: The Commonwealth Fund, 2005.

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Only 1 doctor in 4

receives patient survey data.

◤Audet AJ, Doyt MM, Shamasdin J, et al. *Physicians' Views on Quality of Care: Findings from the Commonwealth Fund National Survey of Physicians and Quality of Care.* New York: The Commonwealth Fund, 2005.

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Fewer than 1 doctor in 5

receives clinical outcomes data.

Audet AJ, Doyt MM, Shamasdin J, et al. *Physicians' Views on Quality of Care: Findings from the Commonwealth Fund National Survey of Physicians and Quality of Care.* New York: The Commonwealth Fund, 2005.

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"When it comes to post-discharge care,

April 4, 2009

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The Reality Of Health Care Today In The US

- Culture of low expectations
- Tolerate poor performance / performers
  - Accidental deviance from available evidence
  - Purposeful deviance from available evidence
- Waste about 40 cents of each health care dollar spent
- Fail to use available technology to empower
  - Absence of "forcing functions"
- Develop workarounds for inefficient processes
- Limited use of EHR/EMRs

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The Quality Gap In The US

Condition	% Recommended Care Received
Alcohol Dependence	10.5
Hip Fracture	22.8
Urinary Tract Infection	40.7
Headaches	45.2
Diabetes Mellitus	45.4
Hyperlipidemia	48.6
Benign Prostatic Hypertrophy	53.0
Asthma	53.5
Colorectal Cancer	53.9
Orthopedic Conditions	57.2
Depression	57.7
Hypertension	64.7
Coronary Artery Disease	68.0
Low Back Pain	68.5

McGlynn et al., NEJM; 2003

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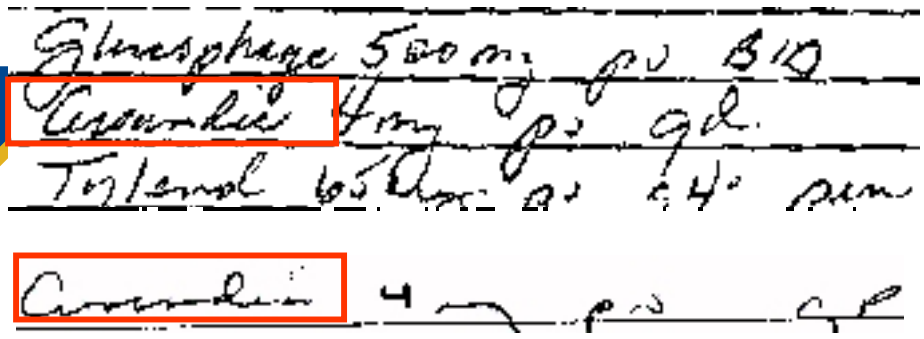

Is it Avandia (rosiglitazone) or Coumadin (warfarin)?

Avandia (rosiglitazone) misread as Coumadin (warfarin)

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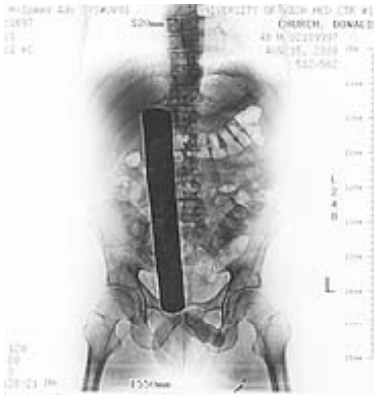
Surgical Errors



Forgotten 13” Surgical Retractor
New York Times, December 11, 2001

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Sentinel Event Data

Type of Sentinel Event	2004 -June 30, 2011 Total	2009	2010	January-June 30, 2011
Abduction	22	1	1	0
Anesthesia-Related Event	76	15	6	5
Criminal Event	211	34	28	23
Delay In Treatment	604	123	95	59
Dialysis-Related Event	6	2	2	0
Elopement	65	8	14	4
Fall	408	81	56	42
Fire	76	15	8	8
Infant Discharge to Wrong Family	2	0	1	0
Infection-Related Event	130	28	14	9
Inpatient Drug Overdose	50	7	8	8
Maternal Death	90	13	16	9
Med Equipment-Related	151	24	25	14
Medication Error	310	43	44	19
Op/Post-op Complication	570	94	86	67
Other Unanticipated Event****	326	52	38	31
Perinatal Death/Injury	185	31	31	18
Radiation Overdose*	23	5	8	4
Restraint Related Event	99	11	5	4
Self-Inflicted Injury	37	6	7	2
Severe Neonatal Hyperbilirubinemia*	3	0	2	0
Suicide	518	87	67	49
Transfer-Related Event	17	2	3	3
Transfusion Error	86	12	5	8
Unintended Retention of a Foreign Body*	546	119	133	76
Utility System Failure	4	0	0	0
Ventilator Death	32	6	6	2
Wrong–patient, wrong-site, wrong-procedure	734	149	93	67
Total Incidents Reviewed	5381	968	802	531

