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Calming the Perfect Storm— Health Care Quality Initiatives in 2002

Background Information for . . .

THE NEW JERSEY HEALTH POLICY FORUM

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TABLE OF CONTENTS

*ISSUE: In 2001, the Institute of Medicine's Committee on Quality of Healthcare in America published its report entitled "*Crossing the Quality Chasm*" in which it raised questions focusing on the issue of building quality into systems that may be outmoded, as well as the ways in which the roles and relationships among clinicians, patients, payers and regulators can be coordinated in quality efforts. The tasks of defining quality in health and medical care and reaching consensus regarding its critical dimensions are works in progress.*

What is the status of past and current health care quality initiatives in New Jersey, and what types of coordination are taking place among providers, purchasers and regulators?

INTRODUCTION

Throughout the height of health reform activities in the mid-1990's, public and private health care stakeholders focused on the "three-pronged ballast" of the health care system – access, quality and cost. During the course of the past few years, health care costs are again escalating after a brief period of containment. At the same time, access is being affected by downward changes in the economy and public and private pullbacks from coverage expansions as a result of federal and state budget crises and double-digit increases in the costs of employer health premiums. These factors have converged at the same time to create what some experts have described as the *perfect storm* in health care.

The quality "prong" in the health care system is also under scrutiny as it relates to costs and access to appropriate medical care and is considered by some as a means to calm the storm.[1] Since the Institute of Medicine's (IOM)

> *"The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety in the system."*

report in 2000 – *To Err is Human: Building a Safer Healthcare System* – found that medical errors cause between 44,000 and 98,000 deaths annually in the U.S. and cost between $17 billion and $29 billion annually, coalitions of experts have come together to develop evidence to identify errors and practices that lead to such errors: "The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety in the system."

Remedies range from health care clinicians' and providers' developing and implementing core sets of healthcare safe practices to legislators introducing laws to strengthen reporting of medical errors and adverse events as part of a package of patient protection provisions. The federal government has launched a major quality initiative through its Medicare program's Quality Improvement Organizations. In the private sector, commercial insurers, employers and employer coalitions contracting directly with providers are exploring the viability of provider incentive models as a component of value-based purchasing.One of the current challenges facing the health care industry vis-à-vis quality is to remove the obstacle of fear of litigation in order to break the silence about reporting and identifying the root causes of medical errors. In its 2000 report, the IOM report strongly pointed out that fear that information from reporting systems may potentially be used to prepare a lawsuit – even when parties are not negligent – acts as a deterrent for doctors and hospitals from making reports.

The focus of the July/August 2002 issue of the health policy journal *Health Affairs* was the question of quality in health and medical care. Under the theme of "The Quality Conundrum," analysts and researchers pondered the question "Why is there a quality chasm?" and observed that even after being

challenged by the Institute of Medicine's Committee on Quality of Health Care in America to "under-take major redesign of both the delivery system and the policy environment that shapes care delivery . . . major headway on this ambitious goal has come slowly and grudgingly." *Health Affairs* editor John Iglehart posits that: "One reason for slow movement is the disparate interests that divide stakeholders involved in moving the quality needle forward."

BACKGROUND ON QUALITY

In April 2002, the Commonwealth Fund published a 164-page Chartbook, *Quality of Health Care in the United States*. It focused on the many facets of quality initiatives in the current health care environment. The sheer size of the Chartbook represents the scope and complexity of quality assurance and quality improvement activities. The issue of quality in the health care system is challenged by several factors including:

- consensus on a definition of quality;
- agreement on how to measure quality; and,
- agreement on how to evaluate the quality of health care delivery systems.

Depending upon the role and perspective of each stakeholder, the definition of health care quality may vary considerably: from the physician's point of view compared to the patient's point of view following a medical encounter;

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and from the payer's perspective regarding cost effectiveness of a specific treatment plan compared to the regulators' mandates regarding appropriateness of care. Each of these situations often yields a separate assessment of quality.

