

Crossroads In Quality

Successful reform must address coverage, costs, and quality at the same time.

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ABSTRACT: Expanding insurance coverage is a critical step in health reform, but we argue that to be successful, reforms must also address the underlying problems of quality and cost. We identify five fundamental building blocks for a high-performance health system and urge action to create a national center for effectiveness research, develop models of accountable health care entities capable of providing integrated and coordinated care, develop payment models to reward high-value care, develop a national strategy for performance measurement, and pursue a multistakeholder approach to improving population health. [*Health Affairs* 27, no. 3 (2008): 749–758; 10.1377/hlthaff.27.3.749]

MOUNTING PUBLIC CONCERN ABOUT the affordability of health care has captured the attention of state and federal policymakers and the presidential candidates. As pressures mount and reform efforts take shape, Americans have an important opportunity to advance the quality agenda as an integral part of addressing cost containment and coverage. The danger is that if reforms focus too narrowly on expanding health insurance coverage, without addressing the underlying problems of quality and rising costs, the reforms will fail.¹

Quality improvement, cost containment, and coverage expansion are intri-

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cately interwoven goals. To achieve and sustain broad-based access to high-quality, affordable care requires understanding and eliminating major structural barriers that impede the development of a high-performance U.S. health care system.

This paper describes those barriers and key strategies that policymakers should pursue as integral components of health reform. Many past reform efforts have failed, and there are no guarantees of success moving forward, but unless we address the systemic problems, current reform efforts will ultimately fail.

■ **Three policy objectives.** The policy changes described in this paper address three objectives: (1) developing the science base needed for better decision making in health care; (2) structuring a combination of performance reporting and payment policies that would facilitate development of more-effective and -efficient models of care; and (3) marshalling broad-based efforts, in the health care delivery system and beyond, to avert dire health and financial consequences from our looming population health problems (such as obesity).

These objectives are inherently linked. A solid base of evidence enables rational decision making about health care and development of robust measures of quality. Credible performance evaluation is essential to recognize and reward high levels of performance for patients and populations. Strong incentives are needed to encourage diverse health care providers and other stakeholders to take on the hard work of cultural and organizational change that is needed if we are to achieve consistently high performance in health care.

■ **Mobilizing change.** Mobilizing change in our \$2.1 trillion health care industry is immensely challenging. The reforms discussed in this paper call for a comprehensive response by multiple stakeholders, including public- and private-sector leadership. Given the tremendous diversity of the industry, transition will also require a range of developmental approaches to promote system evolution.

There are important steps that Congress and others can take now to move in this direction: (1) Create a national center to support effectiveness research, with stable public-private funding. (2) Encourage the Centers for Medicare and Medicaid Services (CMS), state Medicaid programs, and private purchasers to continue developing and testing models of accountable health care entities that achieve effective integration and coordination of care for the populations they serve. Standardize evaluation criteria across models to facilitate benchmarking and comparison of value. (3) Encourage public and private purchasers to develop payment methods to reward high-value care, such as shared savings models and bundled, severity-adjusted payments, while ensuring a high degree of transparency of information on quality, cost, and use patterns. (4) Develop a national strategy for performance measurement, including standardized measures of patient and population health. (5) Pursue a comprehensive approach in the public and private sectors to improving population health with measurable goals and resources tied to achievement of goals.

Build The Evidence Base For Rational Decision Making

A fundamental building block of any high-performance health system is reliable information about the effectiveness of care, including benefits, risks, and costs of alternative technologies and services. Evidence is needed to support national and regional decisions about Medicare coverage, development of practice guidelines and performance measures, design of value-based insurance plans, and informed patient and clinician decision making about treatment alternatives. The United States spends tens of billions of dollars on clinical research to increase understanding of diseases and to discover new treatments and drugs (for example, by the National Institutes of Health and the pharmaceutical industry) and hundreds of millions of dollars on health services research to study better ways to organize and finance care.² By contrast, minimal funding is directed to effectiveness research to build the evidence base needed for decision making in health care.

We need a major initiative to systematically identify where critical gaps in evidence exist, prioritize those questions, and efficiently generate evidence that is relevant and adequate to fill the gaps.³ This will take a major organizational effort and substantial funding, but it is essential if we are to deliver high-quality care, reliably evaluate performance, and eliminate waste.

