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Quality in the Making:

Perspectives on

Programs and Progress

Quality in the Making

***Overview**—This paper considers the evolution of quality evaluation efforts, tracing their development from early initiatives to keep track of patients after surgery through the various guidelines, surveys, and measurement tools in use today. It looks at both quality assurance and quality improvement strategies, highlighting the different philosophies that guide them. The paper examines the roles of purchasers, providers, consumers, and governments in furthering a quality agenda. Both regulatory and voluntary approaches are assessed.*

The scope and depth of information about the quality of health care have grown dramatically over the past ten years. Both the public and the private sectors have invested substantial resources in collecting, analyzing, and reporting data. Yet fundamental questions remain about the safety and appropriateness of the care delivered to American consumers and the extent to which the quality of that care is accurately measured and reported.

Many dedicated people are working to improve health care quality through research and education. Numerous quality assessment tools have been developed. Clinical guidelines, practice protocols, and performance measures are available from a variety of sources ranging from professional societies to Medicare's peer review organizations. But this collection of tools and methods does not add up to one handy and widely accepted toolkit. There is no agreed-upon model or rubric for thinking about raising the level of quality across the whole tangled health care system. Quality initiatives have focused mainly on improving the knowledge and practice of individual clinicians; systems issues have been raised but are only beginning to be addressed. Quality programs also have been generally grounded in an acute-care model, while chronic care needs, increasingly prevalent, may require a different approach. Moreover, to date, measurement has been used primarily to evaluate quality rather than to improve it.

Strategies to control and improve quality may rely on market forces, regulatory authority, or professionalism. With market-based managed care possibly past its heyday, market proponents promote the power of the consumer. However, agreement on the ultimate repository for quality-improvement authority—be it the medical professions, the federal government, an acknowledged body of experts, or an organization of empowered consumers—is again elusive.

Key questions remain about two main thrusts of quality-focused efforts in health care—quality assurance (“Are we doing OK?”) and quality improvement (“Are we getting better?”)—and about the role and needs of consumers. Private purchasers, government at the state and federal levels, and medical professionals all have had a hand in developing, demanding, and applying quality standards. To what extent have activities moved from measuring organizational behavior (“How often does the infection control committee meet?”) to measuring actual processes and outcomes (“In what percentage of orthopedic procedures were prophylactic antibiotics administered?”)? How is this shift affecting responsibilities for data collection, analysis, and application? To what degree are results once held mostly in private now being disseminated more publicly? Who is to pay for all these activities?

Many of the issues in improving quality relate to organizational dynamics. How can roles and relationships among clinicians and patients and payers and regulators be coordinated? Can outmoded systems be redesigned to build in quality, as recommended in the new Institute of Medicine publication, *Crossing the Quality Chasm*? How can reimbursement mechanisms be changed to reward quality? How can the various purposes to which quality information is put be reconciled?

Increasingly, consumers as well as purchasers are expected to exert greater pressure for high-quality care. What information about the performance of a health plan or provider do they need to make appropriate

BACKGROUND PAPER

National Health Policy Forum

2131 K Street, NW, Suite 500
Washington, DC 20037

202/872-1390

202/862-9837 (fax)

nHPF@gwu.edu (e-mail)

www.nHPF.org (Web site)

Judith Miller Jones, Director
Karen Matherlee, Co-Director
Judith D. Moore, Co-Director
Michele Black, Publications Director

NHPF is a nonpartisan education and information exchange for federal health policymakers.

choices? How much of this is available to them? Can high-quality care be both delivered and demonstrated to all concerned?

An understanding of the evolution of quality efforts as well as the current tools and programs being used to assure quality or to improve it may be useful as policy-makers struggle with these difficult issues.

QUALITY ASSURANCE

The roots of quality assurance efforts in hospitals go back to Florence Nightingale in England. After her Crimean War experiences, she dryly wrote in her 1859 book, *Notes on Hospitals*, “It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm.” Fifty years later in the United States, Ernest Codman, M.D., urged the establishment of a “hospital standardization program” designed to track patient treatment to determine whether patients were helped or harmed.¹ The American College of Surgeons worked on an early form of such a program in 1917; in due course, it evolved into today’s Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

The process for measuring performance under the hospital standardization program was one that still goes on in some “morbidity and mortality” conferences today: retrospective review and discussion among medical colleagues. The underlying principle is that an individual can learn from his own mistakes and those of others and benefit as well from the advice of peers.

The modern conceptual framework for evaluating patient care was conceived by Avedis Donabedian in the 1960s and refined thereafter. It posits three components of health care quality—structure, process, and outcomes—that are both hierarchical and interdependent. That is, structure measures, such as the types of equipment a hospital possesses or whether surgeons are board-certified, are indicators of capability rather than results but may be necessary prerequisites to more patient-specific indicators. Process measures, such as the percentage of heart attack patients for whom beta-blockers are prescribed, may be used to systematize treatment patterns across a population of patients. Outcomes, the pinnacle of patient-focused analysis, may be more difficult to pin down (How much has John’s quality of life improved or decreased?) or to tie to a specific intervention (If Jane begins a new pharmaceutical regimen, will it keep her out of the hospital?). Outcomes may be only partially

or distantly attributable to clinical interventions. Or they may be too long in coming; one would not, it has been suggested, want to measure the number of strokes that occur (long-term observation) rather than the administration of blood pressure controls known to reduce the likelihood of stroke.

Another factor that has favored process over outcomes measures is the relative ease, or even feasibility, of data collection. Information on process can frequently be obtained from data collected for another purpose, such as billing. Information on outcomes is far more likely to exist only in the form of a paper patient record.