The Chartbook's authors stress that quality improvement in six areas of performance could significantly affect the process and outcomes of health care:

- consistently providing appropriate and effective treatment and prevention for acute and chronic disease[2];
- reducing unjustified geographic variation in care[3];
- eliminating avoidable mistakes;
- lowering access barriers, including lack of insurance;
- improving responsiveness in patients;
- eliminating racial/ethnic, gender, socioeconomic and other disparities and inequalities in access and treatment.

Each of these potential outcomes holds significant policy implications.

The subject of quality in health care has had a varied developmental history, influenced by distinct factors and forces in the health care system. Before the penetration of managed care protocols in the health care market, purchasers

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and accreditation entities – such as the Joint Commission on Accreditation of Healthcare Organizations (JACHO) in the private sector and the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) in the public sector – utilized structural measures of quality, such as facilities evaluation and training.

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. 1988

In many ways, the managed care environment, under which the financing and delivery of health care services are integrated, has set the stage for efforts in refining quality assurance and evaluation. Quality measures began to emerge in the mid-1990's that integrated the evaluation of structure, process and outcomes in health care delivery.[4] For example, in a 1995 Journal of the American Medical Association article, JACHO asserted its belief that compliance with contemporary standards is a basic measure of quality health care: "The thinking behind the 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" (JAMA, May 10, 1995). In a move representative of the changing practice of quality assurance and improvement, JACHO announced in October 2002 the phase-in of a new accreditation process with the goal of encouraging organizations to focus more on care systems critical to the safety and quality of patient care.

The formulation and implementation of these initiatives continues to be an evolving art in the industry and exists as a significant public policy issue as it affects the entire health care delivery system: providers, policymakers, regulators, purchasers, health plans and consumers. The National Forum for Health Care Quality Measurement and Reporting (NQF), a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting, identifies three principal indicators of quality problems in the health care system: error rates, overtreatment and undertreatment.[5]

Noting that experts estimate that approximately 20 to 30 percent of health care treatments are unnecessary, NQF cites that overtreatment leads to complications, reduced productivity and higher health care costs. Regarding undertreatment, only an estimated 50 percent of patients receive recommended preventive care. For example, among individuals suffering from depression, 59 percent are not treated and 19 percent receive ineffective treatment, resulting in an estimated $12 billion annual loss in employee productivity (National Quality Forum, 2002).

In its September 2002 *State of Health Care Quality Report*, the National Committee for Quality Assurance (NCQA) documented improvements in clinical performance on more than a dozen key measures among selected health plans serving Medicare, Medicaid and commercially insured populations. However, the report's authors avered that concerns persist regarding patient safety and the health care system. Report findings indicated that "more than 6,000 deaths and 22 million sick days could be avoided annually if the best practice care found at the nation's top organizations were adopted universally" (NCQA, 2002).

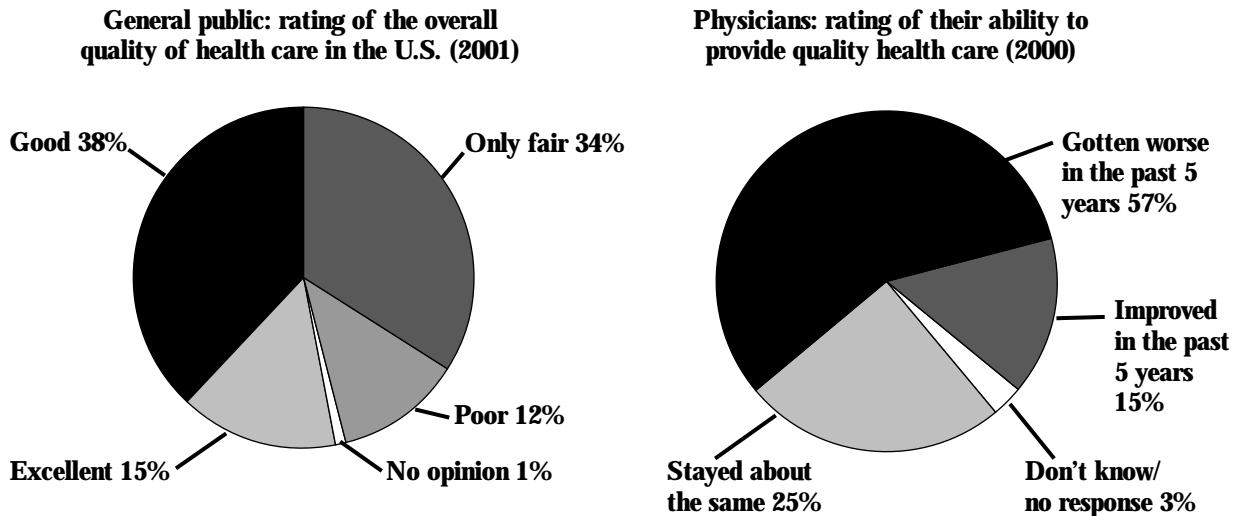## DEFINING QUALITY – PERCEPTIONS VS. TOOLS

