

# Improving the Quality of Health Care Services

The quality of American health care is not what it should be. Despite its many strong points, our health care system is also marked by problems that limit its ability to provide the technically excellent and personally sensitive care that Americans want and expect. Quality suffers when patients encounter long waiting times or language barriers, when they have difficulty getting referrals to needed specialty care, or when their doctors fail to explain their conditions or treatments in terms they can understand. When important information about a patient gets lost in transit between physicians, facilities, or even departments within a single hospital, quality gets lost, too. When substandard care or even outright errors go unnoticed and unaddressed, or when physicians fail to provide preventive care or manage their patients' chronic conditions, quality is compromised.

The Fund has long been involved in work that affects the quality of health care. Much of that work has focused — and will continue to focus — on the care received by specific populations, such as very young children, the elderly, racial or ethnic minorities, and low income families. Ultimately, however, the quality of

health care cannot be improved sufficiently for any specific group of patients unless attention is drawn to the necessity of improving care for all. As a result, the Fund has recently developed a plan to devote a substantial share of its concern and resources to the goal of activating a strong movement toward health care quality improvement.

Several forces could help lead the way: employers and governmental agencies, as health care purchasers; the general public, as patients and consumers; physicians and managers, as knowledgeable insiders; insurers, as knowledgeable intermediaries; and regulators and accreditors, as overseers of the health care professions. The questions are, What will energize each group to get involved? And what will inspire them to make common cause and work together? The Fund's plan, organized in three parts, is intended to address the interests of each group, then link those interests behind practical actions.

The first element of the plan is to take a critical look at the issue of health care information and patient choice. It is certainly true that patients need more information about their health care choices, and that choice can lead to improvements in health care quality. Yet consumer choice cannot spur the necessary changes unless patients have access to meaningful information. Physicians also need more and better information if they are to be effective advocates for quality, and they need support in identifying and sharing information that will help patients be active partners in their care.

The plan's second element is to advance the coordination and continuity of American health care. To make a difference here, the Fund will need to consider how physicians and other health care professionals work together now, then look for ways to improve communication and collaboration on behalf of patients.

Processes for delivering care warrant particular attention, as do the logistics of electronic medical records, physician order entry, and other systems that could improve accuracy and reduce medical errors.

Finally, the Fund intends to examine the "business case" for improving quality of care. Toward that end, the Fund will support new analysis to calculate the financial costs of poor quality care, taking into account lost health and productivity and a range of other factors, and consider the development of financial incentives to spur quality improvement. New information and proposals developed under the program will be presented to governmental agencies and other employers that purchase health care.

As of the 2000–2001 fiscal year, the Fund has begun to pursue this plan for improving health care quality through several new and reformulated programs:

- *Health Care Quality Improvement*, which is spearheading the development of mechanisms and incentives to improve quality throughout the health care system

- *Quality of Care for Underserved Populations*, which embraces the Fund's former Bettering the Health of Minority Americans programs, while giving new emphasis to quality of care issues
- *Quality of Care for Young Children*, which is designed to capitalize on the synergy of the Fund's Healthy Steps for Young Children and Assuring Better Child Health and Development programs and to magnify their effectiveness
- *Picker/Commonwealth Quality of Care for Frail Elders*, which clarifies the significance of quality in the provision of care to elderly Americans, especially in nursing homes
- *Task Force on Academic Health Centers*, which helps academic health centers preserve their missions in a changing health care environment

These programs are now under way, and we look forward to reporting on our first year's progress in the Fund's next annual report.

Prior to the establishment of the Fund's Goals 2005 and the reformulation of our work on health care quality, several programs were already working toward establishing a better understanding of the quality of care provided by the American health care system. Some will continue under the new program framework, and many projects funded under their auspices are continuing to operate and produce results.

## Picker/Commonwealth Program on Health Care Quality and Managed Care

The Picker/Commonwealth Program on Health Care Quality and Managed Care, now completed, sought to build the nation's capacity for measuring, reporting, and improving the quality of care provided by managed care plans. Much of its work has been subsumed within the Fund's new Health Care Quality Improvement and Quality of Care for Underserved Populations programs, which will intensify the emphasis on quality while expanding the focus beyond managed care.

