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Pushing the outpatient quality envelope

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In its 2001 report *Crossing the Quality Chasm*, the Institute of Medicine outlined six domains of quality in medical care: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.¹ Anyone practicing medicine or receiving care probably agrees that quality should be defined broadly, as broadly as the Institute outlined. However, current quality measures for the outpatient setting do not encompass many of these domains. As a result, quality measurement and quality improvement efforts in the outpatient setting have neglected critical areas of high quality care.

The majority of outpatient quality measures focus on preventive care, chronic disease care, and patient experience. In 2005, the Ambulatory Care Quality Alliance Workgroup (an organization that included stakeholders from the American Academy of Family Physicians, American College of Physicians, America's Health Insurance Plans, and Agency for Healthcare Research and Quality) endorsed 25 ambulatory care measures.² Only two measures (testing for pharyngitis and appropriate treatment for upper respiratory infections in children) were for the diagnosis and management of acute conditions. The remaining 23 measures were for preventive care and chronic disease management. Similarly, of the 47 effectiveness of care measures in the 2013 Healthcare Effectiveness Data and Information Set (HEDIS), 36 are for preventive care and chronic disease management.³ Patient experience surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey focus on domains such as timeliness of care and patient-centeredness.

As a result, quality of care in the outpatient setting has become synonymous with preventive care and chronic disease management with some measures of patient experience. Safety, high-level effectiveness, coordination, and efficiency are not captured in the current measures of outpatient quality.

The notion that quality measurement is inadequate is not controversial. Others have highlighted problems that arise when quality measurement centers on a small aspect of care.⁴ These problems include the potential for unmeasured quality to be reduced and conclusions about overall quality to be drawn from a small segment of measured quality. For example, clinicians who are measured only for providing preventive care and chronic disease management might focus less on equally (if not more) important aspects of care such as diagnostic accuracy and appropriateness of testing. Similarly, evaluations of quality of primary care have shown similar levels for care delivered by different types of clinicians; but these studies measure quality of chronic disease management (e.g. diabetes, congestive heart failure) neglecting many other aspects of high quality primary care.⁵

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Nonetheless, health care is in a period of cascading changes in contracting and delivery system reform. Accountable care organizations (ACOs), models of primary care such as the patient-centered medical home, payment-for-performance, and bundled payments all tie payment into measures of quality. As a result, it is important to revisit the issue of what quality is measured and consider ways to improve and expand quality measurement.

The medical community needs to focus more attention on two domains of outpatient care: patient safety measures and measures (or surrogate measures) of high-level care (Table).

For safety, the Joint Commission's National Patient Safety Goals are a good place to start but need to be expanded. Outpatient safety measures could be similar to never events that have been defined for the inpatient setting (e.g. surgery performed on the wrong site).⁶ Examples of outpatient patient safety/never events include select prescribing errors (e.g. prescribing a medication to which a patient is allergic), failure to inform patients of important test results, medical-setting acquired infections (e.g. infection from contaminated equipment), and failure to properly monitor for adverse effects of treatments (e.g. failure to screen for hepatitis in statin-users).

High-level quality is more difficult to define and measure but likely represents a domain that matters most to patients and their physicians. Examples of high-level quality include diagnostic error and accuracy, treatment decisions for complex conditions or in the face of uncertainty, and judicious use of resources.

The medical community is starting to define some measures of high-level quality. For example, the ABIM's Choosing Wisely list of medical services that are potentially overused is a good starting point to measure the judicious use of resources.⁷ As others have noted, these measures are framed around quality and safety and the potential for unnecessary medical services to cause harm.⁸

But measures of high-level quality remain difficult to define and measure. There is growing interest, for example, in diagnostic error but methods to measure diagnostic error have been difficult to develop. Similarly operationalizing the Choosing Wisely measures may prove to be difficult if specifications are not clear.

One way to approach high-level quality is to consider surrogate measures such as physician reputation, physician training, or patient's trust in their physician (which are often used as measures by commercial physician rating systems). Although surrogate measures are by no means perfect, if research shows that they correlate well with more objective measures of high-level quality care then surrogate measures may be feasible alternatives.⁹ For example, a physician's reputation among peers may be a good surrogate measure if it can be correlated with more objective outcomes like diagnostic accuracy and judicious use of resources.

Pushing the outpatient quality envelope will face challenges - new measures will be difficult to define; new sources of data should be considered. Although some argue that too much in medicine is currently measured, there are several reasons why this may be an optimal time to push the outpatient quality envelope. First, the medical community is defining more and more quality measures through comparative effectiveness research and through expert panels when that research is incomplete or inconclusive. Second, electronic medical records can more easily capture clinical data that are not captured in claims. Third, there is interest in new measures and increasing funding for development of these measures through organizations such as the patient-centered outcomes research institute (PCORI).

The rapidly changing payment and delivery system, may introduce the risk of many unintended consequences if quality measurement is too myopic. Fortunately, the present era

is characterized with more knowledge about quality and more tools to measure quality. Nevertheless, pushing quality measurement for the outpatient setting needs to be a priority for the medical community and more work must be done to develop, test, and use new measures.

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Table

Framework for expanding outpatient quality measurement

	Examples	Representation in current quality measures	Possible interventions to improve quality
Safety never events	Medication errors Failure to inform of Infection acquired from outpatient procedures	Joint Commission National patient safety goals but not used for small physician practices	System-level improvements such as EMRs, standardized processes
Preventative and chronic disease care	Process measures such as attainment of vaccinations, preventative cancer screening, and use of chronic medications	Well-represented in HEDIS measures	System-level improvements such as EMRs, standardized processes
High level of quality	Diagnostic accuracy Judicious use of resources Treatment decisions for rare or complex diseases	Poorly represented	Individual-level improvement