

Chapter 3: Quality of Care

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Previous debates over national health reform have focused on the dual problems of the uninsured and rising costs. Today's debate includes a third key component: Improving the lagging quality of the health care delivered to patients.

Experts put quality shortcomings into three major categories:

- **Underuse** occurs when patients do not get care that is medically indicated. An example is the failure to use commonly available screening tests for every patient who could benefit from them.
- **Overuse** occurs when patients receive care that isn't medically indicated. Typical examples are use of antibiotics to treat a cold or the use of imaging devices for someone with the first signs of lower back pain.
- **Misuse** describes care that is provided poorly or erroneously, such as wrong-site surgery.¹ At least 44,000 people, and perhaps as many as 98,000, die in hospitals each year as a result of medical errors that could have been prevented.

Medication errors harm 1.5 million Americans annually and treating injuries caused by these errors costs an estimated \$3.5 billion a year.²

To help reduce these shortcomings, almost all quality measures seek to assess one of four things, and the results of these measures are often used to drive improvement in performance and quality:

- Are the **structures** and policies in place to assure performance?
- Are the right **processes** being followed to lead to better care?
- Are the right **outcomes** being achieved?
- Are the patients' **satisfied** with their care experience?

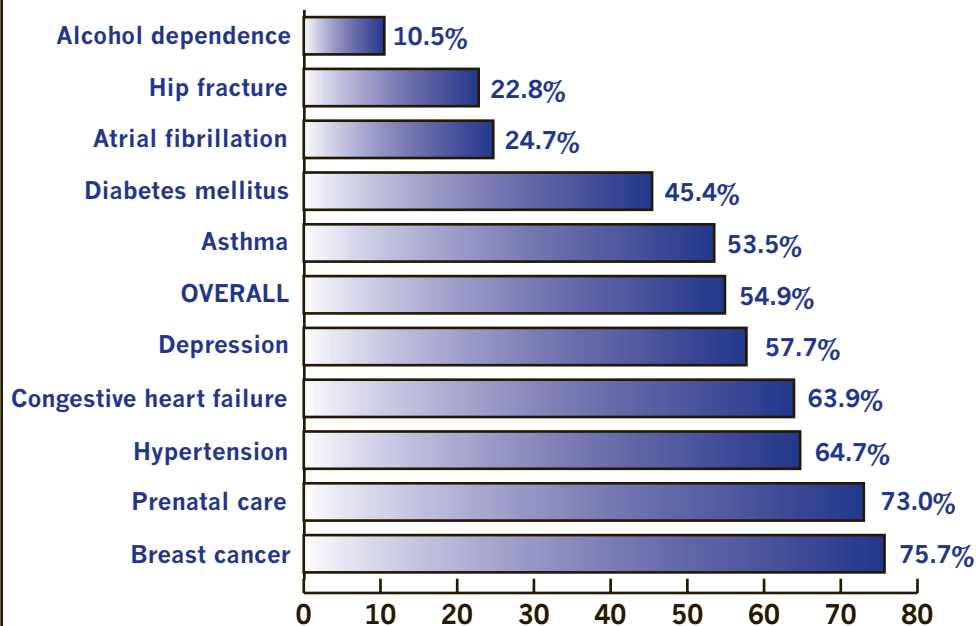
The federally-chartered Institute of Medicine (IOM) offers this definition of quality: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."³ The IOM vision of quality calls for care that is safe, effective, patient-centered, timely, efficient and equitable (does not

FAST FACTS

- In a ranking of 19 industrialized countries, the U.S. had the highest number of unnecessary deaths.^a
- Among 37 nations, the U.S. ranks 29th in terms of infant mortality with nearly twice as many infant deaths per capita than France.^b
- Americans receive recommended evidence-based care, on average, 55 percent of the time. Care for some conditions is even worse, and for other conditions, much better.^c Care for some conditions is even worse, and for other conditions, much better.^d
- Medication errors harm 1.5 million Americans annually. Treating injuries caused by these errors costs an estimated \$3.5 billion a year.^e
- Variations in the quality of care do not seem to be linked to how much we spend on health care.^f
- The goal of most quality measurement is to improve health care services by monitoring and analyzing data and, based on what the data indicate, changing practices to improve performance.^g
- Evidence shows that when quality data are released each year over many years, it stimulates improvement in those areas being measured.^{h,i}

For story ideas on quality of care, see page 34. A list of experts and websites begins on page 35.

