CHAPTER 3 - QUALITY OF CARE

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FAST FACTS

- In a study of 16 industrialized countries, the U.S. had the highest number of preventable deaths.1
- The U.S. ranks 30th in terms of infant mortality among 31 selected countries, with nearly twice as many infant deaths per capita as France.2
- Compared to 6 other nations, the U.S. health system ranks either 6th or 7th in dimensions of quality, access, efficiency, equity, and healthy lives.3
- Americans receive recommended evidence-based care, on average, 55 percent of the time. Women are more likely than men, and those age 18 - 30 are more likely than those age 65 and older, to get the care recommended.4
- Hospital-acquired infections (HAI’s) affected approximately 1 in 20 hospitalized patients in the U.S. in 2002.5 Estimates of the annual direct medical costs of health care-associated infections to U.S. hospitals range from $28.4 billion to $45 billion.6
- Variations in the quality of care do not seem to be linked to how much we spend on health care.7
- The goal of most quality measurement is to improve health care services by monitoring and analyzing data and, based on what the data indicate, changing practices to improve performance.8 9
- Evidence shows that the release of quality data annually over a period of years stimulates improvement in the measured areas.10 11
- The health reform law enacted in 2010 builds on previous law to encourage quality improvements in myriad ways.

BACKGROUND

The American health care system is often lauded for its first-rate surgical centers, innovative technologies and groundbreaking medical research. But it is by no means perfect.

Study after study has identified significant concerns with the quality of care delivered to Americans. In a landmark 2001 report, “Crossing the Quality Chasm,” the federally chartered Institute of Medicine (IOM) said, “The performance of the health care system varies considerably. It may be exemplary, but often is not.”12 Many infant deaths per capita as France.13

Indeed, the IOM report estimated that between 44,000 and 98,000 people die in U.S. hospitals each year as a result of preventable medical errors.13 Since then, a major investigative project by Hearst Newspapers concluded that the number could have risen to as high as 200,000 deaths per year.14 A recent government study found that 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays, costing the Medicare program an estimated $4.4 billion in FY 2009. Physician reviewers of the study determined that 44

Scores for U.S. Care on Dimensions of a High Performance Health System, 2006 and 2008

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Americans receive recommended evidence-based care, on average, only 55 percent of the time, with significant variability according to the specific condition.16 (See chart, "How Often Recommended Care is Received, Selected Conditions.")

There are more surgical and medical mishaps per capita in the U.S. than in Germany, the United Kingdom, Canada or the Netherlands.17 (See chart, "Deaths Due to Surgical or Medical Mishaps per 100,000 Population, 2007.")

The IOM defines quality 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.18 This vision calls for care that is safe, effective, patient-centered, timely, efficient and equitable (i.e., does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status).19

The IOM and other experts often put quality problems into three major categories:20

- **Underuse** occurs when patients do not get care that is medically indicated. An example is the failure to use commonly available screening tests for every patient who could benefit from them.

- **Overuse** occurs when patients receive care that is not medically indicated. Typical examples are use of antibiotics to treat a cold or the use of imaging devices for someone with the first signs of lower back pain.

- **Misuse** describes care that is provided poorly or erroneously, such as wrong-site surgery.21

Support for efforts to measure and improve quality has grown rapidly as purchasers and consumer advocates sought information about the underlying value of the health care services for which they were paying an ever-increasing price. This “value agenda” played a key role in the policies of the administration of President George W. Bush22 and continues to be a focus of the Obama Administration and the 112th Congress.23

**How Do We Measure Quality?**

The first step to improving health care quality, most experts believe, is to measure performance – a concept largely initiated by employers in the 1980s.24

To help reduce gaps in quality, most quality measures seek to assess one of four things:

- Are the structures and policies in place to assure performance?

- Are the right processes being followed to lead to better care?

- Are the right outcomes being achieved?

- Are the patients satisfied with their care experience?

Simply measuring a process can improve it. According to a phenomenon known as the Hawthorne effect, behavioral change can be triggered by the mere act of measuring or observing.25

A classic example of measurement leading to improvement is the use of a class of drugs known as beta blockers following a heart attack. Research has shown that such treatment significantly reduces the risk of a second and often fatal attack.26 Yet, fewer than half of patients overall were given beta blockers after a heart attack as of mid-1996.