Two new projects in 1999–2000 supported collaborative efforts by health plans to compare their performance and learn from one another's experiences. The Foundation for Health Care Policy and Evaluation is working with UnitedHealth Group to collect patient experience data from Medicaid and commercial enrollees, compare performance, and convene medical directors to develop strategies for improvement. The American Association of Health Plans Foundation (AAHP) is organizing collaborative efforts involving health plans in three localities — Albuquerque, New Mexico; Kansas City, Missouri; and Westchester County, New York — to

improve the quality of care for diabetic patients. Pursuing common goals but using different organizing models, the collaboratives are testing the idea that partnerships, rather than competition, can improve quality.

Shared learning was also the objective of two sets of case studies produced by independent research organizations and disseminated through the AAHP. Mathematica Policy Research, Inc., profiled plans that excel in providing clinical care, while the Picker Institute examined plans known for superior patient-centered care. Both projects concluded that few specific practices are likely to lead automatically to high-quality care, although certain fundamental approaches — such as creating a culture of respect for physicians, using data to drive clinical improvement, or responding to competition within a local market — were strongly associated with high-performing plans.

To advance quality improvement for low income patients, the American Public Human Services Association created the first national database of quality of care data for Medicaid managed care. Analysis of the first year's data revealed a tremendous range of performance. Now in its second year, the project is using information from 29 states to set national benchmarks and pinpoint differences in performance between Medicaid and commercial

plans. Program director Arnold M. Epstein, M.D., and colleagues at Harvard University School of Public Health also focused on differences in the quality of care provided to Medicaid and commercially insured populations. A survey of plans showed few differences in quality management practices but equally lackluster records for actual improvements in quality. Now under way are a follow-up survey of state Medicaid agencies, comparisons of for-profit and not-for-profit plans serving Medicaid patients, and analysis of the relationship between accreditation status and quality of care.

Reducing medical errors was another major priority. According to a report by the Institute of Medicine, funded in part by The Commonwealth Fund, at least 44,000 patients die each year in U.S. hospitals from medical mistakes. Sparked by this finding, the National Academy for State Health Policy has begun conducting case studies of medical error reporting systems in four states. Lessons learned from those studies could provide a basis for stronger policies, including a model state law, aimed at uncovering errors and preventing similar mistakes. The Health Research and Educational Trust is encouraging hospitals to conduct self-assessments of their current medication ordering and delivery systems, a major source of medical errors.

## Program on Managed Care and Minority Health

Throughout its history, the Fund has attempted to address the disparities in health that characterize segments of the American population. In recent years, it has invested in research on the impact of changes in the health care sector, especially the growth of managed care, on the health of minority Americans, their communities, and the institutions that serve them. The new Quality of Care for Underserved Populations Program, directed by Fund vice president Karen Scott Collins, M.D., will extend and sharpen that work around issues of health care quality.

Today, African Americans, Latino Americans, Native Americans, and some Asian Americans continue to suffer disproportionately from chronic disease, cancer, and infectious disease. Even more than race, however, socioeconomic status has been found to be a powerful predictor of health status. These problems are at least partly attributable to inequities in access to health care services. Yet new studies show that increasing coverage is not enough to ensure good health care, especially for minority and low income patients. For example, a recent Fund-supported study by Marian Gornick, *Vulnerable Populations and Medicare Services: Why Do Disparities Exist?*, indicates that minority Medicare beneficiaries receive lower-quality care than white Medicare beneficiaries, as indicated by their receipt of fewer



To provide high-quality health care, physicians need to work closely with patients and their families. Good communication improves the quality of care — and could ultimately help reduce the disparities in health and health care that divide American racial and ethnic groups. As associate director of the

