

Quality of Care and Performance Improvement: Two Ideas that Go Hand-in-Hand

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Americans have become accustomed to hearing the statement that “the United States has the highest quality healthcare in the world!” There is little doubt that the best and most advanced medical care exists in this country. But, the term “quality of care” encompasses both *qualitative* and *quantitative* aspects of care. As Shuster, et al.,¹ have pointed out, “poor quality” can refer to too much, too little, or the wrong care. Assuring access to appropriate and needed basic healthcare services is an integral part of what we mean by quality care. We also recognize that some receive far more care and services than is really necessary, effective, or safe. Moreover, receiving the appropriate procedure or therapeutic intervention does not mean that such services were provided correctly, or in a timely manner. Hence, quality of care, as an implied standard or goal of the healthcare industry or of healthcare professionals, is a multifaceted and complex concept. Achieving this goal or standard of care requires concerted action on the part of all who provide, organize, regulate, pay for, and receive healthcare services.

The Paradox of Quality Improvement

Physicians are confronted by a number of seemingly paradoxical dimensions of the increasing emphasis on quality of care. On one hand, there is the claim that we have the best medical care on the planet, but, on the other, there is the crescendo of claims that American healthcare suffers from serious problems of overuse, omissions, and lack of access and errors that have led to serious compromises in patient safety. Physicians and other healthcare providers are admonished to provide *all* appropriate clinical and preventive services appropriate to the age and gender of their patients, while at the same time healthcare insurers, purchasers, and policy makers seem to impose ever more stringent criteria for both performance and payment as part of so-called “utilization-management” programs.

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Systems of Care: The Focal Point for Performance Improvement

So, what does (or should) an increased emphasis on quality of healthcare mean for the individual healthcare professional? There is no question that any attempt to improve the overall quality of care within any defined population will depend on the day-to-day attention to standards of care, clinical guidelines, and available scientific evidence on the part of individual practitioners. However, nearly all physicians and other healthcare professionals practice in some relationship to organized “systems” of care—most of which have specified (and often legal) responsibility for the provision of medical services to defined populations. Hence, quality of care improvement efforts are conventionally defined and developed within these systems of care and in consideration of patterns of health conditions and healthcare needs within the target populations being served. Insurance and managed care companies often consider even unaffiliated physicians to be participants in qualified “panels” of providers approved to participate in the care of patients who share a common employer or insurance carrier. It is within these formal and informal “systems of care” that organized efforts toward the improvement of care quality have received most attention in recent years, and it is within such systems of care that the potential for the greatest overall public benefit may lie.

Within defined populations served by care systems, patterns and categories of health conditions that represent the predominant burden of illness in a given population may be identified, and therefore the greatest proportion of overall healthcare costs.

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Although simultaneously addressing quality of care across the full spectrum of health and illness conditions encountered in a conventional practice situation may be daunting, it is important to agree to “start somewhere.” That “somewhere” should be with a focus on health conditions or diseases demanding the most time and resources.

As an illustration of this incremental approach, assume that every fifth patient seen in a primary care practice is a person of middle-age or older with hypertension. In such a practice, systematic steps to assure that all clinical screening and monitoring of this condition—as well as a consideration of recommended

pharmaceutical interventions to control blood pressure and counseling for smoking cessation, diet, and physical activity, take place *as a matter of routine* with every hypertensive patient encounter—is a starting point. Data and information from the practice summarizing the extent to which the blood pressures of *all* diagnosed hypertensive patients are being monitored regularly and under control is an essential element of any approach to internal practice (or system) evaluation of care quality. Similar approaches are appropriate for other categories of patients representing significant proportions of overall practice volume (e.g., numbers and proportion of diabetic patients needing hemoglobin A1C testing, having regular ocular and foot examinations, etc.).

This approach, which is increasingly a matter of routine in physician practices of all sizes and complexity, is an integral part of healthcare system *performance improvement*. Having clinical epidemiological information from one’s practice can be a source of lifelong intellectual interest in one’s major career activities, and serve as a means of self-evaluation.