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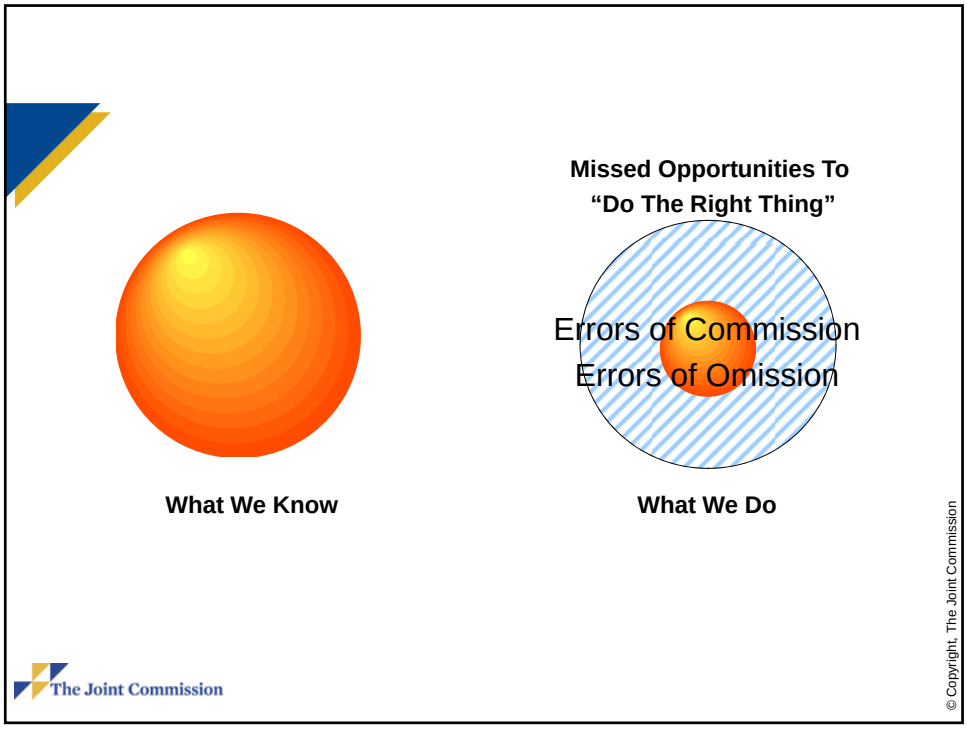

Evolution of Quality Improvement in Health Care

- "If you publish it, they will come"
  - Passive diffusion; early optimistic phase
- "If you read it for them, they will come"
  - Guidelines and systematic reviews
- "If you TQM/CQI it, they will come"
  - Industrial-style quality improvement
- "If you completely rebuild it, they will come"
  - Systems reengineering
- "Next stop – high reliability"

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Modified from Shojania, KG and Grimshaw, JM
Health Affairs 2005;24 138-150

APRIL 2011 VOL. 30 NO. 4

Published by Project HOPE

PATIENTS' VOICE IN QUALITY
Floyd J. Fowler Jr., Carrie A. Levin & Karen R. Sepucha

NARRATIVE MATTERS
Why Was Dialysis The Predetermined Route For A 95-Year-Old?

THE CARE SPAN
Improving Quality In Care Transitions
Mary D. Naylor et al.

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

HealthAffairs

Still Crossing The Quality Chasm

The Ongoing Quality Improvement Journey
Mark R. Chassin & Jerod M. Loeb
Page 559

Making The Trade-Off With Costs
Mark V. Pauly
Page 574

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THE QUALITY JOURNEY

By Mark R. Chassin and Jerod M. Loeb

The Ongoing Quality Improvement Journey: Next Stop, High Reliability

DOI: 10.1377/hlthaff.2011.0076
HEALTH AFFAIRS 30,
NO. 4 (2011): 559–568

ABSTRACT Quality improvement in health care has a long history that includes such epic figures as Ignaz Semmelweis, the nineteenth-century obstetrician who introduced hand washing to medical care, and Florence Nightingale, the English nurse who determined that poor living conditions were a leading cause of the deaths of soldiers at army hospitals. Systematic and sustained improvement in clinical quality in particular has a more brief and less heroic trajectory. Over the past fifty years, a variety of approaches have been tried, with only limited success. More recently, some health care organizations began to adopt the lessons of high-reliability science, which studies organizations such as those in the commercial aviation industry, which manage great hazard extremely

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Jerod M. Loeb is executive vice president for health care quality evaluation at the Joint Commission.