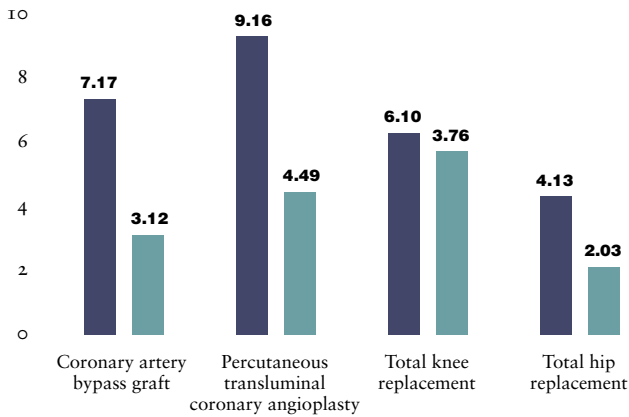
Center for Multicultural and Minority Health at Weill Medical College, Cornell University, former Minority Health Policy fellow Joseph Betancourt, M.D. (right), seeks to improve cross-cultural communication between physicians and patients.



**Medicare provides universal health coverage for Americans age 65 and over, yet equal coverage does not necessarily mean equal receipt of care. Federal data show that elderly blacks are much less likely to get certain common cardiovascular and orthopedic procedures than elderly whites.**

■ White  
■ Black

Rate per 1,000 Medicare enrollees age 65 and over, 1996



Source: Marian Gornick, *Vulnerable Populations and Medicare Services: Why Do Disparities Exist?*, Century Foundation, 2000, based on data from the Health Care Financing Administration.

specialty and preventive care services. One explanation for this problem may be misperceptions between physicians and patients, a possibility that raises the issue of cultural competence as an important factor in considering quality of care.

The Fund has also emphasized the importance of understanding cultural issues in health care and developing better reporting systems for different patient groups. A continuing project by David Nerenz and colleagues at Henry Ford Health System and Michigan State University is developing a report card on the performance of health plans serving minority populations. A new project by the Summit Health Institute for Research

and Education will explore state and federal policies regarding the collection of health data by racial or ethnic group and socioeconomic status — categories of information that are not routinely available to health policy researchers at the present time.

Two new projects will compile information on what is currently known about strategies to improve cultural competence. Maren Monsen, M.D., based at Stanford University, has begun work on a documentary film and related materials on cross-cultural communication in health care, to be used for training medical students and residents. At Cornell University, Joseph Betancourt, M.D., is conducting a survey of the best available practices for facilitating communication and understanding between health care providers and culturally diverse patients.

## Commonwealth Fund/Harvard University Fellowship in Minority Health Policy

Committed health policy leaders are crucial to improving the health of racial and ethnic minority populations. The Commonwealth Fund/Harvard University Fellowship Program in Minority Health Policy is developing a generation of physician leaders with the analytic, professional, and policy skills to become effective advocates for minority communities. It is anticipated that these fellows will improve the

capacity of the health care system to address the health needs of minority and disadvantaged populations.

Designed as a one-year, full-time program to create physician-leaders who will pursue careers in minority health and health policy, the program is directed by Joan Reede, M.D., associate dean for faculty development and diversity at Harvard Medical School. The fellowship combines an intensive year of training in health policy, public health, and management with special program activities on minority health issues. Applicants to the program complete academic work for a master's degree in public health or public administration.

Each year since 1996, the program has awarded up to five fellowships, for a total of 19 fellowships. Alumni fellows have gone on to become actively engaged in health policy, research, and service delivery to minority communities. Most fellows hold faculty appointments at schools of public health or medicine, and several now lead departments of public health or community health centers. Alumni fellows also serve on numerous local and national advisory committees related to minority health.

The program continues to work on developing future opportunities for fellows. In conjunction with the federal Health Resources and Services Administration (HRSA), for example, the fellowship office at Harvard developed the HRSA Senior Health Policy Field Internship Program, a full-time training program that provides further experience in health policy.

### *2000 Fellows in Minority Health Policy*

ALICE CHEN, M.D.

