Enhancing Provider Quality

BY RHODA WEISS

What do *Consumer Reports, Fit Pregnancy, Self* magazine, *U.S News & World Report, AARP* magazine, state governments, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the local media, employers, and various health plans have in common? They have all joined the quality report card bandwagon, bestowing awards for clinical outcomes, creating "best of" lists, surveying the community for "consumer choice" awards, and publishing mounds of studies to help their audiences choose among health care providers and health plans.

While consumers have been slow to respond to this avalanche of data, the impact of ratings and rankings is growing. Hospitals that appear on the "best" lists or receive high scores are scrambling to tell the world about their accolades. Those with low scores quickly enter crisis mode, preparing responses while at the same time actively identifying activities intended to improve their future standing.

Yet despite dollars spent on marketing aimed at targeted audiences and the general public, consumers have in the past largely ignored these quality report cards. Instead, they have, when choosing a family doctor, relied heavily on family members, friends, co-workers, and acquaintances. And they primarily listened to their doctors for recommendations concerning hospitals, health plans, nursing homes, home health agencies, hospices, and other health-related services.

By and large, consumers have based their satisfaction, or lack of it, on more human factors. Patients traditionally have made such decisions according to their interactions with physicians and the hospital staff; how long they have to wait for medical attention; how quickly staff members respond to their needs; whether the hospital is clean; and other elements. Consumers evaluate health plans according to reputation and price. Clinical outcomes have rarely been part of the quality equation. In fact, a Harris Interactive poll based on 2001 and 2002 data showed that quality ratings have little to no influence on consumer choices of hospitals, health plans and physicians.[1]

Ms. Weiss is a Santa Monica, CA–based health care consultant and speaker.

The public, moreover, often has trouble evaluating the relevance of quality reports. Many report cards can be challenged on the grounds of inconsistent and incomplete data collection and interpretation, little use of information concerning severity of illness and demographics, and excessive delays before outcome data is released. In some cases, report-card organizations require participating hospitals to pay a five-figure or higher fee to promote the report card's results or participate in the survey, raising questions about the validity of "purchased" results.

However, all this may be changing. As reporting organizations unveil data on what seems to be a daily basis, consumers are beginning to respond to a much more reader-friendly format. Today's more sophisticated and savvy consumer—armed with information from multiple media sources, easily accessible medical journals, and thousands of websites—have begun to question the U.S. health care system and seriously examine the ratings and rankings available by a host of government, medical, research, employer, and popular media organizations. Consumers are looking at and slowly beginning to act upon comparative quality data on performance/clinical outcomes, as well as how providers have scored.

The internet and other media fuel this growing interest in provider rankings by making this information more understandable and easier to access. Even accrediting organizations are joining the trend. In July, the JCAHO, following the lead of a number of quality-related associations, unveiled its own online hospital performance-measurement tool, thereby providing both consumers and providers with access to information about patient quality, safety, accreditation, and disease-specific care certification. For the first few days, access to the website was impossible because of the overwhelming number of people seeking information. (The majority of those early Web visitors may have been hospital staff wanting to check out ratings of their own performances.)

CHA recently conducted focus groups to follow up on six years of research into how the public views hospitals, especially Catholic hospitals.

That research indicates that the public overwhelmingly ranks "quality" as the primary attribute it looks for in a hospital. Focus group members, in describing the key characteristics they sought in a hospital, said they looked for the latest technology, compassionate treatment, and excellent customer service.

Given growing consumer concern over how health care providers are rated, *Health Progress* readers might find interesting the following ideas about enhancing provider quality.

Partnering with Employers

In recent decades, business coalitions have tried to influence employer health decisions with surveys concerning patient safety and clinical outcomes. But most of these surveys had little impact and have ceased to exist. However, the influential Leapfrog Group remains successful. Leapfrog was founded by the Business Roundtable. Its members, including some of the nation's largest and best-known employers, spend $50 billion annually for employee-retiree health care.

The results of Leapfrog's hospital patient-safety survey, which can be found in the media and on employer websites, influence decision making about health plans. Leapfrog aims to continue measuring quality and rewarding the best performers, while pressuring hospitals to submit results—those that do not respond are also listed in its survey. Leapfrog encourages hospitals to spend millions on information-management technology and improve the clinical quality of staff and physicians. Efforts like this, on the part of employers and health plans, arm employers with the outcomes data they need to direct their workers to quality health care providers; they also present opportunities for collaborative activities.

In the communications arena, hospitals are persuading employers to use report cards and outcomes data for provider selection, website links with which workers can access health prevention information, and as collaborative opportunities for improvement in the quality of care. Providers are also tapping employer know-how in their quality-improvement efforts.

Take General Motors (GM), for example. GM, the largest private-sector purchaser of health care in the United States, spends $4.8 billion on health care for 1.1 million U.S. employees, retirees, and dependents.[2] (Together GM, Ford Motors, and Daimler-Chrysler paid $8.5 billion combined in health care in 2003). For nearly a decade, GM has applied its "lean" management, fast-track manufacturing process in a way that helps its suppliers improve efficiency, productivity, and quality. Some health care organizations—the Detroit Medical Center, University of Michigan Medical Center, Intermountain Health Care, and the Cleveland Clinic, for example—have benefited from GM-sponsored workshops. These workshops show the organizations how to improve themselves in many areas, including imaging, radiation oncology, surgery, and emergency departments.

