April 2002

Issue Brief

Improving Health Care Quality: Can Federal Efforts Lead the Way?

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Introduction

The quality of health care in the United States is on the national policy agenda. Research suggests that quality of care varies across different population groups, regions, and institutions and among clinicians.[1] The significant changes that occurred in the U.S. health care delivery system since the advent of managed care focused the attention of purchasers, payers, providers, and consumers on the state of health care quality, the reasons why quality deficiencies arise, and ways to improve quality. The federal government has assumed a central role in developing better ways to measure quality, gathering evidence regarding quality problems, and implementing strategies to address them.

Quality of Care in the U.S. Health Care System

The Institute of Medicine (IOM) defines quality in health 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."[2] Over the past two decades, evidence of quality deficiencies has mounted, demonstrating widespread misuse, overuse, and underuse of clinically effective treatments.[3] Evidence has also emerged that the quality of health care is uneven, with gaps in acute, chronic, and preventive care across regions, populations, and systems of care. In 1999, the IOM's Committee on Quality of Health Care in America issued a report, *To Err Is Human,* documenting serious errors in medicine and recommending strategies to reduce medical errors by 50 percent over the next few years.[4] The report garnered substantial media attention

This *Issue Brief* was prepared for The Commonwealth Fund/John F. Kennedy School of Government, Harvard University Bipartisan Congressional Health Policy Conference, January 17–19, 2002.

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and galvanized the health care community in both the public and private sectors to address the problem. These efforts to reduce the occurrence of errors and improve patient safety are only one component of a larger endeavor to improve health care quality in the United States.

In 2001, the IOM committee followed up its earlier report with a broader examination of the quality of U.S. health care. This report, *Crossing the Quality Chasm,* documents the causes of the quality gap in the health care system, identifies current practices that impede quality care, and explores how systems approaches can be used to implement change.[5] The committee suggests that health care in the United States has safety and quality problems because it relies on outmoded systems. The U.S. health care system is characterized as a "highly fragmented web that often wastes resources by providing unnecessary services and duplicating efforts, leaving unaccountable gaps in care and failing to build on the strengths of all health professionals."[6] The report concludes that improving quality is not simply a matter of improving current systems of care, but that these systems need to be restructured to achieve safer, higher quality care. The committee's recommendations include new rules to guide patient-provider relations, ways to align payment and performance incentives with quality improvement, and steps to promote evidence-based practice and strengthen clinical information systems.

The Role of Federal Agencies in Health Care Quality Improvement

Public and private sector organizations that purchase and provide health care are increasingly being held accountable for quality. Leaders in Congress and the executive branch recognize that the federal government, as the largest provider and payer of health care in the United States, can play a valuable role in accelerating progress in quality improvement activities. Millions of Americans are served by various federal health programs, including Medicare, Medicaid, the Federal Employees Health Benefits Program, the Indian Health Service, the Veterans Health Administration (VHA), and the Bureau of Primary Health Care (BPHC). Federal program beneficiaries receive care at a variety of public facilities across the country, including veterans' hospitals, nursing homes, and community health centers, as well as from private providers.

To achieve improvements in quality, the federal government is taking a lead in efforts to reorient the health care system toward improving primary care, preventing medical errors, and providing quality information to physicians and patients. Major quality activities of the federal government include:

- conducting research on care improvement, quality measurement, and patient safety;
- providing people with information to assist them in making choices about health care;
- improving the care delivered by federal providers and purchased for federal beneficiaries;
- improving safety and quality through value-based purchasing;
- developing the information infrastructure needed to improve the health care system.

The VHA: Reducing Medical Errors and Increasing Patient Safety

The Veterans Health Administration (VHA) within the Department of Veterans Affairs (VA) is the largest integrated health care system in the United States, with a budget of more than $20 billion. The VHA provides health care to veterans through approximately 180,000 staff, 173 medical centers, over 771 ambulatory care and community-based clinics, 134 nursing homes, 42 residential facilities, 206 counseling centers, and various other facilities.[7] In addition to its medical care mission, the veterans' health care system is the nation's largest provider of graduate medical education and one of the nation's largest medical research organizations. The VHA is an important part of the health care safety net in the United States because over 42 percent of its patients are low-income veterans who might not otherwise receive care. It also is a leading health care provider for veterans with substance-abuse problems, mental illness, and HIV/AIDS. In FY1998, more than 3.4 million of 26 million veterans used the VHA system.

