Quality at a Crossroads

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THE NATIONAL ROUNDTABLE ON HEALTH CARE Quality that was convened by the Institute of Medicine (IOM) in October, 1997, represented an extraordinary assemblage of expertise in the management and study of quality in systems of health care. The participants came together at a unique moment, when the "backlash" against managed care had reached a crescendo, in order to address several key questions for the Institute. The first, and central, question was whether we can draw any fundamental conclusions about the nature and scope of problems in the quality of U.S. medical practice and the performance of provider organizations today. Second, the experts considered several ways to improve clinical quality, through financial incentives, competition, regulation, and continuous quality improvement, and they discussed the extent to which these strategies have been able to, or could, effect change. Finally, they outlined a series of approaches for the IOM to consider in the future.

Most of the participants in this conference have spent most of the last decade, or more, studying medical quality or trying to improve it. They all brought to the meeting a considerable degree of frustration over the meager improvements that have resulted from their efforts and the

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limited understanding—and weak market pressure for improvement—evinced by purchasers and the public. They debated the extent to which physicians themselves recognize the widespread and substantial gaps between best practices and current practice and the associated harm this represents. They concluded that a succinct statement of the deficiencies of current medical practice is needed, together with an assertion that quality can indeed be adequately defined and measured, in order to estimate the scope of these deficiencies and to organize and prioritize efforts to address them.

The workshop participants agreed that the deficiencies in medical practice are rooted in a lack of systems to support improvement and practice consistent with professional recommendations, rather than in the failures of individual physicians or other providers. It is also difficult, and probably impossible, they agreed, to “fix” one component of health care organizations without addressing systems as a whole—or, as one speaker remonstrated, “trying to fix the parts when the whole chassis is broken.” The “broken chassis” in question, moreover, is not managed care. The patterns of practice we contend with today were largely established under fee-for-practice medicine, and the transition to managed care has generally held quality constant or, in some instances, has improved it. The lack of support for improvements in practice bridges both forms of reimbursement and their respective incentives, but the conference participants were not neutral on this issue. Organized systems, with a continuous flow of information about the patterns, processes, and outcomes of care, will be required to improve the quality of care.

Not every health plan or provider organization labeled “managed care,” of course, is doing much to manage care beyond limiting utilization. Because we are in a period of no substantive accountability for results other than price, when the continued surplus of hospital and physician capacity makes discounted prices a profitable strategy, some participants suggested that it is futile to expect progress in this regard. Moreover, what the press and the public label “quality”—and hold plans and providers accountable for—are largely issues of consumer satisfaction, which extend to access, amenities, and the responsiveness of plans and providers. Easier to understand and to measure, these “service” aspects of quality are, in fact, improving in many markets, thereby delivering increasing value to consumers, who have been baffled and enraged by the complexities of health insurance and fragmented, seemingly indifferent, delivery systems.

Comparing information about the processes of care, and, more important, the results of care and the health status of populations, is considerably more difficult. Even when the clinical and patient-reported measures themselves are well understood, meaningful evaluations will require standardized reporting across a vast industry in which most physician and hospital organizations themselves cannot share standardized information internally. The conference participants discussed at some length the difficulties of holding either health plans or providers accountable because of their varied roles across the country. In many markets, health plans directly contract with physicians and are the only organizations that hold comparative information on provider performance and thus have the potential to assess and change these patterns of care. In some markets, plans delegate most care management functions to the medical groups and networks of affiliated physicians (IPAs) and do not even collect from providers the necessary information for evaluating their performance. In both cases, the growing overlap between plans and providers—as consumers insist on greater choice and exclusive plan–provider networks disappear—has further diluted the ability of purchasers to hold either side accountable or to provide incentives that can appropriately reward them for their performance.