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EXHIBIT 1

Stages Of Maturity In Health Care Organizations' Path To High Reliability

Organizational characteristic	Stage of maturity		
	Minimal	Developing	Approaching
Leadership	Quality activities focused on regulatory requirement Strategic impo e of quality improvement recognized Metrics for qu goals not part of strat plan or incentive co sation Information te ogy provides little suppor quality improvement Physicians not vely engaged in quality im ement	Chief executive officer leads proactive quality agenda Board reviews adverse events Organization sets a few measurable quality aims Information technology supports some quality and safety initiatives Physician leaders champion quality goals in some areas	Organization commits to goal of high reliability for all clinical services Organization aims for near-zero failure rates in vital clinical processes Some services demonstrate near-zero failure rates in some vital clinical processes Reward systems for staff prominently reflect accomplishment of quality goals Information technology integral to sustaining quality improvement Physicians routinely lead quality efforts
Safety culture	No program to ss safety culture No assessmen trust or intimidating behavior Root-cause an s limited to most serious adve events; close calls not rec ed or evaluated	Establishing safety culture accorded high priority by leaders at all levels First measures of safety culture deployed Beginning initiatives to encourage reporting and analysis of close calls	Safety culture is well established Measurement of safety culture is routine and drives improvement Regular reporting of close calls and unsafe conditions leads to early problem resolution
Robust process improvement	No formal qua anagement system External requi nts are focus of improvement orts No commitmer sustainable ovement	Organizational commitment to adopt strong quality improvement tools Training of selected staff beginning Improvement tools used to achieve gains in quality and safety in addition to routine business processes	Robust process improvement tools used throughout organization Patients engaged in redesigning care processes Mandatory training of all staff in robust process improvement Proficiency in robust process improvement required for career advancement

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Barriers To Implementing Evidence-Based Quality and Safety Practices

- *Absence of organizational culture* that focuses on quality and patient safety
- *Lack of knowledge and experience in systems thinking*, including systems analysis and process redesign
- *Few practical tools and solutions available* to guide implementation of specific practices
- *Ineffective methods for creating behavior change* among health care professionals
- *Tendency to add specific evidence-based practices* to existing chassis rather than redesign the process
- *Toxicity of related health care systems* (i.e., regulatory, reimbursement, legal)

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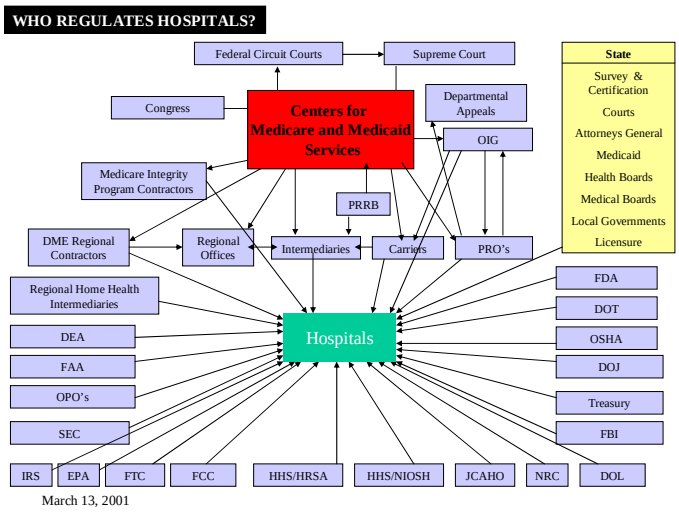
US Health Care Organizations Face A Regulatory Morass……..



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The Key 2011 Measurement Issues

- A very complex (and fragile) infrastructure with many players
- Measurement overload among providers continues
  - IPPS and OPPS regulations (new data sources)
- Little harmonization of measures across settings of care
- Questions remain about putative relationships between processes and outcomes
- Using data to improve care is an elusive problem
- Measure maintenance requires enormous resources
- Health information technology and the EHR
  - "Meaningful Use" provisions
  - e-Measure specifications ("measure retooling")
- Absence of agreement respecting data reporting and data portrayal
  - Composite measures

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Can Measuring Things Help To Solve Some Of The Problems In Health Care?