Some have suggested that the Donabedian framework may need refinement under a systems-based approach to quality. For example, some structural characteristics are relatively set, such as the land available for expansion or the medical schools the surgeons attended. Other indicators considered structural, such as the sophistication of the information system or the organization of a physician’s office operations, are more amenable to redesign.

As measurement standards evolved, institution-level analysis moved beyond case review to look at data reflecting entire caseloads. By focusing on a population of patients, quality analysts could judge how well a hospital treated a particular disease or condition. Hospital statistics were audited, measured against predetermined criteria, and compared with national averages.

In an article about the development of quality assurance systems, Martin D. Merry, M.D., has pointed out some shortcomings. First, an audit, like an individual case review, is retrospective, a snapshot of performance for a specified period in the past. It also lacks motivational value past a certain point:

Since hospitals have tended to use “national averages” as thresholds, such monitoring and evaluation states conceptually that “no problem” exists as long as the institutional rate is no worse than the average for peer facilities . . . [T]raditional health care quality assessment has had the unintended, and largely unrecognized, effect of establishing performance *not worse than average* as an implicit goal.² (emphasis added)

Hospitals were the first focus of quality evaluation efforts, but today health plans also are held to scrutiny. JCAHO, the National Committee for Quality Assurance (NCQA), and URAC/the American Accreditation Healthcare Commission all accredit health plans and/or components thereof (for example, a plan’s credentialing process or nurse triage call center).

Whatever the setting, two predominant lines of inquiry are pursued: adherence to clinical criteria and patient perceptions of care.

Performance Standards

Comparing provider performance to specified standards may serve a variety of purposes, such as (a) helping a physician to improve his or her own performance, (b) showing a health plan which clinical areas are most in need of attention, (c) guiding a purchaser's contracting decisions. The aim is to improve actual clinical outcomes and—to the extent the results are made known—to raise public awareness of performance differences and the accountability that should be attached to them. Proponents of making a provider's or plan's performance public in a comparative "report card" format expect to influence consumers to choose those with the highest quality scores.

Since the same performance standards will not necessarily serve all audiences equally well, different categories have evolved, for example clinical guidelines aimed at physicians and health plan performance measures geared to purchasers and consumers.

Guidelines. Clinical practice guidelines are protocols that guide a clinician in making diagnosis and treatment decisions. Guidelines have been developed and are available from a variety of sources ranging from hospital systems to medical specialty societies to consulting firms, but there is no final arbitrator among competing sources. A clinician may consult a source he already respects, such as his specialty society, in a voluntary effort to enhance his own skills. Choosing a source gets to be a more daunting task as guidelines, decision support tools, and reported research proliferate. As one physician has observed, "doctors are on information overload. And yet we have some excellent clinical guidelines that nobody ever reads. If applied, they have the potential to improve both clinical outcomes and perhaps reduce health care costs."³

It is presumed that both consulting and applying guidelines on the spot will be facilitated as physicians adopt hand-held computer technology, although they will still be faced with competing guideline and software sources. More importantly, if guideline-stocked personal digital assistants are to be more than an updated pocket card, there is also the challenge (in terms of both policy and technology) of putting patient and institutional records at the clinician's fingertips.

The Agency for Healthcare Research and Quality (AHRQ) is working to identify and disseminate informa-

tion about quality and outcomes of care. Originally created to develop guidelines, the agency has evolved in a more advisory direction. In addition to supporting and conducting research to establish the science base for improvements in clinical care, AHRQ also maintains—in partnership with the American Medical Association and the American Association of Health Plans—the Web-based National Guideline Clearinghouse.

Guidelines may be evidence-based, derived from expert consensus, or a combination of both. AHRQ, for example, requires that all guidelines included in the National Guideline Clearinghouse be supported by creditable scientific research. A milestone of consensus was recently marked by the announcement that five Minnesota health plans (among them covering almost all the state's insured residents) have endorsed and will employ standard treatment and prevention procedures for 50 common ailments, such as back pain, high blood pressure, and diabetes.

Guidelines are controversial because some view them as a means of limiting a physician's options or as a reason to deny claims. "Cookbook medicine," many have muttered scornfully. Particularly contentious have been length-of-stay norms for particular medical procedures, produced by the consulting firm Milliman & Robertson, which have prompted states and Congress to adopt legislation forbidding insurance companies to require "drive-through" (outpatient) births and mastectomies. Under claims procedure rules promulgated by the U.S. Department of Labor, health plans will be required to give claimants detailed information about any guidelines relied upon in making an "adverse" benefit or claims determination (that is, denying payment).

Performance Measures. With both cost and quality in mind, accrediting bodies, health plans, hospital systems, and others have tried to standardize certain dimensions of clinical practice by prescribing specific behaviors that can be measured. What is measured is primarily *process*, but process that has been shown to be associated with positive outcomes. For example, annual mammography for women over 50 does not in itself cure or prevent breast cancer but, by promoting early identification and diagnosis, can lead to earlier intervention and thus an improved chance of successful treatment.

The acknowledged leader among these mostly process-oriented measurement sets is NCQA's HEDIS (Health Plan Employer Data and Information Set). HEDIS is a continually evolving set of performance measures, currently numbering 56, with a range of emphasis, from primary prevention (such as the percent-

age of children immunized for chicken pox) to screening (for example, cervical cancer screening tests) to specified physiological outcomes (such as the percentage of cardiovascular patients with LDL-C levels under 130 mg./dl. after 60 days).

HEDIS measures are applied at the health plan level. Participation is voluntary for commercial plans, though some employers make it a contract specification. Medicare+Choice plans and some Medicaid plans are required to collect and report HEDIS data on some subset of measures. It has been suggested that concentrating on a specified number of measures encourages plans to “perform to the test” to the detriment of quality considerations that are not being measured.

