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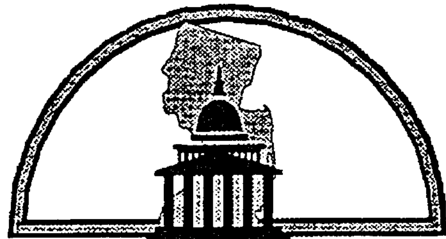

Quality Assurance – Guidelines and Measurement

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Background Information for the Discussion at the

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The Evolving Art Of Quality Assurance In Health Care Delivery: An Overview

An issue brief prepared by Joanne T. Fucello, MSW
for discussion at the June 14, 1995 Capitol Forum

The Issue:

Given the dynamically changing environment of New Jersey's health care delivery system — especially the growth of managed care market penetration and the deregulation of an industry relying on market forces to keep health care costs in check — which entity or entities is responsible for formulating and establishing quality assurance measures, monitoring providers and the services they provide for compliance and appropriateness, and evaluating outcomes?

Introduction

In the dynamic environment of today's evolving health care system, we are confronted by the challenge of balancing the three traditional pillars of health care policy: quality, access and cost. As various attempts are made to curtail the escalation of health care costs, whether it be through the proliferation of managed care entities or the increased vigilance of utilization review in traditional, fee-for-service medicine, the other supporting pillars of quality and access are certain to be affected. Basically, any attempts to improve a system's performance in one dimension, such as cost, will in all likelihood affect its performance in the remaining dimensions, i.e., accessibility and quality.

How is quality in health care to be assured and measured? Currently, managed care entities, under which the financing and delivery of health care services are integrated, have set the stage for efforts in refining quality assurance measurement and evaluation. While in the past, purchasers and accreditation entities, such as the Joint Commission on Accreditation of Healthcare Organizations in the private sector and the Health Care Financing Administration in the Federal public sector, utilized structural measures of quality, such as facilities evaluation and training. Owing to developments in the managed care environment, quality assurance measures have emerged which integrate the evaluation of structure, process and outcomes in health care delivery. This focus on outcomes measures is no longer limited to managed care entities and is occurring throughout the health care delivery system. The formulation of these quality assurance measures and their evaluation is currently an evolving art in the industry and exists as a significant public policy issue, as it affects the entire health care delivery system: providers, policy makers, regulators, payers/insurers, and consumers.

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This issue brief presents an overview of the issues related to the system of quality assurance in health care, its guidelines and measurement. Specific topics include a discussion of the definition and evolving models of quality assurance, current compliance standards established by licensing and accreditation authorities, and an overview of some current quality assurance initiatives throughout the country.

Quality Assurance: Background

What is quality assurance? Its definition is inextricably tied to its application and measurement. Consequently, identifying measures that are reasonably accepted as indicators of service quality is fraught with methodological complexity. Not only have questions of reliability and validity been associated with quality assurance and its measurement, but how and what those measures mean may vary greatly. It seems not unlike the fable of several blind men touching an elephant: each individual man identifies the nature of the entire animal only by the specific part he touches, i.e, how the animal is defined depends upon the individual's perspective. In the same way, the way in which a consumer defines "quality" in the health care may vary broadly from how a purchaser of health care may define it. For these reasons, the issues of ensuring the public good regarding quality and identifying with whom that responsibility primarily lies are significant ones. Of equal significance is that all indicators point to the reality that the lead role in this process is being left up to the individual states, working with professional accreditation entities and healthcare management firms.

Quality traditionally refers to "the extent to which a service increases the probability of desired outcomes and reduces the probability of undesired outcomes, given the constraints of existing knowledge" (U.S. General Accounting Office (GAO) Report, 1994; Office of Technology Assessment definition). The Institute of Medicine extends its definition of quality to populations, by defining quality of care as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Employee Benefit Research Institute (EBRI) Brief, March 1995).