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Kent and Hayward; American Scientist; 95: 60-68, 2007

Themes In Reform Legislation Related To Measurement

- National strategy for quality improvement and measure prioritization
- Common database architecture
- CMS Center for Innovation
- Value-based purchasing initiative
- Meaningful use mandates
- Database modernization at CMS
- Clinically-enriched claims data

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National Strategy For Quality Improvement In Health Care

- Released March 21, 2011
- Three aims guide and assess local, state, and national efforts:
  - **Better Care**: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe
  - **Healthy People/Healthy Communities:** Improve the health of the US population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care
  - **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government

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Hospital IQR Program Measures FY 2013-FY 2015

- **FY 2013** retain 55 FY 2012 measures, add 1 chart-abstracted and 1 HAI via NHSN measure; total 57 measures
- **FY 2014** retain 57 FY 2013 measures, retire 2 measures, add 4 chart abstracted and 1 HAI via NHSN; total 60 measures
  - FY 2012 final rule **NOW** retiring 4 measures, retaining 56 measures (includes 4 suspending data collection), adding 1 HAI via NHSN, 1 claims-based, 1 structural measure for total 59 measures; CMS will only collect data on 55 measures for purposes FY 2014 payment determination
- **FY 2015** retain 59 measures for FY 2015, add 3 HAI via NHSN, 14 chart abstracted measures; total 76 measures; CMS will only collect data on 72 measures for purposes FY 2014 payment determination
- **Total** FY 2013 – FY 2015 = 76 measures (data collected on 72, minus 4 suspended data collection)

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Hospital Value Based Purchasing

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Medicare Hospital Inpatient Value-Based Purchasing (VBP) Program

- Gradually increasing payment withhold (from 1% in 2013 to 2% in 2017) – coupled with incentive payments based on "Total Performance Score"
- Applies to payments for discharges occurring on or after October 1, 2012
- Scoring based on whether a hospital meets or exceeds the performance standards established with respect to the measures; rewarding the higher of achievement or improvement

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Medicare Program: Hospital Inpatient Value-Based Purchasing (VBP) Program

- Final rule issued April 29, 2011
  - 17 process measures were originally proposed and 12 were finalized for FY 2013
  - More to come (whether through IPPS, OPPS and/or VBP)
  - HCAHPS (selected questions)
  - TPS = 70% process measure data and 30% HCAHPS data
- 13 more measures finalized for FY 2014
  - Three 30-day mortality measures
  - Two AHRQ composite measures (did not adopt 7 individual AHRQ measures; comments noted double-counting as composites already include these measures)
  - 8 hospital acquired conditions

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The Ultimate Composite Measure

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Hospital Value Based Purchasing

The Financial Stakes Are High!

Sample VPB Incentive Payment Calculation						
Year	**Annual Medicare revenue**	**% of DRG payment withheld**	**$ amount withheld**	**% of VPB incentive payment earned***	**Incentive payment**	**Net loss/ gain**
2013	$50 million	1.00%	$500,000	80%	$400.000	-$100,000
2014	$50 million	1.25%	$625,000	80%	$500,000	-$125,000
2015	$50 million	1.50%	$750,000	80%	$600,000	-$150,000
2016	$50 million	1.75%	$875,000	80%	$700,000	-$175,000
2017	$50 million	2.00%	$1,000,000	80%	$800,000	-$200,000

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Proposed Domain Weighting for Total Performance Score FY 2014

- Process of care domain proposed to reduce weighting to 20 percent, from 70 percent (FY 2013)
- Patient experience of care domain proposed remaining at 30 percent
- Add Outcome domain proposed at 30 percent
- Add Efficiency domain proposed at 20 percent

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And If It Wasn't Complicated Enough……..

Welcome To The Era Of "Meaningful Use"

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Meaningful Use (MU)

- Mandates three types of requirements:
  - Use of certified EHR technology in a meaningful manner (e.g., e-prescribing)
  - Use of certified EHR technology for electronic exchange of health information to improve quality of care
  - Use of certified EHR technology to submit clinical quality measures and other such measures selected by the Secretary of DHHS

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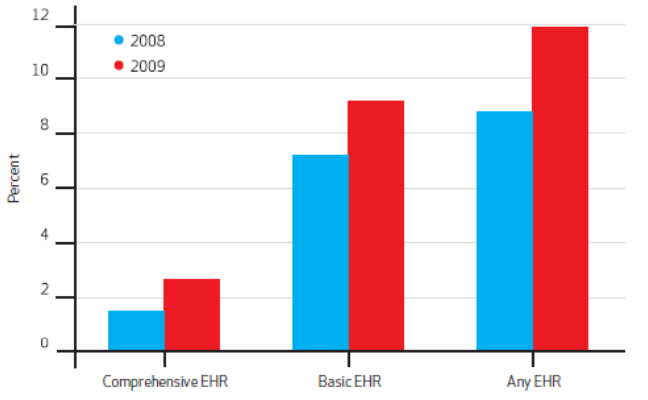
EXHIBIT 1

Changes In Electronic Health Record (EHR) Adoption Rate From 2008 To 2009



SOURCE Authors' analysis of data from the American Hospital Association Annual Survey Health Information Technology Supplements of acute care hospitals in the United States. **NOTE** *N* = 3,049 hospitals (2008) and 3,101 hospitals (2009).

