

# The Hunt for Healthcare Quality

BY JANE HIEBERT-WHITE

**I**n the past few years, a public backlash against managed care has prompted a spate of legislative proposals designed to represent the interests of consumers. In the first half of 1996 alone, 33 states enacted laws to protect managed care patients. Congress, in September 1996, approved a measure regulating the length of hospital maternity stays. And it nearly passed a bipartisan bill that would have barred health maintenance organizations (HMOs) from imposing "gag rules" that restrict physicians' ability to fully advise patients on treatment options.

Now, "after two years of mounting criticism and a flood of proposed state and federal measures to limit their alleged excesses, HMOs and other managed care health plans are trying to become less rigid and more consumer-friendly," *USAToday* reported in an April 16 cover story.<sup>1</sup> According to economist Paul Ginsburg, president of Washington, DC's Center for Studying Health System Change, "Consumers have sent a clear message in the last year. They don't like all the restrictions and problems. . . . They want choice and flexibility and a more user-friendly system."<sup>2</sup>

Although managed care plans have been the focus of consumers' and policymakers' complaints, hospitals should listen to them, too. Mark Chassin, MD, chairman of the Department of Health Policy at Mount Sinai Medical Center in New York City, writes, "This flood of activity and public commentary seems to suggest that serious quality problems in American medicine are limited to managed care. This view is incorrect. Our quality problems are far more widespread and substantial and predated the growth of managed care."<sup>3</sup>

This column examines what consumers say they want from hospitals, looks at President Bill Clinton's new healthcare quality advisory commission, and outlines some strategies for quality improvement, including regulation, competition, continuous quality improvement, and financial incentives.



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## WHAT CONSUMERS WANT

In the spring and summer of 1996, the American Hospital Association (AHA) surveyed public opinion concerning hospitals and healthcare. (The organization conducted a series of 31 focus groups, in 16 communities in 12 states; in September, it also conducted telephone interviews with 1,000 registered voters.) The AHA combined its findings with the results of a survey conducted by the Picker Institute. (The latter questioned 37,000 patients about the care they had received in 1996 from 120 hospitals, clinics, and physicians' offices in various parts of the nation.) The AHA-Picker Institute report, called "Eye on Patients," was released in early 1997 on the World Wide Web, an increasingly popular forum for consumer healthcare information.<sup>4</sup> Updates to the report continue to be added.

The AHA-Picker Institute report found that hospitals generally fared well in patients' eyes on issues concerning physical comfort. They did less well, however, on providing patients with emotional support, alleviating patients' fears and anxieties, and preparing patients to go home from the hospital. The Picker Institute data indicated that only about 10 percent of the patients surveyed reported problems with physical comfort during a hospital stay. The largest number of patient complaints concerned continuity of care and preparation to leave the hospital: 31 percent said they were not told about "danger signals" to watch for after they went home; 31 percent said they were not warned about possible side effects of medication; and 37 percent said they were not told when they could resume normal activities.

AHA found, in its focus groups and interviews, that "what patients care most about is not necessarily what health professionals think they care about." For instance, the patients surveyed expect the basics: physical care and alleviation of pain. But they made "little mention of the 'hotel' amenities (such as the quality of food or the variety of menu choices) that hospital administrators or marketers have often emphasized." The report

suggests that "perhaps because issues like these are fairly easy to address, they are often the first ones service quality programs take on. Such programs do not address the the issues of core concern to patients or the public, however."

The patients surveyed also want, along with more attention to continuity of care and transition from the hospital, more say in the treatment they receive. More than a third of hospital patients (36 percent) complained that they had had insufficient input in treatment decisions.

Information is also very important to patients, the report indicated. About a third of the hospital patients surveyed reported problems in getting answers to important questions they had asked. About 34 percent reported problems in talking to providers about their concerns.

The AHA-Picker Institute surveys found that some healthcare institutions do markedly better than others in patients' eyes. For example, the hospital patients reporting problems in being adequately warned about possible postdischarge "danger signals" ranged from a low of 20 percent in one hospital to a high of more than 44 percent in another. Those reporting problems with being told when they could resume normal activities ranged from 55 percent to less than 25 percent.

#### **THE PRESIDENT'S COMMISSION**

In March, Clinton named 32 members of his new Advisory Committee on Consumer Protection and Quality in the Health Care Industry, with four more members to be appointed later. He charged the commission with developing "a consumer bill of rights so that health care patients can get the information and care they need when they need it."<sup>5</sup>

The commission is due to issue a preliminary report by the end of the year and a final report by March 1998. It will also advise the president on specific bills before Congress that deal with consumer protection as it relates to managed care.

The commission's members include such hospital leaders as Gail Warden, CEO of Henry Ford Health System; Steven Sharfstein, CEO of Shepard Pratt Hospital in Baltimore; and Herbert Pardes, vice president of Columbia University's College of Physicians and Surgeons. Among the commission's other members are consumer advocates, managed care and insurance industry executives, corporate purchasers, labor leaders, policy analysts, and state and local government officials. Interestingly, the commission does not include members from quality measurement organizations such as the Joint Commission on the Accreditation of Healthcare Organizations, the National Committee for Quality Assurance

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(NCQA), and the Foundation for Accountability. On the other hand, the commission's executive director is Janet Corrigan, a former NCQA vice president who was until recently with the Center for Studying Health System Change.

