Health care quality in the 21st century

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ABSTRACT

The concepts of healthcare quality have evolved over the years. Many stakeholders have become quite engaged in the movement towards improvement in healthcare quality and safety. The standardization and national endorsement of performance measures, the assessment of outcomes, and the reporting for accountability are now being coupled with more transparency, and technological innovation. As the quality landscape changes to evaluation of episodes of care and performance at the individual clinician level measures (primary and specialty care), collaboration is critical among consumers, purchasers, measure developers, implementers of measures to identify and adopt national standards to tell a clear story of healthcare quality.

Introduction

The concepts of quality have evolved over the years, especially after the publication of the Institute of Medicine's (IOM) reports *To Err is Human: Building a Safer Health System* in 2000 (1) and *Crossing the Quality Chasm: A New Health System for the 21st Century* in 2001 (2). For the first time, there was widespread acknowledgement of safety and quality concerns and the need to close the "quality gap." Both reports highlighted that quality improvement should be a dynamic process supporting a culture of quality in healthcare that goes beyond the previous quality assurance that focused mainly on individual cases, utilization and mortality. Although some improvements in quality have been documented (3), concerns about safety and quality have continued to intensify due to a steady flow of research and reports documenting the seriousness of the quality challenge.

The two reports set a path that has stimulated the engagement of all stakeholder groups in healthcare – consumers, purchasers/payers, healthcare professionals, providers (*e.g.*, hospitals, nursing homes, etc.), health services researchers and quality improvement organizations. This engagement has set about breaking down the silos within the healthcare arena and has introduced more transparency – both internal and external – to the healthcare industry. As a result of this increasing transparency, opportunities for collaboration are emerging that did not exist before. There are now well over 100 pay-for-performance programs and demonstration projects sponsored by Medicare, Medicaid and private insurance programs (4).

In continuing to move forward with a renewed sense of urgency, this transparency and a collaborative approach to fostering a culture of safety and quality are two of the concepts underlying quality in the 21st century.

A nod to the past

A rich history of pioneers in healthcare quality developed many of the basic concepts and tools upon which current quality movement efforts still build. People such as Florence Nightingale, Ernest Codman and Avedis Donabedian – each from different eras and addressing different aspects of quality – have left legacies by constructing pathways for assessing quality, understanding the cause and effect of systems, and developing models for conceptualizing quality (5). As the quality movement rises to a new level of maturity, we are seeing equally groundbreaking efforts; however, understanding progress in quality improvement has been hampered by our insufficient ability to assess the outcomes of interventions consistently or to compare performances among like entities, because of differences in the ways organizations have measured aspects of care and service. A level of standardization has been needed.

National Quality Forum: facilitating the standardization of measurement tools

The National Quality Forum (NQF) was established in 1999 pursuant to rec-

ommendations made by a Presidential Commission (Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998) as a privatepublic partnership that operates as a democratic forum to bring together multiple stakeholder groups. NQF's primary purpose is to facilitate agreement among a diverse group of stakeholders on sets of standardized performance measures to be used by public and private purchasers and other stakeholders for public reporting (accountability). NQF does not develop measures; rather it provides a forum to review already developed measures and the "best in class" is determined based on the validity, reliability, pilot test results, and overall usability and feasibility of the measures. NQF also plays an active role in disseminating information, and sponsoring education and recognition programs.

The key distinguishing feature of NQF's mission is its Consensus Development Process (CDP). The NQF is recognized as a private sector standard-setting body that follows a process consistent with the National Technology Transfer and Advancement Act of 1995 (NTTAA) and its attendant guidance, Office of Management and Budget (OMB) Circular A-119. The NTTAA gives the standards of the NQF legal standing, meaning that if there are NQF-endorsed™ standards available for a particular medical area, federal programs are directed to adopt those standards, and may do so without going through the federal rule-making process. For example, the Centers for Medicare and Medicaid Services (CMS) Pay for Performance (P4P) initiatives are being formulated in an effort to endorse quality improvement through financial incentives, focusing on patients with chronic illnesses.