When surveyed regarding their perceptions of quality in the health care system, two key stakeholders – physicians and patients – express concern regarding the level of health quality. In a 2001 Gallup poll, only

a little more than half of individuals surveyed believe that the overall quality of care in the U.S. is good or excellent. In a separate poll conducted by the Commonwealth Fund International Health Policy Survey, almost three in five American doctors agreed with the statement that the quality of care has deteriorated over the past five years (Leatherman and McCarthy, 2002).

PERCEPTIONS OF HEALTH CARE QUALITY

General public: rating of the overall quality of health care in the U.S. (2001)

Good 38%
Only fair 34%
Excellent 15%
Poor 12%
No opinion 1%

Physicians: rating of their ability to provide quality health care (2000)

Gotten worse in the past 5 years 57%
Improved in the past 5 years 15%
Stayed about the same 25%
Don't know/ no response 3%

Sources: Gallup (National Journal Poll Track 2001). Sampling error +/-3 percent. Commonwealth Fund International Health Policy Survey (Blendon et al. 2001). Sampling error +/-4 percent. Leatherman and McCarthy, *Quality of Health Care in the United States: A Chartbook*, 2002

In the field of quality measurement and definition, both public and private sector stakeholders have developed sets of performance standards. In her analysis of quality measurement tools, Sprague (2001) delineates the differences between performance standards for physicians and those for health plans. Clinical practice guidelines developed for physicians "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" (ibid.). The federal Agency for Healthcare Research and Quality (AHRQ) maintains – in partnership with the American Medical Association and the American Association of Health Plans – the web-based National Guidelines Clearinghouse. AHRQ, within the U. S. Department of Health and Human Services, funds research on quality measurement and outcomes and works to disseminate research findings to a wide range of health industry stakeholders, including clinicians and policymakers. The issue of clinical guidelines continues to be a contentious one as, for example, guidelines setting forth length-of-stay norms have resulted in states' regulating length-of-stay for procedures such as births and mastectomies (ibid.).

The development of performance measures for health plans has focused primarily on process measures. The National Committee on Quality Assurance (NCQA) has led the way with using HEDIS (Health Plan Employer Data and Information Set) performance measures, a set of specific measures that range from primary prevention to screening. For example, HEDIS data can measure a health plan's capacity to provide mammography screening to its members, or childhood immunization rates for specific diseases.

Performance measurement data comes from a variety of sources, including standardized measures such as HEDIS and the Consumer Assessment of Health Plans (CAHPS). Purchasers may use a combination of these standardized measures, or develop their own data sets. For example, New Jersey's Health Care Payers' Coalition offers HealthGrades scores for all New Jersey hospitals and physicians by using hospital and physician report cards with evaluation and quality data for various procedures and diagnoses, e.g., coronary bypass surgery, stroke and death and mortality data. HealthGrades is a healthcare quality ratings, information and advisory services company whose clients include employers, providers, health plans, insurance companies and consumers (www.healthgrades.com).

