

Establishing Health Care Performance Standards in an Era of Consumerism

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AS THE US HEALTH CARE SYSTEM begins to reengineer itself to address the need for quality improvement,^{1,2} it also is being actively reshaped by the expectations of consumers.³⁻¹⁰ The heightened focus on quality and the rise of health care consumerism are manifestations of numerous interrelated dynamics, especially including the aging of the “baby boomers” and greater prevalence of chronic conditions, the explosion of biomedical scientific knowledge and technology, changes in the prevailing method of health care financing, a recent prolonged period of economic prosperity, widespread concerns about patient safety, return of disproportionate health care cost increases, and the democratization of medical knowledge consequent to widespread use of the Internet.^{1-6,10-16} The confluence of these forces has created a turbulent environment that requires a new approach to establishing health care performance standards.

The State of US Health Care Quality

Health care, in the aggregate, is the largest enterprise in the United States, employing more people than any other industry, consuming nearly 15% of the gross domestic product, and having expenditures of more than \$1.2 trillion a year. Given this, it is remarkable how little is known about the quality of US health care. The snapshots of information that exist indicate serious and systemic quality problems.¹⁷⁻²⁴ Problems of overuse, underuse, and misuse are common. There are large gaps between the care people should receive and the care

they actually do receive. Only about 50% of patients receive recommended preventive care; 70%, recommended acute care and 60%, recommended chronic care, while about 30% of patients receive contraindicated acute care.¹⁹⁻²⁴ The quality problems transcend the patient’s age, clinical condition, method of financing, and mode of care delivery. While the deficits in US health care quality are now well established, the movement to improve health care quality remains diffuse and not yet at the tipping point²⁵ as demonstrated by the paucity of health care organizations having quality improvement as their primary business strategy. However, there are clear signs that the quality movement is gaining momentum.

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The Need for a New Approach

Conventional wisdom has held that consumers do not understand the complexities of health care delivery, are focused primarily on service quality and access to care, and are not generally interested in clinical performance data.^{26,27} However, it is now known that such views are overly simplistic. Consumer attitudes and expectations about health care have changed in recent years with consumers increasingly being interested in clinical performance and pub-

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lic accountability.¹¹⁻¹⁵ As patients, family members of patients, research subjects, and purchasers of health care, consumers are increasingly becoming activists, demanding and using information about medical treatments, health care products, and health care standards.¹⁵ Contributing to this trend has been the growing recognition of health care quality problems.

The new assertiveness of consumers, as well as that of purchasers,²⁸ has challenged the traditional roles of physicians and health care provider organizations in establishing quality standards and in determining quality improvement priorities. To understand how health care quality priorities will be set in the emerging era of consumerism, it must be recognized that the stakeholders include everyone (ie, patients, purchasers, payers, policy makers, health plans, clinicians, public health officials) and that in this evolving environment the new rules of engagement are still being worked out.

At this time, the myriad health care stakeholders have divergent views about who should determine quality standards, how performance measures or standards should be set, and who should be allowed access to data about compliance with the measures. This diversity of opinion has often resulted in high-spirited debate about the purposes of quality performance measures and the validity of the measures. However, not often has such debate led to a shared understanding that facilitated health care improvement.

In order to balance the different perspectives so that a common agenda for improving health care quality can be agreed upon, it is necessary to bring all the stakeholders into the discussion on an equal basis. A forum is needed where no one interest dominates the others. Experience from other activities has shown that obtaining agreement among diverse viewpoints is enhanced when the discussions are firmly grounded in explicit evidence and standards are more likely to be accepted and implemented if representatives of those who will have to implement and use the

standards are involved throughout their development.

Formation of The National Quality Forum

The National Quality Forum (NQF) was established to develop a common vision for health care quality improvement, create a foundation for consistent data reporting and collection, and galvanize the support needed to substantially improve the delivery of health care services. The NQF, formally incorporated as The National Forum for Health Care Quality Measurement and Reporting pursuant to section 501(c)(3) of the Internal Revenue Code, is a private, nonprofit, open membership, public benefit corporation whose mission is to increase the delivery of superior-quality health care.

The idea of establishing a unique public-private organization to promote a national agenda for health care quality improvement was advanced by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.²⁰ The proposal reflected the commission's understanding that reliably and consistently measuring quality in comparable ways across the continuum of care is essential for value-based purchasing of health care, as well as being necessary to support oversight and quality improvement efforts. The recommendation also reflected an understanding of the value placed on individual autonomy and the skepticism of authority (whether the authority be government, corporate, or professional) that characterizes the US culture.