NCQA estimates that more than 90 percent of health plans in the United States use HEDIS data for quality assessment.⁴ Employing a common measurement set is the foundation for meaningful comparison among plans. Refining HEDIS over time, NCQA’s Committee on Performance Measurement can respond to current health care concerns, as is demonstrated by a look at the measures new in 2000: chlamydia screening in women, controlling high blood pressure, use of appropriate medications for people with asthma, and management of menopause. Again, performing to the test may force health plans to focus on the prescribed data set rather than what most greatly benefits their particular population.

Large employers rely extensively on HEDIS data in their own quality-promotion efforts. Consumers are less likely to be aware of HEDIS, even where health plans choose to make their scores public. The 1999 Survey of Employer Health Benefits published by the Kaiser Family Foundation and the Health Research and Educational Trust found that only 10 percent of workers in firms offering a health maintenance organization (HMO) or point-of-service plan cited HEDIS ratings as important in choosing a plan.⁵ It should be noted, however, that these figures do not give insight into consumer weightings under different circumstances, such as changing health status.

Though widely used, HEDIS cannot serve as a measurement tool across the entire spectrum of health care. It is a managed-care phenomenon, designed with closed-panel HMOs in mind. With a definable total population to serve as a denominator, percentages can be calculated, such as the proportion of children in a plan who received appropriate immunizations. In a fee-for-service environment, a denominator must be constructed—for example, the total number of two-year-olds for whom appointments were scheduled—and may be incomplete (for example, leaving out those who

never saw a doctor). Open-network plans such as preferred provider organizations can make use of claims data, but this will not permit them to determine, for example, whether a physician has advised a patient to quit smoking.

Perhaps the most significant limitation of performance measures such as HEDIS is their application at the health plan level. Employees rarely have free, or even broad, choice among plans. Quality information would be more personally valuable when the question is “Who is the best surgeon for repairing an aortic aneurysm?” or “Which hospital has the lowest infection rates?” While some comparison among medical group practices has been undertaken, making performance information at the individual provider level publicly available continues to raise strong resistance. Nevertheless, many believe that performance measures optimally would furnish the data for public accountability of clinicians and organizations and serve as the basis for developing improvement strategies.

Patient Perceptions of Care

In the competitive environment of modern health care, health plans and many providers have become accustomed to surveying their own customers for feedback on their health care experience. Like performance standards, such surveys may also serve a variety of purposes, including guidance on improving practice conditions and procedures, generating marketing copy aimed at insurance purchasers and potential members, and demonstrating compliance with accrediting body standards such as HEDIS or directives from the Health Care Financing Administration (HCFA) and the states.

A salient difference between performance measures and perception-of-care (also called “satisfaction”) surveys is that the former are meant to be as objective as possible, while the latter are by definition and intent subjective. Only an individual’s own feelings can respond to a question such as “Did the doctor explain the treatment plan well enough for you to feel comfortable?” Time in the waiting room beyond the scheduled hour of one’s appointment may overshadow the physician’s splendid credentials in a patient’s mind. And most patients—despite growing use of the Internet and barring egregious provider ineptitude—are not sophisticated enough to judge subtle gradations of clinical quality. So, in effect, process is being measured here as well. In some cases, particularly when a patient has a chronic or long-term condition, process may in fact be a more important determinant than outcome. That is, the way a physician helps a patient to live with and manage

a condition that is never going to improve physiologically is a more realistic and significant quality indicator than clinical improvement. Moreover, the patient's understanding of the illness may be one of the key determinants of his or her prognosis.

Satisfaction survey instruments may be administered to discrete populations, such as enrollees in a particular health plan or employees of a particular company. An instrument with wider application is the Consumer Assessment of Health Plans Survey (CAHPS), developed under cooperative agreement among AHRQ, Harvard, RAND, and the Research Triangle Institute. Adopted by numerous sponsors and purchasers, including HCFA, CAHPS was incorporated into HEDIS in 1999.

CAHPS includes questions relating to general perceptions and specific consumer experiences and asks about both the consumer's health plan and his or her individual providers. Its goal is "to provide an integrated set of tested and standardized survey questionnaires and accompanying report formats that can be used to collect and report meaningful and reliable information from health plan enrollees about their experiences" and ultimately to assist consumers in choosing a health plan.⁶

The impact of satisfaction surveys is difficult to assess. As noted above, consumers typically do not have the broad range of health plan choices that a plan-satisfaction comparison would seem to envision. However, research sponsored by AHRQ found that Washington state employees, with the uncommonly broad choice of 20 health plans, made use of the CAHPS performance report when it was provided to them. Employees who used CAHPS information were more likely than those who did not to switch plans and to report that they were confident they had selected the best plan for their situation.⁷

Critics have observed that the survey instrument's dual focus on experience with the health plan and the individual provider can be confusing for consumers. They also note that reporting is slow and question the value of a months-old "snapshot." Typically reported to the health plan or the plan sponsor, survey data are not always made available to consumers or providers. And, while survey results may be used in a variety of ways by health plans and providers, without consumer buy-in (and cooperation in responding), they are difficult to justify in terms of time and resources.

Even where consumer response is enthusiastic, paying for a broad-based survey is a challenge. A statewide survey conducted by the Minnesota Health Data Institute in 1995 generated comparative data on 46

health plans in a variety of formats (such as comparisons across all plans and among categories such as Medicare HMOs). The same survey instrument was used across Medicare, Medicaid, state employee, and privately insured populations. The results were distributed with copies of 60 daily newspapers across the state and made available on the Internet and in public libraries. The plan at the time was to repeat this process periodically, but to date no sponsor has stepped forward.

