# Improving State Health Care Quality

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SOLUTIONS-ORIENTED CONVERSATIONS IMPROVING HEALTH POLICY

Frequently missing from the policy conversations about solutions to rising health care costs is the role that quality plays in reducing waste, health disparities and complications from chronic illness. Americans pay more for healthcare than any other nation in the world; yet, 28 other countries have life expectancies that exceed the United States, raising serious questions about the quality of care Americans receive.[1, 2]

Health care quality means providing appropriate care to the right person at the right place and time. The concept may appear simple and intuitive, but studies show that the current health care delivery system does not provide consistent, quality medical care to all individuals. To remedy this, the Institute of Medicine (IOM) has called for a major redesign of both the delivery system and the policy environment that shapes care delivery.[3] The IOM's Committee on the Quality of Health Care in America has identified six key aims for quality health care: safe, effective, patient-centered, timely, efficient, and equitable.[4]

### THE MULTIPLE DIMENSIONS OF QUALITY

| *Elements of quality care* | | *Type of quality problem* |
|---|---|---|
| People get the care they need | Effectiveness | Under use |
| People need the care they get | Effectiveness | Overuse |
| Provided safety | | Error |
| Timely | | Delays |
| Patient centered | | Unresponsive |
| Delivered equitably | | Disparities |
| Delivered efficiently | | Waste |

**Source:** Institute of Medicine Crossing the Quality Chasm (2001).

## 50% Chance of Receiving Quality Care

Studies have shown that over the last four decades the U. S. health system has demonstrated sizable deficits in the quality of care.[5] Adults receive only about one half of the recommended care for common acute and chronic conditions, as well as for key preventative services.[6]

Patient safety and the quality of health care received are undeniably linked together. Patients failed to receive needed services 46 percent of the time, while 11 percent of patients received services they did not need.[7] Furthermore, when there is an adverse drug event (ADE), 56% of the time it is an ordering issue and 34% of the time it is when the drug was administered.[8]

## Challenges to Improving Quality

While 16 percent of the gross domestic product is spent on national health expenditures, the health care industry does not behave like most markets in several ways.[9]

- **Delivery Fragmentation:** The U.S. health care delivery system is uncoordinated and overly complex. Patient care is often administered without the benefit of complete information about the patient's condition, medical history, services provided in other settings, or medications prescribed by other clinicians.[10]
- **Information Technology Deficits:** Lack of integrated patient information is further worsened by the fact that the health industry spends only 2.3% on information technology, compared to manufacturing (7.7 %) and financial services (13.8%).[11] The lack of automation is often cited as a contributor to poor quality and medical errors.[12]
- **Slow Adoption of Evidence-Based Practices:** While there have been rapid advances in medical science and technology that should improve the quality of care, it takes an average of 17 years for new knowledge to be incorporated into practice, and even then application is highly uneven.[13]
- **Rewards for Acute Care:** With increased longevity comes a higher occurrence of chronic conditions. Chronic conditions affect almost half of the U.S. population.[14] Yet the current reimbursement system focuses on acute, episodic care needs and does little to reward keeping people healthy.
- **Lack of Price and Quality Transparency:** The government and employers pay approximately 80% of health care costs nationwide.[15] Patients are largely shielded from the true costs of care and for the most part are unaware of the variation in care. Little information is available for them to make informed decisions about where to receive care, and its price and quality.

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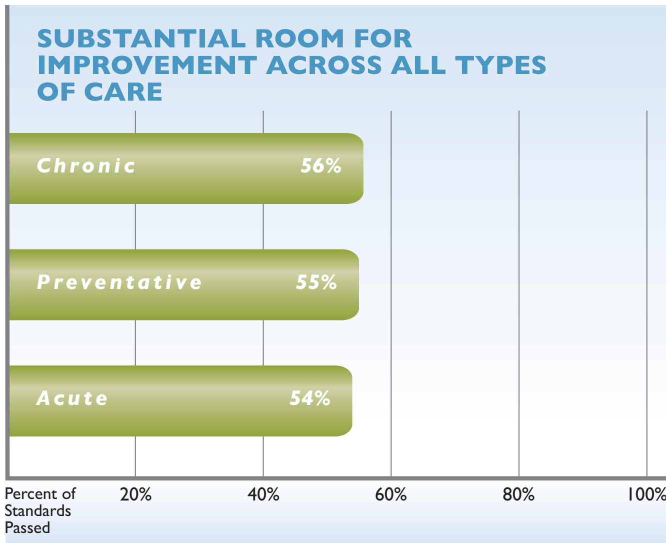