History

The terms "quality assurance" and "quality measurement" are used in a variety of ways. Quality assurance (QA) has been used to describe prospective processes or compliance requirements — such as licensure, inspections and training — implemented to ensure an acceptable quality level in the health care system. The licensing or accrediting authority establishes specific standards, e.g., staff-to-patient ratios or physical plant requirements, which must be met in order to earn licensure. Historically, the system was based on the assumption that licensure of physicians and other health care professional providers, the accreditation of hospitals, nursing facilities and other health care provider entities

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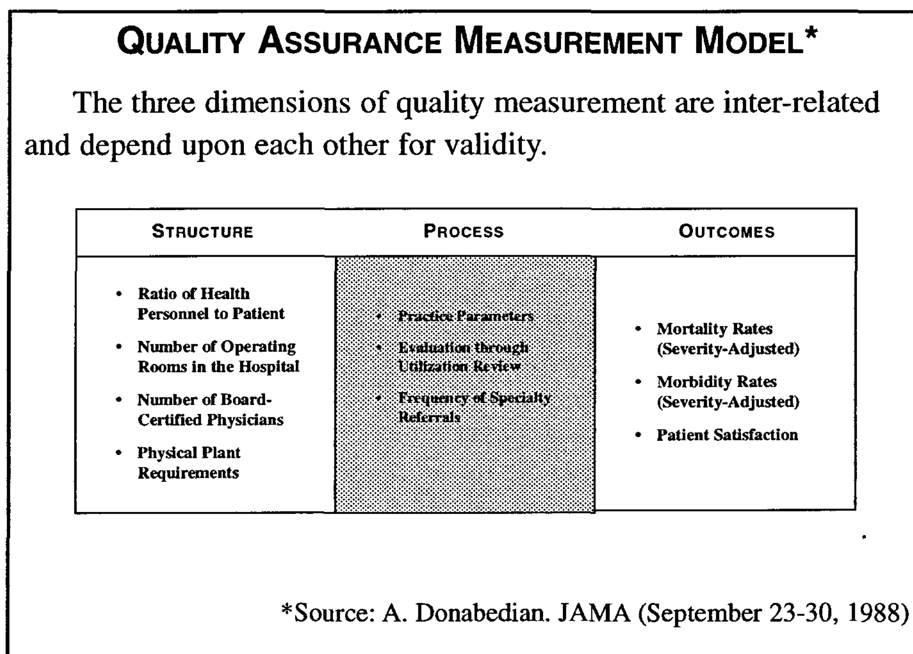
through both public and private organizations, and the implementation of internal quality assurance programs, would ensure and maintain a high quality of care. The belief that compliance with contemporary standards is a basic measure of health care pervaded the health care industry. The Joint Commission on Accreditation of Health Organizations (JCAHO), in a recent article in the Journal of the American Medical Association summarized the concept in this way: "The thinking behind this system [in which evaluation of compliance with contemporary standards represented the core of quality assessment in health care organizations] was that organizations that 'do things right' are likely to achieve good outcomes" (Journal of the American Medical Association, (JAMA) v.273-18, May 10, 1995).



QUALITY ASSURANCE MEASUREMENT MODEL*

The three dimensions of quality measurement are inter-related and depend upon each other for validity.

STRUCTURE	PROCESS	OUTCOMES
• Ratio of Health Personnel to Patient • Number of Operating Rooms in the Hospital • Number of Board-Certified Physicians • Physical Plant Requirements	• Practice Parameters • Evaluation through Utilization Review • Frequency of Specialty Referrals	• Mortality Rates (Severity-Adjusted) • Morbidity Rates (Severity-Adjusted) • Patient Satisfaction

*Source: A. Donabedian. JAMA (September 23-30, 1988)

The state of quality assurance measurement has evolved from accepting this basic assumption that "doing things right" will yield good outcomes to actively measuring and quantifying outcomes. How do we measure these " good outcomes?" It is widely agreed upon by experts in the field of clinical practice, evaluation methodology and health care information and public policy that quality assurance compliance requirements, in and of themselves, are insufficient to assure quality services. JCAHO's article calls for the integration of evaluation of standards compliance with the utilization of performance measurement to include the evaluation of actual results achieved, i.e., outcomes. The Commission, in acknowledging the need to collaborate with health care organizations on performance measurement and outcomes, has set up a Council on Performance Measurement to establish sound measurement systems.

Quality measurement refers to retrospective quantitative or qualitative assessment of specific criteria of care or service. In the field of acute health

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care, the service characteristics that are the focus of quality measurement mechanisms are usually divided into structure, process and outcome criteria (U.S. GAO Report, 1994) (See Chart 1) . As integration of these three elements — structure, process and outcomes, is refined in quality assurance measurement, it is important to remember that each of these dimensions is inter-related and each has an impact on the other (Donabedian, 1988). Structure refers to the actual attributes of care, such as the number of operating rooms in a hospital or the provider's professional qualifications.

