

# CHARTING THE COURSE TO HIGH-VALUE HEALTH CARE

There are serious gaps between the health care Americans *should* receive and the care they *actually* receive. Patients get significantly different care—some better, some worse—depending on where they live and which doctors and hospitals they use. Meanwhile, the cost of care, even for patients with similar outcomes, varies significantly among providers and regions across the country.

The problem is that it is hard to tell the good from the bad or determine the best value. Unlike most well-functioning markets, there is a lack of consistent information about our fragmented health care system that can be used to improve outcomes for patients while keeping costs down.

Against this backdrop, the Quality Alliance Steering Committee's (QASC) High-Value Health Care Project is working with key stakeholders to make consistent and useful information about the quality and cost of health care widely available to patients, physicians, hospitals, health insurers, and others who need information about health care delivery. The project's diverse collaborative of physicians, nurses, hospitals, health insurers, consumers, employers, government, regional and local initiatives, accrediting agencies, and foundations supports the implementation and use of performance information to:

- Help health care providers improve the quality of patient care.
- Help consumers make informed choices about health care providers.
- Help provide payments that support provider efforts to improve quality and efficiency, rather than simply paying for more intensive treatments.
- Help reduce large racial and ethnic disparities in care.

Together, these represent critical steps to a high-quality, affordable, and patient-centered health care system.

## We're paying too much—and health care quality is not what it should be

With each passing day, the pressing need for valid, timely, and consistent information about the performance of the U.S. health care system becomes increasingly obvious. The United States spends more per capita on health care than any other country in the world. Despite this, our nation ranks 10th in life expectancy among industrialized nations, and 27th in infant mortality.<sup>i</sup> Adult patients receive only about 55 percent of recommended care, and children fare worse.<sup>ii, iii</sup> As many as 91,000 Americans die each year because they do not receive the care experts recommend for chronic conditions such as high blood pressure, diabetes, and heart disease.<sup>iv</sup>

Making more accurately informed decisions on how to improve care, how to select the best providers, and how to pay for care can help drive costs down while improving patient outcomes. The problem is we do not always know which providers are doing a good job and which are not. Still, we can build on important progress already underway: Medicare, for instance, now publicly reports key measures of the quality of care hospitals provide and the experience of their patients. Moreover, there are more than 70 regional measurement and reporting efforts underway. These include the organizations working with the Robert Wood Johnson Foundation's *Aligning Forces for Quality* program and the U.S. Department of Health and Human Services' Chartered Value Exchange program. They rely on a variety of measurement approaches and often face substantial barriers in obtaining consistent data. These pioneering efforts are a great start; the next step is to strive for consistency. Without it, we will be left with multiple conflicting initiatives that hold the potential for significant and unintended consequences, ranging from unnecessarily burdening physicians, nurses, clinics, and hospitals to creating confusion among consumers and detracting from employers' efforts to design programs that meet their employees' needs.

Patients' chances of getting the care they need to help them stay healthy or effectively manage their chronic diseases—such as women getting recommended mammography tests or patients with diabetes getting essential blood tests—varies significantly depending on where they live. A recent study<sup>6</sup> of Medicare patients found:

- In Mississippi, 57 percent of female patients ages 65–69 got regular mammograms in 2004–2005, compared to the national average of 64 percent, or the best performer, Maine, with 74 percent.
- In Alaska, only 71 percent of patients with diabetes got important tests for blood sugar control in 2003–2005, compared to the national average of 84 percent, or the highest performer, Vermont, with 91 percent.

What is needed now is a nationally consistent, technologically sound, and efficient approach to make performance information widely available. The need is clear – you cannot improve what you do not measure. This is why measuring and reporting on performance in health care is a vital first step in fixing our fragmented health care system:

- Patients can use information about the quality and cost of care that doctors and hospitals provide to demand improvements and make informed choices. Only 12 percent of Americans surveyed in 2008 said they had seen quality information about doctors.
- Doctors and hospitals need information about the quality of care they provide to improve it, but few doctors have access to such information. Only one doctor in three gets any data about performance, and fewer than one in five receives clinical outcomes data, which tells him or her if the patient's health has improved following treatment.
- Payers can use information to reward providers for the value instead of the volume of services they provide.