How Often Recommended Care is Received, Selected Conditions



Source: McGlynn, Elizabeth; Asch, Steven; Adams, John et al. (2003). "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine* 348; 26, June 26, p. 2643. (www.nejm.org)

vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status).⁴

HOW DO WE MEASURE QUALITY?

It has been said that if we can't measure quality we can't improve it. The goal of most quality measurement is to improve health care services.⁵

Americans receive recommended evidence-based care, on average, only 55 percent of the time, with care for some conditions falling well below 50 percent and some areas performing much better.⁶ (See chart, "How Often Recommended Care is Received, Selected Conditions.") There are more surgical and medical mishaps per capita in the U.S. than in Germany, the United Kingdom, Canada or the Netherlands.⁷ (See chart, "Deaths Due to Surgical of Medical Mishaps per 100,000 Population.")

Research has shown that giving patients a class of drugs known as beta blockers following a heart attack significantly reduces the risk of a second and often fatal attack.⁸ But fewer than half of patients overall were given beta blockers after a heart attack as of mid-1996. Once researchers began to

systematically measure how often patients received beta blockers after a heart attack, physicians, hospitals, and health plans put steps in place to assure a beta blocker is given to every heart attack patient. The overall use rate has improved so that such treatment is now standard practice, saving thousands of lives and millions of dollars in health care costs.⁹

The most widely used set of quality measures is the Healthcare Effectiveness Data Information Set (HEDIS), developed through an alliance between health care

plans and employers.¹⁰ Since its creation in 1991, HEDIS¹¹ has evolved to include a broader range of measures that examine underuse, overuse, and misuse of services.¹²

A more recent addition seeks to measure the relative resources expended to treat a patient linked to the quality of those service. These relative resource use (RRU) measures could provide a clearer picture of the efficiency of health plans by identifying which plans provide higher quality at a relatively lower cost, those that provide high quality at a high cost, as well as those plans that provide lower quality care at either high or low costs. The use of such measures could help employers and consumers direct their business toward the more efficient (high quality/low cost) plans and drive improvement in costs and quality by others.¹³

HEDIS has spawned a number of other measuring tools that are used to assess care in a variety of settings. (See text box, "Quality Measures.")

In the past decade additional measurement sets have been developed to assess the performance of hospitals, nursing homes, home health care and,

most recently, physicians. In fact, measure development expanded so quickly that many health care providers report a high burden associated with different requirements of accreditors, regulators and payers to report data.

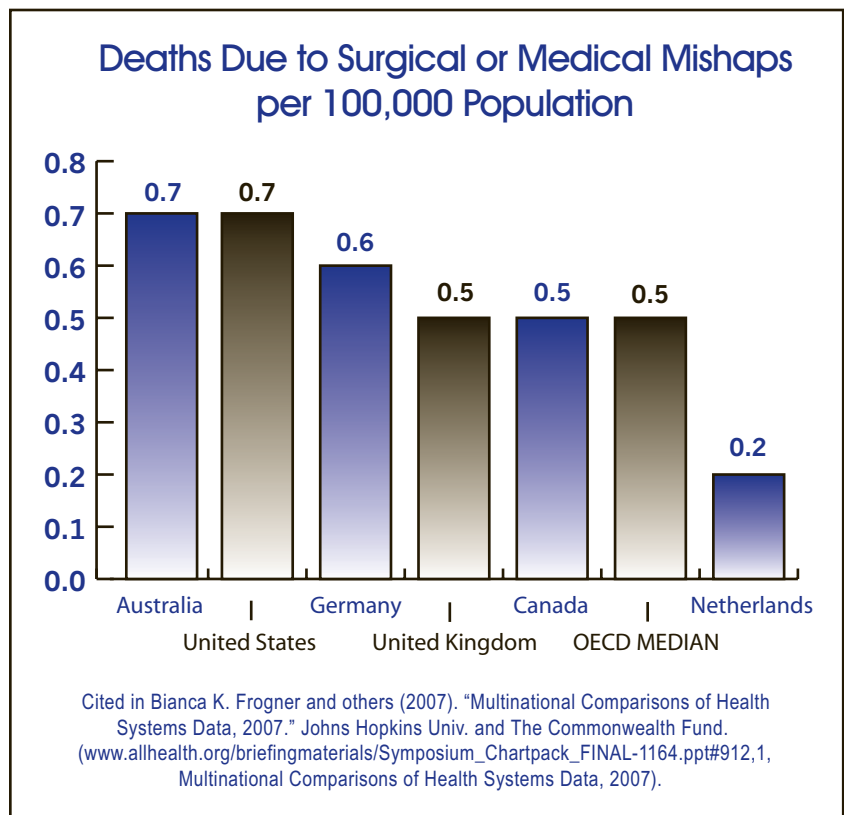
In 1998, the National Quality Forum (NQF) was created to sort through existing quality measures and identify those that have the most relevance to purchasers, providers and consumers.¹⁴ Leaders of the Medicare program, in particular, have turned to NQF to help them choose which measures should be adopted.¹⁵

