Quality Matters

THE COMMONWEALTH FUND

Tracking Hospital Performance

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Welcome to Quality Matters, a bimonthly roundup of news and opinion on quality and efficiency, information technology, performance improvement initiatives, and policy innovations.

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In Focus: Paying Attention to Performance Data

Summary: *An updated analysis of Hospital Quality Alliance data by Harvard School of Public Health researchers shows that hospitals have made greater-than-expected strides in improving care for patients suffering from acute myocardial infarction, heart failure, and pneumonia. Quality Matters asked the researchers who analyzed the data, Arnold M. Epstein, M.D., and Ashish K. Jha, M.D., M.P.H., what they conclude from the results.*

By Sarah Klein

When Harvard School of Public Health faculty Arnold M. Epstein, M.D., and Ashish K. Jha, M.D, M.P.H, published their first analysis of data supplied by hospitals to the Hospital Quality Alliance in 2005, the results weren't very reassuring.

Not only was the quality of hospital care for three conditions—acute myocardial infarction (AMI), heart failure (HF), and pneumonia—less than optimal, it varied widely by geographic region and type of hospital. It also varied across conditions within individual hospitals, disproving the popular notion that a good hospital is good at treating all problems. A subsequent study by Epstein and Jha showed why the widespread

variation was problematic: poor performance on these indicators, which measure adherence to evidence-based processes of care, was associated with higher risk-adjusted mortality for each of the three conditions.

It appears that hospitals have been tracking their performance. An update of the analysis, done by the same Harvard researchers for the current issue of *Quality Matters,* shows hospitals nationwide made great strides in improving their performance in just 18 months. The median score, which reflects a summary of performance on all 10 quality indicators, increased five points to 89.1, according to the second analysis, which compared HQA data from July 2005 to June 2006 to data from January to December 2004. The improvement was even more dramatic in the treatment of pneumonia and heart failure, for which performance had been low in the first analysis. The data also showed that, for all three conditions, the gap between the scores of the worst-performing hospitals and the best-performing hospitals narrowed.

The second analysis also examined data supplied by hospitals on 12 additional measures, which cover the original three conditions and one new area: the prevention of surgical infections. While hospitals did not perform as well on the new measures as the older ones, they were clearly paying attention to them. Performance declined only a small amount as a result of the additional measures.

Quality Matters asked Epstein and Jha to share their interpretation of the results from this second analysis.

Q: Were you surprised by the results?

Jha: The magnitude of increase in quality scores across the board was surprising. We saw dramatic improvements in scores in all conditions. The biggest surprises were in areas like pneumonia care, where national scores increased nearly 10 points. We had expected that, while individual organizations might show dramatic improvements, national scores would rise by one or two points for a condition. The magnitude of the change seems to suggest that public reporting itself can be a powerful catalyst for improvement.

Q: In what areas did you see the greatest improvement and why?

Jha: The largest improvements were in those conditions where the initial scores were lower, such as congestive heart failure and pneumonia. This is, of course, not surprising since these conditions represented the greatest opportunities for improvement.

Epstein: We have seen this pattern of improvement in several studies of pay for performance. When we draw attention to performance, those at the lower end of the spectrum seem to make the greatest improvements.

Q: The current set of data measures hospital performance on 22 measures, more than double the previous year. Did adding measures lower their scores?

Jha: Expanding the data set had only modest effects. When we included measures that were recently added to the public reporting program, there was only a slight decrease in national performance on these quality scores.

Q: What do you conclude from that?

Jha: We expected to see a bigger drop because hospitals had a much shorter time period to focus on these new measures. The fact that the drop was modest suggests that hospitals likely knew these measures were

going to be adopted for public reporting and began to focus in these areas.

Q: In a year-to-year comparison on the same measures, it appears the low performers improved significantly in some categories, while top performers stayed more or less where they were. What do you make of this?

Jha: Given that the top performers were already well above 90 percent, it is not surprising that their performance didn't change very much. First, they had very little room to improve. Second, improving when your performance is already very high is very costly, and we suspect that most high-performing hospitals wisely chose to invest their quality improvement efforts elsewhere.