The president's commission proposed the establishment of 2 entities. The formation of the NQF was the first entity and a public agency called the Advisory Council for Health Care Quality was the second. The commission envisioned the Advisory Council as setting national goals for health care quality improvement and providing oversight on their accomplishment, while the NQF would devise a national strategy for measuring and reporting health care quality, which would achieve the identified goals. At this time, neither Congress nor

the current or previous administration has shown interest in establishing the Advisory Council, so the NQF is pursuing the functions originally envisioned for the council (setting national goals for health care quality improvement).

Efforts to formally establish the NQF were initiated by the Quality Forum Planning Committee that was convened by Vice President Gore in late 1998. This planning committee conceptualized a governance structure and operating strategy that culminated in the NQF being incorporated in the District of Columbia in May 1999. A chief executive officer and initial staff were hired in late 1999 and the NQF began to function in early 2000. Funding has been provided by The Robert Wood Johnson Foundation, California Health Care Foundation, Henry Goldsmith Foundation, United Hospital Fund, and Commonwealth Fund. The NQF's ongoing operational funds come from membership dues, contracts, and grants.

The NQF Strategy

The mission of the NQF is to improve the delivery of health care across the continuum of care, not just in hospitals, health plans, or any other single venue of health care delivery. At the most basic level, the NQF will work to increase quality by establishing a platform for consistent data reporting and collection. The primary tactics the NQF will use to accomplish its mission are the measurement and public reporting of health care quality data combined with efforts to encourage health care purchasing decisions to be made on the basis of quality data. In pursuing this strategy, the NQF is especially interested in promoting performance measures that can be used to assess quality in multiple care settings.

Underlying all of the NQF's activities is a philosophy that health care quality data are a public good and should be in the public domain, and when joining the NQF, member organizations acknowledge a statement of principle, indicating their willingness to use indicators of health care quality and to publicly disclose the results. Another key principle

underlying the NQF's activities is that health care quality is premised upon ensuring patient safety. A health care provider cannot be considered to be providing high-quality care unless everything is being done that can be reasonably done to ensure that the patient remains free from injury or illness during the process of care. Since medical science and health care technology are always changing, ensuring patient safety is a continuously evolving pursuit.

In considering what is high-quality health care, the NQF has adopted the president's advisory commission's statement of purpose for the health care system: "The purpose of the health care system must be to continuously reduce the impact and burden of illness, injury and disability, and to improve the health and functioning of the people of the United States."²⁰ In operational terms, high-quality health care is viewed as care that is known to be effective; to produce better health outcomes, greater patient functionality, and improved patient safety; and that is easy to access resulting in a satisfying experience for all concerned.

Similarly, the NQF has specified that the purpose of a health care quality measurement and reporting system is to (1) evaluate the degree to which the US health care system is providing safe, beneficial, timely, and patient-centered care; (2) assess whether the distribution of high-quality care is efficient and equitable; (3) enable substantial progress to be made toward achieving established national goals; (4) provide easily accessible information on quality to a variety of audiences, including consumers, purchasers, and providers, to facilitate individual and collective decision making; and (5) provide information that regulators, purchasers, and providers can use to support continued improvement and achievement of goals.

The NQF's initial operational strategy is 3-fold. First, the NQF will strive to standardize the myriad measures of health care quality that are currently being used to ensure that they are evidence-based, provide reliable and comparable data, and are consistent with a national agenda for health care qual-

ity measurement, which includes specified national goals for health care quality. The NQF has proposed 12 national goals for improving health care quality in the United States²⁰; these goals are currently being reviewed by the NQF's member councils. Second, the NQF will promote public disclosure of quality data so that they can be used in consumer and purchaser decision making. Finally, the NQF will encourage health care purchasing decisions to be made on the basis of quality data.

In pursuing this strategy, the NQF does not anticipate that it will develop new quality performance measures. Many research, accreditation, and oversight organizations, as well as commercial interests, have already developed measures or are developing new performance indicators. The NQF sees a greater need, at this time, for weighing the evidence behind existing measures and endorsing those that are both evidence-based and linked to national priorities for health care quality. The NQF believes that by standardizing health care quality measures the compliance burden on health care providers will be reduced and the measures will become more useful. Standardized evidence-based measures will be more helpful to quality improvement efforts and will facilitate competition based on quality, promote consumer choice, and inform public policy.

