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High-Value Care Every Time: Recommendations From The National Quality Task Force

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Editor's Note:

Shantanu Agrawal and Ken Kizer will discuss the ideas presented in this post at the Health Affairs *event, "The Care We Need: NQF and 20 Years of Quality," at 2:00 PM ET today.*

Health care in the United States costs too much and delivers too little. The Commonwealth Fund ranks the U.S. health care system last among western developed countries in overall performance, access, administrative efficiency, equity, and outcomes. The U.S. spends nearly twice as much on health care as other high-income countries without comparable outcomes.

Despite significant policy efforts and investments in the past two decades, notable shortcomings in the health care system persist. Health equity concerns continue to grow, and care is increasingly fragmented and insufficiently person-centered. Although notable progress has been made towards ensuring patients receive high-quality, cost-effective care, this goal remains illusory for too many, and the most feasible strategy to achieve it remains unclear.

The National Quality Task Force

To address these concerns, the National Quality Forum (NQF) launched the National Quality Task Force (the "Task Force") in 2019. The Task Force sought to address systemic limitations and define actionable opportunities to improve delivery system alignment, so that every person in every community consistently receives high-value care by 2030. Through a process that engaged diverse leaders, subject matter experts, innovators, consumers, and patients, the Task Force reflected on challenges that have emerged since the Institute of Medicine (IOM) published its landmark report *Crossing the Quality Chasm* in 2001. The Task Force's report, *The Care We Need: Driving Better Health Outcomes for People and Communities*, affirmed two key points.

The IOM Aims Remain Foundational

Developments over the past twenty years have not altered the fundamental improvement aims and health system redesign recommendations identified in *Crossing the Quality Chasm*. The Task Force did update certain IOM recommendations to reflect current priorities and evidence. For example, the Task Force evolved the IOM aim of "patient-centered care" to "person-centered care," given the need for health care to promote wellness and equity while treating episodic and chronic illness. A second evolution broadens the aim of "effective" care to "appropriate" care, recognizing the growing evidence of harm and waste associated with overuse, underuse, and misuse of health care services.

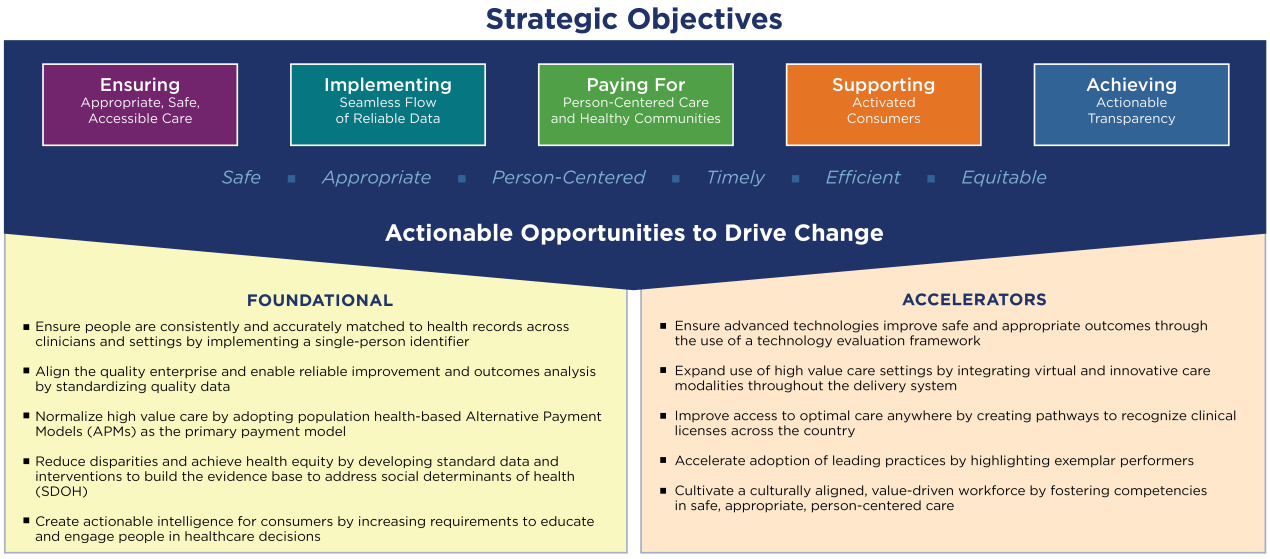
Quality Can And Must Be Measured

Quality gains over the past 20 years have demonstrated the critical importance of rigorous measurement. Quality measurement's role in increasing accountability through transparency and reimbursement is widely accepted. Diverse stakeholders now consider well-designed quality measurement central to delivery system improvement and the transition to value-based care.