Many policy observers are worried, however, that the commission will fall prey to politics and will be unable to accomplish meaningful change for consumers. Some are especially concerned because, they say, the president's charge to the commission is too unspecific and the time frame he gave it to conclude its work is too long.

Paul M. Ellwood, a founder of the Jackson Hole Group and a proponent of the managed competition plan that formed the centerpiece of Clinton's failed healthcare reform proposal, recently warned the president about the problems facing the commission. "For the commission to be effective, its report ought to be available in six to seven months and should concentrate on a new, unambiguous institutional quality framework that matches the restructured health care industry," Ellwood wrote in an open letter to Clinton. "If the industry's deliberations take longer, while prescribing actual quality standards, the administration will experience Managed Competition II."<sup>6</sup>

#### **STRATEGIES FOR QUALITY IMPROVEMENT**

In appointing a commission to recommend ways to improve quality in healthcare, the president is trying to both focus public attention on quality and bring a more coordinated effort to bear on behalf of patients. In the United States, attempts to improve healthcare quality have been "sporadic, often one-time projects or efforts limited to single institutions, usually hospitals," according to Chassin. "Long-term, multi-institutional programs to improve quality are infrequent, and regional attempts are rare." Perhaps that is why, because it seems to him grandiose, Ellwood likens Clinton's nationwide quality-improvement agenda to his failed healthcare reform plan.

What can be done now to improve healthcare quality? In a recent essay, Chassin, who also cochairs the Institute of Medicine's National Roundtable on Health Care Quality, assesses the merits of four current approaches.<sup>7</sup>

**Regulation** Although out of favor with a Republican-led Congress, regulation does have some advantages. It can be used, Chassin notes, to set some basic ground rules of acceptable performance and to "weed out egregiously poor health care performers." Chassin proposes a new use for regulation in regard to hospitals: "Many more patients could benefit if we used regulation to restrict the number of hospitals performing com-

plex procedures when the data demonstrate unequivocally that high volume means better outcomes."

**Competition** Today most healthcare experts seem to think that quality is best improved by increasing competition. If consumers are given more information—through healthcare "report cards" and other means—they will choose the highest-quality providers. Providers and health plans will then improve quality to attract consumers. So the rationale goes.

But Chassin argues that "at present, the notion that the market can stimulate real quality improvement is no more than a theory, because virtually all of the competition occurring in the marketplace revolves around price." He also cites the unsolved problem of furnishing consumers with timely, accurate, and useful data on healthcare providers, without which they cannot make intelligent decisions.

Then there is the problem of the average consumer's ability to make meaningful decisions based on the information he or she *does* receive. Chassin describes it thus:

Let us assume that we had 100 exemplary measures of quality relating to hospital care that were published in a timely way. The chance that a single hospital would score at the top of each measure is incredibly small. Therefore, if consumers were to choose on the basis of these measures, it is likely that a patient with diabetes and severe complications would select Hospital X, while a diabetic with serious vascular complications would choose Hospital Y, while a third patient with diabetes and heart disease would be directed to Hospital Z. Even assuming that consumers still have this kind of choice, and setting aside the problem that many important consumer choices must be made before consumers know what hospital services they will need, do we really believe that a large number of consumers will select hospitals and physicians in this manner?

Despite such problems, healthcare report cards have become a popular new tool in the healthcare industry. Large healthcare purchasers are driving some of the demand for more report cards and other quality measures, because they help the purchasers decide which health plans to offer employees.

Most report cards use at least some of the quality indicators reported in the Health Plan Employer Data and Information Set (HEDIS),

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which was developed by NCQA. HEDIS indicators cover measures of prevention, appropriateness of care, and patient satisfaction, as well as some information on chronic disease management.

Judith H. Hibbard and Jacquelyn J. Jewett, policy analysts at the University of Oregon, have recently conducted surveys and focus groups to determine, first, whether consumers understand report cards, and, second, whether such cards help consumers make informed decisions.<sup>8</sup> Hibbard and Jewett found that the quality measures best understood, and most highly valued, by consumers were: (1) patient ratings of the health plan's overall quality; (2) patient ratings of physicians' communication with them; (3) patient ratings of the respect given them; and (4) patient ratings of the satisfaction they derived from the time spent with physicians. Only about 9 percent of the consumer comments on these indicators reflected a lack of understanding.