Epstein: In two studies of pay-for-performance programs, one by Meredith Rosenthal, Ph.D., and colleagues and the other by Peter Lindenauer, M.D., M.Sc., and colleagues, we have seen the largest improvement by medical groups and hospitals that initially had the lowest performance and were not likely to attain levels of performance that would be above the pay line. There are two potential overlapping explanations: improvement is easier when initial performance is low; and pay for performance not only motivates providers by the financial incentive, but it also has signaling value that heightens the impact of public reporting and particularly effects low-performing providers.

Q: Did you notice any significant changes in the state rankings?

Jha: While there are some differences in state rankings, those that tended to be high performers in the last report are still the high performers, and vice-versa.

Q: Are we setting the bar high enough using composite scores? Right now, hospitals are getting credit for providing some of the required care. Would we see more improvement if hospitals only got credit when they followed all of the recommended guidelines? If such an all-or-nothing approach were used, how would you introduce it without provoking a backlash from the provider community?

Jha: I do think that the utility of these composite measures is diminishing as performance gets very high. All-or-nothing measures would, of course, be more challenging and therefore give providers something to strive toward. The backlash from the provider community would be manageable if the HQA program chose to go down this road.

Epstein: I think we need to wrestle more with the issue of cost-effectiveness. We need to try to improve performance for quality indicators that represent the greatest opportunity to improve health outcomes. Similarly, we need to focus attention on indicators where improving current levels of performance can be done cost effectively. Getting from 99 to 100 percent may be laudable but difficult and expensive to achieve.

Q: How else would you refine the current measures?

Jha: We clearly need more breadth. These measures are narrowly tailored toward care for three common medical conditions (plus infection prevention in surgery). Given that these three conditions represent less than 15 percent of hospital care for the elderly, developing measures for other conditions and focusing on other aspects of care, such as patient safety, is critical.

Q: At what point do such process measures become too prescriptive?

Jha: Given that each of these measures is evidence-based, even if it is prescriptive—I favor using them. The issue is that people might choose to focus on these and ignore other aspects of care. Therefore, more global measures, such as patient outcomes, are valuable.

Q: Is there a risk of unintended consequences? Could the zeal to hit targets lead to overtreatment?

Jha: You always have to worry about unintended consequences. The solution is to put measurements in the data system to test for them.

Q: Should we retire measures once hospitals achieve the desired results?

Jha: There is very little value in active surveillance of measures where everyone has achieved performance in the mid to upper 90s. Therefore, removing these measures from an active surveillance or incentives program makes sense. However, given that we don't know if "retiring" them will lead to a drop in future performance on these measures, some ongoing monitoring to ensure that these essential aspects of care are still being delivered at a high rate is important.

Q: What do you think about exempting hospitals that demonstrate consistently high performance? How would you define high performance: a perfect score or something less?

Jha: Even high-performing hospitals should be subject to ongoing performance measurement and monitoring. This performance measurement program is not particularly onerous and ensuring that there is universal participation is valuable.

Perfect scores are difficult to achieve and not necessarily the goal. Clinical documentation is rarely perfect and, occasionally, organizations will fail to achieve perfection due to issues of documentation. It is more important that an organization be near perfect consistently across conditions over a long period of time.

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Case Study: Improving Performance at Charleston Area Medical Center

By Martha Hostetter

Summary: *Multidisciplinary improvement teams at a medical center in Charleston, W. Va., implemented new care processes, supported by "change agents" and rapid-response data reporting, that led the hospital to achieve benchmark performance across multiple indicators of health care quality.*

Introduction

The Hospital Quality Alliance (HQA), a public/private collaborative effort to measure and publicly report on the quality of hospital care, now measures performance on 22 process-of-care measures. Specifically, it examines what percent of patients receive evidence-based processes of care for acute myocardial infarction (AMI), heart failure (HF), pneumonia, and prevention of infection related to surgery. Because the Centers for Medicare and Medicaid Services

(CMS) provides higher reimbursements to hospitals that report HQA data, nearly all do so. The quality results are posted on the CMS Web site, Hospital Compare.

As discussed in this month's *In Focus* article, analyses of the HQA data have found that performance on these indicators varies widely and that better performance is associated with lower risk-adjusted mortality for AMI, HF, and pneumonia. [1] An analysis for the December 2005 issue of *Quality Matters,* completed by Harvard University researchers, used HQA data to identify the top-performing hospitals on composite measures of quality across the three clinical conditions then being measured (AMI, HF, and pneumonia). The case study for that issue looked at how one top performer, Reid Hospital & Health Care Services, was able to achieve high-quality care for multiple conditions.