Once physicians, hospitals, health plans, researchers and others began to systematically measure how often patients received beta blockers after a heart attack, steps were put in place to assure a beta blocker is given to every heart attack patient. The overall use rate has improved so that such treatment now occurs in 75 percent of cases.

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The most widely used set of quality measures is the Healthcare Effectiveness Data and Information Set (HEDIS), developed through an alliance between health care plans and employers and now overseen by the National Committee for Quality Assurance (NCQA). Since its formation in 1991, HEDIS has evolved to include a broader range of measures that examine underuse, overuse, and misuse of services.

HEDIS has spawned a number of other measuring tools that are used to assess care in a variety of settings. These include patient experience metrics, such as the H-CAHPS and C/G-CAPHS, as well as measures of cost and efficiency.

In the past decade, additional measurement sets have been developed to assess the performance of hospitals, nursing homes, home health care and, more recently, physicians. In fact, the development of quality measures has expanded so quickly that many health care providers tell of a high burden associated with reporting data to accrediting bodies, regulators and payers with diverse data requirements.

In 1999, the National Quality Forum (NQF) was created to sort through existing quality measures and to endorse those that have the most relevance to purchasers, providers and consumers. Administrators of the Medicare program, in particular, have turned to the non-profit NQF to help them choose which measures should be adopted.

In 2009, the U.S. Department of Health and Human Services (HHS) awarded a contract to NQF to help establish a portfolio of quality and efficiency measures that will "allow the federal government to more clearly see how and whether healthcare spending is achieving the best results for patients and taxpayers." The contract is a part of Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. According to the U.S. Government Accountability Office (GOA), NQF has initiated work in all areas required by MIPPA. The Affordable Care Act (ACA), enacted in March 2010, envisions broader roles for the NQF as government programs seek to measure results to determine payment for a variety of providers.

Since 2003, the Agency for Healthcare Research and Quality (AHRQ) has published an annual report noting the progress and opportunities for improving health care quality in the United States. The Institute of Medicine (IOM) provided guidance to AHRQ in developing the report.

In its 2010 annual report on health care quality in the United States, the Agency for Healthcare Research and Quality (AHRQ) found that "quality is improving slowly. Across all 179 measures of health care quality tracked in the reports almost two-thirds showed improvement." The report also noted a lack of progress in improving access to health care and health disparities.

How Can We Improve Quality?

Quality improvement is the result of measurement, reporting and action. Health care organizations and practitioners often compare their internal measurement results to national or regional benchmarks and make necessary adjustments.

For example, the mortality rate for heart attack patients at Hackensack University Medical Center in New Jersey was approximately 5 percent in 2005, significantly below the national average of 10.9 percent. The medical center improved care and outcomes for heart attack patients by making sure patients receive aspirin and a beta blocker immediately upon arrival at the medical center, an EKG within 10 minutes of arrival, catheterization within 90 minutes, and a balloon dilation of the affected artery within 120 minutes.

Public release of performance information in the form of report cards, online databases and other means can be a powerful driver for improvement. Public disclosure of performance information drives health plans and providers to target improvements so that they know how they do compared with their competitors and can show improvement over their last scores. Evidence shows that when data are released annually over many years, it stimulates improvement in the measured areas. Beginning in 2015, all physicians participating in Medicare will be required to report performance measures to the Physician Compare Website.

Many employers and other purchasers of health care coverage use quality measurement results to guide their choices of plans and providers. State insurance regulators and administrators of such public programs as Medicare and Medicaid often encourage or require hospitals, HMOs, nursing homes and others to report quality information.

The Robert Wood Johnson Foundation is engaged in a national effort to improve the quality of care, called Aligning Forces for Quality (AF4Q). The program sponsors community-based quality initiatives in 14 states and 271 counties, reaching over 37 million individuals living in those communities. These initiatives are focused on three areas: performance measurement and public reporting, consumer engagement and quality improvement. It is the largest effort of its kind by a U.S. philanthropy.
Several public initiatives have been developed from the Aligning Forces model, including the Agency for Healthcare Research and Quality’s Chartered Value Exchange project and the Office of the National Coordinator’s Beacon Community program. For more information on this topic, see the Alliance for Health Reform Issue Brief “Improving Health Care Quality Through Community Collaborative,” at http://ow.ly/9Y0Os.