In 2008, Congress authorized annual funding of up to \$10 million to set national priorities that identify reforms that will yield the biggest results; endorse and maintain measures that promote health, safety, and efficiency; and promote the development of electronic health records that support performance management by making the coordination and monitoring of practices possible.¹⁶

HOW CAN WE IMPROVE QUALITY?

Quality improvement results from a combination of measurement, reporting and action. Health care organizations and practitioners often use measurement results internally to compare their results to national or regional benchmarks, and make adjustments where necessary.

For example, the mortality rate for heart attack patients at Hackensack University Medical Center in New Jersey is approximately 5 percent, significantly below the national average of 10.9 percent. The medical center improved care and outcomes for heart attack patients by setting up mechanisms for patients to receive aspirin and a beta-blocker immediately upon arrival at the medical center, an EKG within 10 minutes of arrival, catheterization within 90 minutes, and a balloon dilation of the affected artery within 120 minutes. The quality improvements were aided by a Pursuing Perfection program grant from the



Robert Wood Johnson Foundation.¹⁷

Public release of performance information in the form of report cards, online databases and other means can be a powerful driver for improvement. Public disclosure of performance information drives health plans and providers to target improvements so that they know how they do compared with their competitors and can show improvement over their last scores. Evidence shows that when data are released each year over many years, it stimulates improvement in those areas being measured.^{18,19}

Many employers and other purchasers of health care coverage use quality measurement results to guide their choices of plans and providers. For example, two-thirds of Fortune 500 employers currently require health plans to be accredited by NCQA and/or to report HEDIS data.²⁰ State insurance regulators and administrators of such public programs as Medicare and Medicaid often either require or encourage hospitals, HMOs, nursing homes and others to report quality information.

LIKELY POLICY DEBATES

As Congress debates comprehensive health care reform, quality issues are almost certain to play a

role. Among the issues likely to be discussed are:

COMPARATIVE EFFECTIVENESS RESEARCH

There is a growing consensus that we need to know more about how well certain treatments, drugs and devices work when compared to other forms of treatment (or to a "watchful waiting" form of nontreatment). While the U.S. invests billions in medical research through the National Institutes of Health (NIH) and private industry, there has been relatively little money targeted at comparative research. This changed with the \$1.1 billion allocated for such research in the economic stimulus bill signed by President Obama in February 2009. A council of 15 federal employees will coordinate research and advise the president and Congress on how best to spend the funds.²¹

A major driver in this debate is the growing evidence of sweeping variations in the type of care patients receive in different parts of the country (and often different parts of a state). The work of John Wennberg, M.D., and others at Dartmouth University to analyze and identify these variations is documented in a publication known as the Dartmouth Atlas (www.dartmouthatlas.org).²²

Several nations already have robust comparative effectiveness research entities, including Australia, Canada, Germany and the United Kingdom.²³ Legislation introduced in 2008 by Senators Kent Conrad (D-ND) and Max Baucus (D-MT) would establish the Health Care Comparative Effectiveness Research Institute, to review evidence and produce new information on how diseases, disorders, and other health conditions can be treated to achieve the best clinical outcome for patients.²⁴ Other proposals can be expected in 2009.

Some questions that will be debated:

- Should a new comparative effectiveness entity be created, or should the work be carried out by existing agencies?
- If a new entity were created, would it be solely public, or a public-private hybrid?
- To what degree would publicly supported comparative effectiveness studies look at the cost of treatments under evaluation, and their cost vs. benefit ratios?