**Source:** McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A and Kerr EA. "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, 348(26): 2635-2645, June 26, 2003

## State Government as a Lever of Change

State government, employers, consumers and health care professionals each have a role to play in improving health care quality.

State government, as a large *purchaser* of health care, has the ability to demand performance and efficiency measures, and create rewards for health plans, disease management companies, other vendors and providers by wielding its considerable financial clout. In California, the state is a significant purchaser, spending more than $34 billion for Medi-Cal, $2.7 billion for the California Public Employees Retirement System and $950 million for Healthy Families.[16, 17, 18] Moreover, the state is responsible for caring for other populations such as incarcerated persons, persons with developmental disabilities, and low-income persons needing mental health services.

In its role as a *regulator* of care, the state can also influence quality. For example, the California Departments of Insurance and Managed Health Care are responsible for ensuring quality among California insurers, health maintenance organizations, and other ancillary companies. The Department of Health Services maintains oversight of hospitals, nursing homes, and other health facilities throughout the state. The Medical Boards of California oversee licensing of physicians and other practitioners, and the University of California Regents (subject to the Legislature) oversee California's university-based medical schools.

As a *policymaker*, the state can dramatically influence quality through the creation of standards, collection of data and issuance of guidelines. In California, the Office of Statewide Health Planning and Development collects hospital data and issues reports on quality for certain conditions. The Office of the Patient Advocate publishes an annual report card on quality among health maintenance organizations and certain physician organizations.

As a *convenor*, the state can bring key stakeholders together on such issues as accelerating the adoption of information technology and evidence-based practice guidelines. The federal Agency for Health Care Research and Quality (AHRQ) released the congressionally-mandated 2004 National Healthcare Quality Report, which is designed to help state health officials identify areas where quality improvement is needed.[19]

## Opportunities for Stakeholders

**Employers** can provide market reinforcement for the quality and safety of health care by basing their purchases on quality principles. The Integrated Healthcare Association (IHA) of Walnut Creek, California, is an example of collaboration among key stakeholders including health plans, physician groups, hospitals, and healthcare systems, plus purchaser, pharmaceutical, technology, consumer, and academic representatives.[20] In July 2000, IHA formed a high-level working group of purchasers, health plan medical directors, and physician group executives and medical directors to work on the concept of a new statewide initiative that would pay physician groups for documented performance.[21]

### Endnotes


1 Institute of Medicine. The Future of the Public's Health in the 21st Century. November, 2002.

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6 McGlynn EA, Asch SM, et al (2003).

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> **"…[Up to] 98,000 people die in hospitals each year as a result of medical errors that could have been prevented."**
>
> Source: Institute of Medicine To Err is Human: Building a Safer Health System, (Washington DC: National Academy Press) 1999.

**Consumers** can demand greater public access to information that is user-friendly. Consumers can develop health care literacy by seeking information from trusted sources, working with their physicians and others to ensure that they receive recommended care, and complying with recommendations to maintain their own health.

**Health care professionals'** role in health care quality change is determined by their openness to systems change. Many physicians, hospitals, community clinics and other providers participate in collaboratives that improve quality for prevention, chronic conditions, or create systems change that help all patients. The IOM suggests that when redesigning the health care system, health professionals should be trained in the six aims for improvement, modifications should be made in the ways in which professionals are regulated and accredited, and the liability system should support changes in the delivery of care while preserving the accountability of professionals and health organizations. [22]