Five Critical Questions

During the course of the workshop, five questions emerged for further consideration:

1. Why Has Health Care Lagged Behind Other Sectors in Quality Improvement?

Health care has been much slower than other sectors to incorporate quality improvement into the basic “production processes” of clinical care, to adopt quality standards pegged to actual results, and to monitor the quality of care against these expectations. The workshop participants identified several factors contributing to this deficit. First and foremost, competition based on accepted, valid measures of clinical quality has not been a feature of health care. Purchasers have traditionally accepted hospital accreditation and the board certification of professional staff as proxies for quality, without imposing requirements or soliciting information on the actual performance of plans or providers.

With the notable exception of some large employers and purchaser coalitions, whose pioneering efforts in the development and use of quality performance measures led to the establishment of the National Committee on Quality Assurance (NCQA) and the Health Plan Employer Data and Information Set (HEDIS), most U.S. purchasers exact little or no accountability from contracted health plans or providers for the quality of their clinical services.

Most physicians still believe that their personal clinical judgment is equal—if not superior—to that generated from aggregated data on physicians and patients. In their experience, medical care is so complex and individualized that comparisons of practice patterns and results between physicians and across medical communities are largely invalid and potentially misleading. The conference attendees therefore concluded that there is still a substantial degree of misunderstanding among most practicing health professionals and managers regarding the nature of the problem and prospects for improvement. Because they harbor a pronounced assumption that medical and health care in the United States is “good,” both in its care for individual patients and as a system for disseminating and implementing medical knowledge, health care providers have a much narrower understanding of quality management than workers or executives in other sectors. They equate quality assurance with the correction of deficiencies uncovered by institutional peer review and malpractice cases, rather than with continual feedback on, and improvement of, patterns of care.

It is true that many providers are dissatisfied with the current restructuring of health insurance and delivery systems, but most of their irritation is directed toward attempts to interfere with physician autonomy and established patterns of care. Despite periodic activity within hospitals and medical groups intended to “re-engineer” clinical processes, however, too few physicians and administrators believe that our clinical care is broadly deficient or that we need a fundamental reexamination of the infrastructure, organization, and processes of care. The workshop participants considered this failure to understand the systemic nature of quality deficits in health care the second major contributor to the “lag” in integrating quality improvement into the core processes of the health sector. The quality lag in health care is reflected in excruciatingly slow rates of adoption for many specific clinical improvements, even those widely recognized as delivering superior outcomes. Moreover, this misplaced confidence on the part of health care providers is mirrored in the attitude of the public—creating the very

opposite of a “marketplace” of consumers and purchasers who scrutinize the evidence of quality in plan and provider performance and who are willing to reward both for better outcomes at lower costs.

The conferees acknowledged that our field is still riven by controversy about how best to accomplish the transition to a system focused on value and appeared to agree that an admixture of market forces and regulation will be required. In general terms, the potential contribution of regulation would be to standardize the elements of quality measurement and to establish a floor for performance. With this accomplished, market forces—private- and public-sector purchasers and consumer pressure—could effectively create a competitive market rewarding quality. The workshop participants glumly concluded that there is little likelihood of such a circumstance arising without substantially new and concerted efforts.

This discussion led to a further question: if we do manage to foster competition on the basis of quality, who is our primary audience—the consumer? the purchaser? There was no agreement among the participants on the likely role of consumers. Some argued that consumers will become increasingly educated about their own health and that those carrying a diagnosis of chronic disease will be especially likely to shop for clinical quality in selecting a provider or health plan. Others felt that consumers would prefer to assume that quality performance is a “floor,” relying on purchasers and regulators for monitoring and enforcement, and selecting their providers and health plans for other characteristics. The conferees also discussed the limitations of competition as a tool to improve quality, agreeing that it is a particularly blunt and imprecise tool, with unpredictable and often perverse effects, such as health plan efforts to select against high-risk patients and enrollees.

Meeting participants were well aware of the impending increases in health care costs forecast for 1998. They speculated that most of the “low-hanging fruit”—savings attributable to excess capacity in the system—has already been extracted by the competitive discounting of prices and strategies like utilization management. Agreeing that the health care market is still primarily driven by price competition, the participants voiced grave concern that the expected inflationary pressures and consequent reactions of purchasers would restrict even further the resources available for investments in quality improvement and divert purchaser attention from issues of quality. In the absence of a market-induced shift to competition based on quality, those assembled reluctantly considered the potential need to apply tools of policy development and regulation.