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The Kubler-Ross Model of EHR Adoption

- **Denial**
- **Anger**
- **Bargaining**
- **Depression**
- **Acceptance**

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The Health Care Blog; April 25, 2011; Margalit Gur-Arie

HIT: What Does All This Mean For The Joint Commission – And For Hospitals?

- The Joint Commission's ORYX infrastructure has been operational since 1998
- Nearly 50 Joint Commission-listed performance measurement systems serve the hospital community
- Data quality has been a fundamental driver
- But – what will happen with Meaningful Use and the move to electronic data capture?
- Need for 2 concurrent infrastructures for at least the next several years
  - Existing performance measurement systems
  - Ability to accept EHR-derived data

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Going Forward Measurement Issues

- Transition, balance, and conversion
  - Paper to eMeasures
  - Policies, politics and performance
  - Learning a second language: “eTalk”
- Impact of measure designations
  - Competing and “best available” measures
  - Reserve status for “high achievement”
  - Retirement (aka: “topped out” measures)

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Going Forward Measurement Issues

- Emerging issues related to privacy and security
  - “eConsent” – patients agreeing to sharing their “electronic” health data
  - Unique patient identifier needed
- HIT – When will we reach widespread adoption?
  - MU Stage 2 and 3 timelines???
  - What about other settings of care???

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Going Forward Measurement Issues

- Explosion of initiatives
  - Use for public reporting, performance-based payment, improvement, effectiveness, efficiency, informing consumers, encouraging innovation, cost containment……
- National strategy
  - Aggressive time line, measure availability in multiple settings? magnitude of measurement gaps?

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The Changing Measure Environment

Hospitals - 2000	Hospitals Today	PPACA – Going Forward
Few measures across relevant areas	Too many measures or not the right ones	National strategy/national priorities to improve: Delivery of health care services, outcomes, population health
Industry resistance	Willing participation	Interagency Working Group on Health Care Quality; multi-stakeholder input
No uniform data collection	Increasing standardized data collection and reporting	Secretary to establish and implement overall framework public reporting; defined steps between measure identification and public reporting
Little improvement driven by measures	More efforts devoted to improvement	Use performance measures to track quality, form the basis of payment incentives or reductions, and help the public make informed choices
No experience with measure use	Wealth of experience with measure use	AHRQ new authority to identify, develop, evaluate, and disseminate innovative strategies for QI practices

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The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Accountability Measures — Using Measurement to Promote Quality Improvement

Mark R. Chassin, M.D., M.P.P., M.P.H., Jerod M. Loeb, Ph.D., Stephen P. Schmaltz, Ph.D., and Robert M. Wachter, M.D.

Measuring the quality of health care and using those measurements to promote improvements in the delivery of care, to influence payment for services, and to increase transparency are now commonplace. These activities, which now involve virtually all U.S. hospitals, are migrating to ambulatory and other care settings and are increasingly evident in health care systems worldwide. Many constituencies are pressing for continued expansion of programs that rely on quality measurement and reporting.

markably recent. In 1998, the Joint Commission launched its ORYX initiative, the first national program for the measurement of hospital quality, which initially required the reporting only of nonstandardized data on performance measures.[1] In 2002, accredited hospitals were required to collect and report data on performance for at least two of four core measure sets (acute myocardial infarction, heart failure, pneumonia, and pregnancy)[2]; these data were made publicly available by the Joint Commission in 2004.

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NEJM; August 12, 2010

Table 1. Four Criteria for Accountability Measures That Address Processes of Care.

1. There is a strong evidence base showing that the care process leads to improved outcomes.
2. The measure accurately captures whether the evidence-based care process has, in fact, been provided.
3. The measure addresses a process that has few intervening care processes that must occur before the improved outcome is realized.
4. Implementing the measure has little or no chance of inducing unintended adverse consequences.