Efforts in measuring quality also include those that collect and evaluate the patient's perception of care. The Consumer Assessment of Health Plans (CAHPS) survey is one tool that is used to measure consumers' level of satisfaction related to the health care they have received. CAHPS was developed through the collaboration of AHRQ, Harvard University, RAND and the Research Triangle Institute and was incorporated into HEDIS in 1999.

The development of a health information infrastructure and the collection and analysis of computerized clinical data are critical for measuring performance, and the establishment of a national health information infrastructure is necessary for improving the safety and quality of health care (National Association for Healthcare Quality, 2002). The lack of standardized data sets

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increases overlaps, redundancies and limits the ability to compare institutions, providers and patients (ibid.). The Institute of Medicine in its 2002 report observes that the health care delivery sector has not kept pace with other industries in making innovative use of information technology.

The U.S. House Ways and Means Committee recently approved a revised version of the medical errors bill (H.R. 4889) – the Patient Safety Improvement Act of 2002. The legislation would establish a system to collect information that is voluntarily reported for the purposes of quality improvement and patient safety activities (http://thomas.loc.gov). Data reported for this purpose would have legal protection, and safety information would be reported to new Patient Safety Organizations (PSOs) that would analyze the information and provide feedback to providers.

ROLE OF THE FEDERAL GOVERNMENT

In its latest report just released in November 2002 – *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality* – the IOM called on the federal government to play a lead role in developing clinical standards in order to help the industry's multiple stakeholders, including hospitals, patients, insurers, regulators and accrediting bodies.[6] The report committee pointed out that:

> "No other stakeholder has the federal government's ability to produce fundamental change throughout the healthcare sector." It underscored that the measures recommended "are not intended to represent another layer of government oversight, but rather to replace the patchwork of quality-measurement activities and projects already under way" (Tieman, 2002).

At the federal level, the government acts as both purchaser and regulator of health care and in these roles is responsible for a range of quality initiatives. The Quality Interagency Coordination Task Force (QuIC)

has as its mission to ensure that all federal agencies involved in purchasing, providing, studying or regulating health care are working towards a common goal of improving quality of care. The Medicare program has long had a set of structural performance standards in place through its regulations regarding Medicare conditions of participation for hospitals and health care facilities.

Through its Quality Improvement Organizations (QIOs, formerly known as PROs, or peer review organizations) located in each state, the Medicare program aims to improve the quality of medical care delivered to its beneficiaries in both fee-for-service and managed care settings.[7] Their focus on quality improvement efforts in hospitals, nursing homes, physicians' offices and home health settings is a priority for QIOs, as is Medicare beneficiary outreach and public education on beneficiary rights, quality of care issues and preventive health measures.

Based on CMS' Health Care Quality Improvement Program (launched in 1992), the PRO of New Jersey, Inc., partners with all of New Jersey's hospitals, 13 nursing homes, 5 Medicare+Choice plans, various community-based organizations, federal, state and local agencies and corresponds with over 8,000 physician offices to improve the quality of healthcare to the state's Medicare beneficiaries (*2001 Medicare Annual Report*). The PRO's acute care focus includes the following clinical areas: acute myocardial infarction, heart failure, atrial fibrillation, pneumonia and stroke/transient ischemic attack. It also works with community-based organizations, physicians and Medicare beneficiaries to improve rates of screening and immunizations, as well as offering technical assistance and beneficiary advocacy. In addition, CMS and the PROs with which it contracts have committed themselves to reducing health and treatment disparities related to race, ethnicity and gender within the Medicare population.

