Measuring Quality Is Key Task

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The NQF consists of 375 member organizations, including hospitals, consumer groups, insurers, and physician organizations. The forum has developed a complex process for endorsing measures, including formation of a steering committee, calls for measures, measure evaluation, public comment, member voting, and review by the forum's consensus standards approval committee as well as the board of directors. Organizations that are unhappy with a measure that has been approved by the NQF's board of directors have 30 days to appeal the decision.

When evaluating a measure, the NQF's approval committee considers four areas: the importance of reporting the measure; the extent to which the measure produces consistent, credible results about quality of care; the usability of the measure; and the feasibility of the measure.

Feasibility is particularly important, Dr. Burstin said. "Some of the recent projects we've been doing include those done [using] readily available electronic data sources [such as] pharmacy information, lab ordering, test results, and diagnostic data." Although there are always some costs associated with measurement, "you can only improve what you can measure," she added.

Flowers Hospital uses the NQF's measures as part of its overall quality improvement program, said hospital president and CEO Keith Granger. "It's one of the components we use as [part of] a working list of items we want to address." The measures fall into several areas, "some related to clinical performance, such as reducing infections, and others that are more environmental, such as improving hospital security. Our focus is heavier on the clinical side than the environmental side."

And the program is working, according to Dr. Calvin Reid, who has been at Flowers since 1982 and joined Flowers' hospitalist program when it started in 2006. "There's no question in my mind that the overall system has definitely improved quality," he said. "Patients experience fewer infections, and they are treated more promptly with appropriate medications. That effort is an everyday thing around here."

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The NQF has approved more than 300 quality measures so far. But it's hard to concentrate on 300 things at once, noted Jayne Hart Chambers, senior vice president for strategic policy at the Federation of American Hospitals, which is a member of the forum.

In an effort to better target quality improvement efforts, the NQF developed the National Priorities Partnership, which has developed six areas for health care facilities to focus on over the next 5-10 years:

▶ **Patient and family engagement.** Engage patients and families in managing their health and making decisions about their care.

▶ **Population health.** Establish communities that foster health and wellness, and create national, state, and local systems of care dedicated to the prevention of disease, injury, and disability.

▶ **Safety.** Improve the safety and reliability of health care. The forum says it envisions "a health care system that is relentless in continually reducing the risks of injury from care, aiming for 'zero' harm wherever and whenever possible."

▶ **Care coordination.** Ensure that patients receive well-coordinated care within and across all health care organizations, settings, and levels of care.

▶ **Palliative and end-of-life care.** Guarantee appropriate and compassionate care for patients with life-limiting illnesses.

▶ **Overuse.** Eliminate overuse while ensuring the delivery of appropriate care.

Now that the priority list has been developed, Ms. Chambers explained, the NQF plans to identify gaps in areas where new quality measures are needed.

Hospitalist groups also are interested in the forum's work. The Society of Hospital Medicine has been a member of the NQF's health professionals council for a little more than 2 years, according to Jill Epstein, senior adviser for quality standards and compliance at the society. In addition, one society board member is a member of the forum's steering committee on its care coordination project.

The society also is active with the Physician Consortium for Performance Improvement (PCPI) and is coleading a PCPI working group on the development of several measures related to care transitions, she added.

Hospitalists are getting more positive about the value of following protocols, according to Dr. Reid. "I remember back 20 years ago when physicians would moan and groan about cookbook medicine. What a lot of physicians didn't realize was that the cookbook was a good cookbook," he said. "Of course, you have to have some leeway—not every patient fits this formula, but most do. Occasionally there will be an exception, and if you document that, that's appropriate."

Having all physicians buy into a protocol isn't always automatic, however. When the hospital was looking at a protocol to reduce surgical site infections by administering appropriate antibiotics in a timely way, "there were one or two physicians on the staff who didn't want to follow the protocol," Dr. Reid said. They were given the opportunity to present their own data to support their approach, and bought into the protocol after realizing that their data were not compelling.