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TheScientist
MAGAZINE OF THE LIFE SCIENCES
News & Opinion
Current Issue
Archive
Surveys & Supplements
Careers
Volume 24 | Issue 12 | Page 32
Date: 2010-12-01
Reprints | Issue Contents
By Richard Smith
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7 comments
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Evidence: A Seductive but Slippery Concept
Medical guidelines based on so-called scientific evidence are not a panacea.
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HELP
INFORMATION FOR:
Vol. 171 No. 1, January 10, 2011
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Original Investigation
Analysis of Overall Level of Evidence Behind Infectious Diseases Society of America Practice Guidelines
Dong Heun Lee, MD; Ole Vielemeyer, MD
Arch Intern Med. 2011;171(1):18-22. doi:10.1001/archinternmed.2010.482
The Joint Commission
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Maximizing Improvement In Health Outcomes

- Define the characteristics of measures that best facilitate improvement (i.e., accountability measures)
- Incorporate expectations of levels of performance on accountability measures into Joint Commission accreditation requirements
- Eliminate non-accountability measures from accreditation/certification (and advocate that other stakeholders do the same)
- Assist hospitals in finding relevant solutions to improve performance
- Recognize consistent excellence

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Improving America's Hospitals

The Joint Commission's Annual Report on Quality and Safety

2011

New: Top Performers on Key Quality Measures

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Demographic Characteristics Of Top Performers

Demographic Characteristic	Percent of 2010 Top Performers (n=405)	Percent of All ORYX Participating Hospitals and CAHs (n=3000)
< 100 beds	33.3	27.7
100 – 299 beds	52.0	47.0
300+ beds	14.7	25.3
Rural	22.4	8.8
For-Profit	43.3	19.2
Not-for-Profit	47.5	63.3
Government	9.2	17.5
Teaching	5.2	11.6

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Recognizes

Oakbrook Regional Hospital
Oak Brook, Illinois

as a

Top Performer on
Key Quality Measures

2010

Surgical Care
Heart Attack
Heart Failure
Pneumonia
Children's Asthma

Mark R. Chassin, M.D., M.P.P., M.P.H.
President

Jerod M. Loeb, Ph.D.
Executive Vice President
Division of Healthcare Quality Evaluation

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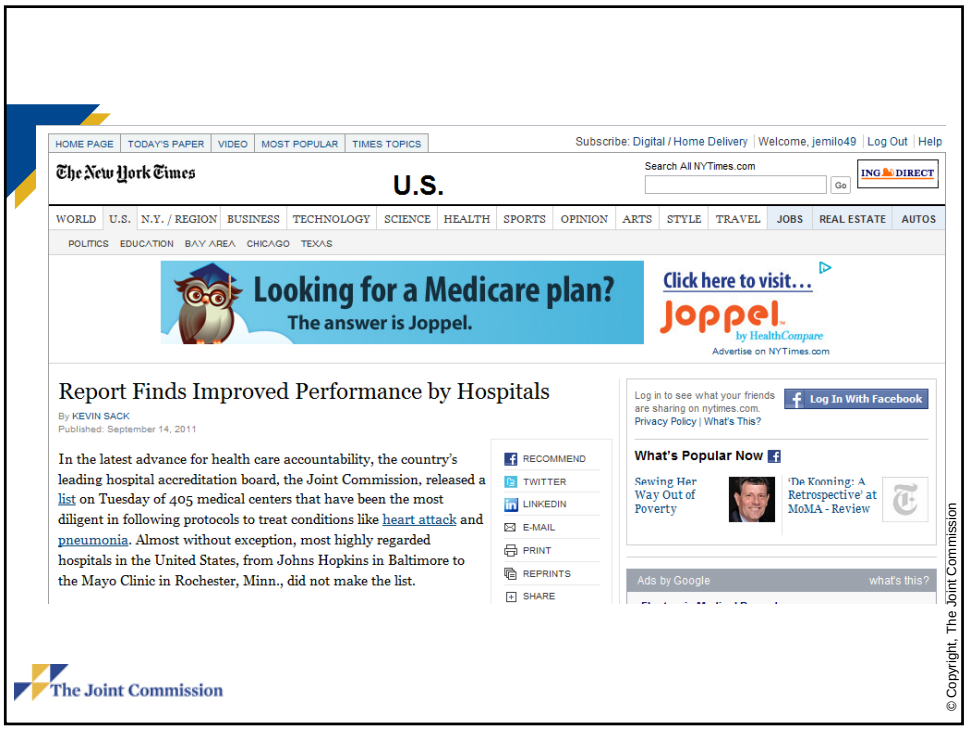

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Report Finds Improved Performance by Hospitals

By KEVIN SACK
Published: September 14, 2011

In the latest advance for health care accountability, the country's leading hospital accreditation board, the Joint Commission, released a list on Tuesday of 405 medical centers that have been the most diligent in following protocols to treat conditions like heart attack and pneumonia. Almost without exception, most highly regarded hospitals in the United States, from Johns Hopkins in Baltimore to the Mayo Clinic in Rochester, Minn., did not make the list.

