FLORIDA HOSPITAL

HEALTH CARE Quality Brief

Florida Hospital's Quality Goals

1. Rank in the Top 10% of hospitals nationwide
2. Show ongoing cycles of improvement in all areas of patient care

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This is the first in a series of bi-monthly Health Care Quality Briefs that will outline patient safety indicators and quality indicators for common disease categories. We will discuss Florida Hospital's performance on these indicators; define key "influencers" of the results; and describe our Continuous Quality Improvement processes.

Defining Health Care Quality

On the face of it, the definition of quality health care seems straightforward enough: "Patients getting the right medicine, treatment or test at the right time, given the patient's condition." So why is there such an "alphabet soup" – CMS, AHCA, JCAHO, AHRQ, NCQA, NQF, ASQ, and more[1] – of groups working to measure hospital quality? And why do consumers have such a hard time finding and understanding the data?

The reality is, health care quality is actually very difficult to measure. In fact, there are so many variables that the groups listed above – and many other experts – have disagreed for years on meaningful comparisons of quality.

Some experts favor standardized data systems and/or hospital "report cards." These reports provide many objective measures of the differences in quality of care, but they can be subject to "gaming" that leads to better report card scores but not necessarily better care. Secondly, the "standardized" data isn't always "apples to apples." Some data is mandatory, and other data is voluntary. In either case, the formats vary and may include different quality measures. Thirdly, different hospitals use different data systems and have multiple caregivers documenting their processes – not necessarily in the same way.

Even the most unrefined measure, mortality rates, is subject to variation depending upon the severity of disease, the age of the patient, existing medical conditions, and other factors. For example, if Hospital A had a "simple mortality (death) rate" of 3% for heart surgery and Hospital B had a rate of 5%, the simple conclusion is that Hospital A is better than Hospital B. *But*, if Hospital B were treating older patients with complicating conditions who were having a second surgery, and Hospital A was treating younger and healthier patients, then Hospital B would be providing higher quality health care than Hospital A.

[1] Center for Medicare and Medicaid Services, Agency for Healthcare Administration, Joint Commission on the Accreditation of Healthcare Organizations, Agency for Health Care Research and Quality, National Committee for Quality Assurance, National Quality Forum, and American Society for Quality.

This complexity applies not just to outcomes like mortality, but also to outcomes like infection rates and medical complications. A surgical patient with diabetes is more likely to have problems healing, is more susceptible to infections, and has a greater risk for kidney failure. Obviously, comparisons need to account for these factors – but how? Even when raw data is adjusted based on severity of these and other factors, variations can exist.

Comparing hospitals not only on **outcomes**, but also on the **processes** assumed to result in better patient outcomes, is one approach to getting at more meaningful comparisons among hospitals. In other words, what processes are hospitals using that make patient outcomes "better" over time?

Medicare has taken this approach, and has issued benchmarks for certain treatment processes and outcomes. JCAHO[2] (which accredits hospitals) and private organizations like the Leapfrog Group (which collects hospital data on a voluntary basis) use similar methods to provide consumers and employers with information about health care quality. Private organizations like Leapfrog look at processes such as having fulltime physician intensivists in the ICU, computerized physician order entry, etc. The goal is to demonstrate (high) correlation between certain prescribed processes and patient outcomes.

Florida Hospital has adopted Medicare and JCAHO benchmarks, and monitors the Leapfrog required indicators. Benchmarks for each are set for the 50th Percentile and Top Decile (best of the best). Florida Hospital has chosen the Top Decile as its internal goal for all indicators.

This process/outcomes correlation will be useful – but is still not the total answer. While a correlation as high as .80 explains the majority of variances in outcomes, it leaves some other factors unaccounted for – again challenging the validity of comparisons among institutions.

An alternative approach to report cards is to have each hospital monitor these benchmarks over time, and report them regularly. At least over the short term, the patient base and other environmental factors are stable. And self-tracking through trends – using Medicare and other quality benchmarks – tells the consumer and others whether the hospital is exhibiting ongoing cycles of improvement.

Complexity aside, the reality is that hospitals must be more open about quality measures and be more "transparent" with their quality data. And consumers must recognize that quality measures are complex and comparisons among hospitals should be viewed cautiously.

In the next Issue: Measuring quality in Heart Attack Care

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[2] Joint Commission on the Accreditation of Healthcare Organizations