QUALITY IMPROVEMENT

As noted above, traditional quality assurance (QA) tends to focus on achieving a respectable level of performance. A new genre of thinking about health care quality came to prominence in the 1980s, drawing on the work of industrial quality gurus, preeminently W. Edwards Deming. Deming, a venerable thinker given much of the credit for the Japanese post-war industrial revival, developed a "system of profound knowledge" that came to be known as continuous quality improvement. His directives include "improve every process" and "break down barriers." Manufacturing firms were the first demonstration sites; health care, arguably, is still only partially on board.

As Merry describes it, "Continuous quality improvement (QI) is first a mind-set and then a process. The mind-set of traditional health care quality has been reactive: 'If it isn't broken, don't fix it.' That of QI is pro-active: 'It may not be broken, but we can still improve it.'" As Deming himself wrote, "Meeting specifications is not enough."⁸ While many people use the terms interchangeably, QA and QI actually have different orientations. QI looks forward, seeking ever-better ways to improve upon the organization's past performance, while QA measures performance in comparison to a predetermined threshold or floor.

QA and QI are not mutually exclusive; ideally, they are complementary. QA's focus is consumer protection and individual accountability, which encourage a competitive or regulatory—essentially external—approach. QI seeks internal system improvement and demands consultation and cooperation within an organization. QA can be used to cull bad apples and ensure acceptable quality of care. QI operates in a higher portion of the quality continuum, where organizations and individuals are willing to commit the necessary resources to move from acceptable to excellent.

For all the zeal of its proponents, QI has for some a New Age aura of trendiness about it. Skeptics wonder why, if QI is so wonderful, health care delivery has not been transformed. Certain organizations with a long-term

commitment to QI would say it that it has made a significant difference in their own operations. For example, Kaiser Permanente Colorado Region, with multiple care facilities comprising the area's oldest HMO, has established a Regional Quality Resource Management Committee (RQRMC) to review aspects of the performance of each clinical department and facility on an annual basis. Each is required to define its scope of care and to identify one or more important aspects of care within that scope to work on during a given year. Projects culminate in a detailed evaluation by the RQRMC, including assessment of results and recommendations for next steps. (It should be noted that selection of projects is influenced by data collection requirements and priorities related to NCQA accreditation and HEDIS).⁹

While QI programs vary in their scope and rigor, organizational managements that have made a commitment to such programs recognize in them a foundation for the kind of systems redesign and team-think that experts point to as the key to medical error reduction and other improvements in patient care. In this conception, the market and the group's own professionalism push clinicians to improve, and QI programs give them the tools to do so.

ROLES IN QUALITY ASSURANCE AND IMPROVEMENT

Private Purchasers

Frustrated by years of double-digit inflation in health benefits costs, employers fueled the transformation of health care financing that has come to be called managed care. Though cost containment was by far the chief aim, some employers were keen to pursue value, a concept incorporating both cost and quality. Before the entire project was turned over to NCQA in 1992, HEDIS was the creation of a group of large employers (including Xerox, GTE, and Digital Equipment Corporation), who saw it as a means to standardize the information they scrutinized in the contracting process. U.S. automakers have been leaders in holding their contracting health plans to performance standards. The Buyers' Health Care Action Group in Minnesota experimented boldly with direct contracting with providers.

Most recently, the Leapfrog Group, sponsored by the Business Roundtable and comprising large employers as well as business coalitions and liaison relationships with the U.S. Office of Personnel Management and HCFA, has undertaken an initiative to improve patient

safety. This is a voluntary program aimed at mobilizing large purchasers "to alert the health care industry that big leaps in patient safety and customer value will be recognized and rewarded with preferential use and other intensified market reinforcements."¹⁰ A failure to reward high-quality providers has been a shortcoming many have pointed to in today's health system, and the Leapfrog move to align incentives with goals is a start at redressing that failure. Whether rewarding by means of "preferential use" (greater volume of patient referrals) can be meaningful in an era of broad and overlapping provider networks remains to be seen. However, Leapfrog also emphasizes non-economic rewards such as recognition, prestige, and press.

In a healthy economy with a hungry labor market, employers would be likely to maintain or even improve their benefit packages. But in conditions of economic uncertainty, their behavior is less predictable—especially since the cost relief initially achieved by turning to managed care seems to have run its course.¹¹ Small employers have always struggled with the economics of benefits coverage. Increasingly, large employers talk about moving to a defined-contribution approach to health benefits. So far it is mostly talk, but the retirement-plan landscape, in which 401(k) plans have long since supplanted defined-benefit plans, could be read as a harbinger. On the other hand, some analysts suggest that, since a fundamental change in health insurance would have far more immediate impact than a change in retirement plans, employees would resist it.

Under a defined-contribution model, employers might provide comparative information to assist their employees in choosing among plans, but their economic spur to steer employees toward low-cost, high-quality plans would be blunted. That is, once an employer contribution level has been defined and paid, the employer has no further financial responsibility, whatever plan the employee chooses. The lessening of financial risk also calls into question employers' stake in continuing to hold health plans accountable for quality markers such as NCQA accreditation.

Market enthusiasts have suggested that, if consumers are spending their own money, they will be more cautious and canny with respect to health-related expenditures. This was the theory behind medical savings accounts, which—in the limited demonstration authorized by the Health Insurance Portability and Accountability Act of 1996—have not proved a hit with large numbers of consumers. There is no evident groundswell of consumers demanding to manage the details of their health financing. However, if forced to shoulder more of

the burden, consumers are likely to demand tools that will help them make advantageous decisions.