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White Coat Notes

News from the Boston-area medical community

AN UNCOMMON LIST OF TOP HOSPITALS FROM THE JOINT COMMISSION

9/14/2011 5:32 PM

By Chelsea Conaboy, Globe Staff

The Joint Commission, which accredits health care providers, today released its first list of top hospitals, using metrics meant to track quality of care. The results may surprise you.

Nationally and in Massachusetts, the list skewed small and rural. On it was tiny Athol Memorial Hospital, a 25-bed hospital whose operating expenses in the tax year that ended in September 2009 were about $23 million. Absent are the powerhouses that make Boston a world-famous medical city. The state list includes no teaching hospitals.

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Modern Healthcare

Article published September 14, 2011

Many big names don't make top-performer list

Chassin

By Ashok Selvam
Posted: September 14, 2011 - 3:15 pm ET

Related Content

Joint Commission names 405 top-performing hospitals
Some familiar names fail to appear among the 405 organizations listed as top-performing hospitals (PDF) on the 2011 annual report on quality and safety from the Joint Commission.

Results of the study, released Wednesday, show improvement in the quality of care for heart attack, pneumonia, surgical and children's asthma care using information from last year. However, Joint Commission President Dr. Mark Chassin hoped hospitals could improve care for fibrinolytic therapy for heart attack victims and antibiotic treatment for pneumonia patients. The results are based on 22 accountability measures from hospitals in 45 states.

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BMJ

BMJ 2011;343:d6539 doi: 10.1136/bmj.d6539

OBSERVATIONS

YANKEE DOODLING

Quality rankings for US hospitals are released

The big dogs get blanked

Douglas Kamerow *chief scientist, RTI International, and associate editor, BMJ*

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It is interesting and perhaps emblematic that none of the "big dogs" in US healthcare made the initial list of high performing hospitals. No one would question the skill, capabilities, and accomplishments of these very prestigious hospitals and their doctors and staff, and most would agree that a hospital's quality does not rise or fall on the basis of whether 95% of its surgery patients are shaved appropriately before the operation begins. Similarly, it is easy to dismiss the quality improvement movement as a nitpicking exercise in finding and tweaking individual "quality nuggets" for unimportant minutiae. What we need is a global rating system that would incorporate and rank every relevant hospital activity and provide a summary score.

Lacking that, however, it seems to me that building and enforcing an increasingly large set of evidence based measures that are linked to important outcomes is the way to go. Before I have my cholecystectomy or hip replacement, I think I'll check to see whether my hospital is on the list of 405 rather than the honour roll of 17.

Competing interests: DK works for RTI International, which produces *US News & World Report*'s hospital ratings, although he is not involved in that work.

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Reporting Of Performance

Here's my report card…..I wanted to leave plenty of room for improvement

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Increasing Transparency – Yes!

But, Are Stakeholders Using The Data For Making Better Health Care Decisions?

The Joint Commission

Reports Are Little Seen, Less Often Used

Type of Report	1996 % Patients Using Report	2000 % Patients Using Report	2004 % Patients Using Report	2006 % Patients Using Report	2008 % Patients Using Report
Health Plans	12%	9%	13%	12%	9%
Hospitals	6%	4%	8%	10%	7%
Physicians	4%	4%	6%	7%	6%

The Joint Commission

2008 Update on Consumers' Views of Patient Safety and Quality Information; Henry J. Kaiser Family Foundation, October 2008

International Journal for Quality in Health Care Advance Access published August 12, 2011

International Journal for Quality in Health Care 2011; pp. 1–8 10.1093/intqhc/mar056

The perceived impact of public reporting hospital performance data: interviews with hospital staff

JOANNE M. HAFNER, SCOTT C. WILLIAMS, RICHARD G. KOSS, BRETTE A. TSCHURTZ, STEPHEN P. SCHMALTZ AND JEROD M. LOEB

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The perceived impact of public reporting hospital performance data: interviews with hospital staff

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Conclusions. Public reporting of performance measure data appears to motivate and energize organizations to improve or maintain high levels of performance. Despite commonly cited concerns over the limitations, validity and interpretability of publicly reported data, the heightened awareness of the data intensified the focus on performance improvement activities. As the healthcare industry has moved toward greater transparency and accountability, healthcare professionals have responded by re-prioritizing hospital quality improvement efforts to address newly exposed gaps in care.

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A Single Snapshot Is Not Always Effective

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CHICAGO SUN-TIMES

CHECKING HOSPITAL PERFORMANCE

Here are the percentages of pneumonia patients at city and suburban hospitals who received antibiotics within four hours of arrival, were given the pneumococcal vaccine if needed, and got the type of antibiotics in line with current guidelines. Most Chicago area hospitals scored below national averages.