Resident, Primary Care and  
Internal Medicine  
Brigham and Women's Hospital  
Boston, Massachusetts

PATRIK JOHANSSON, M.D.

Resident, Primary Care and  
Internal Medicine  
Cambridge Hospital  
Cambridge, Massachusetts

ARTHUR HAYASHI, M.D.

Resident, Family and  
Community Medicine  
University of California, San Francisco

## Healthy Steps for Young Children Program

Established in late 1994, Healthy Steps for Young Children responds to the needs of parents of young children for information and guidance on child health and development. Its approach is largely based on the results of the Fund's Survey of Parents with Young Children, conducted in 1995–96, which found that parents want more information from their pediatricians about how to help their children grow and learn, are more satisfied with providers who offer such information, and tend to heed advice regarding such beneficial practices as breastfeeding and reading aloud.

Soon after, the Fund launched a pilot group of Healthy Steps local initiatives in pediatric and family practices around the country. Over the past six years, the Fund's \$11 million investment has

attracted additional support from 70 cofunding partners, bringing total contributions to \$32 million. The program is currently operating in 34 pediatric and family practices and has served more than 4,800 families. Healthy Steps is directed by Michael C. Barth of ICF Incorporated and is overseen by a national advisory committee chaired by Margaret E. Mahoney of MEM Associates, Inc.

Healthy Steps sites offer a comprehensive range of services for parents of young children from birth to age three, including enhanced well-child office visits, home visits by Healthy Steps specialists, tools to gauge child development and family health, parent groups, a child development telephone line, written material for parents, and links to community resources. Healthy Steps specialists coordinate the delivery of those services and work closely with each family. Typically trained as nurses, child development experts, or social workers, Healthy Steps specialists also receive intensive training in child development and the components of the Healthy Steps approach.

A multidisciplinary pediatric team, led by Barry Zuckerman, M.D., and Margot Kaplan-Sanoff, Ed.D., at Boston University School of Medicine, developed the original Healthy Steps curriculum

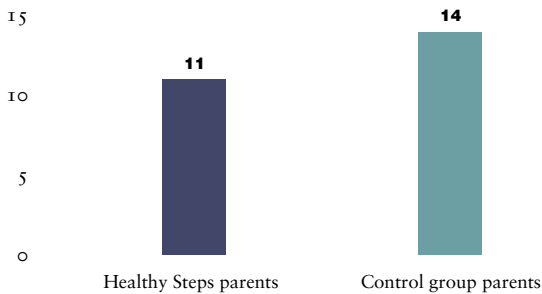
and training materials and has conducted annual training institutes for Healthy Steps practices. The team is now leading training efforts to enable new sites to adopt the Healthy Steps approach.

In addition to its goals as an intervention program, Healthy Steps incorporates several important research objectives. Bernard Guyer, M.D., and a team of researchers at the Johns Hopkins University School of Hygiene and Public Health are conducting an ongoing national evaluation of the Healthy Steps approach. Early findings suggest that Healthy Steps is making a difference. After being enrolled in the program for 2–4 months, parents say they are more satisfied with their pediatric providers and, by 6–12 months, are more likely than comparison parents to turn to them with questions about their child's behavior and development. Significantly, Healthy Steps parents are also more likely than comparison parents to follow the American Academy of Pediatrics safety recommendations regarding infant sleep position. Over the next few years, the national evaluation will document the program's effectiveness by measuring child outcomes (including behavior, language ability, and social skills), parents' satisfaction with pediatric care and their own skills and confidence, and cost effectiveness.

Efforts to sustain the program past the initial three-year period have been begun by the existing practices, and 16 of the 24 sites are now offering Healthy Steps services to over 1,600 families

**Healthy Steps provides parents with important information about their young children’s growth and development—and parents appear to be putting it to good use. For example, early evaluation findings show that control group parents are more likely than parents enrolled in Healthy Steps to lay their babies down to sleep on their stomachs, a position considered unsafe by the American Academy of Pediatrics.**

Percent of parents using the wrong infant sleep position



Note: Owing to increased risk of Sudden Infant Death Syndrome, the American Academy of Pediatrics recommends against putting infants down to sleep on their stomachs.

