centres, intuitive choice of axes and hence easy plotting, and exact binomial control limits obtainable from the most popular spreadsheet package. I suggest that funnel plots could provide a useful adjunct to any performance monitoring system.

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Cleveland Health Quality Choice was a failure, not a martyr

We read with interest the article entitled “Too good to last: did Cleveland Health Quality Choice leave a legacy and lessons to be learned?” published recently in QSHC.1 Perhaps relevant in this regard is our study of the claim, repeated by Neuhouser and Harper, that the Cleveland Health Quality Choice (CHQC) project may have improved mortality rates in Cleveland at a faster rate than they were improving elsewhere.2 Using OHA data we found that not to be the case. The rate of improvement in inpatient mortality in Cleveland was the same as that in the rest of the state and would therefore have to be attributed to other factors.3

CHQC’s bright promise unfortunately went largely unfulfilled as it never got much beyond mortality and length of stay, neither of which is a very good surrogate for quality. Although CHQC’s risk adjustment may have been the best available, it was only marginally better than simpler, far less expensive methods. That was just one of the many problems with this project, which seemed incapable of improvement almost from the moment it began releasing reports.

In their article Neuhouser and Harper allude to the Cleveland Clinic’s intent to focus the money previously being spent on CHQC to improve quality in its system of hospitals. We have been doing that on a disease-by-disease basis through the Cleveland Clinic Health System’s Quality Institute, actually spending about the same amount as on CHQC. This program measures well proven indicators of quality care, producing demonstrable, credible, timely results that lead to productive actions. The Joint Commission recognized this activity with the 2001 Codman Award.

Although we certainly agree that CHQC was a pioneering project, we disagree that anyone ever used the data for its original purpose—to influence the medical marketplace. We were able to find no evidence that this ever occurred. The “business model” as it applies to health care did not work in Cleveland, nor has it worked in other areas such as Pennsylvania and New York where report cards have been published. The production of academic articles was never the purpose, and research grants rather than operational money should support such activities.

We are aware of another 5 year ongoing study in Dayton, where a collaboration of business and hospital leadership has led to substantial improvement in both outcomes and processes of care. The Dayton project has been successful because its goal is to improve health care in the community, not to reward or punish providers based on their outcomes.

We doubt that the loaded word “martyrdom” accurately describes the fate of this failed program. We need, either as communities or as individual institutions, to move on to new approaches as we learn from the failures of the past.

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References

BOOK REVIEWS

Review of e Clinical Governance: A Guide for Primary Care


Unlike elephants, clinical governance is easy to describe in theory but hard to know if you have seen a good example in practice or not. This book, which introduces the reader to the field of health informatics, helps this process of turning clinical governance from rhetoric to reality. Health informatics is more than just using a computer in a clinic or surgery. It is, the editors tell us, a “scientific approach to information, which includes how we think, how data become information and knowledge, and how we communicate in clinical practice, how we represent data, information and knowledge in computers, how we learn, how computers can support clinical practice”. It is this staggering wide definition that provides the clue to the book’s strength and weakness. It scops the field of health informatics comprehensively, urging the reader and all healthcare professionals to record clinical data more accurately, use it more fruitfully, and reflect on it as part of continuing personal and professional development. The book deals with the practical aspects of this challenge adequately. The authors advocate using Prodigy, unsurprisingly, as a number of the contributors have helped develop that programme. They explain the use and availability of Prodigy well, and signpost the reader to a host of useful websites for clinical guidelines, protocols, and other evidence based centres and groups. And they explain clearly the contribution of Read codes, and the value of the PRIMIS and MIQUEST programmes in organising and retrieving clinical data. But the book has taken on this huge brief—outlined in its definition—and doesn’t deal with the theory underpinning health informatics robustly. The authors never really nail the connection between clinical governance and health informatics, and provide somewhat bland sections on risk management and the theory of knowledge. They do stray occasionally into the odd platitude, and stand accused, like many others, of misusing the word “paradigm”. But this is essentially an introductory guide, a practical book to help people navigate through a tricky and increasingly important field, as shown by the final section which is full of practical advice on education. Readers who seek that level of information won’t be disappointed.

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