For the current issue, *Quality Matters* asked the same Harvard researchers to once again identify the top-performing hospitals, this time using HQA data from July 2005 to June 2006 for the 21 indicators of quality care hospitals reported on during that time period (for AMI, HF, pneumonia, and surgical infection prevention). Their analysis placed Charleston Area Medical Center among the top performers (Table 1).

Issue

Public reporting of standard health care quality measures helps hospitals to understand how well they are performing compared with their peers, gives them targets for improvement, and provides external motivation to improve. In addition, the reports enable consumers to compare hospitals and select the best institutions for their particular conditions.

Table 1. Top Hospitals: Composite Measures of Health Care Quality in Four Areas
(AMI, HF, Pneumonia, and Surgical Infection Prevention)

Hospital	City	State
Charleston Area Medical Center	Charleston	WV
St. Joseph's Mercy Health Center, Inc.	Hot Springs	AR
Meriter Hospital	Madison	WI
Mercy San Juan Medical Center	Carmichael	CA
Crozer Chester Medical Center	Upland	PA
Mercy Medical Center	Redding	CA
Wheeling Hospital	Wheeling	WV
Centura Health-Penrose St. Francis Health Services	Colorado Springs	CO
Barnes Jewish Hospital	Saint Louis	MO
York Hospital	York	PA

Source: A.K. Jha et al. (2007) Unpublished analysis of Hospital Quality Alliance data collected by the Centers for Medicare and Medicaid Services.
Note: AMI is acute myocardial infarction; HF is heart failure. Indicators for each condition are available at http://www.hospitalcompare.hhs.gov.

Organization

Established in 1972, Charleston Area Medical Center (CAMC) is West Virginia's largest medical center, with more than 5,000 employees. CAMC is a nonprofit, 893-bed, regional referral and academic medical center composed of three facilities: General Hospital, Memorial Hospital (which includes the nation's fourth largest cardiology program), and Women and Children's Hospital.

Dale Wood, M.B.A., M.H.A., vice president for system performance and chief quality officer, and Glenn Crotty, M.D., executive vice president and chief operations officer for CAMC Health Systems, Inc., lead the hospital's improvement efforts.

Target Populations

The medical center's improvement initiatives focus on various care processes and/or patient populations, including those targeted by the Hospital Quality Alliance reports (patients with AMI, HF, pneumonia, and those who undergo surgery).

Implementation Timeline

CAMC began to focus on performance improvement in 2000. Since then, it has initiated more than 100 quality improvement projects across its three facilities.

In 2003, CAMC joined the CMS/Premier Hospital Quality Improvement Demonstration, a voluntary program in which more than 260 facilities submit data on process-of-care and outcome measures for AMI, coronary artery bypass graft, pneumonia, HF, and hip and knee replacements. As part of the demonstration, hospitals performing in the top two deciles were promised higher payments for their Medicare patients.

In 2004, CAMC began reporting data through the HQA initiative.

Key Measures

The CMS/Premier demonstration includes all of the process-of-care measures reported through HQA. In addition, participating hospitals report on patient safety indicators and on patients' perspectives of their care, using items from the Hospital CAHPS (Consumer Assessment of Healthcare Providers and Systems).

Process of Change

Overall, the medical center's improvement process includes the following steps:

- **Implementing process improvement tools.** CAMC uses the Six Sigma methodology—Define, Measure, Analyze, Improve, and Control—to examine quality problems and standardize care processes.

- **Collaborating in multidisciplinary improvement teams.** The teams focus on areas for which there is good information on evidence-based care, including AMI, HF, pneumonia, and surgical infection prevention. Other teams focus on dispensing antibiotics for hysterectomy patients, reducing central line infections, and providing end-of-life care. The teams report to the evidence-based steering committee, which examines improvement efforts across clinical areas.