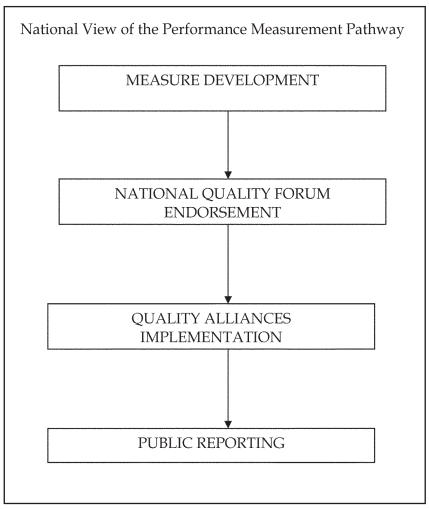
In January 2006, CMS began the Physician Voluntary Reporting Program (PRVP) as a pilot program of physician incentives for actions taken on an initial set of 16 quality measures. This evolved into the Physician Quality Reporting Initiative (PQRI), which began in 2007 and includes 66 quality measures. In July 2007, physicians reporting on at least 3 of these measures will receive a 1.5% bonus on all MCR Part B billings. These measures will evaluate the number of persons receiving the prescribed care compared to the total number of persons eligible to receive such care, allowing for exclusions and focusing on the physicians' actions rather than on the patients' acceptance (6). Many of the measures used in this effort are NQF-endorsed™ measures. The use of a consensus process assures, to the greatest extent possible, buy-in from consumers and purchasers who use such data for decision making, as well as providers.

Harmonization of measures

In addition to the standardization of tools, the new efforts of measure developers to harmonize definitions, data elements and other details of measure specifications assure that all of those engaged in measurement are speaking the same language. This facilitates the more efficient and effective implementation of public reporting programs, as well as assuring that the performance information for stakeholders is consistent. As an example, the NQF endorsed a Patient Safety Event Taxonomy (PSET), which the Joint Commission developed with a workgroup comprising provider and health professional organizations and federal government representatives. Along with the taxonomy, definitions and standard reporting domains for public patient safety reporting systems were endorsed. The benefit of this was the achievement of common definitions and domains that help to standardize patient safety information across healthcare entities for prudent decision making (7).

Collaborations on the quality agenda

Another aspect of the NQF mission is the setting of national priorities and goals for performance improvement. Public-private collaborations across the health care industry have been valuable in bringing order to the disparate ways of measuring quality and in bringing more focus onto clear goals. The growth of quality alliances – the Hospital Quality Alliance (HQA); the Ambulatory Quality Alliance (AQA),



which focuses on physician-level reporting; and most recently the Pharmacy Quality Alliance (PQA), which focuses on pharmacist-level reporting – has been helpful in identifying measures for public reporting efforts, an important goal. Furthermore the alliances, in working with measure developers such as the National Committee for Quality Assurance, the American Medical Association Physician Consortium for Performance Improvement, CMS and others, have helped to drive the development of measures that fill important gaps (*e.g.*, provider-level measures, specialty care) in quality measurement which are crucial for public reporting and internal quality improvement. Some of the measures advanced by the quality alliances, particularly the AQA, are being used in the above-mentioned CMS PQRI.

New paths for the quality agenda

To date, many of the performance measures and measurement sets have been narrowly focused on a handful of diseases or medical conditions (*e.g.*, diabetes, heart disease) and have usually focused on a specific point in time (*e.g.*, having appropriate treatment in the emergency room for an acute myocardial infarction). The new pioneers in healthcare quality are now looking at the use of composite measures (several measurements that can be rolled up into a single score to measure the specific management of a disease); ways of measuring episodes of care, including care coordination from the acute

onset of a condition to resolution; and efficiency of care including longitudinal efficiency, expressed as the value equation "the best outcome, at the most reasonable cost possible that meets the values of each individual patient" (8).

Patient self-management is a critical part of overall care for chronic illnesses such as rheumatoid arthritis, congestive heart failure, cancer and others. Self-management goes beyond knowing the practical aspects of one's medical condition. It includes developing skills and confidence to engage in problem solving, which requires close collaboration with the physician and other healthcare professionals (9). As a part of the quality equation, patient readiness and confidence in self-management, and tools for collecting patient-reported data will become increasingly important.

Moreover, the push for the adoption of more information technology has already yielded greater innovation in quality, and will continue to do so. The promise of electronic health records, personal health records, and better support/communication tools for healthcare professionals and patients will indeed spur more innovation in the quality agenda. Finally, there is a move underway to re-organize current provider reimbursement methodologies in such a way as to reward quality and innovation. As the quality movement marches forward, these issues and others will continue to shape and mature the field in ways that our earliest leaders in quality never dreamed of.

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