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## **Making Sense of the Chaos**

**By Richard Umbdenstock**

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It is time for a change of direction in quality measurement and improvement. Fifteen years ago, public policymakers and health care leaders debated over whether we could define and measure quality. We have safely put that debate to rest. The Institute of Medicine gave definition to the elements of quality in its 2001 report *Crossing the Quality Chasm* and the National Quality Forum has endorsed more than 400 measures of quality as national standards, leading all to agree that quality is both definable and measurable.

A decade ago, policymakers wondered whether health care providers would willingly be transparent about quality. Through the Hospital Quality Alliance, hospitals have allayed any doubts about willingness to be public. Hospitals are engaged in public reporting, highlighting both how well they are doing and where improvement opportunities exist. In fact, there is now a dizzying array of public reporting activities. The groundswell of reporting initiatives from government agencies, insurers, employer coalitions, professional societies and others has created an avalanche of work for hospitals—so much that it is getting in the way of quality improvement.

American Hospital Association staff recently catalogued the variety of organizations and initiatives at the national level asking for quality data, and the list was five pages long. The requests varied enormously in scope and measures used. Some used process measures abstracted from the medical records, others used clinical data from bills. Some used patient and employee surveys, while others assessed structural measures. And of course, there is a similar array of state and local efforts under way in many regions of the country, augmenting this national measurement cacophony.

The entire array was overwhelming in number and confusing in its differing data sources, differing methodologies, and different periods for data collection and reporting. These differences make it impossible even for knowledgeable clinicians to aggregate related information across the initiatives and draw a comprehensive picture of the quality of care in each of our hospitals. Organizations trying to use these data to steer their quality improvement efforts are frustrated by this lack of focus and coordination. And if knowledgeable clinicians are frustrated, it is no wonder that the public shows little propensity to learn to use the published data.

On Nov. 17, a group called the National Priority Partners announced a set of priority areas. The NPP was convened by the National Quality Forum and includes individuals who have the ability to represent large health care stakeholder communities. The specific aim is to get concrete agreement on the priority areas for quality improvement. The group selected six areas: preventive health, safety, end-of-life care, overuse of services, patient-centered care and care coordination. The intent is for measurement, improvement, pay for performance and other quality initiatives to focus on just these areas, bringing some order to the chaos.

As 2009 nears, our challenge is to identify the hospital-specific agenda from within these priority areas, which we will then share with our partners at the NPP to gain input and agreement. While the NPP is still in its infancy, its work offers us a great opportunity to identify and focus on the most important quality issues confronting hospitals and to get insurers, government agencies and others working in concert on those high-priority issues. I welcome your counsel on how we can use this opportunity.

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