- **Focusing on evidence-based processes of care.** CAMC created recommended courses of treatments and tests for patients admitted with particular conditions, called standing orders. Color-coded "order sheets" for AMI, HF, and other conditions are placed in patients' charts to alert providers to the recommended care. Also, to ensure that all patients receive advice on smoking cessation—one of the HQA quality indicators for AMI, HF, and pneumonia—the medical center incorporates questions about smoking and patients' willingness to undergo counseling into its registration and discharge procedures. Further, each CAMC provider carries a pocket card on which they record their department's performance targets and what those targets mean to them. For example, the pocket cards might remind them to wash their hands, provide discharge instructions to HF patients, or put red socks on patients at risk for falls.

- **Supporting improvement through clinical "change agents."** Each of the improvement teams includes a clinical "change agent," typically an advanced practice nurse, whose role is to educate staff members, coordinate change processes, and ensure compliance. These change agents work on the hospital floor, reviewing patient charts and querying providers if certain recommended procedures have not been followed.

- **Collecting and rapidly feeding back performance data.** CAMC's Clinical Quality Management Department collects data on an ongoing basis for all process-of-care measures reported under the CMS/Premier demonstration, and for the HQA reports on AMI, HF, pneumonia, surgical infection prevention, CABG, and hip and knee replacements. It is able to analyze and feed back performance information to department heads within two months after the data are collected. (Patient chart reviews enable real-time oversight and identification of defects.) Analysts work with providers to ensure they are accurately reporting the care they provide to patients, for example, by documenting that a patient's condition indicates certain drugs should not be prescribed.

More specifically, CAMC took the following steps to improve care for acute myocardial infarction patients:

- The AMI team developed and implemented order sets for all patients who are admitted with AMI. It also developed standing orders for discharging cardiovascular patients.

- Nursing staff are educated on AMI care processes, and performance targets were posted in nursing units.

- Nurses track adherence to the eight HQA indicators of quality care for AMI patients, using purple-colored order sheets.

- On a weekly basis, 10 patient charts are randomly pulled for review by change agents and case coordinators. The results are recorded and shared with members of the AMI team.

- A quality improvement specialist tracks all AMI patients by going on nursing rounds and using chart review to monitor compliance with indicators.

These changes were based on evidence that giving heart attack patients proven medications, when indicated, as well as smoking cessation counseling, reduces their risk of recurrent heart attacks and death. [2] Studies also show that patients who do not receive a prescription for recommended medications at discharge are less likely to take these medications. [3]

The changes implemented by the medical center led to improvements on several AMI indicators. However, CAMC lagged behind in one area—providing percutaneous coronary intervention (PCI) to heart attack patients within 90 minutes of arrival, a benchmark that many hospitals have struggled to achieve. Performing PCI procedures as quickly as possible improves blood flow and can lessen heart damage but, as of June 2006, CAMC met this goal only 25 percent of the time.

In July of that year, the AMI team formed a special group to focus on shortening the delivery of PCI procedures by moving patients quickly from the ambulance to the

emergency department to the catheterization lab. The team members reviewed all the processes that occur along this continuum of care, pinpointed opportunities to improve their delivery times, and researched what other hospitals were doing. They made the following changes:

- EMS teams were asked to perform EKGs on patients and report the findings to care teams before their arrival at the hospital.
- A system was put in place to alert providers and the catheterization lab to the arrival of cardiac patients. Cardiologists receive a special page that distinguishes AMI patients who need to go the catheterization lab from those who don't.

CAMC cardiologists and emergency department physicians have been instrumental in ensuring prompt response times for PCI procedures. In particular, a new group of cardiologists began to practice in the community in the spring of 2007. These providers are frequently on unassigned call in the emergency department and their performance on this indicator has improved overall response times.

Results

In the fourth quarter of 2003, CAMC's performance was at 77 percent for the HQA measures of pneumonia care. By August 2007, performance across the pneumonia indicators had risen to 95 percent. Performance in the fourth quarter of 2003 for AMI and HF care was already high—at 90 and 93 percent, respectively. By August 2007, CAMC had achieved performance of 98 percent for measures of AMI care, and 96 percent for heart failure measures (Table 2).