Consumers already are interested in information relating to their medical conditions. As they are made to assume more responsibility for managing both their care and their coverage, they will need some source to turn to for reliable, understandable information about both health plans and providers.

The Medical Profession

Common sense would suggest that physicians and other providers would accept QA as a matter of course and be first in line for QI. Several factors interfere with this picture. First, there is the undeniable effect of reimbursement incentives. Fee-for-service says, “Do more and you will get paid more”; capitated managed care says, “Do less and you will keep more.” Neither says, “Do what is optimal for the patient and you will be rewarded.”

A second obstacle is the tension between quality improvement in a pure state, for the good of science and mankind, and quality measurement interpreted as accountability or “being told how to practice medicine.” Physicians are conspicuously unenthusiastic about answering to anyone but their peers, as witness the battles with managed care organizations over who is permitted to define what is medically necessary. And regulation of physician practice is largely delegated to the profession itself. That is, states have licensure requirements, but obtaining one’s license is a one-time event (like passing a bar exam) and any subsequent disciplinary action is at the discretion of the state Board of Medicine.

At the individual physician level, impediments to quality improvement processes may be purely logistical. Most physicians do not have a sufficient number of patients presenting with a particular condition to establish a typical practice pattern. Often, they lack an accessible patient registry even to determine their overall patient profile—for example, how many diabetics are there in this group and how many would be classified as severe?

Some health plans track the performance of physicians or groups they contract with, allowing providers to see how they compare to others in the plan. (Setting mandatory levels generally is possible only where a managed care plan has some means, such as contract renewal, to enforce QA or QI requirements.) Some medical groups provide the same feedback to their member physicians.

Longer-term studies, requiring tracking of patients over time, are apt to be disrupted by attrition. As a physician states,

I’ve noticed that most of the patients that I was seeing five or 10 years ago, I had been taking care of for 10 or 20 years. Now there’s a tremendous turnover of patients related to people changing managed care plans and, as a result, relationships are more superficial.¹²

Superficial doctor-patient relationships have combined with media horror stories to erode public trust in the medical profession. Widespread coverage of managed care’s incentives to undertreat and of medical error rates have made patients suspicious and doctors defensive. And indeed doctors feel beleaguered from all directions: patients they do not know and do not have time to get to know; managed care plans with varying rules, regulations, and predilections for second-guessing; reporting requirements on the part of health plans and states; seemingly endless paperwork; and so on. The resulting siege mentality is not conducive to teamwork or willingness to take on new projects.

The lion’s share of blame for all this has been laid at the door of managed care. But physician efforts to wrest destiny back into their own hands have not been notably successful so far. A physician accreditation program sponsored by the American Medical Association, billed as a means of enabling the profession “to respond to the demand for accountability for quality in health care,” was eventually abandoned as overexpensive and undersubscribed.¹³ The provider-sponsored organization (PSO) was seen as a strong new model at the time the Balanced Budget Act of 1997 (BBA) was enacted, but PSOs have not materialized as significant Medicare+Choice (M+C) contractors.¹⁴ Physician groups in parts of California, having initially embraced capitation and risk assumption, are finding managed care contracts more onerous than anticipated. Even paperwork is not strictly a burden imposed by HMOs, insurance companies, and HCFA; it is physicians, after all, who developed and still guard ownership of the very complex coding systems used in making claims for services provided.

State Government

State agencies play a variety of roles in measuring, monitoring, and assuring health care quality. Most state Medicaid agencies collect data on utilization, consumer satisfaction, and disenrollment. Some states, such as Arizona, Minnesota, and Massachusetts, have incorporated quality indicators and performance measures into

their contracts with health plans. (From the health plan perspective, this may mean more tailoring of data to uncoordinated specifications; there is little consistency across states.)

In addition, some state legislatures have created health data organizations that collect and report certain process and outcome measures of health care organizations across payers. Among these are the Pennsylvania Health Care Cost Containment Council, which publishes comparative quality and cost reports on providers (primarily hospitals); the Minnesota and Kansas Health Data Institutes; and Maryland's Health Care Access and Cost Commission, which generates comparative plan performance reports. Several states, including New York and Virginia, make comparative hospital information available on state Web sites.

As James Fossett and colleagues observed in an article earlier this year, states may face hurdles in promulgating and enforcing performance standards.

First, standards or benchmarks developed in the commercial market may not transfer well to the Medicaid population. Establishing these benchmarks for local use may require considerable negotiation. Second, quality reporting conventions and standards are only partially standardized, so states wishing to institute performance standards may need to invest considerable effort and money in systems development, negotiating over reporting conventions, and auditing to ensure that reported data are comparable and of reasonable quality.¹⁵

Federal Government

As both purchaser and regulator of a substantial portion of the country's health care, the federal government has many avenues to influence the quality of that care. The Departments of Defense and Veterans Affairs determine the policies followed in their own facilities. Other agencies exert influence via research dollars or regulations. HCFA, the self-described "800-pound gorilla," is engaged in a variety of quality-related initiatives. An interesting development in the past few years has been the convening and activity of the Quality Interagency Coordination Task Force (QuIC), the mission of which is to ensure that all federal agencies involved in purchasing, providing, studying, or regulating health care are working in harmony toward a common goal of improving quality of care.

Medicare Conditions of Participation. In 1965, the original Medicare legislation required hospitals to meet certain requirements set forth in regulation as the Medicare conditions of participation. These are struc-

tural criteria according to the Donabedian model, such as staff qualifications, written policies and procedures, governance, and record-keeping. These are now codified in hundreds of pages of federal regulation and govern to a great extent the structural quality of U.S. hospitals and health care facilities. The 1965 legislation (in Section 1865 of the Social Security Act) also provided that hospitals accredited by JCAHO would be "deemed" to meet the conditions of participation; this still prevails. It is perhaps worth noting that physicians are not subject to any conditions of participation beyond willingness to accept Medicare payment rates.