**Pay for Performance**

In recent years, public and private sector leaders have been experimenting with ways to incentivize quality improvement. Often lumped under the rubric “pay for performance” or “P4P,” these include financial bonuses and positive publicity for high-quality providers, while retaining the basic fee-for-service payment structure.

In an analysis of a pay for performance demonstration project executed by the Centers for Medicare and Medicaid Services and Premier Inc., researches found that the performance of the hospitals in the pay for performance project improved more than the performance of the hospitals in the group that did not implement pay for performance. Researchers concluded that, “Improvements were largest among hospitals that were eligible for larger bonuses, were well financed, or operated in less competitive markets. These findings suggest that tailoring pay-for-performance programs to hospitals’ specific situations could have the greatest effect on health care quality.”

Much of the momentum for P4P has come from the private sector. Bridges to Excellence (BTE), for instance, is a nonprofit, employer-driven initiative that recognizes physicians for making changes that achieve better outcomes for patients. It focuses on areas with a deep history of measurement: diabetes care, cardiovascular care, and patient self-management systems. Participating physicians receive bonus payments and are highlighted in provider directories, helping employees and their families make informed choices. Results are encouraging.

In California, the Integrated Healthcare Association (IHA) works with health plans, medical groups and independent practice associations to reward quality in three domains: clinical outcomes, patient satisfaction, and adoption and clinical use of information technology by practitioners.

A similar organization, the Leapfrog Group, rewards hospital performance via public recognition and bonus payments to hospitals that report data in several areas of patient care: heart bypass and coronary angioplasty surgery, treatment of heart attacks and pneumonia, and births and neonatal care. Medicare has begun using these measures to reward hospitals in a demonstration project.

**QUALITY PROVISIONS IN ARRA & CHIPRA**

The Obama Administration and the 111th Congress began to tackle some of these quality issues in the American Recovery and Reinvestment Act (ARRA) and the Children’s Health Insurance Program Reauthorization Act (CHIPRA), both enacted in 2009.

The ARRA invested some $20 billion to help physicians, hospitals and other providers obtain and use health information technology to improve health care quality and coordination of care. The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as a part of the ARRA, directed HHS to develop health IT standards. Physicians are eligible for grants of $40,000 to $65,000 to purchase health IT that conforms with those standards, while hospitals can receive several million dollars each to make such purchases. Eventually, physicians and hospitals that do not have certified electronic health records will be penalized by Medicare and Medicaid.

The CHIPRA contains a series of provisions aimed at measuring and improving quality for children enrolled in the Children’s Health Insurance Program (CHIP) and Medicaid. The law requires HHS to develop and publish a core set of quality measures for the care of children in either program, encourage standardized reporting by states and improve and expand on the core measures over time. The Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) have been working with the CHIPRA workgroup to implement provisions of CHIPRA. Initial core quality measures were posted in January 2010 for public feedback. In 2011, AHRQ and CMS appointed an expert panel to provide insight on the criteria. And currently, AHRQ is asking for submission of quality measures for possible inclusion in the CHIPRA 2013 Improved Core Set of Health Care Quality Measures.

**QUALITY PROVISIONS IN HEALTH REFORM**

The ACA contains several significant provisions aimed at improving the quality of care in America. These include the development of a national quality improvement strategy, funding for quality measure development, support for comparative effectiveness research, pilot and demonstration projects to test promising payment reforms, and targeted efforts to improve patient safety and reduce preventable errors.

**A National Strategy**

In 2011, the HHS secretary began implementing a National Strategy for Quality Improvement in Health Care (the National Quality Strategy). The three broad aims of the strategy include better care, healthy
people/health communities, and affordable care. To support these aims, there are six initial priorities:

- "Making care safer by reducing harm caused in the delivery of care."
- "Ensuring that each person and family are engaged as partners in their care."
- "Promoting effective communication and coordination of care."
- "Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease."
- "Working with communities to promote wide use of best practices to enable healthy living."
- "Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models."

Every three years, HHS will identify both improvements to existing measures and gaps where no quality measures exist. Federal funds of up to $75 million are authorized to support the development of measures in those areas.

