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From the Editor

The Vision for a National Quality Report

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From the Editor
The Vision for a National Quality Report

By now, most readers are familiar with the far-reaching Institute of Medicine (IOM) reports on American medical care. Taken together, To Err is Human[1] and Crossing the Quality Chasm[2] reveal a health system that is disjointed, inefficient, and, too frequently, harmful to patients. "Americans ought to be able to count on receiving care that is safe and uses the best scientific knowledge…there is strong evidence that this is not the case."1 It is not my intent to summarize these widely publicized reports in this space. Rather, I want readers to focus on another task directly related to these reports; that is, former President Clinton's Advisory Commission on Consumer Protection and Quality (in the Healthcare Industry) call for a national commitment to improve quality.

This Presidential Advisory Commission recommended that there be an annual report to the President and Congress on the nation's progress in improving healthcare quality. As a result, Congress enacted the Healthcare Research and Quality Act of 1999 directing the Agency for Healthcare Research and Quality (AHRQ) to prepare an annual report on national trends in the quality of healthcare provided to the American people. In short, while the two infamous IOM reports outlined the shortcomings and made recommendations for change, a third, somewhat unheralded, report envisions the actual structure of a National Healthcare Quality Report in response to this Congressional mandate.[3]

Imagine for a moment the challenge we would face as a group of Jeffersonians charged with the task of creating an annual comprehensive national report card on quality for our nation. This would be daunting indeed! This conclusion to the IOM trilogy on quality envisions just such a national quality report and lays out specific recommendations as to its design, construction and implementation. In these pages previously, I have discussed aspects of a national quality report including such groups as The Foundation for Accountability (September 1997, Vol. 10, No. 3), The Leapfrog Group (December 2000, Vol. 13, No. 4), The National Quality Forum (March 2001, Vol. 14, No. 1) and others. I would like to summarize the main message in Envisioning the National Healthcare Quality Report.[3]

As a result of the Congressional Act directing AHRQ to prepare this annual report, AHRQ asked the IOM to undertake a planning effort for designing just such a report, recognizing that the first annual report must be published in 2003. As a result, the IOM appointed a blue-ribbon panel to conduct a feasibility study and make specific recommendations as to the creation of this Quality Report. The authors of the IOM study believe that such a Quality Report would set the context for accountability for the entire healthcare system in our country. In addition, it would enhance awareness of quality, monitor the possible effects of policy decisions and initiatives on quality, and assess our progress in meeting national goals regarding quality. I believe Drs. Roper and Epstein, the Chair and Vice-Chair of the IOM committee said it best when they noted that, "Just as today, everyone from the stock broker on Wall Street to the person in the street follows the economic indicators, someday soon, the Congress, executive branch agencies, providers, consumers, and the public at large will be tracking trends in healthcare quality via the National Health Care Quality Report."

In order to envision a day when such a Quality Report would compete with the latest numbers from Wall Street, the committee distilled its work into ten critical recommendations. The first recommendation calls for a new conceptual framework for the Quality Report. Namely, the Quality Report should have two dimensions focused first on the components of healthcare quality and second on the perspective of the consumer. The key components of healthcare quality include such concepts as safety, effectiveness, patient centeredness, and timeliness. The consumer perspectives focus on changing consumer needs for care over the life cycle associated with staying healthy, getting better, living with illness, and coping with the end of life. Safety in this context refers to avoiding injuries to patients from care that is intended to help them. Effectiveness means providing services based on scientific knowledge to all who could benefit. Patient centeredness refers to healthcare that establishes a partnership among practitioners, patients, and their families to ensure that decisions respect patients' preferences. Timeliness refers to obtaining needed care and minimizing unnecessary delays.

The second recommendation calls for the AHRQ to apply a uniform set of criteria in the Quality Report. The criteria ought to focus on the importance of what is being measured, the scientific soundness of the measure, and the feasibility of using the measure. One example might be: Can the healthcare system meaningfully address a particular problem, and what will it cost to do so? The third recommendation calls for the AHRQ to establish an on-going independent committee or advisory body to help assess and guide improvements over time in the Quality Report. This advisory body would serve as a vehicle for collaboration among interested public and private sector parties.

The fourth recommendation calls upon AHRQ to set the long-term goal of using a comprehensive approach to the assessment and measurement of quality as a basis for the national dataset. While such a comprehensive quality measurement system does not yet exist, the report recommends that aspects of available systems be tested before they are implemented at the national level. The fifth recommendation calls upon AHRQ to combine related individual measures into summary measures of specific aspects of quality. For example, a report could include a summary measure of the safety of surgery based on measures for a variety of surgical procedures.

The sixth recommendation notes that the Quality Report should reflect a balance of outcome-validated process measures and condition- or procedure-specific outcome measures. This means that some combination of both process and outcome measures will satisfy the needs of policy makers, clinicians, and consumers. If the report were to institutionalize specific measures about the infrastructure of organizations or the technology involved in reporting, it could soon become outdated.

The seventh recommendation sets forth a series of guidelines for selecting the sources of data for the national healthcare quality dataset. Recommendation eight recognizes that AHRQ will have to draw on a mosaic of public and private data sources to comprise the dataset. This recommendation also recognizes that there will likely be an evolution toward a comprehensive health information infrastructure involving the electronic medical record or related tool. This standardized electronic data system, it is hoped, will greatly facilitate the definition of an integrated and comprehensive dataset used as the core of the Quality Report. In short, the dissemination and adoption of electronic clinical data systems will go a long way toward helping experts create the Quality Report.

The ninth recommendation emphasizes how important the national representativeness of the data will be in creating the Quality Report. Finally, recommendation ten calls for the creation of several versions of the report card tailored to meet the needs of key audiences including policy makers, consumers, purchasers, providers, and researchers.

It is, indeed, a formidable task when one thinks about creating a nationally representative, comprehensive annual report card about the quality of care delivered to the nation. My own view is that these ten recommendations are thoughtful and well reasoned. They represent the thinking of some of our best minds already at work in the quality of care measurement arena. The more compelling questions remain, however. Who will use such a report card and how will they use it? Regrettably, current evidence[4] points to the fact that despite many local, regional, and even statewide efforts in reporting information about quality, it often goes unheeded by consumers. What will make this national report card different?

From a selfish perspective, however, I am very pleased with the IOM trilogy of reports concerning the quality of medical care. These reports have gone a long way toward removing the taboo often associated with public discourse about the poor state of health care quality and have stimulated many organizations to undertake the hard work of a deep self-evaluation of their efforts in this arena. Improving quality is everybody's business. Maybe one day, as Roper and Epstein suggest, we'll be tracking the data in the Quality Report the way we track the data in our own financial portfolios. I, for one, am looking forward to that day. As usual, I am interested in your views. You can contact me at my e-mail address, david.nash@mail.tju.edu. You can also review all three reports at the Institute of Medicine website, which is www.iom.edu.

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