Critical gaps in evidence are widespread for both new and existing technologies and services. For example, every year the United States spends about \$20 billion managing patients with chronic wounds, such as pressure ulcers or diabetic ulcers.⁴ A recent review of scientific studies of negative pressure wound therapy (a common treatment) found only six trials reported, all of them having major methodological problems, and five having fewer than twenty-five patients.⁵

Another example is the use of autologous bone marrow transplant/high-dose chemotherapy (ABMT/HDC) to treat metastatic breast cancer. Rigorous trials performed in the 1990s showed that contrary to the preliminary findings from the late 1980s, conventional therapy is superior to ABMT/HDC. Meanwhile, some 30,000 women were unnecessarily subjected to ABMT/HDC, and an estimated 600 women died prematurely as a result.⁶

We are now seeing a groundswell of support for increased investment in effectiveness research.⁷ The Institute of Medicine (IOM), America's Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association, and the Medicare Payment Advisory Commission (MedPAC) have all issued reports recommending expansion of federal support for development of the evidence base—all of them focusing on the need for independence, transparency, credibility, and reliable funding.⁸ Some have called for Congress to establish a new independent public/private agency. A December 2007 Congressional Budget Office (CBO) report concludes that comparative effectiveness information, linked to changes in financial incentives, seems “likely to reduce health care spending over time—potentially to a significant degree.”⁹

Strengthening the evidence base will not assure diffusion of evidence into prac-

tice, but it is an essential prerequisite for performance measurement, accountability for care, and tying payment to quality. As noted by the CBO, it is linking these changes that offers promise.¹⁰

Promote Development Of Coherent, Proactive Models Of Care

A fundamental barrier to a high-performance health care system is the severely fragmented configuration of our current delivery system, which is both ratified and reinforced by current payment policies and performance measures. The inadequacy of current organizational models is most evident for the sickest patients, who typically see multiple physicians and often move across multiple settings. These patients are at risk of miscommunication, redundant testing, and dangerously uncoordinated care.¹¹

■ **Promise of information technology.** Health information technology (IT) offers tremendous opportunities to make care safer and more effective and efficient.¹² As more and more physicians, multispecialty group practices, hospitals, and health systems make sizable investments in health IT, the benefits in terms of quality of care have become clear and compelling.¹³ Overall, IT adoption continues to be slow, with 4 percent of physicians having access to fully functional electronic health records (EHRs) and 14 percent using EHRs with minimal capabilities.¹⁴ Three of every four physicians are in small practices (1–4 physicians). They, in particular, face major economic, cultural, and technical challenges to implementing health IT.¹⁵ For the most part, large group practices have successfully transitioned to EHRs.¹⁶ Continued efforts to promote health IT adoption at all levels of the delivery system are crucial to achieving system transformation.

■ **System supports.** Health IT alone will not solve the problem. We also need to enable and support clinical entities that can coordinate care across providers and settings, deliver against coherent plans of care, and be accountable and rewarded for performance. The Veterans Health Administration (VHA) system is often cited as such a model because of its sophisticated information systems.¹⁷ In fact, a constellation of factors has produced its excellent results (for example, management systems; aggressive and strategic quality management; alignment of financial incentives of employees, including physicians; and an annual budget). Its IT is an enabler of excellent management but is not sufficient to produce high-quality, efficient, and patient-centered care.

Envisioning Future Models Of Care

Evolving from our highly fragmented delivery system to one made up of high-performance organizations requires transitional strategies. The challenge is to develop performance measurement systems and payment policies that will encourage physicians, medical groups, hospitals, and other providers to develop models of care that can evolve to produce excellent results across the entire delivery system. No single organizational model would work in all circumstances, but we

should promote the development of a variety of “accountable health care entities.” Primary care physicians could create “medical homes.” Multispecialty groups and independent practice associations with and without hospitals might form the nexus of “virtual” groups. They could be held accountable for outcomes for their patient populations across providers and over time and for delivering health management through clinical systems such as registries, electronic prescribing, EHRs, coordination of care, patient education, coaching, and self-management functions (either internally or through partnerships). The way to encourage development of such entities is to pay them to take on those responsibilities and reward them based on performance. Efforts such as the California Pay for Performance Program illustrate the potential for collaborative movement in this direction.¹⁸

■ **Leveraging health plans.** All types of health plans should have strong incentives to improve performance and encourage delivery system change. Some health plans have already demonstrated capability to improve quality. We have seen significant gains in the Health Plan Employer Data and Information Set (HEDIS) scores during the fifteen years that plans have been reporting.¹⁹ Health plans can improve quality through direct-to-beneficiary health management processes (wellness programs and disease and case management) and indirectly through benefit plan design, provider contracting strategies, gain sharing, and other provider incentives.