Hospital	Timely antibiotics	Vaccination	Used right drugs
U.S. average	**75%**	**51%**	**76%**
Illinois average	**76%**	**45%**	**75%**
Adventist GlenOaks, Glendale Hts.	93%	19%	63%
Adventist Hinsdale, Hinsdale	86%	38%	60%
Adventist La Grange Mem., La Grange	84%	16%	68%
Advocate Bethany, Chicago	67%	6%	90%
Advocate Christ, Oak Lawn	65%	8%	52%
Advocate Good Sam., Downers Grove	77%	14%	84%
Advocate Good Shep., Barrington	86%	34%	81%
Advocate Illinois Masonic, Chicago	58%	14%	79%
Advocate Lutheran Gen., Park Ridge	82%	37%	57%
Advocate South Suburb., Hazel Crest	55%	39%	73%
Advocate Trinity, Chicago	52%	18%	85%
Alexian Brothers, Elk Grove Village	88%	48%	87%
Centegra Memorial, Woodstock	80%	59%	82%
Centegra Northern Illinois, McHenry	78%	52%	86%
Central DuPage, Winfield	83%	60%	85%
Condell Medical Center, Libertyville	67%	18%	75%
Delnor Community, Geneva	79%	81%	77%
Edward Hospital, Naperville	80%	60%	86%
Elmhurst Memorial, Elmhurst	76%	69%	74%
Evanston N.W. Healthcare,** Evanston	87%	22%	87%
Gottlieb Memorial, Melrose Park	78%	85%	85%
St. Mary, Chicago	74%	15%	69%
Sherman, Elgin	66%	32%	70%
Silver Cross, Joliet	78%	38%	82%
South Shore, Chicago	75%	6%	62%
Stroger Hospital, Chicago	32%	0%	70%
Swedish Covenant, Chicago	71%	17%	42%
Thorek Memorial, Chicago	60%	17%	71%
University of Chicago, Chicago	70%	21%	81%

The Joint Commission

What Did The CEO Say?

Chicago Sun Times
Article on Pneumonia
March 6, 2006

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So, Why Is Care Improving?

The Joint Commission

shm Journal of HOSPITAL MEDICINE www.journalofhospitalmedicine.com

ORIGINAL RESEARCH

Hospital Performance Trends on National Quality Measures and the Association With Joint Commission Accreditation

Stephen P. Schmaltz, MPH, PhD[1*], Scott C. Williams, PsyD[1], Mark R. Chassin, MD, MPP, MPH[1], Jerod M. Loeb, PhD[1], Robert M. Wachter, MD[2]

[1]*The Joint Commission, Oakbrook Terrace, Illinois;* [2]*University of California, San Francisco, San Francisco, California.*

BACKGROUND: Evaluations of the impact of hospital accreditation have been previously hampered by the lack of nationally standardized data. One way to assess this impact is to compare accreditation status with other evidence-based measures of quality, such as the process measures now publicly reported by The Joint Commission and the Centers for Medicare and Medicaid Services (CMS).

OBJECTIVES: To examine the association between Joint Commission accreditation status and both absolute measures of, and trends in, hospital performance on publicly reported quality measures for common diseases.

DESIGN, SETTING, AND PATIENTS: Performance data for 2004 and 2008 from U.S. acute care and critical access hospitals were obtained using publicly available CMS Hospital Compare data augmented with Joint Commission performance data.

MEASUREMENTS: Changes in hospital performance between 2004 and 2008, and percent of hospitals with 2008 performance exceeding 90% for 16 measures of quality-of-care and 4 summary scores.

RESULTS: Hospitals accredited by The Joint Commission tended to have better baseline performance in 2004 than non-accredited hospitals. Accredited hospitals had larger gains over time, and were significantly more likely to have high performance in 2008 on 13 out of 16 standardized clinical performance measures and all summary scores.

CONCLUSIONS: While Joint Commission-accredited hospitals already outperformed non-accredited hospitals on publicly reported quality measures in the early days of public reporting, these differences became significantly more pronounced over 5 years of observation. Future research should examine whether accreditation actually promotes improved performance or is a marker for other hospital characteristics associated with such performance.
Journal of Hospital Medicine 2011;6:454–461.

The Joint Commission

A (cynical) Mantra For Improvement

The Joint Commission

(Source: Tim McDonald, MD, JD; Univ of IL College of Med)

The Unanswerable Question – Why Isn't Improvement More Widespread?

- ***Fundamentally, this is a struggle for the heart and soul of medical care…….***
- How much personal autonomy should be sacrificed to improve the overall reliability of systems of care?
- Why isn't standardization accepted in health care?
- Why can't we create High Reliability Organizations (HROs) in health care?

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