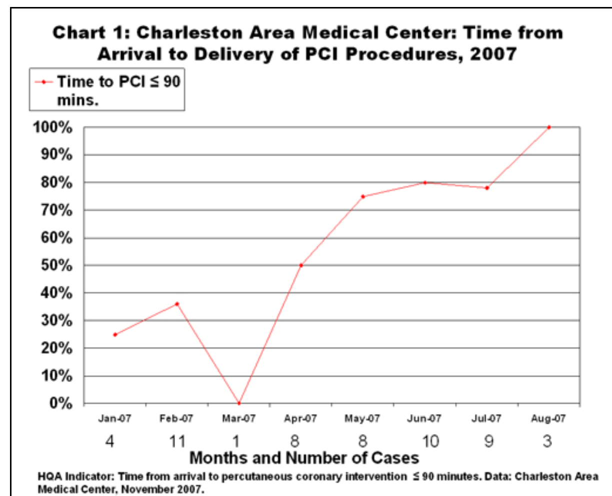
Table 2: Charleston Area Medical Center: Composite Scores on Process-of-Care Indicators of Health Care Quality

	Q4 2003	2004	2005	2006	2007*
Acute Myocardial Infarction	90	95	98	97	98
Heart Failure	93	92	94	95	96
Pneumonia	77	82	89	86	89
Surgical Infection	**	**	**	93	95

*As of August 2007
** data not collected for these years

Note: The 21 indicators for these conditions include process of care measures initially reported for Premier/CMS Hospital Quality Improvement Demonstration, and later incorporated into HQA measure set.

In addition, CAMC achieved a more rapid delivery of PCI procedures. By the summer of 2007, performance levels exceeded statistical control limits, demonstrating real improvement as a result of the process changes (Chart 1).



For internal reporting purposes, CAMC calculates monthly composite performance scores for AMI, HF, and other conditions, which show the average performance level among all the indicators for a particular condition. It also tracks an "all or nothing"

score to see what proportion of patients receive *all* of the recommended care for that condition. In October 2004, the medical center's compliance with the eight HQA indicators for AMI treatment was 50 percent—meaning that patients received all recommended care just half of the time. By August 2007, patients received all eight of the recommended care processes 95 percent of the time.

Implications

CAMC's leadership chose to focus on performance improvement in response to the needs of the community it serves. West Virginia's population is older than the rest of the nation (15 percent were 65 or older in 2005, compared with 12 percent nationally), so demand for services is high and is expected to continue rising. In addition, West Virginia is one of two states where medical service rates are set by state regulators. This forces hospitals to control costs because they are not able to raise prices.

The financial incentives offered through the Premier pay-for-performance demonstration and the public reporting of performance through the HQA program served to reinforce CAMC's improvement efforts, focusing them on evidence-based measures of care for common conditions. In January 2007, CMS announced that CAMC received the second-highest incentive award, $701,000, for their performance. This demonstration has been extended and CAMC continues to participate.

CAMC's administration and medical staff officers have led the medical center's improvement process, both by allocating necessary resources and removing barriers to change. Yet, system improvements could not be achieved without clinical leaders and agents of change to implement the data collection and process improvement tools, and to monitor providers' progress on a daily basis. "If you have people at the top who completely support and want these changes to occur, you can still fall flat on your face," says Wood. "You need a group of networkers who can carry change across an organization."

Benchmarking performance enables organizations to focus their improvement efforts on achievable goals; once a certain level of reliability is achieved, they can aim for higher performance or even perfection. "Certain types of improvements will only work if you have already achieved a certain level of performance," Wood explains. "If you have a 20 percent defect rate, you don't have a process—or it's a chaotic process, at best—so you can't focus on improving the process. You have to focus first on creating one. If you get to where you're performing at a higher level, you can then consider how to automate your system, so that, for example, you identify CHF [congestive heart failure] patients every time and match them with the recommended elements of care."

While hospitals may see rapid progress in some areas, it takes a high level of reliability to consistently deliver all aspects of care. CAMC's tracking of "all-or-nothing" scores helps it monitor how reliably its patients receive all recommended care.

Performance data that demonstrate steady improvement have helped to achieve buy-in among CAMC providers. "I meet with new physicians each quarter and I tell them: 'The hospital, physician leaders, and faculty have worked to develop systems and processes to support the care process. The systems and processes we've designed together will produce better results than one can do working independently,'" says Wood. "It's hard to argue with the outcomes we've seen."

Some worry that public reporting could cause health care providers to focus only on those aspects of care being evaluated, to the neglect of others. Wood argues that the systems and processes CAMC has put in place have created a foundation for improvement, leading to positive change across all conditions. CAMC leaders are now asking how much further they can go: What if they were tracking 40 conditions, and 400 quality indicators?

