

Executive Summary

“Better health is an individual responsibility, and it is an important national goal. We’re making great progress in preventing and detecting and treating many chronic diseases, and that’s good for America... We’re living longer than any generation in history. Yet we can still improve. And we can do more.”

President George Bush, June 2002.¹

This first annual National Healthcare Quality Report (NHQR) echoes the President’s message on the quality of health care in the Nation: We are making progress, we can improve, and we can do more.

Key Findings:

- High quality health care is not yet a universal reality.
- Opportunities for preventive care are frequently missed.
- Management of chronic diseases presents unique quality challenges.
- There is more to learn.
- Greater improvement is possible.

The Department of Health and Human Services plays a critical role in ensuring that the American people have the safest, highest quality health care services. To that end, HHS has embarked on a multifaceted health care quality initiative. Strategies supported under this include efforts to reduce medical errors with research, implementation of proven evidence-based practices, and improving reporting systems for errors and adverse events; increasing the appropriate use of effective health care services by medical providers; increasing consumer and patient use of valid, reliable health care quality information; improving consumer and patient protections; and accelerating the development and use of an electronic health information infrastructure.

High Quality Health Care Is Not Yet a Universal Reality

The observation that quality of health care in America can be improved is not new. Lack of consistent provision of the best quality care means that not all Americans benefit from the nation’s investments in biomedical science.²

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“As great as our health care system is, my friends, you know and I know that it can be even better.”

Tommy G. Thompson

Secretary, U.S. Department of Health and Human Servicesⁱ

In many areas, the report shows that the health care system is performing very well. For example.ⁱⁱ

- Quality of care has markedly improved—for measures that have trend data, 20 of 57 areas have improved over time.
- The vast majority of patients are getting the care they need in many areas. For people with diabetes, most have their blood sugar and cholesterol levels checked. Most people have their blood pressure and cholesterol levels checked to help prevent or control heart disease, and 85% of people experiencing a heart attack receive aspirin upon arrival at the hospital. Women are being screened for breast cancer with mammography at rates that already reach Healthy People 2010 objectives. For child health, over 73% of children aged 19 to 35 months have all recommended vaccinations. Seniors receive influenza immunization at very high rates.
- Health care is improving in many areas. For cancer patients, more cancers are being detected at earlier stages. As a result of investments in biomedical research, new treatment options now exist to extend the lives of individuals with cancer. For diabetic patients, there are fewer unnecessary admissions to the hospital. For maternal and child health care, the percent of women using prenatal care in their first trimester has increased over the last 30 years. For adult asthma patients, fewer are admitted to hospitals. In nursing homes, progress has been made in reducing use of physical restraints. In patient safety, there has been significant progress in reducing infection rates in certain types of hospital intensive care units.

In other areas, improvement can be made, including:

- Thirty-seven of 57 areas with trend data presented in the report have either shown no improvement or have deteriorated.
- Despite the sophisticated diagnostic and therapeutic options now available, rates remain low for provision of some basic and cost-effective preventive care (e.g., colorectal cancer screening and checking for high cholesterol levels).

ⁱ Health Forum Leadership Summit, August 2, 2003, online at www.hhs.gov/news/speech/2003/030802.html.

ⁱⁱ Source of data: See Measure Specifications Appendix, 2003.

- Only 23% of those with hypertension have it under control. Control of hypertension is essential to continued successes in reducing mortality from heart disease, stroke, and complications of diabetes.
- Half of the people with depression stop using their medicines within the first month, a far shorter time period than recommended by experts and scientific evidence.
- In terms of patient safety, about 1 in 5 elderly Americans is prescribed medications that may be inappropriate for him or her and thus are potentially harmful.

Opportunities for Preventive Care Are Frequently Missed

Too much of medicine today focuses on treatment of illness after it occurs, rather than preventing it before it begins. At the launch of the *Steps to a Healthier US* initiative in April 2003, Secretary Thompson said the following about the importance of such preventive care:

“Approximately 95% of the \$1.4 trillion that we spend as a Nation on health goes to direct medical services, while approximately 5% is allocated to preventing disease and promoting health. This approach is equivalent to waiting for your car to break down before you take it in for maintenance. By changing the way we view our health, the *Steps* initiative helps move us from a disease care system to a true health care system.”

While we are justly proud of the progress made in the treatment of heart attacks, cancer, diabetes, and end stage renal disease, we neglect opportunities to stop these same diseases before they start. The report shows areas where more focus on prevention can save more lives and resources. For example, while smoking remains the single most preventable cause of mortality, rates of smoking cessation counseling of patients, both in the hospital and during office visits, are only 40% and 60%, respectively. Likewise, data on screening for high cholesterol show that 67% of adults have had their cholesterol checked within the past 2 years and can state whether it is normal or high. Screening for high cholesterol—which is also a risk factor for diabetes—can prevent the development of heart disease. The percentage of people 45 years of age and older on this same measure is over 80%; however the percentage for those under 45 years of age is 53%. Screening for colorectal cancer is 42.5%. Too many cancers are detected at a late stage, leading to suffering and premature death.