Quality Measures

Public and private sector insurers use a variety of quality measures to assess the performance of different parts of the health care system. Key measure sets are:

HEDIS. The Healthcare Effectiveness Data and Information Set was developed by a group of large employers to assess the performance of health plans. Today HEDIS is primarily used to measure the quality of care delivered by HMOs. HEDIS is maintained by the National Committee for Quality Assurance (NCQA). (www.ncqa.org/Programs/HEDIS/)

CAHPS. The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of patients' experiences with care. Health care organizations, public and private purchasers, consumers, and researchers use CAHPS results to assess the patient-centeredness of care, compare and report on performance, and improve quality of care. CAHPS was developed by the Agency for Healthcare Research and Quality (AHRQ) in partnership with numerous private organizations. (www.cahps.ahrq.gov)

Hospital Compare. Medicare's voluntary hospital quality system reports how often hospitals provide recommended care for a heart attack, heart failure or pneumonia, and to prevent infections acquired during surgery. Measures were developed by the Hospital Quality Alliance (HQA) and adopted by Medicare in 2003. Hospitals that report the measures receive a full annual update in Medicare payments; those that do not lose 2 percentage points on the update. (www.hospitalcompare.hhs.gov)

Nursing Home Compare collects information on nursing home residents' health, physical functioning, mental status and general well-being using a tool known as the Minimum Data Set (MDS). (www.medicare.gov/NHCompare/home.asp)

Home Health Compare uses the Outcome and Assessment Information Set (OASIS), which is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient. (www.medicare.gov/HHCompare/Home.asp)

MEDPAR. The Medicare Provider Analysis and Review (MEDPAR) File contains data from claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals and skilled nursing facilities (SNF). (www.cms.hhs.gov/IdentifiableDataFiles/05_MedicareProviderAnalysisandReviewFile.asp)

Aims and Measures for Model Medical Homes (Hudson River HealthCare, New York)

Table 1: Hudson River HealthCare's Strategic Aims and Measures

Safe	Aim: 100 percent of patients have electronic health records (EHRs) Measure: EHR reports of encounters by provider
Timely	Aim: Same-day appointment available with own provider; average office visit cycle time of 45 minutes or less Measure: Time to third next available appointment; average cycle time
Effective	Aim: Improve health outcomes through preventive and planned care model Measure: 90 percent of two-year-olds are fully immunized; 90 percent of diabetes patients will have two HbA1c tests performed within one year, with at least three months between tests
Equitable	Aim: Eliminate differences in clinical care and health status between racial, ethnic, and socioeconomic groups Measure: No disparity by race or socioeconomic characteristics for all effectiveness measures
Patient-focused	Aim: 100 percent of patients recommend the health center to friends and family Measure: 100 percent of patients reply "Agree" or "Strongly Agree" to the following statement on the patient satisfaction survey: "I would recommend this practice to my friends and family."
Accessible	Aim: Serve 50 percent of center's target population Measure: Evaluate the health service penetration rate for underserved and other target populations in specified service areas
Vital	Aim: Achieve high productivity and staff satisfaction Measure: 20 billable patient visits per primary care provider per day; 90% staff retention

Source: The Commonwealth Fund (2008). "Quality Matters: Patient-Centered Medical Homes." January 24. (www.commonwealthfund.org/usr_doc/2008_01_02_QM.pdf?section=4039).

For more information on this topic, see the Alliance for Health Reform issue brief, "Comparative Effectiveness: Better Value for the Money?" at www.allhealth.org/pubs_issuebriefs.asp and the Alliance - Robert Wood Johnson Foundation briefing on the same topic at www.allhealth.org/briefing_detail.asp?bi=125.

PATIENT-CENTERED MEDICAL HOMES

Policymakers have become increasingly aware that the care needed by many people living with chronic disease is not well coordinated. They also have taken note that the number of primary care providers is falling behind projected needs. This has led to leaders in the private and public sectors embracing the concept of a "patient-centered medical home."^{25,26,27,28} (See the glossary for a definition).

(See the Alliance - Commonwealth Fund briefing on this topic at www.allhealth.org/briefing_detail.asp?bi=137.)

Some issues related to reimbursement tied to medical homes:

- Will the term "medical home" be applied only to physicians, or can non-physician providers also qualify?
- Can specialty physicians qualify, or only family practitioners, internists, gynecologists and others traditionally under the "primary care" umbrella?

(See text box, "Aims and Measures for Model Medical Homes.")

PAYMENT REFORM

In recent years, public and private sector leaders have been experimenting with ways to spur quality improvement through incentives. Often lumped under the rubric "pay for performance" or "P4P," these efforts offer incentives ranging from financial bonuses to positive publicity for health care providers who excel.