## Quality Resources

### *National*

**Agency for Healthcare Research and Quality (AHRQ)—research www.ahrq.gov**

**Ambulatory Quality Alliance (AQA)—collaborative on ambulatory care www.ambulatoryqualityalliance.org**

**Center for Health Care Strategies (CHCS)—health coverage for the safety net www.chcs.org**

**Institute for Health Care Improvement (IHI)—advancing quality and value www.ihi.org**

**Institute of Medicine (IOM)—adviser to the nation to improve health www.iom.edu**

**Leapfrog Group—quality focused employer purchasing of health care www.leapfroggroup.org**

**MacColl Institute for HealthCare Innovations—bridges research and clinical care www.centerforhealthstudies.org**

**National Committee on Quality Assurance (NCQA)—information on health plans www.ncqa.org**

**National Quality Forum—quality measurement and reporting www.qualityforum.org**

### *California*

**California HealthCare Foundation (CHCF)—hospital report card, nursing homes, chart books, etc. www.chcf.org**

**California Physicians' Group (CAPG)—creating quality collaboration for organized physician groups www. capg.org**

**California Primary Care Association (CPCA)—quality improvement collaborative for clinics www.cpca.org**

**Integrated Health Association (IHA)—integrated healthcare and managed care, P4P www.iha.org**

**Office of the Patient Advocate (OPA)—report card on plans and physician groups www.opa.ca.gov**

**Office of Statewide Health Planning and Development (OSHPD)—provides equitable healthcare accessibility for California www.oshpd.ca.gov**

**Pacific Business Group on Health (PBGH)—business coalition focused on quality and moderating costs www.pbgh.org www.healthscope.org**

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## State Innovations to Improve Quality

States are increasingly taking bi-partisan steps to improve quality, in partnership with the private sector.

**Washington:** On January 20, 2006, Washington Governor Christine Gregoire (D) sent a "directive" letter to the state Department of Social and Health Services (Medicaid), the state Department of Health, and the Health Care Authority requesting collaboration on an initiative to improve chronic illness care in the state, evaluate and make recommendations for the Governor's 2007-09 biennial budget and by January 2007 develop a new patient-centered model of disease management.[23] The "directive" was sent out in response to the growing costs associated with chronic illness and long-term care services in the state.

**Minnesota:** A three-point quality improvement effort has moved forward with bi-partisan support. In September 2003, Governor Tim Pawlenty (R) formed the Citizens Forum on Health Care. In response to the Citizens Forum final report (released February 2004), Governor Pawlenty formed the Health Cabinet, which is responsible for implementing and developing health care reform initiatives for his administration. In November 2004, the Smart Buy Alliance was created with representatives from the Health Cabinet, business and labor to pool their purchasing power to drive value in the health care delivery system.[24] Participants in the Alliance agreed to common principles in their purchasing decisions, which result in similar demands placed on health plan contracts, shared use of tools and technologies, and greater empowerment of members.

### State Agenda for Quality

The state of California occupies a unique position as purchaser, convenor and regulator of health care services. The state can become the champion of quality improvement discussions to expand better health care and reduce costs. A first step can be the charting of current California quality initiatives and findings for policymaker review. Further, efforts can be made to include quality dimensions in the evaluation of current programs, and the development of new or renewing health care legislation.

**New York:** New York is currently focusing on a statewide demonstration of Pay-for- Performance (P4P) which encourages physicians and hospitals to: 1) develop and use standardized measures by payers; 2) fund up to five regional "cross-payer" P4P projects using those measures; 3) promote public and private payer (as well as provider) collaboration on projects implementing P4P; 4) promote evaluation of the impact of P4P on quality and efficiency; 5) budget approximately $200,000 to each project for organization/implementation and the rest of the remaining $9 million appropriated for "matching funds" directed at actual incentives to providers.

The federal government has also taken steps toward improving the quality through the establishment of pilot Medicare P4P projects[25] and community clinic quality collaboratives through the Bureau of Primary Health Care.[26]

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The California Health Policy Forum (CAHPF) provides an independent platform for education, idea sharing and conversations among legislative and executive branch health policy staff about the complex and vast array of health issues facing the state today. CAHPF is an initiative of the Center for Health Improvement (CHI). CHI is an independent, nonprofit health policy center dedicated to improving population health and encouraging healthy behaviors.

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