Management of Chronic Diseases Presents Unique Quality Challenges

Of the specific conditions covered in this report, the vast majority—cancer, chronic kidney disease (CKD), diabetes, HIV and AIDS, depression, asthma, and congestive heart failure—are chronic diseases. Some of these conditions are inextricably intertwined with one another. For example, diabetic patients have high rates of chronic kidney disease, and those with chronic kidney disease are at greater risk of developing cardiovascular problems. Tracking quality of care for chronic disease, therefore, involves not only examining individual measures of quality for these diseases, but the related measures as well. Data reported in the NHQR reinforce the

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challenges associated with ensuring quality preventive and curative health care for chronic conditions.

- **Diabetes:** Across the five “process” measures of care (annual retinal eye exams, annual influenza vaccinations, annual HbA1c checks, annual foot exams, and biannual lipid profiles), there is considerable variability in the delivery of services (from 54% for influenza immunization to 94% for lipid profiles). Yet, in 2000, only 20.7% of patients reported having received all five major tests in the past 1 to 2 years (depending on the standard for the test).
- **Smoking:** The relationship between smoking and a number of diseases, including cancer and heart disease, is well established.^{3,4,5} Identification of smokers and counseling them to quit has been demonstrated to be both effective and cost effective.⁶ National data show the potential of targeting quality improvement to where it can have the biggest impact on chronic diseases. Data on routine office visits show that in 2000, only 62% of smokers reported that their doctors had advised them to quit. However, less than half of AMI patients who smoke report receiving counseling to quit while in the hospital (42%). Advice to quit smoking to hospitalized AMI patients is associated with a 50% quit rate at 1 year, compared with a 1 year quit rate of 8% in ambulatory settings.
- **Chronic Kidney Disease:** The large number of people with CKD is partly attributable to an increase in the rates of diabetes (especially type 2 diabetes) and hypertension.⁷ Forty percent of all CKD patients have diabetes, and 26% suffer from hypertension.^{8,9} The growing number of people with these two diseases is partially due to lifestyle factors, such as obesity and lack of exercise. That said, data on in-center hemodialysis patients show that nearly 90% are receiving adequate dialysis.

There Is More To Learn

There is no one national survey tracking quality of health care in America. Rather, the report relies on a variety of existing national data sources to present and report quality information. Because of data and measures availability, this first quality report is uneven in its coverage of the areas selected for reporting. While measures for a number of areas have been thoroughly tested, widely accepted, and implemented by providers, in other areas this is not the case. For example, there are agreed upon and commonly used measures to track quality of care performance for treating heart attacks, diabetes, respiratory disease, and end stage renal disease. However, not all conditions tracked in the report have such developed, broadly accepted, and widely used measures (e.g., mental illness, HIV/AIDS, early stage chronic kidney disease). For several conditions, measures are currently being developed; for others, consensus among experts on a core set of measures is not imminent. Finally, even when there is widespread support for core measures, the national data needed for reporting oftentimes are not yet in place. The reasons for this unevenness are as follows:

- **Meeting the criteria for measure selection.** Criteria for selection of quality measures include clinical importance, scientific soundness, and feasibility; all measurement and reporting efforts must strike a balance among the tensions inherent in meeting all three.

Whenever possible, measures presented in this report use assessments of performance that are consistent with current science and supported by professional consensus.

- **Rapid advances in knowledge.** Part of this unevenness in measure development is due to the rapid change in certain fields. As knowledge of optimal detection and treatment improves, quality measures must be updated to reflect the most current scientific knowledge.
- **Limitations and advances in information technology.** Limitations in the availability of data constrain the ability to track certain conditions. Data can come from several different sources: medical charts, patient surveys, facility surveys, vital statistics, surveillance systems, and administrative and claims records. The degree to which data are collected from any of these sources varies widely. Expected gains in information technology, including the adoption of electronic medical records, will directly address this dearth of data by providing one data source without imposing any additional burden of collection on providers. Such gains in quality of care have been seen in large systems such as the Veterans Health Administration following the implementation of an electronic medical records system and efforts to track and use quality of care data coming from those medical records.¹⁰ The Department of Health and Human Services is making a substantial investment and providing leadership for the development of a national health information infrastructure. For example, on July 1, 2003, Secretary Thompson announced that a standardized medical vocabulary system (SNOMED, developed by the College of American Pathologists) would be made available free of charge to all health care providers. This will facilitate the sharing of electronic information.