For Further Information
Contact Dale Wood, vice president for system performance and chief quality officer, Charleston Area Medical Center, at dale.wood@camc.org or 304.388.7168

References
[1] A. K. Jha et al. (2005) Care in U.S. Hospitals—The Hospital Quality Alliance Program. *New England Journal of Medicine* 353, 265–274; A. K. Jha et al. (2007) The Inverse Relationship Between Mortality Rates and Performance in the Hospital Quality Alliance Measures. *Health Affairs* 26, 1104–1110.
[2] E. M. Antman et al. (2004) ACC/AHA Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation* 110, e82–292.
[3] J. Butler et al. (2002) Outpatient Adherence to Beta-Blocker Therapy After Acute Myocardial Infarction. *Journal of the American College of Cardiology* 40, 1589–1595; J. Butler et al. (2004) Outpatient Utilization of Angiotensin-Converting Enzyme Inhibitors Among Heart Failure Patients After Hospital Discharge. *Journal of the American College of Cardiology* 43, 2036–2043.

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News Briefs

Senate Bills Would Reform QIO Program
This month, Senators Hatch (R-UT), Rockefeller (D-WV), Lott (R-MS), and Kennedy (D-MA) introduced a bill designed to strengthen the Medicare Quality Improvement Organization (QIO) program.

Currently, there are 53 QIOs working in the states and U.S. territories, providing assistance with health care quality improvement techniques to providers, practitioners, and public and private health plans and purchasers. Sponsors of the reform bill say that existing QIO legislation, created in 1982, does not reflect the organizations' current roles in promoting quality measurement, quality improvement, and public accountability in health care.

The proposed legislation would focus the QIO program on the following core goals: reducing health care disparities, improving rural health quality, strengthening coordination of care, supporting the adoption and use of health information technology, assisting providers in measuring and publicly reporting performance, and informing health care consumers of their rights.

This action follows the introduction of another bill aimed at overhauling the QIO program, the "Continuing the Advancement of Quality Improvement Act of 2007," by Senators Grassley (R-IA) and Baucus (R-MT) in August. The Grassley-Baucus bill would create a Medicare Provider Review organization to review beneficiaries' complaints about the quality of care they

receive and report the results of these investigations back to beneficiaries. Currently, QIOs are charged with beneficiary complaint review.

CMS Pilot: Higher Payments for HIT Use

In late October, the Centers for Medicare and Medicaid Services announced that it will recruit 1,200 physicians to implement health information technology (HIT) systems in exchange for higher Medicare payments. Under the five-year pilot program, physicians will use HIT to order prescriptions, document lab test results, and perform other tasks; the more aggressively physicians use HIT, the more they stand to gain in increased pay.

Participating physicians must use electronic health record systems that have been approved by the Certification Commission for Healthcare Information Technology, an independent certification organization.

Currently, only about 10 percent of doctors in solo or small-group practices use HIT.

Many argue that widespread use of HIT could control health care costs by streamlining care processes and avoiding errors and redundancies. But Peter Orszag, director of the Congressional Budget Office, warned recently that the evidence thus far shows that the cost-cutting impact of electronic health records "is not going to be as substantial as people think."

Hospitals, States Target Infections

A new survey from Premier, a hospital consortium, found that more than 22 percent of hospitals are using an automated system to help monitor and control infections. This reflects a 9 percentage point rise in the use of surveillance for hospital-acquired infections from February to October 2007.

This month, New Jersey Gov. Jon Corzine (D) signed into law a bill requiring hospitals to publicly report nosocomial infection rates. New Jersey hospitals will file quarterly reports to the state health department on their nosocomial infection rates and the measures they have taken to control infections, and the health department will post this information on its consumer Web site. Supporters of the bill maintain that it will encourage hospitals to adopt best practices to prevent infections.

Nineteen other states also require hospitals to report infection rates, though not all of the reports are public.

Minnesota Physician Group Ranks P4P Programs

This month, the Minnesota Medical Association published a report evaluating the state's pay-for-performance (P4P) programs. The association rated the effectiveness of nine P4P programs, operated by health plans and government programs, according to their ability to: drive quality improvement, strengthen the patient–physician relationship, include physicians across medical specialties, and use valid measures of performance.