2. Why Have Clinical Quality Improvement Efforts Apparently Failed to Move the Sector as a Whole?

The group present at the Roundtable spent a good deal of time considering the evidence that clinical quality improvement (CQI) has been implemented less systematically and has had a smaller impact than many of them had hoped for when it was first introduced a decade ago. Only a small number of studies have demonstrated a compelling case for CQI as a method of improving outcomes or reducing costs, and its application has been concentrated in hospital settings and has focused more frequently on administrative procedures than on clinical care. Nevertheless, the discussion recognized that the tools of CQI are simply adaptations for health care of more general quality management techniques that are essential to survival and growth in all other sectors. The participants underscored their agreement that health care organizations will not be able to effect significant improvements in quality without fully implementing CQI, which will require commitment by top leadership, resources for training and information systems support, and accountability for results.

A lengthy debate ensued on the question of why CQI has remained so limited within the health care arena, and it led to the conclusion that the principal cause was probably rooted in an initial observation: purchasers have not yet created a market for quality. Executives within health care organizations, both health plans and providers, generally view quality improvement as an ethical responsibility or a social good, rather than as a business strategy for improved financial performance and competitive market positioning. If a market for quality was created, however, the workshop participants pointed out that some regulatory or quasi-regulatory body would be needed to establish standard metrics, to provide a means of data collection and reporting, and to validate the results.

3. How Do We Enlist Physicians and Other Health Professionals to Work on Meaningful Improvements in the Quality of Health Care?

Physicians and other health professionals are a crucial component of constructive change. The conferees discussed the contradictory needs of enlisting physicians and changing them, and they recognized the dif-

ficulty of doing so in an environment that is itself in turmoil and that many physicians find threatening. Strategies for change will have to be aligned with the core values of practicing health professionals to encourage their cooperation, and some traditional professional values will be redefined, in turn, by the expectations of patients and consumers.

All participants emphasized that physicians do pay attention to what they perceive to be valid data delivered from credible sources. The effectiveness of financial incentives is still poorly understood and difficult to research because of their myriad variations and the complexity of health care markets. As the pace of change accelerates and physicians are increasingly challenged, however, plans and provider organizations—as well as consumers and state and federal policy makers—find themselves contending with a profession that is under enormous strain. Theories of change management suggest that such “crucibles,” with their concomitant arousal of intense fear and anger, are productive only when the actors understand a feasible and positive alternative path to resolution of the crisis. The most successful systems, then, are likely to be those that offer opportunities for ongoing professional involvement, relative stability and security, and the capacity to support improvements in practice with useful and timely information.

In other words, although stress is required to induce positive change, not all stress is positive. The comment was made that the pressure should be shifted to the organizational level—to induce changes in institutional performance. Health plans and provider organizations will be charged with actually managing care, that is, supplying physicians and other providers with the information and infrastructure they will need to improve models of care and supporting the leadership required to “herd cats,” as attempts to organize physicians have been characterized. Among other challenges, organizations can help physicians deal with the current and emerging knowledge base in medicine. Unfortunately, no physician can find, commit to memory, and call up as needed all the relevant knowledge in medicine. The capacity to access and quickly analyze important information and to offer real-time decision support across a variety of clinical settings becomes virtually impossible without the support of computer technology. Although clinical management systems, including “just-in-time” knowledge servers and decision support systems, are only now becoming available to health care systems, health plans and provider organizations are already exploring the behavioral and cultural dimensions of success in the introduction of these innovations.

4. How Will Changes in the Expectations and Behavior of Consumers and Patients Affect Quality?

Consumers will also be a critical part of the transformation of the health care system. The workshop participants speculated that networked consumer health information systems may introduce changes into health care that are just as profound as the economic incentives of managed care, in a revolution driven by the twin engines of consumer demand and technology. Consumer demand will be fueled by the aging of the “baby boomers” into their chronic disease years; their characteristic demands for information and participation in decision making will transform the nature of clinical management and the respective roles of providers and patients in ways that are barely anticipated today.