Peer Review Organizations/Quality Improvement Organizations. Medicare costs grew rapidly after the program's enactment in 1965, raising questions about what was being purchased and its value. In 1970, a demonstration project assembled experimental Medicare care review organizations, voluntary associations of physicians who reviewed services funded by Medicare and Medicaid. These became the model for the professional standards review organizations (PSROs) established by statute in 1972. PSROs were charged with determining for reimbursement purposes whether services were medically necessary, provided in accordance with federal standards, and rendered in the appropriate setting. Their activities included hospital utilization review, development of hospital discharge data, the conduct of medical care evaluation and quality review studies, and the construction and analysis of hospital and physician practice profiles.

When Medicare adopted prospective payment for hospitals in 1983, the PSROs were replaced with peer review organizations (PROs), which Congress envisioned as a leaner and more efficient review mechanism. Review areas were cut from 195 to 54, 1 for each state and territory. Contracts were awarded on the basis of competitive bidding rather than as grants, and their funding cycle was lengthened to two (later three) years. Administrative costs were to be paid from the Medicare trust fund rather than through the appropriations process. Where PSROs had to be physician-sponsored organizations, PROs had the option to be physician-access organizations, that is, organizations with a sufficient number of physicians available to them to ensure adequate review capability.¹⁶

PROs inherited from PSROs a set of sometimes conflicting expectations. As an Institute of Medicine analysis observed in 1990, Congress wanted a cost-control program, PSROs thought they were in the business of quality assurance, and HCFA was forced to proceed as though PSROs could fulfill both functions.

PROs have struggled with wearing both hats simultaneously but at least have managed to hang on to them both. While cost control will never go out of fashion, the PROs (who would prefer to be known as quality improvement organizations) have successfully sustained their QA/QI emphasis.

In 1992, HCFA and its contracting PROs launched the Health Care Quality Improvement Program (HCQIP), aimed at improving the health of Medicare beneficiaries through bringing patterns of care into line with evidence-based best practices. The initial focus was acute myocardial infarction; in succeeding years the effort has added five other clinical targets: breast cancer, diabetes, heart failure, pneumonia, and stroke. In addition, HCFA and the PROs have committed themselves to reducing health (and treatment) disparities related to race, ethnicity, and gender within the Medicare population. For the first time, HCFA has instituted performance-based contracts with the PROs, and will evaluate them based on improvements of quality indicators.¹⁷ To accomplish their mission, PROs actively seek collaboration with physicians, health care facilities and local communities in their service areas.

Quality Measurement in Managed Care. While PROs interact with Medicare providers across the service delivery spectrum, most of HCFA's quality monitoring efforts have focused on managed care contractors. BBA, which established a new Medicare Part C to replace earlier risk contracting arrangements, incorporated a number of quality requirements for M+C contractors to fulfill. Critics have argued that managed care plans face disproportionate scrutiny in comparison with fee-for-service providers. But it was commercial managed care plans, having embraced the notion of accreditation, that offered a quality-measurement model that HCFA could adapt.

A centerpiece of BBA's quality provisions for managed care plans was the Quality Improvement System for Managed Care (QISMC). Participation is mandatory for M+C plans and optional for states with an interest in using this mechanism to assess Medicaid quality. In summary, QISMC standards direct a managed care organization to do the following:

- Operate an internal program of quality assessment and performance improvement that achieves demonstrable improvement in enrollee health, functional status, and satisfaction across a broad spectrum of care and services;
- Collect and report data reflecting its performance on standardized measures of health care quality and meet such performance levels on these mea-

asures as may be established under its contract with HCFA or the state; and

- Demonstrate compliance with basic requirements for administrative structures and operations that promote quality of care and beneficiary protection.¹⁸

Work on QISMC standards actually began in 1996, in advance of BBA. Standards were designed to build on HCFA's earlier Quality Assurance Reform Initiative for Medicaid and on NCQA's HEDIS. The initial draft of QISMC standards was produced under a contract with the National Academy for State Health Policy. The academy reviewed standards used in both public and private settings and circulated a QISMC standard draft in January 1998. A set of standards and guidelines was published in interim final form in September of that year and was subsequently revised to reflect the M+C final rule. New guidance for Medicare plans was released in August 2000; an update for Medicaid plans is forthcoming.

Reaction to the initial QISMC standards from M+C plans and facilities was rancorous, along the lines of "With everything else BBA is asking for, this is too much." Copious comments were taken into account in the recent revision, in which HCFA attempted to provide clarifications and some easing of the administrative burden on managed care plans. For example, the statistical methodology for demonstrating beneficiaries' health status improvement is now less arduous.¹⁹

The private sector had no well-established models for measuring quality in a fee-for-service setting, and in-house development of a fee-for-service performance improvement program has been a long process. In October 2000, HCFA researchers published a description of 24 initial quality measures and corresponding baseline values measured by means of chart abstraction, claims data, and surveys between 1997 and 1999. Stephen F. Jencks and colleagues in HCFA's Office of Clinical Standards and Quality explain that their measures track most of the HEDIS clinical measures but address more conditions and elements of care; they also apply to the 85 percent of the Medicare population in fee-for-service rather than to that portion in M+C plans. Process measures were deliberately chosen, on the grounds that (in comparison to outcomes) there is greater consensus on appropriateness and it is easier for providers to identify reasons that processes were not carried out than to determine why outcomes are not optimal. In addition, measuring processes of care generally does not require the risk-adjustment that has been so controversial in comparisons of outcomes.²⁰

The percentage of patients reported as having received appropriate care ranged from a high of 95 percent to a low of 11 percent. As noted above, PRO contracts include requirements to improve statewide performance on the measures over the three years of their contract cycle.