In general, health maintenance organizations (HMOs) have been required by purchasers to report on quality, whereas others (for example, preferred provider organizations, or PPOs) have not. As HMO enrollment has begun to decline, HMOs’ ability to influence systemwide quality has declined. Extending the accountability framework to include evaluation and public reporting on all types of health plans would go a long way toward strengthening incentives to improve quality and lower costs nationwide. Publicly financed programs such as fee-for-service (FFS) Medicare and state Medicaid programs should also be included.

■ **Pay for quality.** Misaligned incentives inherent in payment approaches are the primary cause of the poor quality and excess costs that characterize the current system. Focusing on cost and quality separately is the wrong way to solve either problem. For example, just adjusting prices across the board per the Medicare Sustainable Growth Rate (SGR) formula will not change the relative advantage of doing more high-price procedures rather than fewer.²⁰ We believe that if quality is not tied to payment, providers’ behavior will not change appreciably, and if it does not change, access to insurance and care will continue to decline.

■ **Restructure payment models.** Current common payment models include FFS, diagnosis-related groups (DRGs), and capitation. All have strengths and weaknesses. FFS theoretically aligns providers’ and patients’ interests by removing any incentive to deny or refuse potentially beneficial care, as long as the patient can pay what providers want to charge. FFS also protects clinicians from substantial financial risk for the contingent and unpredictable health needs of patients. The downside is that FFS creates incentives to provide ever more narrowly defined, special-

ized, and higher-price services, even when the expected clinical value added is doubtful or nonexistent: providers gain from delivering more care but are not rewarded (and will often lose revenue) from evidence-based parsimony. On its own, FFS payment does little to align patients' and providers' interests in improving outcomes while minimizing costs.

The DRG system, while certainly reducing hospital lengths-of-stay, offers no incentive for avoiding admissions in the first place. The incentive for efficiency is within the inpatient episode, not in the overall management of the individual patient or population of patients over time. Payers may attempt to counteract the powerful incentives of this system through pay-for-performance (P4P) and efficiency measurement, but these efforts will not succeed in reining in overall system costs while the underlying payment system continues to reward hospitals for providing more frequent inpatient stays while ignoring population health outcomes.

Capitation is intended to give providers strong incentives favoring efficiency, but it also carries the potential to be abused. Needed care may be withheld, especially if capitation is not combined with transparency about outcomes and patients' experiences. In the 1990s, questions about inappropriate restrictions on access to care led to tremendous public backlash.²¹

We need to replace the still dominant FFS payment system with payment models that reward clinically effective and efficient population health management and that yield high levels of patient satisfaction. A variety of models should be pursued. Where integrated systems exist that can take responsibility for comprehensive and proactive health management of patient populations, the goal should be to pay them for population health outcomes through severity-adjusted bundled payment (that is, full capitation). Where integrated systems do not exist, other payment methods should be tried that reward coherent and proactive care and encourage efficiency, such as bundled chronic care episode payments.²²

Publicly available quality outcomes data will be key to re-earning public trust in any non-FFS payment system. Benchmarking would also play an important role, offering payers the ability to evaluate the impact of different organizational and payment models on both the quality and the cost of care and, over time, differentially reward superior performance.

Initially, the payment system should reward participation in more-integrated entities that can be held accountable for population outcomes, perhaps as a pathway out of the Medicare SGR strategy of recent years, which has penalized all physicians for rising expenditures, despite congressional relief to avert fee reductions. Instead, differential increases in payment rates could be authorized, favoring organizations that demonstrate efficient care management. If the differential reward is great enough, many physicians are likely to choose to practice in accountable health entities.

A transition to paying for quality will require the concerted efforts of public- and private-sector payers to create a business case for providers to change how

they operate. An effective payment system with clear goals and accountabilities is critical to achieving affordable, high-quality health care.

Need For A National Performance Measurement Strategy

As the health sector moves through this period of enormous transition, access to reliable and useful performance information will be critical to developing new payment programs that reward quality, restructuring the delivery system, and maintaining public trust. A comprehensive measurement strategy is needed to focus attention on high-leverage areas having the greatest potential to improve patient and population outcomes, slow the rate of health care spending growth, and systematically raise the bar of performance expectations.

A large number of organizations are involved in developing and selecting measures, including accrediting and certifying bodies, specialty societies and boards, government agencies, proprietary organizations, and quality alliances. Engagement of many stakeholders is crucial for widespread adoption and use of performance measures, but the efforts of the many groups involved are often discordant, leading to major variability in measure specifications, testing, and maintenance.