The quality dimension of process is related to the provider's decisions regarding care and decisions made during treatment. Utilization review (UR), conducted by a panel of providers with expertise in specific areas of medicine, is conducted to determine if the care given is necessary and appropriate. UR is at the core of process measurement tools. Although there is disparity among UR programs, their structure is similar (EBRI Brief, March 1995). Practice parameters or guidelines, such as those developed by the firm Milliman & Robertson, Inc., its Healthcare Management Guidelines, apply process measures prospectively by providing physicians and other providers with information on health care processes that will yield quality care (EBRI Brief, 1995). There are various medical information management firms throughout the country, which may be certified by the national Utilization Review Accreditation Commission, that advise and consult with providers on practice guidelines in an effort to assure quality.

Finally, the evaluation of outcome involves the monitoring and evaluating of the actual results of care, ranging from the effects of care on health status to something as subjective as patient satisfaction with care. The most commonly used outcome measures have been morbidity, mortality and patient satisfaction. Length of stay in hospitals or re-admissions are morbidity measures. These simple outcome measures must be adjusted to account for other factors which may affect health outcomes, such as severity of illness and case mix. The utilization of diagnosis related groups (DRGs), a system with which New Jersey has significant experience, is one way to determine case mix variable, as DRGs categorize hospital inpatient admissions by diagnosis.

Quality Assurance Oversight - The Current Practice

The position of the JCAHO is reflective of the current environment in quality assurance and quality measurement for all players involved: purchasers of health care (public and private), policy makers and regulators, providers and consumers. The evolving art of quality assurance is represented by the current efforts of industry researchers and policy makers to develop the most appropriate tools to measure structure, process and outcomes in health and medical care.

Nationally and in New Jersey, quality assurance oversight is effected by

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various levels of public and private entities. Federal, state and local authorities, through statute and regulation, require compliance with quality assurance standards for licensure and accreditation of health care providers, whether they be hospitals, nursing facilities, Health Maintenance Organizations (HMOs) and other managed care entities, individual practices, hospices or other freestanding providers. This involvement of so many entities underscores the importance of coordination in the oversight of quality assurance measurement and evaluation, particularly at this point when the methodology of quality assurance is evolving so significantly.

The Federal Government

In the Federal government sector, the public programs of Medicare and Medicaid are overseen by the Health Care Financing Administration (HCFA). Quality assurance is one aspect of these programs under HCFA's authority. HCFA, through Peer Review Organizations (PROs), ensures quality of care by reviewing appropriate medical treatments for Medicare beneficiaries. Structural compliance mechanisms are in place for hospitals, nursing facilities and other providers under the Medicare "Conditions of Participation." Hospitals, for example, are required to have JCAHO accreditation, or to be licensed by a state entity.

HCFA also has quality assurance oversight for the Medicaid program. It is currently involved in developing and monitoring process and outcome measures for its rapidly growing Medicaid managed care programs and Medicaid waiver programs. New Jersey, in its move to re-structure its delivery of health care services, has made a commitment to the development and monitoring of quality assurance measures in its Medicaid managed care initiatives. HCFA, through its Quality Assurance Reform Initiative (QARI), is working with the states to develop clinical guidelines and specific sets of indicators which are appropriate to the Medicaid managed care clients, i.e., in the areas of prenatal care and childhood immunizations.

While historically HCFA has been collecting and publishing Medicare mortality rates for hospitals, flaws in the methodology and various objections from the hospitals have affected the validity of the report, which utilized only simple outcome measures absent any adjustment for other variables. For example, providers that treated groups of sicker patients would in all likelihood have higher mortality rates than those providers who had a different patient mix, regardless of the level of quality maintained by the provider. The problems associated with accuracy in quality assessment were reflected by the HCFA Administrator's decision in 1993 not to release the annual Medicare data report because of its unsatisfactory ability to measure quality.

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The State Government Oversight

On the state level, quality assurance efforts are statutorily effected by the licensing and certification authority for hospitals and other health care institutions, physicians and other health care professionals, home health agencies and HMOs. Most state licensure requirements, as in New Jersey, exceed the Federal quality assurance requirements for Medicare and Medicaid participation and involve required on-site inspections and routine review by the licensing authority. The New Jersey Department of Health, Facilities Evaluation and Licensing, Certification and Standards Division, regulates and licenses hospitals, nursing and long-term care facilities, freestanding hospices and freestanding ambulatory surgery centers.