The innovations in technology that are generally referred to as “networked consumer health information systems”—telephone- and Internet-enabled systems that offer patients access to information, permit them to communicate with other patients and with plans and providers, and facilitate the tracking, reporting, and management of chronic disease—will enable provider systems to meet these new consumer demands. In fact, these new technologies promise to unleash a monumental transfer of knowledge from provider systems to patients and to support the formation of expansive and aggressively active “virtual communities” among patients and families.

Neither health insurers nor providers are effectively preparing for this impending revolution. To the extent that insurers have responded, they see it principally as a marketing opportunity to collect information about patient characteristics and preferences and to attract market segments that are early adopters of technology. Although most physicians can now recount stories of patients who arrive armed with Internet printouts and difficult questions, provider systems and managed care organizations have done little to organize a response to this new consumer demand or to turn it to advantage in the efficient management of health and disease.

In the future, patients with chronic diseases will know a great deal more than they do now about their illnesses, treatment options, prognosis, and relevant best practices. Conference participants commented that this poses another challenge to provider organizations: providers will need the support of appropriate databases and communications

technology, or they may well encounter patients who are better informed than they are about effective disease management.

5. What Will Be Required to Transform Health Care into a Sector Capable of Delivering Quality Care and Constantly Improving Care?

Over two days of discussion, the assembled experts returned frequently to a definition or “mental model” for the high-performing health sector that all hoped to engender. No one ignored the complexity of this undertaking; all stressed the urgency of moving quality improvement out of the backwaters of “special projects” and into the mainstream of strategic business initiatives. Unless it is fully integrated into the strategic business considerations of health plans and provider organizations, quality will remain an ethical imperative honored largely in the breach.

An elaboration of the components of a “high-performing health sector” resulted in this list of critical features:

1. *defect-free processes and delivery*: the adoption of performance goals that would represent an essentially error-free delivery system
2. *accelerated cycle time*: the ability to implement improvements rapidly and to deploy them broadly within a similarly compressed time frame
3. *information technology*: an information infrastructure capable of monitoring the relevant aspects of care and supplying analytic reports to support patient care and organizational decision making
4. *transfer of knowledge*: the capacity to access and apply information about best practices and new knowledge within a culture that is capable of accepting exogenously derived knowledge and practices without “reinventing the wheel”
5. *aligned incentives*: the allocation of appropriate rewards for improved performance and the assignment of priority to quality objectives within the management goals for each organization
6. *encouragement of innovation*: the awarding of support and recognition for the generation of new knowledge, the willingness to collaborate with academic enterprises, and the creation of “safe zones” for positive innovation
7. *organized systems of care*: the transformation of fee-for-service medical care into organized delivery systems, to provide the system

supports necessary for full quality implementation and improvement; until this transformation is complete, a requirement that fee-for-service providers must report information on clinical care to support quality assessment

8. *community-based interventions*: the initiation of community-wide projects to alter the more fundamental determinants of health, as this kind of outreach is often the only way to accomplish certain important health outcomes
9. *purchaser and consumer education*: assuring consumer access to useful information about the performance of their health plan and providers
10. *accountability*: support by public and private purchasers for standardized measures and reporting; for the establishment of minimum performance levels through either regulation or required accreditation; and for the creation of rewards in price or volume (enrollment) for plans and providers that successfully improve quality

In light of the considerable gap between current health care in the United States and what we know to be best practices, the scale of this transformation suggests a “great leap forward.” One participant, referring to Moore’s Law in computing, proposed that we need a “smart chip” breakthrough to replace the cards and spindles we currently employ. This would enable us to achieve a manifold reduction in cost with major improvements in processes and outcomes and to bring our delivery systems closer to the “Six Sigma” standards of clinical performance, thereby matching the achievements of the industrial sector. As the Institute of Medicine enters the next phase of its work on quality in health care, it will face the toughest challenge of all: to identify strategies that will, in the face of enormous inertia and significant counterforces, carry us forward to this vision.

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