Important Lessons From Outside Health Care

In formulating its recommendations (see exhibit 1), the Task Force considered cross-industry comparisons and included representation from the automotive and aviation industries. Many quality initiatives outside of health care have focused on safety technologies and processes—such as the Toyota Production System, Lean, and High Reliability—that have provided powerful lessons to reduce variations in care, create safety cultures, and reduce serious reportable event rates in health care. Near miss and sentinel event data is routinely shared in aviation, allowing for real time and predictive analytics of potential quality and safety issues.

Exhibit 1: Strategic objectives identified by the National Quality Task Force.



Source: The Care We Need: Driving Better Health Outcomes for People and Communities

The Task Force drew additional lessons from other industries as well. Perhaps the most significant lesson was the impact of standardized data. Across the financial and

transportation sectors, standardized data and financial reporting processes have provided important consumer safeguards and enabled valid, transparent, and benchmarked metrics to reliably compare information across companies. For example, key financial health terms and underlying data—such as earnings per share (EPS) and earnings before interest, taxes, depreciation, and amortization (EBITDA)—are universally defined and audited for validity. Audited financial statements based on standardized terms and data can be easily accessed from the Securities and Exchange Commission and used for a variety of purposes.

By comparison, in the health care sector, multiple definitions may exist for critical terms and measures, undermining peer-comparisons and data analyses. Furthermore, the relevant data may not be readily available. An organization's accounting system is the hub of financial data, but a unified repository with complete patient data does not exist for health care; data is typically captured in discrete environments with limited interoperability. Electronic Health Records (EHR) are increasingly viewed as the hub of health care data; however, they face challenges in unifying patient data across an increasing number of sources.

The lack of standardized data in health care undermines the free flow of data into, out of, and among silos. This challenge becomes more acute as the number of relevant data sources grows (e.g., condition-specific registries) and as new partners enter the ecosystem (e.g. Community Benefit Organizations that are capturing critical information related to social determinants of health).

The Path Forward: Driving Value Through The Next Generation Of Quality

The Task Force's review of progress, persistent challenges, and lessons from other industries identifies a path forward to a health care system that truly normalizes appropriate, high value, person-centered care. We outline below five strategic objectives that represent critical priorities for policy development and action.

Implement Seamless Flow Of Reliable Data

The Task Force consistently identified the need for standardized, reliable, valid data to address challenges and capitalize on opportunities. Similar to financial transactions flowing from accounting systems to audited financial statements, essential patient data captured through disparate points in the clinical workflow should flow seamlessly to meet the needs of various users. Some steps have been taken to help achieve this goal. For example, the 21st Century Cures Act advances interoperability and thereby facilitates

data sharing. Likewise, health care organizations and health IT companies are improving health data standardization and addressing problems related to interoperability with the Trusted Exchange Framework and Common Agreement.

However, solving interoperability problems has been slow. Similar to accounting systems, EHRs may not be suitable for maintaining all data necessary to support both internally focused quality improvement priorities and externally focused, consumer-driven quality analysis.

Consistent with the 2002 NQF National Framework for Healthcare Quality Measurement and Reporting, the Task Force specified the need to capture accurate data at the point of care to improve data veracity and reduce administrative burden. Timely transparency of valid data is necessary for comparative benchmarking and continuous improvement. Data standardization is also necessary to reduce duplicative measures and administrative burden and bolster measure alignment and development. The Task Force validated the need to align stakeholders to a universal, limited set of identical measures, allowing for additional measure sets as necessary to account for geographic and population-specific variation.

Given health disparities, capturing and sharing data on social determinants of health is worthy of further investment and analysis, even if challenging. Using standardized data across multiple health and non-health related community resources can empower health care delivery systems to act as partners to improve outcomes.

Ensure Appropriate, Safe, Accessible Care

Health care delivery systems have embraced quality improvement and high-reliability principles. However, the workforce of many health care delivery systems is not sufficiently trained or supported by an enabling organizational infrastructure and culture to operationalize quality improvement as part of their routine work. Quality improvement competencies are underdeveloped or siloed, rather than integrated into organizational learning systems that continuously drive high-value care. Leaders should foster organizational cultures that cultivate key value-driven care competencies: e.g., creating engaged patient-partners; integrating care across settings and preferred modalities; delivering safe and appropriate care; routinely utilizing quality improvement practices; and using data and analytics.

Health equity concerns highlight the importance of re-thinking and improving access by integrating new care modalities in both virtual and non-traditional care settings. Effectively utilizing these capabilities to address needs and improve outcomes for

vulnerable communities and populations requires licensure models capable of reaching across the nation.

When appropriately targeted, advanced technologies hold the promise of addressing care process inefficiencies, improving access, and reinforcing safe, appropriate care guidelines. Evidence-driven artificial intelligence and personalized medicine can and should be used to identify and address variations in care. Policymakers should provide guidance to ensure advanced technologies improve outcomes while safeguarding patients from harm or bias.