Although the hospital can make having privileges conditional on accepting the protocols, it has never come to that, Mr. Granger said. "We let them make the [evidence] presentation among their peers, so it's not an 'administration versus the doctor' kind of discussion. With peer-to-peer discussion, the situation takes care of itself." ■

More Hospital IT Linked to Lower Mortality, Lower Costs

BY MARY ANN MOON

Greater automation of a hospital information system appears to be associated with substantial reductions in mortality, complications, and costs for many patients, according to a report.

In a study of 72 general urban hospitals across Texas, a random sample of physicians who provided inpatient care rated the degree to which the hospitals had effectively computerized four information technology (IT) domains: medical notes and records, test results, entry of medical orders, and support for clinical decision making.

These results were correlated with patient outcomes at the hospitals, said Dr. Ruben Amarasingham of the University of Texas Southwestern Medical Center, Dallas, and his associates.

The more than 7,400 physicians who participated in the study practiced internal medicine (including 9 subspecialties), general surgery (including 10 subspecialties), or family practice. Patients older than age 50 years who were being treated for four clinical conditions—myocardial infarction, heart failure, coronary artery bypass grafting, or pneumonia—were assessed.

The study statistically controlled for the likelihood that medical centers with more IT tend to have more resources available and better performance on quality-of-care measures to start with, the researchers noted.

They found "impressive" associations between several information technologies and beneficial outcomes.

For example, hospitals that scored well for computerized entry of medical orders showed a 9% reduction in MI mortality and a 55% reduction in CABG mortality. Those that scored high for computerized support for medical decision making—such as easy online access to treatment guidelines—showed a 21% decrease in complications.

Hospitals that scored high for automation of medical notes and records showed a 15% decrease in all-cause fatalities. "This would suggest that for every 1,000 patients, 5 fewer patients die at hospitals with the highest notes and records scores," Dr. Amarasingham and his colleagues said (Arch. Intern. Med. 2009;169:108-14).

Hospitals with effective IT also had substantially lower costs.

Length of stay was the only outcome that did not show any relation with effective IT. Given that length of stay already is extremely low because of payer scrutiny of hospital stays, "this measure may already be so low as to be resistant to the efficiencies introduced by IT," the investigators noted.

In an editorial comment accompanying this report, Dr. David W. Bates of Brigham and Women's Hospital, Boston, termed this study a "landmark" because it assessed physicians' everyday use of IT across numerous hospitals with a diverse array of patient populations.

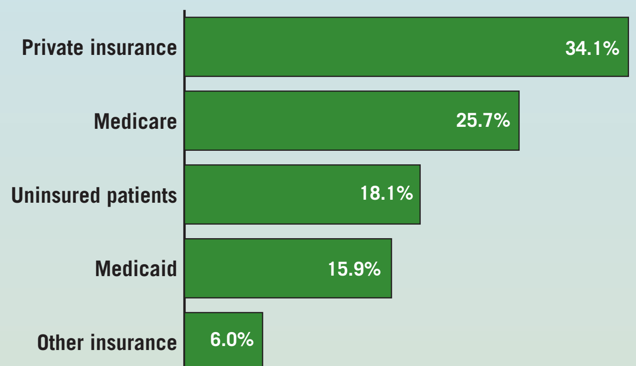
"Hospital IT is expensive, and there have been serious doubts about the extent to which it will actually be beneficial," Dr. Bates noted (Arch. Intern. Med. 2009;169:105-7).

At a time when many hospitals are losing money, most "have been nervous about making large investments in technology that is difficult to implement, creates major issues with change management, carries a substantial risk of failure, and has uncertain benefits," Dr. Bates said.

The findings of this study demonstrate that the negative effects of implementing hospital IT do not "overwhelm or wash out the positive ones, as some have suggested," Dr. Bates added.

Dr. Amarasingham is also affiliated with the center for knowledge translation and clinical innovation at Parkland Health and Hospital System, Dallas. ■

DATA WATCH



Notes: Data are based on a 2005 survey of 23 states. Total doesn't equal 100% because of rounding. "Other insurance" includes worker's compensation, TRICARE/CHAMPUS, and other programs.
Source: Agency for Healthcare Research and Quality

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