Center for Medicare and Medicaid Innovation

The ACA provides for the establishment of a Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services. This center is tasked with examining new ways to deliver and pay for health care in order to save money for Medicare and Medicaid and improve the quality of health care outcomes. The ACA appropriates $10 billion to the CMMI to test such new care models as medical homes, patient safety initiatives and improved coordination of care for individuals eligible for both Medicare and Medicaid.

Comparative Effectiveness Research

Building on provisions in ARRA, the health reform act establishes a nonprofit "Patient-Centered Outcomes Research Institute" to assist patients, clinicians, purchasers and policy-makers in making informed health decisions, and "improve patient safety and reduce medical errors." The institute will support research into the ways that diseases, disorders and other health conditions can be effectively prevented and dealt with. It will also synthesize existing research and disseminate findings to the public.

The Agency for Healthcare Research and Quality (AHRQ) houses a complementary initiative, the Center for Quality Improvement and Patient Safety (CQuIPS), which is tasked with developing and propagating innovative strategies for quality improvement. The ACA authorizes CQuIPS to award grants or contracts to provide technical assistance or to implement models and practices identified in research.

The ARRA provides comparative effectiveness research funding to AHRQ, the National Institutes of Health (NIH), and the Office of the Secretary of Health and Human Services. The initiation of government-sponsored comparative effectiveness research was the subject of apprehension in parts of Congress and among key stakeholders. Some worry that it will lead to rationing of care; others see promise in the concept. Questions remain about the research methods and tools that will be used to compare treatment effectiveness. In 2011, AHRQ released a draft document on research methods, "Methods Guide for Effectiveness and Comparative Effectiveness Reviews." According to AHRQ, the draft is a living document and will be updated as improvements are made.

For more information on this topic, see the Alliance for Health Reform issue brief, "Comparative Effectiveness: Better Value for the Money?" and the Alliance - Robert Wood Johnson Foundation briefing on the same topic at www.allhealth.org/briefing_detail.asp?bi=125.

Health Insurance Exchanges

A key element of the ACA is the creation of state-based health insurance exchanges, which will offer a choice of coverage to individuals and employees of small firms. Congress included several provisions aimed at protecting and informing consumers about the quality of care provided by these plans. For example:

- Health plans offered through an exchange must be accredited on clinical quality measures such as HEDIS, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.
- Qualified plans must have a quality improvement strategy; they must also report information on any NQF-endorsed quality measure to the exchange and the public.
- By 2012, plans must have in place programs to improve health outcomes through activities such as quality reporting, effective case management and care coordination, among other strategies.
- In 2015, plans will be prohibited from contracting with those small hospitals (fewer than 50 beds) without a patient safety evaluation system in place.
• HHS is to develop a system to rate plans in exchanges "on the basis of the relative quality and price."  

**Patient-Centered Medical Homes**

Policymakers have become increasingly aware of the need to improve the quality of health care while also slowing the growth of spending. This will not be easy as 30+ million individuals gain insurance, and the need for chronic care coordination increases with an aging population. These developments will also place additional burdens on the nation's strained primary care system.

This has led private and public sector leaders to embrace the concept of the patient-centered medical home, which allows primary care practices to take responsibility for providing, coordinating and integrating care across the health care continuum.  

(See the Glossary for a definition. Also, see the Alliance-Commonwealth Fund briefing on this topic at: [www.allhealth.org/briefing_detail.asp?bi=137](http://www.allhealth.org/briefing_detail.asp?bi=137).)

The ACA builds on the efforts of previous Congresses in this area by:

• Authorizing states to offer a medical home option through their Medicaid programs.  
• Providing grants to states and others to establish community-based interdisciplinary teams to support primary care practices.  
• Creating a new grant program to support training of primary care doctors to provide care through patient-centered medical homes.

Although the medical home concept has generated substantial interest, it has also stirred controversy. Studies of the model's success in reducing overall costs have generally been inconclusive. Significant examples of medical homes reducing costs do exist; however, it is unclear that these successes are generalizable. There are several barriers to widespread adoption of the model, including the high cost of establishing and running a medical home, a possible shortage of primary care providers, the need for patient and specialist buy-in, and a payment system that rewards service volume over value.

**Accountable Care Organizations**

Another delivery system reform idea gaining attention is the accountable care organization (ACO). An ACO is a health care provider structure designed to manage the full continuum of care and be responsible for the overall costs and quality of care for a defined population. Multiple forms of ACOs are possible, including large integrated delivery systems, physician–hospital organizations, multi-specialty practice groups with or without hospital ownership, independent practice associations and virtual interdependent networks of physician practices. According to the Centers for Medicare and Medicaid (CMS), "When an ACO succeeds...in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program."  