NEW JERSEY – QUALITY INITIATIVES

Although New Jersey has held a long commitment to advancing quality initiatives, Department of Health and Senior Services (DHSS) Commissioner Clifton Lacy recently addressed the challenges of improving the quality of health care in New Jersey:

> ***"We must aggressively move to improve our performance in delivering health care that has been scientifically proven to positively impact longevity and quality of life. The fact that this is a national phenomenon suggests that there is no one simple solution. What's needed is a sustained effort of all our partners in health care to identify and implement performance improvement strategies to make New Jersey a national leader in health care and specifically managed care-delivered health care."***

The New Jersey Health Quality Act – N.J.S.A. 26:2S-1 et seq. – established standards for health insurers, and health, hospital and medical services organizations. Under the Act, the Independent Health Care Appeals Program (IHCAP) was created through which consumers can appeal medical decisions made by their health plan and/or file complaints about quality of care. The IHCAP is comprised of independent experts under contract to the State, who review each case and submit binding decisions. The Health Care Carrier Accountability Act, signed into law in 2001, gives consumers covered under managed care contracts the right to sue their carrier if the consumer believes that the carrier's decision to deny or delay care has or will result in serious harm to the consumer (N.J.S.A. 2A:53A-30 et seq.).

As an example of the state's quality initiatives, 2002 represents the sixth year that New Jersey's DHSS has issued a managed care report card; the *2002 New Jersey HMO Performance Report: Compare Your Choices* evaluates the performance of nine health plans that offer HMO and point-of-service plans in the state (*News Release*, October 24, 2002). The plans are compared in 20 areas of preventive health care, medical treatment and customer satisfaction. While most scores of plans were in the 60-to-80 percent range, the

average scores of plans ranged from a low of 22 percent — for the percent of people taking medication for depression receiving follow-up visits — to a high of 90 percent for people receiving beta blocker treatment after a heart attack. (Reference is made to www.state.nj.us/health for the full report.)

Data for New Jersey's HMO report card comes from two nationally recognized sources: the National Committee on Quality Assurance (NCQA) and the Consumer Assessment of Health Plans (CAHPS) survey. NCQA, which supplies performance data, is a non-profit group that assesses managed care quality throughout the country. The CAHPS survey captured consumer satisfaction data from a 2002 statewide survey of approximately 3,000 health plan members.

Among other quality initiatives, DHSS also released its *2001 New Jersey Experience of Care and Health Outcomes (ECHO) Study*, which was a survey of consumers' experience with managed behavioral health services (ibid.) Under a grant from The Robert Wood Johnson Foundation, ECHO was pilot-tested in New Jersey after being developed by Harvard Medical School. Overall results indicated that members are satisfied with the quality of care they receive, whether it is medical care or behavioral health care. However, behavioral health users were less satisfied than medical care users with the managed care plan itself (ibid.)

New Jersey's State Health Benefits Program (SHBP) is a key player in providing health care coverage in New Jersey with over 700,000 current and retired state employees and family members. The SHBP has been nationally recognized by the National Health Care Purchasing Institute as a model program for its utilization of HMO performance data in informing its members and in developing its contract standards with managed health plans.

There is variation in the types of roles that state agencies play regarding quality measurement, monitoring and assurance. State Medicaid programs, especially in the realm of Medicaid managed care, collect data on utilization, consumer satisfaction and disenrollment (Sprague, 2001).

In a collaborative partnership effort, the Center for Health Care Strategies, a New Jersey-based health policy and research organization, has developed the Collaborating for Quality Initiative. Working with the National Initiative for Children's Healthcare Quality, the Foundation for Accountability and Bailit Health Purchasing, the Center will facilitate a shared approach to quality improvement for state Medicaid and SCHIP programs (www.chcs.org) in order to streamline duplicative and fragmented quality improvement efforts.

NEW JERSEY - THE LEAPFROG INITIATIVE

In spring 2002, the Leapfrog Group announced its New Jersey project initiative, making the state one of eleven other regions in the country to engage it such a program (Health Care Payers Coalition of New Jersey, *HCCP News & Views*, May 2002). One Leapfrog initiative goal is to build community-wide collaboration among public and private health care purchasers, hospitals, health plans, physicians and workforce and consumer groups to reduce the number of patients harmed by preventable medical errors.

The Leapfrog Group is an organization comprised of more than 100 of the largest corporate and public sector payers of health care in the country (representing more than 31 million enrollees). It formally began in January 2000, after an informal working group of leading employers and business coalitions initiated a formal launch with a goal to advance patient safety and develop purchasing strategies to encourage provider adoption of safety standards. Founding national members of the Leapfrog Group included the Buyers Health Action Group, General Electric, General Motors, Verizon and the Pacific Business Group on Health.