Much of the momentum for P4P has come from the private sector. Bridges to Excellence (BTE), a nonprofit, employer-driven initiative, tries to improve quality through programs that recognize physicians who make changes that achieve better outcomes.²⁹ BTE focuses on areas with a deep history of measurement: diabetes care, cardiovascular care, and patient self-management systems. Participating physicians receive bonus payments and are highlighted in provider directories, helping employees and their families make informed choices.³⁰ Results are encouraging.³¹

In California, the Integrated Healthcare Association (IHA) works with health plans, medical groups and independent practice associations to reward quality in three domains: clinical, patient satisfaction, and adoption and use of information technology (e.g., electronic health records or EHRs) and computer physician order entry (CPOE) by practitioners.³²

A similar organization, the Leapfrog Group, rewards hospital performance via public recognition and bonus payments to hospitals that report data in several areas of patient care—heart bypass and coronary angioplasty surgery, treatment of heart attacks and pneumonia, and births and neonatal care.³³

Public programs like Medicare and Medicaid are also embracing the P4P approach.^{34,35,36} For example, on January 15, 2009, the Centers for Medicare and Medicaid Services announced that it would stop Medicare payment for medical procedures performed incorrectly, on the wrong patient or the wrong part of the body. In addition, effective with discharges since October 2008, Medicare will no longer pay hospitals a higher rate for an inpatient stay if the reason for the higher payment is one of a number of hospital-acquired conditions.³⁷

TIPS FOR REPORTERS

- Quality of care varies from community to community and often within a community. Find out how the quality in your community compares to national or regional benchmarks of care. How does the quality of care compare to the best (top 10 percent) of hospitals, health plans, and others?
- Get familiar with Hospital Compare (www.hospitalcompare.hhs.gov). This tool allows you to find out how well hospitals care for patients with certain medical conditions or surgical procedures, and view results from a survey of patients about the quality of care they received during a recent hospital stay.
- The source of measurement is as important as the results. Who developed the measurement tool? Were the results independently audited? If a patient survey was written and fielded by your local hospital or health plan, the results aren't likely to be worth very much. Look for information from independent groups like the Joint Commission, the National Committee for Quality Assurance, and such government sources as Medicare Hospital Compare.³⁸
- Check out the information about provider quality available to the public online. Are summary results provided or is there a "data dump" that serves more to confuse than inform patients and families?

STORY IDEAS

- How do employers in your area, especially large employers, use quality data to choose health plans and providers?
- Every year, the National Committee for Quality Assurance (NCQA) and U.S. News & World Report rank the nation's health plans from best to worst. How do the plans in your city/state/community rank? Why do they rank as they do and what are they doing to improve?
- The quality of care delivered by health plans participating in Medicare Advantage varies widely. How do the plans in your community perform on

the quality measures? Why is their performance so high/low? What are they doing to improve their performance?

- The outcome of the comparative effectiveness debate in Washington will be a very big deal for manufacturers of pharmaceuticals and medical devices, who stand to gain or lose many millions of dollars. If you have manufacturers in your area, what do they think of the comparative effectiveness movement? What outcome are they hoping for? What outcome are they expecting?
- Are physicians in your area trying to recast themselves as medical homes? If so, how? If not, why not? The rub: To be reimbursed as a medical home, a physician must be designated a primary care physician. Some specialists, such as surgeons, are trying to get this designation, to the chagrin of family practitioners.
- Are health care providers in your area involved in pay-for-performance demonstration efforts? If so, how are things working out? Do they think pay-for-performance efforts are fair? (An issue: Some providers, especially those serving low-income patients, think they should be rewarded for improvement in patient outcome, not solely for hitting certain benchmarks.)

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Websites

AARP

www.aarp.org

Academy Health

www.academyhealth.org

Agency for Healthcare Research and Quality
<http://www.ahrq.gov/research/mentalix.htm>

AHA Quality Center

www.ahaqualitycenter.org

Alliance for Health Reform

www.allhealth.org

American Academy of Family Physicians, Center for Health Information Technology

www.centerforhit.org

American Academy of Nurses

www.aannet.org

American Hospital Association

www.aha.org

American Medical Informatics Association

www.amia.org

American Nurses Association

www.nursingworld.org

Bridges to Excellence

www.bridgestoexcellence.org

California HealthCare Foundation

www.chcf.org

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- Robert Wood Johnson Foundation
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- University of Pennsylvania School of Nursing
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- Vanderbilt Center for Better Health
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