How Is NQF Different?

The design of the NQF is unique in several ways. First, it has open membership. Any organization or individual interested in health care quality can join the NQF, contingent upon approval of the NQF Board of Directors and payment of the requisite dues. As of June 2001, more than 125 organizations have joined the NQF.

Second, the broad representation of stakeholders on the board of directors is unique. The heads of 3 federal agencies sit on the 18-member board: (1) the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration); (2) the Agency for Healthcare Research and Quality (rep-

resenting the federal government's Quality Interagency Coordination Council); and (3) the Office of Personnel Management (which selects health plans for the Federal Employees Health Benefits Plan). There also are representatives of state agencies and private sector representatives such as General Motors (the largest private purchaser of health care in the United States), AARP (American Association of Retired Persons), The American Federation of Labor–Congress of Industrial Organizations, March of Dimes, and Empire Blue Cross/Blue Shield. By design, a majority of board members represent consumer and purchaser organizations. In addition to the 18 voting members of the board, there are 4 non-voting liaison seats for the Joint Commission on Accreditation of Health Care Organizations, National Committee for Quality Assurance, the American Medical Accreditation Program, and the Institute of Medicine of the National Academy of Sciences. These seats underscore the NQF's desire to be inclusive and bring additional value to the good work of these and other organizations.

Third, the NQF's Strategic Framework Board (SFB) is unique. The SFB, a carefully selected group of recognized experts in health care quality improvement, organizational change, and related matters, was appointed by the NQF Board of Directors in November 1999 to serve as a special advisory entity having the charge ". . . to develop the intellectual architecture and identify the principles to guide a national [health care quality] measurement and reporting strategy" (NQF Bylaws, Section 8.1). To ensure that the SFB's deliberations were not constrained by any particular organizational interest or position, the entity was deemed to be "quasi-independent." The SFB completed its work in June 2001 and its report is currently going through the NQF's formal consensus process.

Fourth, the NQF is unique in blending consumer, purchaser, and provider perspectives on an equitable basis and then using the combined market power of both the public and private sectors to leverage quality improvement. Lever-

aging the combined purchasing power of both government and private purchasers is an untried but potentially very potent strategy.

Fifth, the NQF's approach to building consensus through its 4 member councils (provider and health plans, consumers, purchasers, and research and quality improvement organizations) and a formal process for achieving consensus is unique. This consensus process is guided by the provisions of the National Technology and Transfer Advancement Act of 1995 (NTTAA)³⁰ and related documents. The NTTAA specifies that when a federal government agency establishes standards in an area it is obligated to "use voluntary consensus standards in lieu of government unique standards except where inconsistent with law or otherwise impractical." The NTTAA further specifies what qualifies as voluntary consensus standards and allows federal agencies to participate in such standard-setting activities.

The Office of Management and Budget (OMB) instructions to federal agencies on compliance with the NTTAA state that for a standard to meet the requirements of the NTTAA it must be developed by a voluntary consensus standards body, which must demonstrate 5 attributes: openness, balance of interest, due process, an appeals process, and consensus. Of these attributes, the only 1 specifically defined by OMB is consensus.³¹ According to OMB, consensus is general agreement but not necessarily unanimity and includes a process for attempting to resolve objections by interested parties, as long as all comments have been fairly considered; each objector is advised of the disposition of his or her objections and the reasons why, and the consensus body members are given an opportunity to change their votes after reviewing the comments. The NQF consensus process has all of these attributes.³²

Challenges

In advancing the health care quality movement, the NQF recognizes many and varied challenges. For example, how will the NQF build upon, coordinate, and systematize the numerous quality im-

provement-related activities already under way by other organizations and find common ground among often times competing entities? Similarly, the variation and immaturity of clinical information systems and the lack of information about critical success factors in deploying and diffusing health care quality improvement pose challenges of a different type. The poorly quantified business case for improved health care quality and the limited societal demand for better health care quality present still other challenges. Finally, and perhaps the greatest challenge of all, how do we create a health care culture of excellence that incorporates the active participation of consumers and nurtures the sense of collegiality and shared responsibility between consumers and caregivers that is necessary in such a culture?