According to the report, the incentive program run by the federal Centers for Medicare and Medicaid Services is most effective, while Bridges to Excellence, a program used by large, self-insured employers, is the least effective.

The report urges Minnesota's health plans, employers, and others to take the following steps to improve P4P programs:

- adopt a common measurement set and a streamlined data collection process;
- provide financial incentives for care coordination, especially for patients with chronic illnesses;

- provide financial incentives for implementing health information technology and electronic medical records;
- eliminate financial penalties for providing care that is in the patient's best interest; and
- ensure that programs don't penalize physicians who accept patients with complex and difficult conditions.

WellPoint and Zagat to Offer Physician Guide
One of the nation's largest health insurers, WellPoint, is joining with the restaurant and entertainment reviewer, Zagat Survey, to develop an online physician ratings guide. As in Zagat's popular restaurant guides, the physician guide will feature reviews and ratings from consumers, not experts. Patients will grade their physicians on a 30-point scale based on their performance in four areas: trust, communication, availability, and office environment. The guide will also include patients' verbatim comments about particular physicians.

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Recent Publications of Note

Selected articles on quality improvement from a number of journals, including the *American Journal of Medicine, Annals of Internal Medicine, Archives of Pediatric and Adolescent Medicine, BMJ, Health Affairs, Health Services Research, International Journal for Quality in Health Care, Joint Commission Journal on Quality and Safety, Journal of the American Medical Association, Journal of General Internal Medicine, Journal of Patient Safety, Journal of Safety and Quality in Health Care, Medical Care, The Milbank Quarterly, The New England Journal of Medicine,* and *Pediatrics.* The articles are nominated by Editorial Advisory Board members from a preselected list.

Health Care System Performance

Managed Care and Quality for Medicaid Beneficiaries
This study used 11 quality indicators from the Healthcare Effectiveness Data and Information Set (applicable to the Medicaid population) to compare the quality of care within and between patient populations in three types of managed care plans: those serving predominantly Medicaid enrollees, those serving predominantly commercial enrollees, and those serving substantial numbers of both types of enrollees. It found Medicaid managed care enrollees receive lower-quality care than commercial managed care enrollees, with no differences in quality between Medicaid-only plans and commercial plans. B. E. Landon et al. (2007) Quality of Care in Medicaid Managed Care and Commercial Health Plans. *Journal of the American Medical Association* 298, 1674–1681.

Improving Quality and Efficiency at the State Level
New data on personal health spending, quality, and health system performance at the state level show that personal health spending is not related to mortality or quality, but Medicare spending is closely linked to preventable hospitalization. Thus, the authors conclude that state policy officials should focus on improving health care quality and efficiency in tandem with their efforts to increase health insurance coverage. K. Davis and C. Schoen (2007) State Health System Performance and State Health Reform. *Health Affairs* Web Exclusive 26, w664–w666.

Pediatric Care and Quality
Quality indicators were developed, using a RAND–UCLA modified Delphi method, to assess whether pediatric outpatients randomly selected from 12 metropolitan areas received recommended care. Children in the study, on average, received 46.5 percent of indicated care, with quality varying according to the clinical area. The authors conclude that strategies to reduce these deficits, which are similar in magnitude to those reported for adults, are needed. R. Mangione-Smith et al. (2007) The Quality of Ambulatory Care Delivered to Children in the United States. *New England Journal of Medicine* 357, 1515–1523.

International Survey Supports "Medical Homes"
A new Commonwealth Fund study found that having a "medical home," or a regular source of care that is accessible and helps coordinate care, is associated with more positive patient experiences. The international survey, which included about 12,000 adults in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States, also identified wide differences among countries in terms of access to care, availability of after-hours care, and coordination, as well as areas of shared concern. C. Schoen et al. (2007) Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007. *Health Affairs* Web Exclusive 26, w717–w734.

Healthy People 2010 and Disparities
At mid-decade, Healthy People 2010 objectives have most frequently led to improvements in the health of the total population, without any reduction in relative disparities among racial and ethnic groups. The authors conclude that, because strategies to maximize improvement in overall population health may have little or no impact on relative disparities—or may even cause them to increase—an independent commitment to eliminating disparities might be necessary. K. Keppel et al. (2007) Improving Population Health and Reducing Health Care Disparities. *Health Affairs* 26, 1281–1292.