The Leapfrog Group advocates the adoption of three proven safety standards to prevent medical errors in hospital systems:

- use of Computer Physician Order Entry (CPOE) systems, which can reduce serious prescribing errors by more than 50 percent. More than 1 million serious medical errors occur every year in U.S. hospitals and the Institute of Medicine estimates that medication errors alone contribute to 7,000 deaths annually (Leapfrog Factsheet, 2000);
- utilization of Evidence-Based Hospital Referral in cases where patients need certain high-risk surgeries they should be referred to hospitals that evidence suggests will produce superior outcomes (based on the annual volumes of those procedures). Research regarding such referrals indicates that a patient's risk of dying could be reduced by more than 30 percent;
- use of Intensive Care Unit Physician Staffing – the care of ICU patients should be managed or co-managed by physicians certified (or eligible for certification) in critical care medicine.[8]

According to Dartmouth Medical School researcher John Birkmeyer, the three safety improvements could save up to 58,300 lives a year and prevent 522,000 medication errors, if implemented by all non-rural hospitals in the U.S. (Birkmeyer et al, 2000). When implementation of a CPOE system was established in a Boston teaching hospital, the rate of overall medication errors (other than missing doses) was reduced by 80 percent when the system was fully developed to detect drug allergies and dangerous drug interactions (Leatherman and McCarthy, 2002). Currently, only 3 percent of U. S. hospitals have implemented computerized physician prescribing systems (ibid.).[9]

The Leapfrog Group is also working to create customizable incentive and reward models that purchasers can use to recognize hospitals' progress toward implementing the Leapfrog Patient Safety Practices.

New Jersey Assembly Bill 1695 (Vandervalk) would establish the New Jersey Medical Error Reduction Study Commission in the state DHSS. The Commission's purpose would be to identify policies and procedures that address the issue of reducing medical errors in both inpatient and outpatient settings and that maximize patient safety. Recommendations would be developed for a statewide medical error reporting and reduction system that can be integrated with any federal medical error reduction programs that may already be in effect.

Introduced in January 2002, Senate Bill 571 (Codey, Vitale) would establish the New Jersey Health Care Consumer Information Act which would require the Division of Consumer Affairs, in consultation with the Board of Medical Examiners, to collect and maintain information concerning all physicians and podiatrists licensed in the state for the purpose of creating a profile of each one. The information contained in the profile would enable health care consumers to make informed choices about their physicians. The profile would include any criminal convictions, any disciplinary actions or revocation of practicing privileges and all medical malpractice judgements and arbitration awards, medical malpractice settlements and pending claims.

EMERGING TRENDS IN QUALITY

Provider Incentives

Recent health care industry efforts on quality improvement are focused on tying reimbursement to quality of care through provider incentives. In its 2002 report calling on the federal government

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to effect quality leadership efforts, the IOM suggested that the federal programs should provide financial incentives for physicians and hospitals that achieve higher levels of quality. A growing number of employers and health plans are shifting the way managed care rewards physicians by paying bonuses for quality or quality improvement, rather than linking incentives to productivity or utilization. For example, in Massachusetts, Harvard Pilgrim Health Care, an insurer, and Partners HealthCare, the state's largest hospital and physician network, agreed to a significant bonus if Partners improves the care of diabetics and asthmatics (Kowalczyk, 2002).

On the federal level, the Centers for Medicare and Medicaid Services (CMS) is soliciting applications for a new demonstration program that will reward physicians in group practice who improve the quality of care and services they provide to Medicare beneficiaries. The three-year demonstration project will allow CMS, the agency that runs the Medicare program, to test physician groups' responses to financial incentives for improving care coordination, delivery processes and outcomes and the effect on access, cost and quality of care to Medicare beneficiaries.