Deeming Authority for Managed Care Quality. BBA gave HCFA the authority to create a program allowing private, nationally recognized accrediting bodies to deem that an M+C organization is in compliance with certain Medicare requirements. An accrediting body may apply for approval to deem M+C plans in compliance in six performance areas: quality assurance, access to services, provider participation rules, information on advance directives, antidiscrimination, and confidentiality and accuracy of enrollee records. The accrediting body is not required to apply for all six areas, nor will HCFA necessarily approve applications in all areas.

As mentioned above, it is long-established practice to deem that hospitals achieving JCAHO accreditation automatically meet Medicare standards. Deeming distills the larger policy question of contracting out government regulatory services to organizations that then operate with quasi-governmental authority. It also raises a concern about a conflict of interest when an organization originally founded for the benefit of a group (such as hospitals) later becomes its regulator.

Managed care organizations, many of which seek private accreditation in any case, believe that deeming will reduce duplicative compliance efforts and expense. On the other side, making use of an accrediting body's surveyors and analysts clearly enhances HCFA's monitoring capacity. However, if a problem comes to light in an accredited M+C organization, HCFA rather than the accrediting body retains the ultimate responsibility.

Expanded deeming authority may facilitate the standardization of quality measures. It also signals a federal willingness to align with private-sector employers, although not perhaps as closely as some might wish. While indicating NCQA's intent to pursue deeming authority, the organization's president, Margaret O'Kane, has expressed disappointment that there are many specific HCFA requirements that NCQA standards at present meet only partially or not at all.²¹ The reverse is also the case, in that NCQA has standards beyond those that HCFA contemplates.

AHRQ. Pursuing quality on another front within the Department of Health and Human Services is AHRQ. Where HCFA is purchaser and regulator, AHRQ is researcher, coordinator, and translator. That is, the

agency funds research on quality measurement and outcomes and then seeks to make research findings accessible to a variety of health care stakeholders, including clinical decision-makers, health care systems leaders, and policymakers. AHRQ-funded research vehicles include the following:

- Evidence-based practice centers—12 consortia of clinical and methodological experts that develop evidence reports and technological assessments on clinical topics that are common, expensive, and/or significant to the Medicare and Medicaid populations.
- Patient outcomes research teams—large multi-site projects that focus on specific conditions, such as stroke and pneumonia.
- Centers for education and research in therapeutics, which focus on appropriate and effective use of drugs and drug combinations with other forms of intervention.

In addition, AHRQ maintains numerous databases, including the National Guideline Clearinghouse mentioned earlier, the Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST), the Healthcare Cost and Utilization Project (known as HCUP), and the Medical Expenditure Panel Survey (MEPS). HCUP quality indicators furnish software developed for use with hospital administrative data, which are used by many states to assess hospital care quality.

Public-Private Partnerships

In many ways, AHRQ deliberately tries to serve as the fulcrum of a public-private partnership, bringing together academics, businesses, health care providers, government agencies, and consumers. Such broad-based collaborations can be unwieldy but have the intrinsic advantage of getting stakeholders at the same table.

Another public-private effort is the National Forum for Health Care Quality Measurement and Reporting, more familiarly the Quality Forum. This group arose from a recommendation made by the President's Advisory Commission on Consumer Protection and Quality in its 1998 report. It was incorporated in the District of Columbia in May 1999 with initial funding from the federal government and foundations.

The Quality Forum's mission statement defines it as a "private, nonprofit entity that will develop a comprehensive quality measurement and public reporting strategy that addresses priorities for quality

measurement consistent with national aims for quality improvement in health care.” To this end, the organization has formed both a board of directors and what is called the Strategic Framework Board, a group of recognized health policy experts who have agreed to devote 20 percent of their time to developing a national quality measurement and reporting strategy. The board has composed a purpose statement to guide its activities and intends to formulate national quality goals focused on clinical conditions that are prevalent or carry a high risk of disability, suffering, or death.

As of December, the Quality Forum had 107 members (ranging from medical specialty societies to large employers to trade associations). President Kenneth W. Kizer, M.D., reported last fall that dues income at one year exceeded projections by more than 50 percent.²² Nevertheless, some observers have been disappointed in the Quality Forum’s low profile and fear that policy experts talking amongst themselves is another variation on preaching to the choir.

The Institute of Medicine’s Committee on the Quality of Health in America is a group representing health care providers, consumers, and researchers as well as insurers, employers, and the press. Its hugely influential 1998 report, *To Err Is Human*, now has a sequel, *Crossing the Quality Chasm*. This report says flatly, “The current care systems cannot do the job. Trying harder will not work” —but also presents a series of recommendations to transform current systems so that all Americans can count on receiving care that meets their needs and is based on the best available scientific knowledge.²³

Consumers

Americans treasure choice, in everything from soft drinks to television channels to pediatricians. Much of the ire directed at managed care organizations in recent years stemmed from restrictions on the ability to choose one’s own doctor. If a person has a choice of health plans and of providers, the reasoning goes, he or she will be able to select benefits and relationships that meet his or her needs. Similarly, if given information on quality, people will factor it into their decisions, as they do when consulting *Consumer Reports* to research the purchase of a refrigerator.