Utilization Management Should Encompass Quality of Care

Physicians and other healthcare professionals for a number of years have complained bitterly with justification about the increasing burden of bureaucratic procedures associated with patient care. As utilization management systems have been promulgated by third parties (insurance carriers, health plans, employers, and managed care organizations) to reduce costs and rationalize clinical care, the reporting requirements of nearly every aspect of care have increased. Yet, it is time that these utilization management approaches be integrated with efforts to improve the overall quality of care.² Instead of a complete focus on cost-containment and the prevention of the overuse of care,

“Quality of care, as defined by scientific evidence of benefit and considerations of accessibility and equity among all population subgroups, can seem to be an elusive goal in the imperfect world of mainstream healthcare practice.”

utilization management efforts should be enlarged to include a consideration of “...the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”³

Moreover, Wickizer and Lessler² have argued that utilization management efforts should give emphasis to areas of care where there is strong evidence of both appropriateness and clinical need in addition to identifying those categories of care where services and procedures are underused and under-prescribed. The emphasis should be on monitoring defined categories

of patients, not total populations of the insured, to ensure that those in these defined categories (e.g., all diabetics) receive all appropriate preventive services and acute medical care.

The special Task Force of the North Carolina Medical Society on Quality of Care and Performance Improvement has recommended that the Society identify evidence-based protocols for managing patients diagnosed with diabetes, asthma, and heart failure. Clinical screening and preventive interventions are appropriate and recommended for obesity, smoking cessation, immunizations, alcohol and substance abuse counseling or other intervention, mammography, colorectal cancer screening, and elevated blood pressure. To ensure these services are provided once protocols are identified, the North Carolina Medical Society should provide physicians with tools that are applicable to office-based practice. The North Carolina Medical Society hopes this will help the general public to understand these conditions and the need for clinical screening and other preventive services.

What about Medical Errors and Patient Safety?

All segments of the healthcare industry are placing greater emphasis on reducing medical errors and assuring patient safety. Since the publication of the 1999 landmark report of the national Institute of Medicine, *To Err is Human: Building a Safer Health System*,⁴ there has been widespread concern among the general public, the news media, and policy makers over both the enormity of these problems and over the apparent reluctance of professional and healthcare industry groups to address these issues.⁵

As an important part of the overall movement to improve quality and performance in American healthcare, efforts to stem the tide of medical errors and assure the safety of patient care are often too little and too late. As Millenson⁵ argues, healthcare

professionals have always maintained that, by virtue of their commitment and training, they are motivated to “do the right thing.” Yet, professionalism alone often is not enough to address some of the systemic problems in healthcare that require concerted and forceful action. When the common routines of practice allow the possibility of inadvertent error (such as in surgically amputating the wrong limb, or hanging the wrong bottle of fluid on an IV pole, or dispensing the wrong medication), and when these errors occur repeatedly, everyone should be incensed. Such errors are both preventable (through proper labeling and computerized ordering) and also unacceptable. Patient safety should be an integral part of any quality of care or safety improvement initiative.

As with quality concerns over the provision of clinical preventive services, errors of omission and commission can result in significant harm to patients. If patients recovering from myocardial ischemic events are allowed to leave a hospital without receiving beta-blockers, despite compelling evidence of beneficial effect and mortality reduction, a serious problem of quality with important implications for patient safety exists. Efforts to improve the quality of care and system performance must include steps that assure that all healthcare professionals are aware of life-saving interventions and are provided reminders that ensure that they will not be overlooked.

What about the Incentives for Quality Improvement?

The United States healthcare system does not recognize the quality of care provided at any level and reward those providers who diligently assure the highest standards of care for their patients. Moreover, there is very little easily accessible data by which patients or the purchasers of healthcare insurance can evaluate the quality of care routinely provided by either individual professionals or by healthcare organizations. As methods for the systematic measurement of care quality (and evidence-based strategies for its provision) are developed, it will be important that healthcare insurers and policy

makers find ways to compensate those who consistently provide the highest quality care for their patients. The so-called “pay-for-performance” movement is controversial largely because of past experience with record-based approaches to physician reimbursement by insurance agencies and by governmental regulatory bodies. But, without such systems, there will remain only the incentive of professionalism as a primary motivator of change toward these higher standards of quality and system performance. Much more can and should be done to reward healthcare professionals who uphold the highest quality of care for their patients. **NCMJ**

“...it is important to agree to start somewhere.”

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