One innovative national program is a grant program – *Rewarding Results* – administered by the National Health Care Purchasing Institute (NHCPI).[10] The program will test ways to implement IOM recommendations to remove payment-related barriers to quality improvement, build in strong incentives for quality and "provide an opportunity for providers to share in the benefits of quality improvement." NHCPI Director Kevin Piper points out: "Repeated studies show that poor health care quality is the third leading cause of death in the United States, increases annual health care costs by $450 billion and costs employers $225 billion a year in lost productivity" (The Robert Wood Johnson Foundation, *News Release*, 2002).

The *Rewarding Results* program represents a partnership of foundations, government, business and the research community and aims to provide incentives to physicians, nurses and other providers to improve quality and patient safety (ibid). Six grants were awarded and include:

- in California - Integrated Healthcare Association for a statewide project affecting 8 million consumers enrolled in commercial HMOs; the program will develop incentives for clinical performance in six areas such as breast cancer and cervical cancer screening, asthma, and diabetes, as well as patient satisfaction and information technology investments
- in Michigan – Blue Cross Blue Shield of Michigan, which serves 4.8 million consumers; the program will develop an incentive pool to reward hospitals based on their use of best clinical practices and best medication safety practices. The Michigan Health & Hospital Association and researchers at the University of Michigan will partner with Blue Cross in this effort.

Throughout the project, NHCPI will share best practices with Fortune 500 companies, health plans, Medicare and state policymakers. The federal Agency for Healthcare Research and Quality (AHRQ) in partnership with the project has funded Boston University researchers to conduct a national evaluation of the six projects. AHRQ is the federal agency focused with supporting research designed to improve the quality of health care, improve patient safety, address medical errors and broaden access to essential health services.

In November 2002, the American Health Quality Association reported that in one of the largest initiatives in the country to shift the way managed care rewards physicians, General Electric, Verizon Communications, and other employers and health plans will launch programs in Kentucky, Massachusetts, and Ohio to pay bonuses for quality. In exploring ways to reduce escalating health care costs, the companies are concluding that improving the quality of care – especially for seriously and chronically ill patients who incur higher medical costs – will lower costs in the long term.

In another Massachusetts initiative, General Electric, Verizon, Partners, and Lahey Clinic in Burlington, another large physician practice, developed the bonus program. Tufts Health Plan, the second-largest insurer in the state, also plans to join. Under the program, all Massachusetts doctors qualify for an annual per-patient bonus of $50 or $100 when they treat Tufts members and General Electric and Verizon employees, their family members, and retirees. A physician receives $100 per patient if he becomes a member of the American Diabetes Association's provider recognition program, which awards the status to doctors who do a good job of controlling blood pressure, cholesterol, blood sugar, and other dangerous indicators in most of their diabetic patients. For all nondiabetic patients, doctors will receive another $50-per-patient bonus for establishing: clinical information programs in their offices, such as a database of seriously ill patients or an electronic medical records system; a system for regularly following up on the care of chronically ill patients, rather than just a yearly check-up; and patient education programs.

CONCLUDING REMARKS

In noting the critical significance of health care quality assurance and improvement initiatives, Dr. Kenneth Kizer, president of the National Quality Forum, has stated: "Quality has to be the Holy Grail for health care for at least the next decade." As policymakers meet the challenge of balancing the demands of escalating costs and maintaining access to care, commitment to quality efforts becomes all the more critical.

POLICY IMPLICATIONS

The National Association for Health Quality Data (NAHQ) reports that the demands for health care data and information continue to escalate from regulatory agencies, accreditation and certification organizations, consumers and purchasing entities in both the public and private sectors.

- How can coordination and standardization of data requirements be accomplished across groups in order to reduce the increased costs to providers such requirements impose?

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The issues of quality assurance and quality improvement are complicated, even as more refined systems of measurement and evaluation are developed. Experts emphasize the need for standardization.

- What entities will establish these standards?
- What is the role of state policymakers and regulators in accreditation and monitoring?
- Should there be a central oversight authority in state government to coordinate the quality activities of public and private organizations?