The indicators consumers valued least and understood least well were: (1) the rate of hospital deaths following heart attacks; (2) the rate at which infants are born with low birthweights; (3) the rate at which children are hospitalized for asthma; (4) the rate at which postsurgical complications occur; (5) the rate at which infections are acquired in hospitals; (6) the rate at which cesarean sections are performed. Hibbard and Jewett concluded that "if consumers do not understand information, they are more likely to dismiss it as unimportant."<sup>9</sup>

In addition, Elizabeth McGlynn, a quality researcher at RAND, points out that report cards tend to present quality measures as *proportions* (the number of people receiving a particular healthcare service divided by the number eligible to receive it). "Proportion-based measures imply that 100 percent performance is the goal," she warns. "We need to evaluate the cost implications of these quality measures."<sup>10</sup>

**Continuous Quality Improvement** A third major strategy for quality improvement has been borrowed from industrial management: continuous quality improvement (CQI). However, Chassin concludes that although CQI has been embraced by a number of hospitals, it has spread slowly and has been used primarily to increase efficiency, not to directly affect patient outcomes.

**Financial Incentives** A fourth approach to improving quality is the use of financial incentives. Unfortunately, notes Chassin, "we have devoted remarkably little creative energy to designing and implementing payment systems that reward excellence in quality." To launch such a system, health-

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## HEALTH POLICY

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care leaders would first need to know how incentives would work, what information would be needed for their use, and what adverse effects might appear as a result of using them. As Ellwood points out in his letter to the president, "We cannot have the best health care organizations going broke because they are good at helping the sickest patients." □

### NOTES

1. Steven Findlay, "Trend in Managed Care Is Flexibility," *USA Today*, April 16, 1997, p. 1.
2. Findlay.
3. Mark R. Chassin, "Assessing Strategies for Quality Improvement," *Health Affairs*, May-June 1997, pp. 151-161.
4. "Eye on Patients: A Report from the American Hospital Association and the Picker Institute," World Wide Web (<http://www.amphi.com/eyeonpatients>).
5. "Commission Charged with Developing Consumer Bill of Rights," *Medicine & Health*, March 31, 1997, p. 2.
6. Paul M. Ellwood, "An Open Letter to the President on Quality," *Health Affairs*, May-June 1997, pp. 268-270. The letter was delivered to Chris Jennings, the White House health policy adviser.
7. Chassin.
8. Judith H. Hibbard and Jacquelyn J. Jewett, "What Type of Quality Information Do Consumers Want in a Health Care Report Card?" *Medical Care Research and Review*, vol. 53, 1996, pp. 28-47; Jacquelyn J. Jewett and Judith H. Hibbard, "Comprehension of Quality Care Indicators: Differences Among Privately Insured, Publicly Insured, and Uninsured," *Health Care Financing Review*, Fall 1996, pp. 75-94; and Judith H. Hibbard, Shoshanna Sofaer, and Jacquelyn J. Jewett, "Condition-Specific Performance Information: Assessing Salience, Comprehension, and Approaches for Communicating Quality," *Health Care Financing Review*, Fall 1996, pp. 95-109.
9. Judith H. Hibbard and Jacquelyn J. Jewett, "Will Quality Report Cards Help Consumers?" *Health Affairs*, May-June 1997, pp. 218-228.
10. Elizabeth A. McGlynn, "Six Challenges in Measuring the Quality of Health Care," *Health Affairs*, May-June 1997, pp. 7-21.

## ANALYSIS

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In addition, in successful systems, primary care physicians are economically integrated, the practice sites provide good geographic coverage, the system is an appropriate size, clinical and management information systems align, and the system offers single-signature authority.

Successful physician integration requires effective strategic and business planning, including a shared vision, a strategic plan that addresses specific goals and initiatives, and a business plan based on solid market research, development initiatives, operating parameters, management requirements, and a financial plan. "You must begin with the end in mind," emphasized Ackerman. "Seventy-five percent to 80 percent of all mergers come apart in five years because they did not have a shared vision and they did not have a good, sound strategic plan that addressed their goals and initiatives."

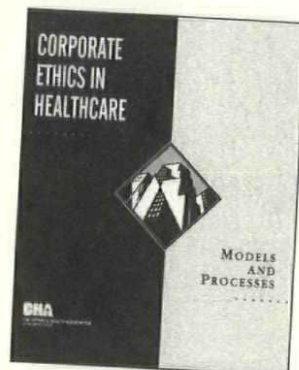
The rewards of such hard work and careful planning include improved quality of care, operating efficiency, accessibility, and patient satisfaction; reduced unit costs; and stronger customer relations. The bottom line: enhanced value to customers.

### MODELS OF INTEGRATION

As examples of leading integrated systems, Ackerman cited Intermountain Health Care, serving Utah's urban corridor and multistate rural regions; Aurora Health System, Wisconsin's leading not-for-profit healthcare system; Carle Clinic Association and Carle Foundation, a system serving central Illinois; and Geisinger Health Care System, serving central and northeastern Pennsylvania. Ackerman outlined success factors common to all:

- A clear, common vision focused on system initiatives
  - Strong physician relationships and investment of resources to establish collaborative relationships
  - Significant physician participation in leadership and management
  - A focus on physician/administrator teams
  - An investment in infrastructure to make integrated practice an attractive option
- Ann Stockho

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