Individual health care providers, such as physicians and nurses, are licensed under the individual professional Boards, e.g. the Board of Medical Examiners for physicians. Ongoing input is also provided by New Jersey Hospital Association and the Medical Society of New Jersey. Local level health planning issues, including Certificate of Need compliance, involve the oversight of the state's regional Local Advisory Boards (LABs). In addition to being efficient planning tools, Certificate of Need (CN) requirements for hospitals, nursing facilities, residential care facilities and home health agencies ensure a high standard of quality. Current reform initiatives to streamline the CN program in New Jersey retain enhanced quality of care standards as a goal.Under HMO regulations, the Departments of Health and Insurance have a regulatory framework under which HMOs may operate in the state. Key components of the law require a Certificate of Authority and that the HMO have a quality assurance program and evaluation, as well as a utilization review long-range plan for the provision of health services. The New Jersey Medical Practice Statute on Licensing covers licensing and revocation for medicine, surgery and chiropractic care. The Department of Health's current initiative reviewing its HMO rules has at its core the development of a comprehensive quality assurance plan, integrating structure, process and outcome measures (See Capitol Forums Issue Brief, "Public Oversight of Managed Care," October 19, 1994).

Professional External Accreditation For Quality Assurance

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a private organization which provides, through external review, certification of that hospitals and other health care organizations are meeting standards of quality. Five thousand of the approximately 6,800 hospitals in the United States are surveyed by JCAHO. As discussed earlier, while JCAHO's quality assurance evaluations consisted primarily of structure and process measures, it is actively involved in developing appropriate outcome measure systems.

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In 1990, JCAHO discontinued its accreditation of managed care services. The National Committee for Quality Assurance (NCQA), an independent, non-profit organization founded in 1979 by several large corporations, began conducting accreditation reviews of managed care entities in 1991. While NCQA's criteria for accreditation are primarily structural, it is engaged in developing and refining performance measures and "report cards" for health plans. Since November 1993, when NCQA released a set of performance measures - the Health Plan Employer Data and Information Set (HEDIS 2.0) - it has refined those measures by working with representatives from health plans, employers and consumer groups. HEDIS 2.0 allows health plans to standardize how they calculate and report performance information.

The goal of the standardization made possible through HEDIS — which is a core set of performance measures that can be adapted to serve the needs of purchasers of health care, whether they be individuals, cooperatives or government entities — is that it would eventually enable all plans to measure performance in the same way. Prior to the implementation of HEDIS, the evaluation of data across health plans was problematic, as not all plans collected or aggregated data in the same way. This situation not only carried with it consistency and validity problems, but also made comparison form one plan to the another impossible. Ultimately, by using HEDIS measures, "apples to apples" comparisons could be made between and among health plans on discrete measures, such as mammography rates, childhood immunization rates and physician turnover. In the Federal sector, HCFA is using HEDIS in its national Quality Assurance Reform Initiative.

Refinement of HEDIS 2.0 based on input from experts and continued research is on-going, with HEDIS 2.5 and 3.0 due out in 1995 and 1996 respectively. As the growth of managed care entities continues to increase, NCQA accreditation for managed care providers is becoming routinely required by companies as purchasers of health plans and state regulatory authorities.

Quality Assurance Programs - Emerging Trends

The role of the state government in implementing and monitoring quality of care programs is vastly expanding. A primary public policy challenge is to identify with whom the responsibility lies to develop and administer such programs and which type of quality measurement system is appropriate, i.e., what combination of structure, process and outcomes measures is most accurate for quality assurance measurement and evaluation. As consumers become more interested and educated about the costs of their health care, they become equally interested in having access to the appropriate information in order to make informed decisions about their care, its quality and its cost.

In 1989, the state of Pennsylvania began to require that hospitals release data concerning costs, morbidity and mortality information to the state's Health Care Cost Containment Commission's database (EBRI Issue Brief, March 1995).

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Employers, insurers and the hospitals themselves are using this aggregated, comparative data in their purchasing decisions and marketing plans. Around the country many states which collect hospital discharge data, including Florida, Illinois and Wisconsin, release reports to the public on costs of certain medical procedures; however, quality is not evaluated in these reports (Ibid.)

As part of its overall health care reform initiative, the state of Florida is requiring health plans to submit quality data to its Agency for Health Care Administration for distribution. Key indicators for 1995 are: (1) incidence rates for certain services and outcomes, e.g. cases of measles and vaccination rates; (2) patient satisfaction; (3) costs and (4) accreditation. The categories for desired high incidence include: mammography screening rate; pap smear and chronic disease follow-up rates; and pediatric immunization rates. Categories for desired low incidence include: cancers diagnosed at late stages; hospital mortality rates and rates of preventable hospitalizations. Other areas for quality assurance review include the accreditation status of the health plan, the percentage of physicians who are board-certified and the number of hospitals in the network. The data is aggregated and analyzed and made available in health plan status reports.

