

Fuzzy Grades

The road to unified standards is long and winding

By Peter Neurath

Several local and national events during recent weeks have advanced the difficult process of measuring, and thereby improving, the quality of health care.

The more headway made with this process, the better, for improving quality would remedy the problems of overuse, underuse and misuse of health-care services.

Quality problems are widespread, according to the National Quality Forum, in Washington, D.C. "Although tens of millions of Americans reap the benefits of modern medicine each year, millions of others are exposed to unnecessary risks, denied opportunities for improved health, or are injured or killed as a result of medical errors."

Still in its early stages, measuring the quality of medical care has been gaining momentum as a means not only for improving patient care but for restraining the overall cost of care, which has been skyrocketing for businesses and for government. Both sectors declare that rapidly rising costs are unsustainable.

"Reporting clinically valid quality measures is an important step toward making it easier to achieve major improvements in quality -- if you cannot measure it, it is hard to take steps to improve it," Medicare Administrator Dr. Mark McClellan recently testified before Congress.

At the local level, [Premera Blue Cross](#) in mid-December published its second quality score card, measuring the quality of care on 11 measures at a dozen large physician practices across the state.

Meanwhile, at the national level, the Institute of Medicine in Washington, D.C., issued a report called "Performance Measurement: Accelerating Improvement," which includes a comprehensive set of health-care quality measures.

Then locally, the [Puget Sound Health Alliance](#), aiming to improve and to rein in the cost of care in five Puget Sound counties, quickly adopted all these measures, though for now it will advocate the use of only some of them.

Back to the national level, Medicare earlier, in October, initiated a program of asking doctors voluntarily to report on 36 quality measures as to whether they have treated patients in accord with care recommended by the latest scientific medical research.

But while many groups are trying to measure the quality of medical care, and while there's a lot of overlap - "Already the metrics are 90 percent the same," said Chief Medical Officer Dr. Al Fisk at The Everett Clinic - as yet there exists no single, standardized regional or national system for doing so.

Which is something that makes doctors crazy.

In their own ways, for instance, Premera, [Regence BlueShield](#), PacifiCare and Aetna -- which compete to distinguish themselves from with each other -- have each taken a shot at assessing how well local doctors treat patients (although Premera claims it initially offered to work together with other carriers).

The problem, said Bob Perna, health care economics director at the Washington State Medical Association, is that multiple score cards, embodying different ways of measuring quality, make the whole measurement effort far less useful for doctors and their medical groups because they may receive widely differing evaluations.

Observed Fisk, "The last thing doctors want is to be measured eight ways by eight different health plans."

With each one slightly different and based on relatively small numbers, Fisk said, doctors don't know what to pay attention to. As a result, doctors are tempted to "round-file" these reports.

Which is not to say that Premera and other health plans have not been doing good, ground-breaking work on measuring physician performance, medical directors seem to agree. (Fisk was among those medical directors who collaborated closely with Premera in devising a quality score card.)

Dr. Rick Ludwig, chief medical officer at Pacific Medical Center in Seattle, praised Premera for making "a really great effort" in drawing together a dozen group medical practices to identify and agree on quality measures.

Still, he and others would like to see a single, common set of measures applied to local medical groups.

Everyone, locally and nationally, is working on the same challenge of measuring quality, Fisk said, but the sooner that quality measures are standardized, the better.

"Ultimately, we would like to have all this work aligned into a single system," concurred Dr. James Bender, a medical director at [Virginia Mason Medical Center](#) in Seattle.

No one, it seems, including Premera, disputes that goal. "There should be one set of core basic metrics," said Premera Medical Director Dr. Mark Sollek. Even so, he added, if medical groups working with Premera want higher standards than those found in the core set, Premera would want to use those as well.

Regence is on board, too. "We staunchly support the development of a nationally consistent set of quality and efficiency measurements," said Regence spokeswoman Jodi Coffey.

Regence agrees with the quality measures recently released by the Institute of Medicine, she added. "However, we caution that some of these measures, such as on-site review of chart notes in all provider offices, are not practical to administer when applied across all physicians and clinics," she said.

Regence suggests beginning with those measures that rely on insurance claims information, Coffey said. "This approach is not perfect, but it is a first step we can take while we wait for the development of universal, searchable electronic medical records."

Bender remarked that all organizations, whether Premera, Regence or the Institute of Medicine, have embarked "on a journey together" to find the right way to measure quality. "I see all these efforts as complementary, not exclusive," he said.

The Institute of Medicine evidently agrees. In its performance measurement report, the IOM recognized that "many public- and private-sector initiatives have make substantial progress in developing, implementing and reporting on measures" of performance by doctors and other health-care providers. "These efforts have yielded a laudable array of assets for performance measurement."

"However," the IOM continued, "a well-functioning national system that can meet the need for performance measurement and reporting is unlikely to emerge from current voluntary, consensus-based efforts, which are often fragmented and lack a consistent connection to explicit, overarching national goals for health care improvement."

The IOM called for Congress to create a new, independent body, the National Quality Coordination Board, as "the lead agency responsible for ensuring the creation of a national system for performance measurement and reporting."

It may take a while for the IOM to get Congress to act, but action locally was almost immediate. The board of the **Puget Sound Health Alliance** swiftly adopted the some 200 quality measures recommended in the IOM report.

"That's a big step forward, and it cuts down on the work we need to do," said **Alliance Executive Director Margaret Stanley** about the IOM's report.

Founded earlier this year, the **Alliance** is a private, nonprofit organization with the avowed goal of "improving health care quality and reducing the rate of cost growth in King, Kitsap, Pierce, Snohomish and Thurston counties."

The **Alliance** plans to use the latest scientific research to identify and measure quality health care, then publicly to issue comparison reports.

What's significant about the **Alliance** is that it's regional and that it brings to the same table physician groups, hospitals, health insurers, unions, consumers and some 75 businesses. "The **Alliance** is the vehicle to come up with a single score card," said Lloyd David, executive director of The Polyclinic, in Seattle. "It's a forum where all the players are coming together."

Stanley said the **Alliance** will advocate regionwide use of some of the IOM's measures: "We expect and hope that everyone will use them so there's only one reporting system for the region, and so health plans don't have to do their own."

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