The ACA established the Medicare Shared Savings Program (MSSP) to help fee-for-service providers become an ACO. In March of 2011, CMS published proposed regulations for the MSSP. These regulations were met with much criticism, with providers citing the regulations as "stringent." In October 2011, CMS published final regulations that took into account many concerns raised by commenter’s. The next cycle of programs for the MSSP are scheduled to start in April 2012 and July 2012.

In addition to the MSPP, CMS is experimenting with a new, pioneer ACO that is "targeted to organizations that already have a track record of managing financial risk and developing systems for being accountable for quality-related performance." The application process for the pioneer ACO model is now closed and awardees will be announced soon. ACOs are also gaining momentum in the private sector where at least 8 insurance companies have entered ACO contracts and 27 have entered shared savings contracts.

HHS will establish performance standards to assess the quality of care furnished by ACOs and will set higher standards and new measures over time to drive quality improvement. Other provisions in the ACA create a Medicaid ACO demonstration project from 2012 to 2016.

Early efforts are underway to form accountable care organizations, though the assessment method and payment structure are still undetermined. Critics worry that certain payment methods, such as capitated payment, might lead to reduced treatment options for patients. Also, concerns persist about the possibility that the formation of ACOs will lead to undue market concentration, allowing these organizations to raise costs without improving quality.

Results from the first ACO-like experiment, the Physician Group Practice Demonstration (PGP Demo) project, conducted from April 2005 – March 2010, signaled that ACOs can improve quality but may not be that successful in generating savings or reducing spending growth.

According to the Urban Institute, "by the end of 2012, we should know how successful CMS’ program was in attracting provider interest in the ACO model in Medicare, and how extensively the private sector plans to experiment with this payment model. Within a few years after that, we should have a much stronger understanding of how successful these experiments are in improving care while controlling costs."
to experiment with this payment model. Within a few years after that, we should have a much stronger evidence base about how to improve quality and reduce costs using ACO-style payment arrangements, given the experiments that Medicare and private sector providers and payers are currently embarking on."  

**Value-Based Purchasing**

Continuing and accelerating efforts begun during the second Bush Administration, the health reform law takes several steps to improve quality and safety in the Medicare program. These initiatives include:

- Making incentive payments to hospitals that meet certain performance standards, like those focused on acute myocardial infarction (AMI). HHS is charged with developing similar programs for skilled nursing facilities and home health agencies.
- Changing the existing Physician Quality Reporting Initiative to begin penalizing physicians who do not report quality measures to CMS. The existing program provides bonuses to physicians who voluntarily report at least three quality measures. The revised program will continue those bonuses through 2014 and switch to penalties for non-reporters in 2015. Similar changes are made to the quality reporting programs for hospices, long-term care hospitals and inpatient rehabilitation hospitals.
- Paying financial rewards to hospitals for reducing hospital-acquired infections and conditions.
- Providing bonus payments to health plans participating in Medicare Advantage for high quality performance and improvement year to year.

**Medicaid Quality**

There are only vague federal guidelines for quality measurement in Medicaid and programs vary widely from state to state. Building on provisions in the Children's Health Insurance Program Reauthorization Act, the health reform law makes new investments in improving the quality of care delivered to adult Medicaid beneficiaries. Given that Medicaid enrollment is expected to increase significantly, these provisions could be important. They include:

- With stakeholder input, HHS published a list of core adult quality measures on December 30, 2010. Updates to this core set will be published annually.
- By January 1, 2013, HHS will create a Medicaid Quality Measurement Program to fund the development, testing and validation of quality measures in priority areas.
- By January 2013, HHS will develop a standardized format for reporting information based on the initial core set of adult health quality measures. It will also create procedures that encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