The VHA's national presence, size, and status as a government entity, plus its vital role in medical research and training, enhance its potential to serve as a national model for quality improvement efforts. Once criticized for the quality of care it provided, the VHA has created programs aimed at raising quality standards throughout the system. In 1995, the agency

underwent extensive reorganization and initiated a number of programs designed to improve quality and efficiency. The VHA is now seen as a leader in many areas of health care, including quality-related issues such as patient safety and quality assessment. The VHA defines quality from many perspectives, with technical quality of care most relevant to patient safety, but its quality initiatives are also focused on access to care, patient satisfaction, and improving patients' functional status. The VHA's quality management strategy includes programs to improve health outcomes, to ensure that providers are competent and well trained, and to maximize the use of technology to achieve health outcome goals.

In 1997, the agency initiated an effort to improve patient safety in VHA facilities. Research suggests that many adverse medical events appear to be preventable and their causes attributable to system design and structural issues rather than to individual provider mistakes.[8] Accordingly, the VHA is taking a systems approach that emphasizes prevention rather than punishment as the preferred method to accomplish quality improvement. By focusing its analysis primarily on systems and processes rather than on individual performance, the agency attempts to identify the basic causal factors that underlie variations in performance associated with adverse events. The overall goal is to measure, develop, and implement methods that minimize the occurrence of negative outcomes associated with medical errors. In 1998, a National Center for Patient Safety within the VHA was created to lead and integrate the agency's patient safety efforts, and to develop a "culture of safety" in its medical facilities.[9]

To track and monitor the occurrence of medical errors, the VHA created a National Patient Safety Registry that involves both voluntary and mandatory reporting. In 2000, the VA entered into a four-year, $8.2 million agreement with the National Aeronautics and Space Administration (NASA) to develop and administer a voluntary Patient Safety Reporting System that lets VA employees report errors confidentially. Anonymous reporting lessens the fear of reprisal, which encourages disclosure of adverse events that otherwise might go undetected or unreported. The VHA system is modeled after the Aviation Safety Reporting System, which NASA operates for the Federal Aviation Administration (FAA). The VHA also established four Patient Safety Centers of Inquiry. Funded through a competitive process, these centers were awarded approximately $500,000 each for next three years to conduct research that identifies safety techniques and technologies and to function as "learning laboratories" for the development and dissemination of evidence-based patient safety practices. Other concrete steps that the VHA is taking to improve quality within its delivery system include a bar code medication administration system for inpatient medications, which also screens for potential problems such as drug interactions, and a computerized medical record that combines prescription order entry with laboratory, radiology, and encounter information.

The VHA has dedicated $478 million over three years to support its national quality improvement and patient safety initiatives. Undertaking such a quality improvement effort is unprecedented in a health care system of the VHA's size, and it may be too early in the implementation of these initiatives to predict they will be successful in returning measurable improvements. Nevertheless, the efforts represent an important step in advancing systemwide quality improvement and could stimulate similar activity within the private sector.

HHS: Advancing Research on Quality at AHRQ

The Agency for Healthcare Research and Quality (AHRQ) within the Department of Health and Human Services (HHS) is the lead agency for the federal government on research on the health care system, including issues related to cost, access, health outcomes, and quality. AHRQ is involved in a broad array of quality-related research topics, including studies to develop valid and reliable measures of the process and outcome of care, causation and prevention of errors in health care, and dissemination and implementation of validated quality improvement methods.[10] In 2000, AHRQ initiated research for the first annual report on U.S. health care quality, *The National Quality Report* (NQR). When completed, the NQR will show how the health care system is faring and where improvements may be needed.