Quality Reporting

Standardizing Quality
An increasing number of quality measures are being reported publicly, yet the measurement of quality in health care is neither standardized nor consistently accurate and reliable. The authors conclude that health care has much to learn from the reporting standards for financial data and pharmaceutical information, and that the time has come to create a stronger environment to help protect patients, clinicians, and payers from misinformation regarding quality of care and to help ensure public trust in the health care profession. P. J. Pronovost et al. (2007) The GAAP in Quality Measurement and Reporting. *Journal of the American Medical Association* 298, 1800–1802.

Evaluating Safety Scorecards
This commentary proposes a framework to help health care organizations more effectively and efficiently develop their safety scorecards, evaluate their validity, and understand measures that are appropriate to present as rates. The goal is to enable them to better address the question, "are patients safer?" P. J. Pronovost et al. (2007) A Framework for Health Care Organizations to Develop and Evaluate a Safety Scorecard. *Journal of the American Medical Association* 298, 2063–2065.

Tiering Hospitals
Four alternative tiering strategies that combine hospital quality and cost data to designate "preferred" hospitals (defined as

those ranking in the top quartile) were compared in five markets (Boston, Miami, Phoenix, Seattle, and Syracuse). The authors found that these tiering strategies led to substantially different results, suggesting the need for clear prioritization by payers and the application of more rigorous methods to identify high-value hospitals. M. B. Rosenthal et al. (2007) Using Performance Data to Identify Preferred Hospitals. *Health Services Research* 42, 2109–2119.

Performance Profiling Systems

Three different methods of performance measurement, focused explicit (38 measures for six conditions/prevention), global explicit (372 measures for 26 conditions/prevention), and structured implicit review physician-rated care (a single global rating of care for three chronic conditions and overall acute, chronic, and preventive care), were used to assess the quality of care provided to 621 patients at 26 facilities in two Veterans Affairs regions. The authors found moderate to high agreement in quality scores across the three profiling systems for most clinical areas, indicating that all three were measuring a similar construct called "quality." E. A. Kerr et al. (2007) Quality by Any Other Name? A Comparison of Three Profiling Systems for Assessing Health Care Quality. *Health Services Research* 42, 2070–2087.

Pay-for-Performance

Quality Incentives' Effect on Care

An observational study was used to assess the levels of recommended care received by preferred provider organization members receiving care from physicians who participated in a quality incentive program, compared with those receiving care from physicians who did not participate. The authors found a consistent, positive association between having seen only program-participating providers and receiving recommended care, suggesting that physician reimbursement models built upon evidence-based quality of care metrics may positively affect whether patients receive high-quality, recommended care. A. S. Gilmore et al. (2007) Patient Outcomes and Evidence-Based Medicine in a Preferred Provider Organization Setting: A Six-Year Evaluation of a Physician Pay-for-Performance Program. *Health Services Research* 42, 2140–2159.

P4P: Improving Care for Chronic Illnesses

The authors outline a strategy to improve the care of Americans with severe chronic illnesses. Specifically, it includes: the federal government investing in a program to improve the scientific management of chronic illnesses, and the Centers for Medicare and Medicaid Services extending its pay-for-performance (P4P) agenda to increase chronically ill patients' access to evidence-based prospective care. J. E. Wennberg et al. (2007) Extending the P4P Agenda, Part 2: How Medicare Can Reduce Waste and Improve the Care of the Chronically Ill. *Health Affairs* 26, 1575–1585.

Patient Safety

"Blame-Free" Error Analysis

Dana-Farber Cancer Institute's (Boston) "Principles of a Fair and Just Culture" define behavioral expectations for when an error occurs. They focus not just on patient safety, but on a culture of safety and transparency in all the organization's functional areas, including nonclinical departments. Introducing these principles is a major undertaking; it requires continual education and discussion among staff at all levels and a commitment to examining and changing many of the systems, policies, and procedures that guide an organization's work. M. Connor et al. (2007) Creating a Fair and Just

Culture: One Institution's Path Toward Organizational Change. *Joint Commission Journal on Quality and Patient Safety* 33, 617–624.

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