**TIPS FOR REPORTERS**

- Quality of care varies from community to community and often within a community. Find out how the quality in your community compares to national or regional benchmarks of care. How does the quality of care compare to the best (top 10 percent) of hospitals, health plans, and others?
- Get familiar with Hospital Compare (www.hospitalcompare.hhs.gov). This tool allows you to find out how well hospitals care for patients with certain medical conditions or surgical procedures, and view results from a survey of patients about the quality of care they received during a recent hospital stay.
- The source of measurement is as important as the results. Who developed the measurement tool? Were the results independently audited? Look for information from independent groups like the Joint Commission, the National Committee for Quality Assurance, and such government sources as Hospital Compare.
- Check out the information about provider quality available to the public online, including the Aligning Forces for Quality community websites (http://www.rwjf.org/qualityequality/af4q/communities/index.jsp) and the Consumer Reports health ratings (http://www.consumerreports.org/health/home.htm). Are summary results provided in a user-friendly way?
- In 2010, the Centers for Medicare and Medicaid Services released Physician Compare (www.medicare.gov/find-a-doctor/), a physician directory tool established by the Affordable Care Act. This directory contains practice quality measures. Find out if new quality ratings came out for physicians in your area. How do they measure up to nearby areas and to national standards?

**STORY IDEAS**

- How do employers in your area, especially large employers, use quality data to choose health plans and providers?
- Are providers in your area grouping into Accountable Care Organizations? If so, are they experiencing growing pains? What barriers must they overcome?
How are providers in your area reacting to the health reform law's provisions supporting value-based purchasing?

The quality of care delivered by health plans participating in Medicare Advantage varies widely. How do the plans in your community perform on the quality measures? Why is their performance so high/low? What are they doing to improve their performance?

Are providers in your area taking part in a quality improvement effort or demonstration project? Examples include the CMS-led Physician Group Practice demonstration, the CMS/Premier, Inc. Hospital Quality Incentive Demonstration and the Robert Wood Johnson Foundation’s Aligning Forces for Quality initiative.

If you have manufacturers of pharmaceuticals or medical devices in your area, what do they think of the comparative effectiveness movement? What outcome are they hoping for? What outcome are they expecting?

Are physicians in your area trying to recast themselves as medical homes? If so, how? If not, why not? The rub: To be reimbursed as a medical home, a physician must be designated a primary care physician. Some specialists, such as surgeons, are trying to get this designation, to the chagrin of family practitioners.

Are health care providers in your area involved in pay-for-performance demonstration efforts? If so, do they think pay-for-performance efforts are fair? (An issue: Some providers, especially those serving low-income patients, think they should be rewarded for improvement in patient outcome, not solely for hitting certain benchmarks.)

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ENDNOTES


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34 Statement of Dr. Janet Corrigan, President and CEO of The National Quality Forum (2008). Medicare law provision will make quality front and center in America’s efforts to successfully reform our nation’s healthcare system.


45 A large number of states are also experimenting with the medical home either in their Medicaid programs or in the private insurance market. Medicare will launch an eight-state demonstration project in 2009 with significant financial rewards for participating physicians. See more at Iglehart, John K. No Place Like Home -- Testing a New Model of Care Delivery N Engl J Med 2008 359: 1200-1202.


47 Bridges to Excellence. Bridges to Excellence Overview. (http://www.bridgestoeexcellence.org/about_us/home.htm)


53 Reference Premier demo


55 House Committee on Ways & Means, January 16, 2009. Title IV - Health Information Technology for Economic and Clinical Health Act: Health Information Technology for Economic and Clinical Health Act or HITECH Act

56 Section 401, Public Law 111-3.


59 Section 3013. PPACA (http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@L&summ2=m&)


61 Section 6301. PPACA (http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@L&summ2=m&)

62 Section 3501. PPACA (http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@L&summ2=m&)


64 Dept. of Health and Human Services. Comparative Effectiveness Research Funding; http://www.hhs.gov/recovery/programs/cer/index.html


70 Section 1311. PPACA (http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@L&summ2=m&)

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72 Section 2717. PPACA (http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@L&summ2=m&)

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75 The medical home concept has been embraced by private health plans and employers. The Patient-Centered Primary Care Collaborative is a coalition of 300+ employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians and others that have been working with local and regional organizations to launch pilot projects of the medical home concept. See more at: Patient-Centered Medical Home: Building Evidence and Momentum. A Compilation of PCMH Pilot and Demonstration Projects. ( http://www.pcpcc.net/content/pcpcc_pilot_report.pdf ).

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100 Section 1102. Public Law 111-152

101 Section 2701. PPACA (http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@L&summ2=m).