## Coordinating the generation of better information—the role of QASC

We can enhance our ability to deliver high-quality, patient-centered care if we can achieve a national consensus on a single method to produce and release performance measurement information. Making a “turn-key” solution available for generating performance information will make it easier for more local and regional efforts to follow the pioneers who are already trying to collect and share data within their areas. Scarce local resources can be used to focus on improving care in their communities or to augment the information where desired.

QASC oversees the High-Value Health Care Project and is co-chaired by Carolyn Clancy, M.D., the director of the Agency for Health Care Research and Quality, and Mark McClellan, M.D., Ph.D., the director of the Engelberg Center for Health Care Reform at the Brookings Institution. The Robert Wood Johnson Foundation provides significant funding to the Engelberg Center, America's Health Insurance Plans Foundation, and the American Board of Medical Specialties in support of the High-Value Health Care Project.

This project builds upon the important work of others in both the public and private sectors, including local communities dedicated to measuring and reporting on the quality of health care. Its performance information is based on priorities and measurement standards established by the National Quality Forum (NQF).

A critical goal of the High-Value Health Care Project is ensuring that all Americans, regardless of their race and ethnicity, get high-quality care. Unfortunately, we are not always able to tell if everyone gets equitable care, as information about race and ethnicity is not always available. The High-Value Health Care Project is working with others to address issues, such as the best way to collect race and ethnicity identifiers; how to use low-cost methods to estimate disparities; how to link data on race with data on health care quality; and promulgating good practices in measurement and reporting that address health care equity.

## How does the project do its work?

The project is initially aggregating data from multiple health plans for 17 NQF-endorsed measures and composite measures of ambulatory care, including preventive care; medication management; and care for diabetes, heart disease, lower back pain, arthritis, and depression. Additional measures will be added in the near future.

The project is working with the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans Foundation to create an effective approach to closely align private sector efforts with similar efforts undertaken by the CMS. Combining private sector and Medicare performance information would allow for a more complete and accurate picture of the quality of care. The project is also working on combining clinical data (e.g., lab results, registry information) with claims data to produce additional meaningful performance information about cardiovascular, diabetes, and cancer care in the future.

The project will initiate this data aggregation approach in two state-wide pilot projects in 2009. Demonstrated success there will allow expansion to other areas of the country. The approach developed by the project will focus on tracking how a patient's care is delivered across providers – family doctors, specialists, hospitals, or others. While this project will not initially publicly report performance information, it will eventually benefit both consumers and providers. Based on successfully tested approaches, consumers will gain access to more comprehensive information that is focused on helping them make smart health care choices. Providers will receive feedback on the overall health care results for patients.

Generated performance information will be about individual physicians and aggregated for entities in which doctors share tax identification numbers. Future efforts,

where feasible, may focus on measuring performance of medical groups and physician practices. Through this effort, doctors will be able to review lists of patients within their practice that are included in the measurement process. Patients' privacy will be protected, and personal health information will stay with the original owners of the data, but doctors will be able to access lists of patients through a single interface.

The project is also working to develop measures that can help those who get, give, and pay for care also understand how different providers use resources and compare them to national benchmarks. To address this cost-based measurement, the project is working with the American Board of Medical Specialties to identify measures of standardized costs and resource allocation for treating 20 common conditions.

Linking measures of cost with measures of quality is essential for creating a high-value, performance-based health care system. As a nation, we need to know that the enormous expenditures we make annually on health care are producing the intended results – improved health and health care for everyone. The first step is to provide health care providers, payers, and consumers with consistent, reliable, and accessible information about the appropriateness and the success of the health care services being delivered. Without a clearer picture of what is happening inside our health care system, we cannot fix it.

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<sup>i</sup> OECD Health Data 2008. France: Organisation for Economic Co-operation and Development and IRDES (Institute for Research and Information in Health Economics), 2008. (No authors given.)

<sup>ii</sup> McGlynn EA, Asch SM, Adams J, et al. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine*, 348(19): 1866-1868, 2003.

<sup>iii</sup> Mangione-Smith R, DeCristofaro AH, Setodji CM, et al. "The Quality of Ambulatory Care Delivered to Children in the United States." *The New England Journal of Medicine*, 357(15): 1515-1523, 2007.

<sup>iv</sup> *The Essential Guide to Health Care Quality*. Washington: National Committee for Quality Assurance, 2007. (No authors given.)

<sup>v</sup> Fisher ES, Goodman DC, Chandra A. *Disparities in Health and Health Care Among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project*. Princeton, NJ: Robert Wood Johnson Foundation, 2008.