Important Enablers for Improving Health Care Quality

Efforts to reach agreement about and to implement standardized health care performance measures that will lead to quality improvement in the emerging era of consumerism will be facilitated by a number of circumstances. First, quality improvement will be facilitated by establishing national goals for health care quality. The current health care quality movement can be characterized by the maxim "If you don't know where you are going, then any road will get you there." It is ironic, if not astounding, given the importance and enormity of the health care industry that the United States has no broadly agreed upon goals and priorities for the enterprise.

National health care quality goals would provide focus for improvement efforts. Clear goals would help develop and refine improvement assessment methodologies and prioritize resource use. If chosen wisely, the goals will capture the passion and imagination of both the public and health care providers, stimulating interest and strengthening the will to achieve them. To help create a context for purchasers and consumers to understand the importance of the national health care quality goals, the performance measures to which they are

linked, and the significance of differences in health care providers reflected by differences in the measures, a broad-based social-marketing campaign similar to what has been done in recent years for smoking cessation, sober driving, fruit and vegetable consumption, and seat-belt use needs to be conducted. It may be unrealistic to think that a large majority of the public will routinely review quality data when making health care decisions, but it is likely that a significant minority will if they understand why it is important and if the information is presented in a way that it is meaningful to individual consumers. As with many other public policy issues, efforts need to be directed at achieving an informed minority that is capable of effecting change beneficial to everyone.

Second, public policy must embrace the concept that quality improvement, cost control, and better access can be complementary, not competing, goals. Quality improvement should not be pursued instead of cost control and improved access. Each of these needs must be addressed and the health care organizations that have successfully improved quality of care while concomitantly lowering cost and increasing access should be held as benchmarks.^{21,33,34} Answers to some of the seemingly intractable issues of cost control and access may be found in improving the processes of care.

Third, the priorities of patients and other health care consumers have to be addressed better. The measurement and reporting of performance need to be better targeted toward what is important to consumers. This includes those parts of the health care system that consumers directly interface with (hospitals, outpatient clinics, and individual caregivers) and the most prevalent conditions that prompt patients to seek care.^{12-14,21} Notwithstanding the technical difficulties inherent in assessing performance at the individual caregiver and facility level, the paucity of usable data for these elements of the health care delivery system has probably contributed to the perceived ambivalence of consumers about quality data. Mechanisms to assess qual-

ity at the provider level that are equitable, reliable, and responsive to the consumer's needs must be found. The Web-based health care decision support tools recently developed by the Foundation for Accountability are encouraging developments in this regard.³⁵

It will be important to especially focus on improving the processes of care that are completely out of the patient's control and those processes of care that make a difference when the patient's health is in serious jeopardy (whether due to the processes of care and/or the disease state). It is in these settings that consumers expect the system to function at its best.

Fourth, health care leadership needs to focus on creating a culture of excellence. There is a great need for a compelling vision of how a patient-centered, safe, efficient, equitable, effective, and timely health care delivery system would operate,²¹ what actions are needed to achieve this vision, and realistic strategies for accomplishing the requisite action. Many complex and

emotionally laden issues will have to be addressed to make the quantum leaps in health care quality improvement that are needed; strongly vested interests and deeply entrenched practices will have to be changed. Leadership firmly grounded in stakeholder collaboration will be needed from health care professional organizations, government health agencies, licensing and accreditation bodies, consumer and advocacy groups, health care purchasers, and individual practitioners. These parties will need to work individually and collectively to promote a health care culture of excellence that recognizes and accepts the limitations of human performance, uses technology and systems to support the essential human caregivers, and strives to deliver consistent and predictable high-quality care through the use of performance measurement and continuous quality improvement methods.

Finally, progress in the health care quality movement will be dependent upon health care's myriad stakeholders

working effectively toward a shared vision. Efforts to define and operationally specify quality, its measurement, and its management are most likely to be successful when those efforts integrate the concerns and perspectives of patients and other consumers, purchasers, providers, and payers. The greatest need is finding common ground and reaching agreement on an agenda for action.

Physicians must learn how to effectively work with and lead collaborative efforts. No longer can physicians and other providers expect to unilaterally define and control health care quality and quality improvement efforts. One of the key determinants of the degree to which physicians and their representative organizations might lead such integrated efforts will be the extent to which they regain trust that the patient's best interests are of paramount concern.³⁶⁻³⁸

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