

A new Institute of Medicine report, *Improving Health in the Community: A Role for Performance Monitoring*,<sup>1</sup> develops two ideas that can help modernize the Healthy People process: (a) health is a shared responsibility of many, diverse community entities; and (b) a performance monitoring framework can help ensure that these entities are held accountable for the activities they undertake to improve the community's health. This suggests that the Healthy People 2010 process should incorporate two central steps.

First, participants should agree on a short list of health status and risk reduction measures that would serve as national health objectives. This list would include 25 to 50 outcome-oriented measures instead of the more than 300 objectives in Healthy People 2000. These objectives should employ measures that, as far as is possible, are applicable at the state and local as well as the national level.

Second, in a variety of focus areas such as heart disease, tobacco, environmental health, maternal and infant health, and violent and abusive behavior, sets of performance indicators should be developed for actions that can be taken by Federal agencies, professional groups, and voluntary organizations at the national level to promote these national health objectives. These indicators could serve as a toolbox of models that states and communities might use to develop performance indicators appropriate for local conditions, problems, and capabilities.

This approach would solve the dilemma that Maiese and Fox describe about Healthy People 2000—that there are simultaneously too many and too few objectives. The large number of objectives makes it difficult to focus on the overall message or identify priority actions, yet they are needed to guide topic-specific action. The

proposed short list of national health objectives would provide focus and a clear message while the more numerous and flexible performance indicators would provide national, state, and local measures to guide action.

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1. Institute of Medicine. *Improving health in the community: a role for performance monitoring*. Washington: National Academy Press; 1997. ■

#### TB Reporting

Few studies have been published of the completeness of hospitals' reporting of tuberculosis (TB) cases to health departments. We report an evaluation of the completeness of TB reporting from hospitals in Missouri. We reviewed *International Classification of Diseases, Ninth Revision, Clinical Modification* [ICD-9-CM] codes<sup>1</sup> for discharges from acute care hospitals in the state, excluding Veterans Administration hospitals, for January 1994 through June 1995 to identify records with TB-related discharge diagnoses (ICD-9-CM codes 010-018.9). We then manually matched those records by name to the state's TB registries. Records of patients with TB-related ICD-9-CM codes that were not found in the registries were reviewed by a physician or TB nurse specialist to verify the diagnosis of TB.

TB-related ICD-9-CM codes were found in 866 hospital records. Registry matching and review of medical records identified 168 duplicate records (patients with more than one hospital admission during the study period). Registry matching of the remaining 698 records found that 240 patients (34%) had been reported to the TB registry. Of the remaining 458 patients, 18 (4%) had confirmed TB,

137 (30%) were infected with non-tuberculous mycobacteria, 69 (15%) had a history of TB that was clinically inactive at the time of hospitalization, 51 (11%) were reported in another state, and 143 (31%) were miscoded. In addition, 40 (9%) charts were missing, so their reporting status could not be determined.

The Missouri TB surveillance registry detected 93% of patients hospitalized with TB. Not counting the 40 patients whose records were missing, the predictive value of hospital discharge ICD-9-CM codes for identifying active TB cases was 47%, considering the 240 TB cases reported to the TB registry, 51 TB cases counted in another state, and 18 unreported cases (309/658).

Thus TB-related ICD-9-CM discharge codes were not a reliable predictor of active TB. Crossmatching TB registries with ICD-9-CM data was labor-intensive but detected 18 TB cases not in the registry. Active surveillance for TB in Missouri hospitals that had unreported cases should be considered to ensure complete reporting of hospital-diagnosed TB cases.

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1. Castillo LA, Hopkins CA, Aaron, WS, editors. *St. Anthony's ICD-9-CM code book for physician payment*. Reston (VA): St. Anthony's Publishing; 1995. ■