Source: Health Steps for Young Children National Evaluation Working Paper, vol. 1, no. 9. Data were obtained from parent interviews at 2–4 months;  $p < .05$  at randomization sites.

beyond those participating in the evaluation. The approach has been integrated into pediatric residency training programs at eight sites, where residents are learning to make home visits, conduct child development and family health check-ups, and provide guidance about child rearing and behavior. The national program office is currently exploring public and private reimbursement mechanisms that could make Healthy Steps more financially viable in the long term.

Meanwhile, Healthy Steps continues to spark enthusiasm within other institutions. Four new community-based practices have begun integrating Healthy Steps into their primary care practices,

and a major urban public health system is using Healthy Steps to deliver services to high-risk young mothers. Four additional residency training programs have begun to integrate Healthy Steps into their curricula. In addition, Healthy Steps was an important source of information in the Fund’s development of its Assuring Better Child Health and Development (ABCD) program, which focuses on the needs of low income families.

The Fund is also reaching out to make the lessons of Healthy Steps available to more pediatric clinicians. In 1998, Independent Production Fund, Inc., and Toby Levine Communications, Inc., began collaborating with the Healthy Steps training team to create a multimedia package of video, CD-ROM, and print materials. Now available, this new package should become a flexible and inexpensive training resource. Another potentially valuable tool is being developed by Michael Regalado, M.D., of Cedars-Sinai Medical Center, who is preparing a protocol that will enable pediatricians to identify parents’ needs and concerns, quantify family risk factors, and assess the developmental and behavioral well-being of young children.

In the year ahead, the Fund will consider the results of the Healthy Steps evaluation and encourage the broader adoption of the most effective elements through the planned diffusion of the Healthy Steps approach.



Four states are now working with the Fund to introduce developmental services into the care provided to low income families through the Medicaid program. At a model pediatric clinic in Greensboro, North Carolina, a reading coordinator helps parents understand the role of

books and reading in children's growth and development. In Vermont, state Medicaid director Paul Wallace-Brodeur (right) has helped make his state an innovator in the provision of high-quality care for young children.



## Assuring Better Child Health and Development Program

Last year, inspired by the promise of Healthy Steps, the Fund launched the Assuring Better Child Health and Development (ABCD) Program. Dedicated to strengthening the capacity of the health care system to provide low income parents with the knowledge and skills necessary to support their young children's healthy development, ABCD emphasizes new opportunities to expand child development services through Medicaid, children's health programs, and community health centers. Specific objectives include working with Medicaid officials to improve well-child health care, enhancing parents' knowledge and use of beneficial child-rearing practices, and identifying family risk factors.

Because states have primary responsibility for implementing health care programs for low income families, the ABCD program works with state Medicaid agencies to develop projects to aid the healthy growth of low income young children. Patricia A. Riley and colleagues at the National Academy for State Health Policy (NASHP) recently managed the establishment of a four-state initiative involving North Carolina, Utah, Vermont, and Washington. Grants from the Fund are enabling the states to create new service models and test innovative policies. Through NASHP, the states have formed a working consortium to exchange information, promote collaboration, and encourage other states to adopt similar strategies.

An evaluation of the initiative is being led by Peter Budetti, M.D., director of the Institute for Health Services Research and Policy Studies at Northwestern University. Dr. Budetti also provides overall guidance to the Fund on this program.

In the year ahead, as the four states develop their initiatives, the program will work with NASHP to monitor progress and consider the potential value of replicating the most successful strategies in other states. In addition, focus groups and surveys will be used to gather feedback on families' health care experiences and needs.

By providing the right incentives and supports, federal agencies and national health care organizations can encourage states to improve the delivery of child health and development services. Sara Rosenbaum, of George Washington University, is devising new approaches to federal health policy that would help states move toward more effective child health care delivery and payment systems. She has also developed model language to assist state Medicaid agencies in purchasing child development services from managed care organizations.

