Hospital Process Measures Improve, JCAHO Finds

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A set of process measures established by the Joint Commission on Accreditation of Healthcare Organizations has helped hospitals to improve performance, according to a study of the first 2 years of implementation.

The study, by Scott C. Williams, Psy.D., and his colleagues at the commission, found that improvements were made in 15 of 18 standardized measures and that there was no deterioration of quality in any of those areas (N. Engl. J. Med. 2005;353:255-64).

In 2002, the commission began measuring performance in the 18 measures at 3,377 of 4,644 hospitals accredited by the organization. Nonparticipating hospitals either did not offer the services being measured or had an average daily census of fewer than 10 patients. The facilities could choose to submit data on at least two of the following conditions: acute MI, heart failure, pneumonia, and pregnancy and related conditions.

Only 74% of patients received ACE inhibitors at discharge at the low-performing hospitals, but 83% received them at the high-performing facilities.

They did not track the pregnancy measures, as two of the measures applied to rare events, and the third, vaginal birth after cesarean section, is controversial, the authors wrote.

The study covered hospitals that submitted data from the third quarter of 2002 to the second quarter of 2004—a total of 3,087 out of the 3,377 hospitals initially identified as study participants.

Of those, 1,473 submitted data on heart attack measures, 1,946 on heart failure, and 1,797 on pneumonia.

One of the measures looked at death in the hospital after acute myocardial infarction, and the other 17 assessed processes of care.

There was no improvement in the death measure, but the authors said most of the improvements in the process measures being assessed would not have had an impact on mortality. And there was no significant improvement in the mean time to thrombolysis for patients with acute MI or in mean time to administration of antibiotics for pneumonia.

For acute MI, researchers looked at measures such as whether aspirin was given within 24 hours of admission and prescribed at discharge, whether an ACE inhibitor was prescribed at discharge for patients with left ventricular systolic dysfunction, and the mean time from arrival to thrombolysis or percutaneous coronary intervention.

For heart failure, hospitals were tracked on whether they had given patients smoking cessation counseling and discharge instructions on medication, diet, weight, and worsening of symptoms, and whether an ACE inhibitor was prescribed at discharge for patients with left ventricular systolic dysfunction.

For pneumonia, the commission monitored whether there was an oxygenation assessment within 24 hours of admission and whether pneumococcal screening, vaccination, or both had been given at discharge, or if blood specimens were cultured before starting an antibiotic.

By the end of the study period, more than 90% of MI patients at most hospitals received aspirin at admission. Although only 74% of patients received ACE inhibitors at discharge at the lowest performing hospitals, 83% received them at the highest performing facilities, the investigators said.

The biggest improvement was seen in offering smoking cessation counseling. Rates went from a range of 1%-7% at the lowest performing hospitals at baseline to a range of 57%-68% at the study's end. At high-performing facilities, however, rates dropped from an 80%-98% range at baseline to a range of 74%-85% at the end.

Even after improvement, pneumococcal vaccination rates were still low, ranging from 35% in the lowest performing hospitals to a high of 66% at the highest performing facilities.

One potential drawback of the study was its reliance on self-reported data, which could introduce bias. And, they said, the data should not be viewed as static. The picture could change as public reporting of hospital data becomes more prevalent and pay for performance spreads. ■