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Enhancing Physician Communications

We have heard a good deal lately about the role of poor physician penmanship in negative medical outcomes—and about hopes for improvement through information technology. But related issues are receiving increased attention. A recent issue of *Annals of Family Medicine* reported that miscommunication, rather than incompetence, usually figures into errors at the primary care level.[3] A study of 75 error reports from 18 family physicians in five states concluded that 80 percent of errors were initiated by miscommunication, including breakdowns between physician colleagues, misinformation in medical records, mishandling of patient requests and messages, inaccessible medical records, and inadequate reminder systems. Steven H. Woolf, MD, one of the report's authors, suggests that more initiatives should focus on management systems to enhance the quality of information transfer. For quality and safety efforts to succeed, they must be led by physicians and involve as many members of the medical and hospital staff as possible, all working in interdisciplinary teams to identify and act on these issues.

Involving Internal Audiences

Employees, who are on the front line of quality and safety issues, should be involved in identifying problems and crafting solutions; they should also be rewarded for their efforts. Quality and safety activities can be discussed in columns in internal newsletters, promoted on an organization's website, and mentioned in every staff and departmental meeting. Because hospital executives and boards are also critical team members, safety and quality should be a regular item on every board meeting agenda. Safety and the quality of patient care are as much a fiduciary responsi-

bility as is business operations and financial management.

Implementing and Promoting Best Practices

A growing number of hospitals are developing and disseminating report cards among employers, payers, and the general public; these cards contain information about clinical outcomes and best practices covering nearly every disease and medical condition. Hospitals and health systems use national, statewide, and regional benchmarks accessed through universities, medical associations, quality organizations, and federal and state health divisions. In various categories—for example, mortality and infection rates, readmission and patient satisfaction rates, treatment effectiveness, patient functionality, and others—these report cards are being distributed among physicians, employers, health plans, and consumers; the cards appear in advertisements, brochures, newsletters, and other marketing materials. At the same time, staff physicians, nurses, and other clinical and ancillary staff are creating clinical guidelines to be implemented on hospital-wide and systemwide bases.

Sharing Clinical Guidelines

In some cases, treatment guidelines are shared with patients to help guide treatment decisions. In 1999, for example, the American Cancer Society partnered with the National Comprehensive Cancer Network to release the first patient version of the latter organization's breast cancer treatment guidelines. Originally designed for oncology specialists, the guidelines provide breast cancer patients with clear, easy-to-understand information on all aspects of the disease. Since 1999, other cancer guidelines have been formatted for patients—a critical practice for a disease that often offers its victims a large, confusing array of treatment alternatives.

Viewing Patients and Families as Allies

The Institute of Medicine's 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century,* focuses on the free flow of information readily available to patients and their families for informed decision making.[4] To facilitate this flow of information, hospitals are extending visiting hours throughout the facility, including critical care units, and offering a full-chart review with patients before discharge. Some hospitals are also involving patients and families in staff team meetings; appointing them as members of quality care and safety committees; including them in classes on lifestyle, prevention, and follow-up care; offering them caregiver training; and asking them to participate in patient-family friendly task forces.

We need a system that is less episodic and more responsive to prevention and patient well-being.

A major cause of medical error involves mistakes made by foreign language interpreters, who are usually either staff members, friends or members of the patient's family, or even bystanders. According to a 2001 study conducted by Medical College of Wisconsin researchers, 63 percent of interpreter errors at a Boston clinic were considered serious enough to have medical consequences.[5]

Health literacy is another major contributor to medical errors: Patients often cannot understand or follow basic health care information. Because this is so, hospitals should involve patients and family members in monitoring the communications skills of health care professionals and in testing the efficacy of educational materials. By doing so, hospitals can gauge whether those professionals and educational material are well comprehended.

CHA, as ministry engaged, will be delving deeper into the quality issue through its initiative, Envisioning a Future Health Care Delivery System. Quality is a vital element of the initiative, which will suggest ways to transform the health care system so that it is less episodic in nature and more responsive to prevention and patient well-being, than the system we have today. □

For more information, contact Ms. Weiss at rweiss@memnet.org or at 310-393-5183.

NOTES

1. www.harrisinteractive.com/news/newsletters_healthcare.asp
2. Danny Hakim, "Carmakers Face Huge Retiree Health Care Costs," *New York Times,* September 14, 2004, which can be found at www.nytimes.com/2004/09/15/business/15retire.html.
3. S. H. Woolf, A. J. Kuzel, S. M. Dovey, et al., "A String of Mistakes," *Annals of Family Medicine,* July-August 2004, pp. 317-326.
4. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century,* National Academies Press, Washington, DC, 2001.
5. Marilyn Marchione, "Language Linked to Medical Mistakes," *Milwaukee Journal Sentinel,* January 5, 2003, which can be found at www.jsonline.com/alive/news/jan03/108507.asp.