As part of AHRQ's broader quality agenda, a Center for Quality Improvement and Patient Safety has been created within the

agency. Its goals are to conduct and support research on the measurement, improvement, and reporting of health care quality and the enhancement of patient safety; to promote the translation of research findings into improved practices and policies; and to educate patients, consumers, and health care providers about patient safety. AHRQ plans to develop a clearinghouse to disseminate information on patient safety practices that researchers have identified as effective. Currently the agency disseminates consumer information brochures and patient guides on improving health care quality, choosing quality health care, and helping to prevent medical errors.

President Bush's FY2002 budget proposal for HHS provides $306 million for AHRQ, an increase of $36 million, or 13.5 percent, over FY2001. Of this amount, $26 million supports additional research on the cost effectiveness and quality of health care and $53 million is allocated for research on reducing medical errors. In October 2001, HHS announced a new research initiative within AHRQ to address patient safety and medical errors, with an initial investment of $50 million in grants. The awards will support research in these areas: supporting demonstration projects to report medical errors data; using computers and information technology to prevent medical errors; developing innovative approaches to improve patient safety; understanding the impact of working conditions on patient safety; and disseminating research results.

BPHC: Ensuring Quality in Primary Health Care Services

The mission of the Bureau of Primary Health Care (BPHC), a division of the Health Resources and Services Administration, is to increase access to primary and preventive health care and to improve the health status of underserved and vulnerable populations. In the delivery systems that BPHC supports, such as federally qualified health centers, the bureau has established quality improvement goals in patient care, service delivery, the health care workforce, and health outcomes. BPHC also seeks to ensure that services provided to its ethnically diverse program recipients are culturally competent. The bureau is working with a global health education organization to develop a web resource to increase awareness and understanding of cultural competence among primary health care providers.

BPHC established a Quality Center to provide a coordinating point for its quality-oriented initiatives and a focus for strategic planning to enhance primary health care quality. The Quality Center is designed to assist health care organizations connected to BPHC throughout the United States to provide high-quality, culturally competent services. Activities of the Quality Center include:

- redesigning the patient visit at community health centers to enhance productivity and patient satisfaction;
- developing a patient satisfaction quality improvement survey;
- implementing evidence-based guidelines for primary care disease management;
- convening a patient safety task force;
- establishing a quality management network to provide a national forum for community-based health care leaders to exchange quality improvement strategies.

CMS: Health Care Quality Improvement for Medicare and Medicaid

The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, is responsible for ensuring that institutions that provide services to Medicare and Medicaid beneficiaries meet certain standards. A recent study of health outcome measures of Medicare beneficiaries suggested that performance varies greatly across states.[11] Across all states for all measures, the percentage of beneficiary patients who received 24 process-of-care measures related to primary prevention, secondary prevention, or treatment of six medical conditions ranged from a high of 95 percent to a low of 11 percent. This study suggests that there are substantial opportunities to improve the care delivered to Medicare beneficiaries.

In pursuit of this goal, CMS has established a variety of quality improvement programs. These projects focus on institutional providers and settings of care such as home health agencies and skilled nursing facilities, care delivery systems such as managed care, and clinical conditions such as breast cancer, diabetes, flu/pneumonia, and stroke. The Quality Improvement System for Managed Care (QISMC), established in 1996, sets quality stan-

dards for managed care plans that serve Medicare and Medicaid populations. The QISMC guidelines clarify the responsibilities of CMS and the states in promoting quality as purchasers of services for vulnerable populations.

CMS also works with state-based Peer Review Organizations (PROs) to improve care for Medicare beneficiaries. In 1992, the PROs were transformed into organizations with staffs of medical professionals trained in quality improvement. PRO staff analyze patterns of care and feed these data back to providers to improve care for patients with common illnesses. Also in 1992, CMS initiated the Health Care Quality Improvement Program in conjunction with PROs, focusing on six clinical priority areas: acute myocardial infarction, breast cancer, diabetes, heart failure, pneumonia, and stroke. These priorities were chosen based on their public health importance and the feasibility of measuring and improving quality in these areas. CMS has also developed performance-based contracts with PROs to improve patient outcomes nationwide.