One of the fundamental tenets of managed care in its early days was that people would choose among competing plans on the basis of their networks of providers and their service as well as their price. In practice, it has remained employers’ responsibility to make an initial selection of plans; employees may or may not be offered multiple options. Ninety-two percent of workers

in firms with more than 5,000 employees have a choice among plans, though this may mean a choice among different products offered by the same plan. Only 24 percent of those in firms with fewer than 200 employees report more than one option.²⁴ Without free choice, comparative information at the plan level has little effect on selection behavior.

Americans do, by and large, choose their own doctors and—depending on physician affiliation—hospitals. Even if they are choosing from a list of network providers, there is some scope for personal preference. But comparative information about physicians, which is compiled by some more sophisticated medical groups, is used mostly to assess physician performance and is not typically shared with patients. Some health plans, such as PacifiCare, have published comparative information at the medical group level, but this is largely a California phenomenon.

Hospital comparisons are not available in most markets and remain controversial where they do exist. Public agencies that have published hospital performance reports (for example, the Health Care Financing Administration and Pennsylvania’s Health Care Cost Containment Council) have faced vociferous criticism from providers, who assert that performance measures do not adequately reflect severity-of-illness differences. Cleveland Health Quality Choice, a private, employer-led effort, was forced to close its doors when the city’s most prominent hospital system refused any further cooperation in comparative data-gathering. Absent a universally acceptable risk-adjustment mechanism, one that fairly accounts for differing caseload risk, such resistance is likely to continue.

Some have suggested that the best way to hold providers accountable to consumers is to educate and empower consumers to take a more effective part in their own treatment. Ideally, such a learning process would occur before a person became ill, but in many cases interest is likely to be sparked only after there is something to worry about. Consumer-education initiatives exist, though their impact to date is debatable. HCFA, for example, has established a Center for Beneficiary Services, whose primary focus is educational. A private group, the Foundation for Accountability (FACCT) is committed to measuring health care quality and communicating results in a way that makes sense to consumers.²⁵ Numerous Web sites, in addition to FACCT’s, have been established, both as commercial ventures and by patient associations. The latter tend to be disease-specific, aimed at fellow sufferers.

In a September 2000 speech to members of the Leapfrog Group, FACCT president David Lansky made an eloquent case for turning to consumers as the necessary drivers of quality improvement. FACCT-sponsored focus groups have revealed that consumers believe they know the difference between high- and low-quality care, that they think of themselves as *customers* and are willing to take action to get the care they require, but also that they recognize they need tools and support (from other consumers, advocates, and employers) in order to be effective.

Lansky suggests that consumers can be mobilized, given that health care is personal and emotional and that, increasingly, consumers do not feel they can trust anyone else to look out for their best interests. Among messages FACCT has tested, those measured most effective have appealed to fear (of medical errors, for instance) and distrust and have emphasized personal responsibility and the need for collective action.

If this empowered-consumer scenario plays out, what will the individual need in order to be his own champion? Paul Elwood, M.D., a primary HMO progenitor who has come to embrace a consumer-centered vision of health care reform, suggests starting with three services packaged as a Web-based module:

- to Coaching: providing elementary information necessary to manage one's illness or health needs, tailored to particular conditions.
- Comparing: personalized feedback to assess one's quality of care.
- Choosing: assistance in selecting a health plan, doctor, or system of care.²⁶

A central tenet of the empowered-consumer strategy is that consumers must move into partnership relationships with their physicians, accepting (or insisting on) an equal role in decisions about their own care.

INTO THE NEXT ERA

Efforts to improve health care quality seem to have taken all the available routes in the last decade or two. There have been provider-based practice guidelines and bonus pools tied to quality measurement. Regulatory and private accrediting bodies have established standards and publicized performance in relation to them. The market has had its shot with managed care contracting. Dot-com entrepreneurs have seized on the need for health care information. And still, in September 2000, *USA Today* can sport the front-page headline, "The operation you get often depends on where you

live," atop an article based on the *Dartmouth Atlas of Health* series and quoting John Wennberg, M.D., who has drawn attention to regional variation for 30 years.²⁷

Can policymakers look to consumers to galvanize what has been a long, slow, technical process? Clearly, further education is needed if consumers are to be able to distinguish gradations in clinical quality or to separate quality from convenience. A recent Kaiser Family Foundation/AHRQ survey found consumers concerned about medical errors and desirous of more provider-based information. But even the best-educated, most judiciously scientific consumer may veer into the realm of emotion when his own life or that of a loved one appears to be at stake.

A number of legislators, wishing to move quality efforts forward at a faster pace, have introduced bills to encourage or demand improvement. In the wake of the Institute of Medicine's much-publicized report on medical errors, for example, Sen. James Jeffords (R-Vt.) introduced a proposal to amend the Public Health Service Act to reduce medical mistakes and medication-related errors. Rep. Pete Stark (D-Calif.) adduced the same report in his statement introducing (with others) a bill to establish quality of care and safety as a major emphasis in Medicare. Other proposals are under consideration in the 107th Congress. However, their authors would probably agree that no one really knows how to write a bill to compel culture change of the kind that is needed to achieve the transition into the next generation of health care in America.

There are some issues that no one stakeholder can resolve. For example, philosophically, does responsibility for quality ultimately come from within—through the professional and ethical commitment of providers—or from without—through the urgings or proscriptions of purchasers or the enforcement power of government? Practically, how do we recognize and value the process of collecting, analyzing, and disseminating data?

The prospect can be discouraging. But there has been visible progress: measuring results rather than capabilities, sharing information more widely. Quality-promoting strategies such as systems thinking and action steps such as computerized prescription entry are becoming more prevalent. And improving health care quality is an aim that unites all camps. What remains to be seen is what organization(s) or leader(s) can achieve critical mass—and the commitment of resources—to launch a quality improvement snowball.

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