Christina Bethell, at the Foundation for Accountability (FACCT), is refining a set of measurements to gauge the performance of managed care plans in providing parents with child development information and services. The measures are based on a parent survey,

fielded in collaboration with state Medicaid agencies in Maine and Washington. FACCT is using the survey to collect baseline information on Medicaid families in North Carolina, Vermont, and Washington to guide development of the states' ABCD projects.

### Picker/Commonwealth Program on Long-Term Care for Frail Elders

During the past year, the Fund's work under the Picker/Commonwealth Program on Long-Term Care for Frail Elders has become increasingly focused on stimulating improvements in the delivery of care to the frail elderly, especially the 1.6 million elderly residents of the nation's 16,800 nursing home facilities. This work builds on the Fund's previous experience with the Restraint-Free Nursing Home Program, which played a significant role in providing training and other support that enabled nursing homes to reduce their reliance of physical restraints.

An evaluation by researchers at the American Association of Homes and Services for the Aging is examining the impact of the Wellspring Program, an innovative approach to quality improvement created by a consortium of nursing homes in Wisconsin. Under the Wellspring model, participating homes establish teams of front-line staff across facilities and authorize them to identify

problems in quality of care, devise solutions, and implement new procedures to solve the problems. Senior managers also work together to monitor and compare outcomes for residents in each facility. The evaluators hope to develop findings about the collaborative model itself, improvements in resident care, and changes in job satisfaction and longevity among staff members.

In addition, the Fund is continuing its commitment to the Elder Life Program, developed by Sharon Inouye, M.D., at the Yale University School of Medicine. Over several years of field testing, the program has proven effective in preventing delirium in elderly hospitalized patients. The Fund is now supporting two related projects to aid the effective replication of the program. Three tertiary hospitals — Intermountain Health System's LDS Hospital in Salt Lake City, Veterans Affairs West Haven Hospital in West Haven, Connecticut, and Mount Sinai Hospital in New York City — have begun to implement the program at their own institutions. In the coming year, Dr. Inouye will continue to lead the expansion of the program to additional hospitals, while Mark Schlesinger, also of the Yale University School of Medicine, will conduct research on the effectiveness of the replication effort.



The quality of care in American nursing homes—and therefore residents' satisfaction with their quality of life—is often a function of the concern and vigilance shown by front-line staff members. In Wisconsin, the Wellspring Program enables staff from a coalition of nursing homes to work together to

diagnose quality problems and devise practical solutions. An evaluation of the program, supported by the Fund, will document the program's most effective features and allow Wellspring's executive director, Mary Anne Kehoe (left), to share its lessons more widely.



## Paul Beeson Physician Faculty Scholars in Aging Research Program

The Paul Beeson Physician Faculty Scholars in Aging Research Program is a nationally competitive fellowship program devoted to addressing the shortage of academic leaders committed to careers in aging-related research, teaching, and practice. Named in honor of Dr. Paul Beeson, the distinguished physician and scholar whose leadership has profoundly influenced medical education and aging research, the program is the largest research and teaching award of its kind. It strives to attract and retain physician-scientists who possess the clinical and scientific knowledge needed for aging research and to build collaboration on issues of aging among physicians trained in a range of specialties.

Initiated in 1994, the program has since awarded three-year fellowships to 61 junior faculty physicians from 29 institutions. Scholars are paired with senior faculty members who serve as mentors, providing research expertise and career guidance. Each fellow carries out a research project on the age-related aspects of morbidity and disease, on topics ranging from alcohol abuse in older persons to risk factors for Alzheimer's disease. The Beeson Scholars Program has begun to address the shortage of

physician-scholars in aging research, and its scholars have made important contributions to the field nationally and to their local institutions' aging programs.