Transparency of standardized performance data is foundational to the payment and delivery system reforms discussed in this paper. The National Quality Forum (NQF), a private-sector standard-setting organization with broad public- and private-sector input, has a critical role in fostering development of a comprehensive measurement strategy and standardized performance measures.²³ Performance information is a public good, and federal funding for the NQF will facilitate development of a comprehensive portfolio of standardized measures.²⁴

Focus On Population Health

U.S. health rankings are consistently poor compared to other industrialized nations, and beneath our overall health statistics are subpopulations faring far worse than average.²⁵ For example, among developed nations, the United States ranks twenty-fifth in female life expectancy at birth. The uninsured and underinsured suffer greatly as a result of reduced access to health services.²⁶

We all pay the price for lack of attention to public health—in terms of “depreciation” of our national health; higher health insurance premiums; and higher tax expenditures for Medicare, Medicaid, and safety-net providers. As costs spiral higher, more employers scale back their coverage or drop it altogether, catching working Americans in a vicious cycle of increasing lack of insurance, underinsurance, and inadequate care.²⁷

Americans' health is poor not just because of shortcomings in health care, but because of lack of a comprehensive public health strategy and concerted efforts in the public and private sectors to achieve strategic goals for improving population health.²⁸ Obesity is an example of a national crisis for which potential solutions lie mostly outside of health care. The burden of illness from diabetes, heart disease,

and musculoskeletal ills is already serious and increasing rapidly.²⁹

A first order of business ought to be to develop a comprehensive, multistakeholder strategy for population health management with clear goals and responsibilities and evaluation of progress. Without a fully developed strategy, we still must make a concerted public- and private-sector effort—like the one we mounted for tobacco control—to achieve the outcomes we know are possible.

Second, aggressive public-sector leadership is pivotal to foster broad-based engagement. The public sector can promote population health from a number of perspectives: through tax policy, from the bully pulpit of public officials, through public health infrastructure development, as an employer, and as an insurer. National efforts on tobacco control demonstrate how effective a deliberate, multi-pronged strategy can be. On the obesity front, Arkansas is providing a model with a strategy targeted to schoolchildren, state employees, and the general public.³⁰

Third, we need to update and upgrade the public health infrastructure with strong leadership, clear accountabilities, and expanded resources. Aside from its environmental mission, public health has devolved in much of the country into a provider for the poor and uninsured, with little connection to the private sector or perspective on the health of the population within its jurisdiction. Individual health departments struggle with inadequate budgets and have little means or authority to take the broad population perspective that is required.³¹

Fourth, public purchasers should promote population health initiatives. The federal government could assume a more proactive role in pursuing better health outcomes for the millions covered through federal health programs. The Department of Health and Human Services (HHS) could become a powerful force leading broad-based population health improvement efforts under Medicare and Medicaid.³² But HHS needs the mandate, latitude, and funding to do so.

Fifth, private purchasers can design value-based benefit plans and report on performance for all insured populations. They can sponsor experimentation with incentives and other strategies to promote healthy behavior. Within the delivery system, providers and purchasers can work toward realigning incentives and evolving performance measurement and reporting, as discussed in this paper.³³

In addition, as the IOM notes, “individuals, communities, and various social institutions can form powerful collaborative relationships to improve health that government alone cannot replicate.”³⁴ Some promising new approaches are emerging. One is Minnesota’s e-Health Initiative.³⁵ Another is the concept of “pay-for-population health performance” initiatives, which entail purchasers’ aligning their goals, incentives, and quality measures in support of promising national and regional population health improvement initiatives.³⁶

As with transformation of the health care delivery system, each of these public health reforms requires leadership, commitment, and resources; each requires overcoming powerful special interests. And none alone is sufficient. Few challenges are more important, and the costs of inaction are becoming so visible and

painful that public awareness and support for change appears to be increasingly strong and widespread.

OPPORTUNITIES FOR TRUE NATIONAL DEBATE over the direction of U.S. health care are rare and difficult to sustain. If the current surge in interest in system reform is to succeed in the near and long terms, it must concurrently address coverage, costs, and quality. By expanding the knowledge base to support rational decision making, by transforming outdated payment systems and building a national performance measurement strategy, and by integrating quality considerations into decisions about everything from benefit structures to public health strategies, we can create reform that reaches well beyond better coverage to better health care and better health.

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The authors are members of the Quality Crossroads Group. Corrigan and O’Kane formed the group in 2006 to identify reform strategies to address the complex challenges confronting the health care delivery system.

NOTES

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