Interagency Efforts to Improve Quality

Along with activities at individual federal agencies, collaborative interagency efforts are underway to promote a high-quality health care system. In March 1998, President Clinton mandated the establishment of the Quality Interagency Coordination Task Force (QuIC) as a vehicle for promoting collaboration among the federal agencies with health care responsibilities to improve the quality of care. The aim is to ensure that all federal agencies involved in purchasing, providing, researching, or regulating health care services are coordinating their efforts toward a common goal of improving quality. Together, the Secretaries of HHS and Labor lead this activity and the Director of AHRQ serves as the operating chair. Members of QuIC include the Departments of HHS, Defense, VA, Labor, and Commerce, the Office of Personnel Management, the Office of Management and Budget, the Coast Guard, the Federal Bureau of Prisons, the National Highway Traffic Safety Administration, and the Federal Trade Commission. A major focus of QuIC activity has been to identify ways to address the problem of medical errors. Other areas for collaborative work include improving patient and consumer information on health care quality, identifying opportunities for improving clinical quality, improving efforts to measure quality, developing the health care workforce, and improving information systems.[12]

HHS also created a Patient Safety Task Force, a joint effort among AHRQ, the Centers for Disease Control and Prevention, the Food and Drug Administration, and CMS, to improve existing systems for collecting patient safety data. The task force will work to develop a unified reporting system to make it easier for providers to communicate information on adverse events, and to identify the data that health care providers, states, and others need to improve patient safety.

Recent Federal Legislation Related to Quality Improvement

Given the prominent national spotlight on patient safety, many Members of Congress have focused legislative proposals on ways to reduce medical errors in the health care system. Legislation responding to some IOM recommendations in the *To Err Is Human* report was introduced in the 106th Congress. While no action was taken on these bills in 2000, the issue of health care quality has reemerged on the 107th congressional agenda. Legislation has been introduced in the Senate and the House of Representatives to require public disclosure by Medicare providers of staffing levels and quality performance data to improve consumer information and promote choice. Another proposal would prohibit discrimination or retaliation against health care workers who report unsafe conditions and practices that affect patient care. Legislation also has been sponsored to establish a health information technology grant program for hospitals, skilled nursing facilities, and home health agencies, to assist these providers with costs related to implementing information systems designed to reduce adverse events and complications resulting from medication errors. Other proposals address the quality of care delivered by the VA and in nursing homes. No action has been taken on these bills.

Challenges and Barriers to Quality Improvement

In accordance with its emphasis on the systems-related nature of quality problems, the IOM has identified a specific set of challenges for the

entire system of care in the United States.[13] These include:

- redesigning care processes to serve the needs of the chronically ill more effectively;
- making better use of information technology to automate clinical information and to make it more accessible to patients and providers;
- managing the growing medical knowledge base and ensuring that the health care work-force has skills they need;
- coordinating care across patient conditions, services, and settings over time;
- advancing the effectiveness of teams;
- incorporating care process and outcome meas-ures into the delivery of health care.

The federal government has taken up many of these challenges. Yet, as quality-improvement activities proliferate across the country in both the private and public sectors, significant barriers to achieving quality gains in the general delivery system persist. These include a lack of purchaser and consumer demand for higher quality, the high investment cost of adopting the necessary measurement and improvement systems, and financial incentives that favor cost-reducing over quality-improving investments.[14] Moreover, existing measures of quality tend to focus on easily quantifiable processes and outcomes, and as a result, quality improvement activities may neglect important aspects of care delivery which are more difficult to measure.

Conclusion

Improving the quality of health care will continue to be a high priority among policymakers, providers, and the public. Various agencies of the federal government have assumed leadership roles in this effort. These agencies are setting an example for purchasers and providers of care throughout the country by making vital investments in research regarding the best practices to enhance quality and patient safety, and taking steps to implement care processes and delivery systems that promote high-quality care. Ultimately, success in quality improvement will require public education, government investment and regulation, payment system restructuring, and leadership from within the public and private sector delivery systems.[15]

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