Greater Improvement Is Possible

Improvement comes about not through mandates, but rather through innovation that is led by “champions” with the vision to customize improvements to local circumstances. Many provider organizations offer quality health care. They strive to achieve the best health care practices as described by experts in the field. While the reasons for superior performance are complex, high scores are often achieved because a group of providers and other stakeholders have identified a quality problem and committed resources and personnel to fix it. In the process they may discover something that works, which in turn can be learned and adopted by others.

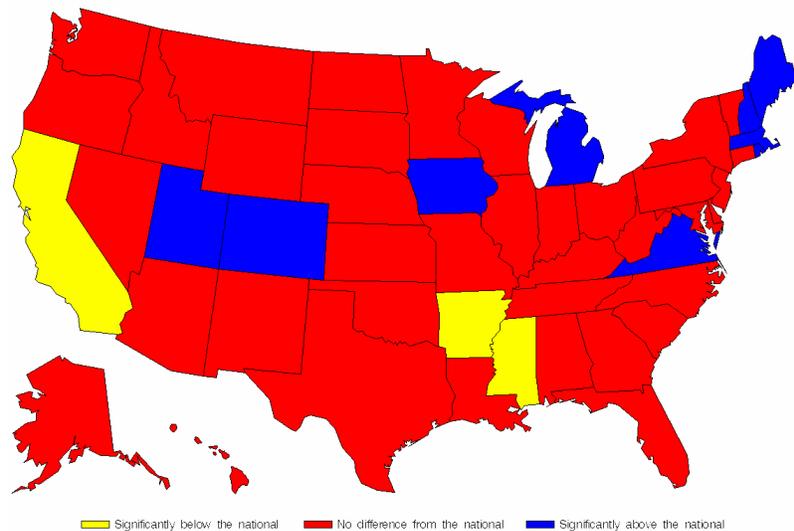
One approach the NHQR focuses on is the variation across States or regions that may indicate the possibility for cross-learning (see Figure 1).

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Improvement is possible in health care quality

Data reported in the NHQR's Heart Disease chapter show how the Nation fares in prescribing beta-blockers for heart attack patients when they leave the hospital. Chosen as a national priority for improvement by the Medicare Quality Improvement Organization (QIO) program, the national rate rose to 79%. Moreover, this performance is up from 21% of eligible patients in the early 1990s.¹¹ It has been achieved by almost every State in the union. Fully 47 States are at or above the national average rate.

Figure 1. Percent of AMI patients prescribed a beta-blocker at discharge by State



The report also presents examples of how efforts to improve quality in the measurement areas covered in the report have achieved results. For example, the Assistant Secretary for Health has recently showcased some outstanding examples of best practices in States across the Nation, many of which correspond to the priority areas of this report. These interventions include:

- A program to encourage greater organ donation in a county in North Carolina (relevant to the low level of transplants for chronic kidney disease patients).
- A successful suicide prevention program instituted by the U.S. Air Force (pertinent to the mental illness section of this report, in which one of the measures is mortality from suicide).
- An initiative in Massachusetts to lower the smoking rate (related to the measures in the report on smoking cessation counseling).

- A Michigan project to provide better prevention, detection, and treatment of diabetes.

Additional inspiring best practices show us how to provide cost-effective, high quality care. For example, the SSM Health Care system sponsored by the Franciscan Sisters of Mary and based in St. Louis, MO, was recently awarded the Malcolm Baldrige Award for excellence in quality of care.¹² SSM simultaneously exceeded national performance goals, strengthened its bottom line, and empowered its employees.¹³ Similarly, the National Committee on Quality Assurance (NCQA), which accredits managed care plans, produced *Quality Profiles: In Pursuit of Excellence in Managed Care*, a publication containing over 38 examples of exemplary practices and designed to help plans “fine tune their own quality improvement (QI) efforts.”¹⁴ These are only some of the excellent examples of programs that are making greater improvement possible.

This is the first of what will be an annual report on the state of health care quality in the United States. As such, there is much that can be improved upon in future reports. The annual nature of the report not only will allow for updating and improving the report, it will also provide ongoing information on a core set of quality measures. The primary role of the report is to provide the data and information that can tell us how the Nation’s health care system is performing in terms of quality of care. The hope is that this information will be used to help focus efforts to change health care quality for the better. In this way, the report, as an ongoing tracking tool, will provide the foundation for the translation of research and evidence into action and practice.

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¹² Established by Congress in 1987 to enhance the competitiveness of U.S. organizations, the Malcolm Baldrige National Quality Award is given to organizations in manufacturing, service, small business, education and health care, that have exemplary achievements and can serve as a model and inspiration to others (NIST News Release, 2003)

¹³ National Institute of Standards and Technology, Award Recipient Profile, *Malcolm Baldrige National Quality Award, 2002 Award Recipient*, Health Care Category, SSM Health Care, November 2002, online at www.nist.gov/public_affairs/releases/ssmhealth.htm.

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