The National Committee for Quality Assurance (NCQA) in also involved in a number of state and local projects that include both accreditation and performance measurement. One such project is currently being conducted with the state of Maryland to assist them in producing a state-wide report card based on HEDIS measures. Both Maryland and Minnesota have mandated the establishment of systems for comparing health plan performance. Minnesota promulgated legislation in 1993 to create a public/private data institute.charged with providing direction and coordination for public and private data collection and with developing a plan for a state-wide data information system to be used by health care industry players. Minnesota's health data information system will provide consumer report cards comparing cost and quality across health plans, outcomes on specific health conditions, studies on administrative costs and will track health care spending in the state.

A 1994 Journal of the American Medical Association article profiles a study on outcome measures for coronary artery bypass surgery conducted by the New York State Department of Health for the period of 1989-1992. By monitoring risk-adjusted mortality rates for 30 hospitals licensed for bypass surgery and the surgeons who performed it and then monitoring those hospitals and surgeons with the highest risk-adjusted mortality rates, the mortality rate over the four-year period decreased by 41 percent (JAMA, v.271: 761-766, 1994). The Department of Health monitored the hospitals and surgeons via site visits and consultations when necessary. The information collected from the study on mortality rates was distributed to the hospitals and physicians, and ultimately to the patients who were candidates for the surgery, in order to assist in their decision-making. This type of study is a primary example of the ways in which state governments are taking a lead role in quality assurance measurement projects.

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Both private and public employer groups, as purchasers of health care, are launching several different types of quality assurance initiatives that incorporate measures of structure, process and outcomes to assist in making decisions about the most cost-effective, high-quality plans. The Business Health Care Action Group (BHCAG), a private Minnesota business cooperative with over 90,000 enrollees, established an Institute for Clinical Systems Integration. Through the Institute, BHCAG has developed practice guidelines and a system to monitor treatment and patient outcomes. Regarding public purchasing cooperatives, CalPERS, the California Public Employees' Retirement System, began in 1994 to require health plans to submit data on a list of indicators, including childhood immunizations, mammography screening, and diabetic retinal exam. Once analyzed, the health plans will be ranked according to their ability to meet target guidelines for the delivery of these services and a "Quality of Care" report will be compiled and distributed to members.

Conclusion

As the pressure of allocating scarce resources and reducing costs in health care spending continues to shape decision making, the areas of quality and access are especially vulnerable. The health care industry is responding across several fronts to ensure that quality will not be diminished in a cost-conscious marketplace. While the perfecting of quality assurance evaluation and monitoring is an evolving art, both private and public players are involved and actively committed to develop accurate and valid measurement tools. As with other health care reform efforts, it seems likely that the primary role of monitoring quality assurance in the delivery of health care will lie with the individual states. The challenge lies in identifying the level of involvement each state will take on in the environment of quality assurance.

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Questions For Discussion

- The role of the individual state is primary when it comes to developing and monitoring quality assurance in the health care delivery system to ensure high-quality health care be accessible and available to its citizens. What entity will have lead responsibility for developing, evaluating and monitoring quality measurement and practice guidelines in New Jersey in the current environment? Should these functions be "split out" to different public and private groups? Should there be a central oversight authority within the state to coordinate these activities?

- The issue of quality assurance is complicated, even as more refined systems are developed to evaluate process and outcomes, as well as structure. What entities will establish these standards? Should accreditation of quality assurance programs by required by the states? Would this improve quality or be viewed as another obstacle and "over-regulation" by the state?

- A coordinated and accurate system of data collection is a critical component of a meaningful system of quality assurance. The state of Minnesota is a lead state in developing its public-private partnership with its health data Institute with the goal of establishing a state-wide health data information system. Is this type of effort a viable option in New Jersey?

- As consumers become more conscious of the costs of their health care, they are becoming equally concerned about maintaining quality of care and access to care. Should New Jersey (as Pennsylvania is doing through its Health Care Cost Containment Database) become involved in collecting data and issuing health plan ìreport cardsî to consumers? Are such reports valid measures of quality? Is this an appropriate role for state government?

- The Health Care Financing Administration (HCFA) has identified the issue of quality assurance and monitoring as a critical one for its Medicaid managed care program. As New Jersey moves forward with its initiative to restructure health care delivery in the Medicaid program and for its uninsured population, how will the stringent oversight and monitoring of quality necessary in these programs be accomplished in a time of limited resources?

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