The program is directed by T. Franklin Williams, M.D., scientific director of the American Federation for Aging Research, and administered jointly with Daniel Perry of the Alliance for Aging Research. Major funders are the John A. Hartford Foundation and the Alliance for Aging Research on behalf of donor friends. The Commonwealth Fund formerly supported the fellowships directly and currently supports the annual meeting of fellows, alumni, and mentors.

## Task Force on Academic Health Centers

The Task Force on Academic Health Centers seeks to address the impact of a changing health care financing system on the traditional missions of academic health centers: medical education, biomedical research, specialized health care services, and, at many institutions, care for indigent and uninsured patients. Task force staff at Massachusetts General Hospital, working with analysts at Georgetown University and the Association of American Medical Colleges, are developing independent information about the future of academic health centers (AHCs) and supplying information to AHC leaders and policymakers. The task force is chaired by Samuel O. Thier, M.D., president and chief executive of Partners HealthCare System in Boston.

David Blumenthal, M.D., professor of medicine at Harvard Medical School and director of the Institute for Health Policy at Massachusetts General Hospital, serves as program director.

Reduced government support and stiff competition are prompting many AHCs to create new strategies to cope with the growth of managed care. A recent Fund-supported study, “Academic Health Centers on the Front Lines: Survival Strategies in Highly Competitive Markets,” published last fall in the journal *Academic Medicine*, describes how AHCs in California and Oregon are changing the way they carry out their

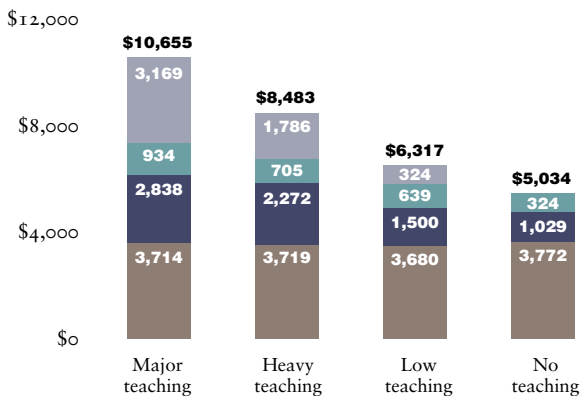
educational and specialty care missions. The authors — program director Blumenthal, Joel S. Weissman, and Paul F. Griner, M.D., of the Association of American Medical Colleges, show that the new strategies fall into four main categories: increasing revenue by exploiting market niches, streamlining management and improving decision making, conducting primary care outreach, and reducing costs.

The newest task force report, *Health Care at the Cutting Edge: The Role of Academic Health Centers in the Provision of Specialty Care*, warns that some highly specialized services, including burn and trauma care, transplants, inpatient AIDS treatment, and neonatal intensive care, may be threatened in competitive health care markets if cost is allowed to take precedence over innovation. The task force recommends that government step in where private markets fail to pay reasonable costs for specialty services, and that payments be tied to AHCs’ ability to provide high-quality care and control costs.

**The cost of care tends to be higher in academic health centers than in hospitals with less commitment to graduate medical education. Other mission-related activities that increase AHC costs include specialized services, maintaining standby capacity (to treat burns or trauma, for example), and clinical research. Labor costs and case mix (or the complexity of cases treated) also play a role.**

- Mission-related activities
- Case mix
- Labor factors
- Base costs

Composition of hospital costs, by level of teaching activity\*



\*Based on ratio of interns or residents to beds.

Source: Georgetown University analysis of data in Coleman et al., *Estimating Provider, Training, Standby Capacity and Clinical Research Costs Using Regression Analysis*, Lewin Associates, 1999.



By opening new paths for collaboration and exchange, the Fund has often succeeded in prompting innovative work. For example, a recent meeting of health officials from the U.K. and the U.S. — including Dr. Liam Donaldson (above, center), chief medical officer for the U.K. Department of Health, Eric Schneider, M.D., of

the Harvard School of Public Health, and others — yielded several proposals for improving health care quality in both nations. Through an international issue of the journal *Health Affairs*, founding editor John K. Iglehart (right) brings lessons from health systems around the world to a policy audience.