Pay for Person-Centered Care And Healthy Communities

To improve care outcomes and encourage the most efficient use of resources, the Task Force emphasized the need to increase efforts to shift to population-focused, value-based care and payment models. The Task Force identified shortcomings of current initiatives tying quality to payment in the present fee-for-service dominated environment. Current efforts (1) are inefficient in meeting patient needs; (2) reward inappropriate, low-value care; (3) under-invest in comprehensive, primary health promotion and disease prevention care; and (4) do not sufficiently reach beyond the Medicare population. The current patchwork of siloed care requires "handoffs," inefficiently moving patients through a maze of providers. It impedes a holistic patient view and efficient delivery of the most appropriate care to achieve the best patient-defined outcomes.

In contrast, population-based payment models, such as Category 3 and 4 cited by the Health Care Payment and Learning & Action Network, put a greater emphasis on the whole person and enable health systems to address growing disparities in health outcomes. One result of such payment strategies is more integrated health care delivery approaches, including virtual care strategies, which are demonstrating success in overcoming access barriers and reducing fragmented care.

Support Activated Consumers

Concerned that consumers lack inclusion and actionable information to be effective care partners, the Task Force noted that the health care delivery system must better define quality and value from the consumer perspective. To support educated, engaged consumers empowered to make informed health care decisions, care options must take account of individual goals and needs. Consumer priorities should define what quality is and how it is measured and reported.

In addition, the Task Force identified the need to increase requirements for shared decision making to help consumers fully understand the consequences of alternate interventions: outcomes, functional status/productivity, quality of life, treatment costs, etc. Engaging early in the care process enables consumers to consider individual needs and goals and avoid overuse and misuse of health care services.

Achieve Actionable Transparency

As the nation moves towards a value-based health care system, consumers, patients, providers, insurers, hospitals, employees, and policy makers still lack an aligned definition of value. A key issue noted by the Task Force is the lack of transparency of actionable information. While the amount of available health care data grows, the lack of standards undermines confidence to use it. Health care must advance to the stage of other high-performing industries, where efficiency is achieved by continuously raising quality performance and expectations by competing on transparent value indicators.

Transparency should be the default standard of the health care system. Health care must establish timely, accessible, consistent, and verifiable reporting standards that motivate all stakeholders to pursue the best value by providing effective comparisons of the consumer experience from the perspectives of safety, outcomes, cost, and service satisfaction. Consumer-responsive reporting should educate consumers to make decisions about the most appropriate care and help them reliably compare valid value indicators at multiple levels of analysis. Consumer reporting transparency should go beyond measures based on raw comments in responding to consumer information needs.

Summing Up

While much remains to be achieved, the historical progression of the quality movement is encouraging. *Crossing the Quality Chasm* established a critical, enduring foundation for health care quality improvement. The National Quality Task Force has identified five strategic objectives advocated by a highly diverse and informed cohort of stakeholders to normalize high-value, person-centered care for every person, everywhere, every time. Policy efforts must be guided by these objectives and must engage the full range of stakeholders. The lessons of non-health care industries have shown that the combination of a consumer-driven mindset, quality improvement disciplines, and reliable data standards to support the frictionless flow of information can transform culture and drive measurable improvements.

Authors' Note:

TOPICS

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Paul Buehrens MD • 6 days ago

I just completed a 39 year career in primary care. EHR for 15 years, 3 as a hospital employee, and 3 months on the hospital EHR. "data" in primary care is now entered by the doctor. 90 minutes of data entry nightly, after hours, not to improve anything but billing and coding. The whole enterprise has become all about more data items to find some way to get paid enough to support primary care. Meanwhile, most have become consolidated into hospital systems for financial survival, as the consolidation is driven by price protection.

Wholesale reform is needed. Everyone should be insured. Every hospital should be on a budget, the providers should be required to organize for efficiency, quality, and provide evidence based care. The coding and billing industry should be eradicated in favor of simplicity. Put every primary care doc on patient care per minute payment with 20% incentives, and put the proceduralists on salary.....

Rebuild the EMR with 21st century mobile cloud storage

Rebuild the EMR with 21st century mobile cloud storage PATIENT based records. Let the providers archive all the crap they want for billing and malpractice defense and bean counting, but let the patients have their own records: just the clinically useful stuff!! It's one page each.

Robert Bowman • 8 days ago

The Case For Not Measuring, Especially Where Health Care is Most Compromised for Most Americans

There are a number of reasons why measurement focus should be suspended or ended where health care workforce and access to care are most compromised.

The evidence based and ethical reason is that studies have not confirmed improvements in outcomes for the half of the nation most behind in workforce with lowest social determinants and inherently worst outcomes. Health care designers should be held to the same standards as physicians and as human subject researchers - particularly as their designs can negatively impact the well being of tens of millions of people.

The financial reason is that the costs of measurement are too high and continue to increase faster than revenue going

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