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The Midwest Business Group on Health in a 2002 report titled: "Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership" underscores the important leadership role purchasers must pursue in the quality arena. Citing research findings that approximately $390 billion spent each year on direct health care outlays is a result of poor quality consisting of overuse, misuse or waste, the Group points out that private purchasers conservatively absorb about one-third of those costs.

• What types of public-private partnerships can be formed and strengthened to address such quality and cost issues?

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Although quality advocates highly regard the role of the consumer and the importance of consumer-driven health plans, a recent poll (October 2002) conducted by Harris Interactive found that although large numbers of individuals polled received report cards rating their health plans and providers, fewer than 1 percent take any action based on the data (www.harrisinteracive.com). "Consumer-driven" plans are those in which enrollees designate their benefit package and providers and pay any cost beyond their employer's fixed contribution, or those that establish "health spending accounts" into which employers contribute pretax dollars.

• How should policymakers view the implications of the role of the consumer in making informed choices regarding health plans and health care?[11]
• How do these behaviors tie in with the design of patient protection laws and regulations?

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Patient confidentiality is critical in maintaining the integrity of the health care delivery system. New Jersey legislation introduced in 2002 –Assembly Bill 810 (Conaway, Connors) — would establish patient health information confidentiality requirements and is designed to provide significant protections in a consolidated statutory format that applies to health care practitioners and health care facilities.

• What are federal and state roles in setting privacy standards to ensure individual privacy protection, to set guidelines for records maintenance and to impose sanctions for violations of patient confidentiality?

ENDNOTES

[1] The issue of health care quality is broad in scope and comprises many substantive areas, including medical errors, patient safety and protections and quality assurance and improvement initiatives. For purposes of this brief, the focus will be on current trends in general quality assurance and improvement activities and collaborative efforts towards improving quality.

[2] For example, studies report findings that individuals with acute and chronic medical conditions receive only about two-thirds of the health care that they need, while 20-to-30 percent of the tests and procedures provided to patients are not needed or beneficial (Leatherman and McCarthy, 2002; Schuster, McGlynn and Brook, 1998).

[3] See the *Dartmouth Atlas on Health Care Quality* in the U.S. (1999) showing, for example. wide variation in surgical rates from one region of the country to another.

[4] Reference is made to two comprehensive papers on the history and evolution of quality assurance and quality improvement initiatives in both the public and private sectors by National Health Policy Forum Senior Research Associate Lisa Sprague: "Quality in the Making: Perspectives on Programs and Progress" (April 2001) and "Contracting for Quality: Medicare's Quality Improvement Organizations" (June 2002).

[5] The National Forum for Health Care Quality Measurement and Reporting was formed from a recommendation made by the President's Advisory Commission on Consumer Protection and Quality in its 1998 report and represents a public-private partnership focused on quality measurement.

[6] The six federal health care programs – Medicare, Medicaid, the State Children's Health Program, the TIRCARE program administered by the Department of Defense, the Veterans' Health Administration and the Indian Health Services – have a combined enrollment of over 100 million beneficiaries with total expenditures at $512.6 billion (2001).

[7] At present, there are 37 QIOs in operation which are private, independent organizations; 33 are nonprofit and 4 are inverstor-owned (Sprague, 2002). Some have multi-state contracts; in general, QIOs employ individuals with professional training in health care quality with both clinical and analytical perspectives.

[8] Reference is made to The Leapfrog Group's website at www.leapfroggroup.org for a detailed explanation of the standards.

[9] In October 2002 the Robert Wood Johnson Health Network announced that its seven hospitals will invest $40 million to become compliant with the Leapfrog Group standards (*Modern Healthcare*, October 14, 2002).

[10] Principal funding for the *Rewarding Results* grant program is from The Robert Wood Johnson Foundation, The California HealthCare Foundation, with additional support from the Commonwealth Fund.

[11] See, for example, Farley et al 2002 study on the "Effects of CAHPS Health Plan Performance Information on Plan Choices by New Jersey Medicaid Beneficiaries" which was accomplished to assess the effects of CAHPS information on plan choices and decision processes of New Jersey Medicaid beneficiaries.

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