Op-Ed

Quality Improvement for Whom?

CATHERINE D. DEANGELIS

IMPROVING THE QUALITY OF ALMOST ANYTHING IS A LAUDABLE goal. However, when it comes to the improvement of health care, a critical question to ask is, who actually benefits from the improvement? Is it the patient, the clinician, the financial officer and the health care corporation, the population at large, other entities, no one, or everyone?

To understand how the current quality improvement in health care movement started, it is important to review a bit of history. In 1999 the Institute of Medicine (IOM) published a hugely influential report, *To Err Is Human*, which revealed that up to 98,000 US citizens were dying each year as a result of medical errors. Although most of the error-caused deaths occurred in hospitals, other settings such as doctor's offices, outpatient surgical centers, and nursing homes were also involved. In addition, the cost of medical errors resulting in injuries was estimated to be between \$17 billion and \$29 billion, with health care costs accounting for more than 50% of the total.¹

Two years later the IOM published another report, *Crossing the Quality Chasm*, in which 6 specific aims for improvement in health care were outlined. These included avoiding injuries to patients from care needed to help them; providing services based on scientific knowledge to all who could benefit and refraining from providing services to those unlikely to benefit (avoiding underuse and overuse); providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide clinical decisions; reducing waits and sometimes harmful delays for both those who receive and those who give care; avoiding waste such as waste of equipment, supplies, ideas, and energy; and providing care that does not differ in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.² The first report revealed a major problem in health care and the second report outlined aims to help remedy the situation. The aims were reasonable and designed to improve patient

care and to lower the cost of providing good care, both essentials of quality improvement. The problem was how to implement the aims.

During the early years of the 21st century, standardized quality measurements were developed and implemented. The Joint Commission, an organization that accredits health care organizations and programs in the United States, convened experts who reviewed evidence and produced the first nationally standardized quality measurements for hospitals for patients with certain illnesses. In 2002 hospitals were required to collect and report performance data on at least some of the illnesses listed. The Joint Commission began publishing such data 2 years later. The Centers for Medicare and Medicaid Services (CMS) then began a program to financially penalize hospitals that did not report data to the CMS that they submitted to the Joint Commission. The CMS soon began reporting these data to the public. The CMS and the Joint Commission expanded the reporting requirements during the second half of that decade.

What about private physicians' offices? Because of reimbursement pressures, overhead costs, and time spent completing insurance forms, a growing number of physicians are leaving private practice to be employed by hospitals. Only 33% of US physicians will remain in private practice by the end of this year.³

Why is this important? First of all, hospitals have made great efforts to hire physicians to work in their clinics and offices because doing so helps them build market share. Hospitals use relative value units (RVUs) because that is how the government reimburses for the care provided. Hospitals, therefore, measure the value of physicians in RVUs, which fail to account for the actual quality of care provided by physicians. Instead, RVUs focus on the correct completion of code charts used for reimbursement. Therefore, it is in the financial interest of hospitals to have physicians see more patients by spending less time with each one.

Further, pay-for-performance arrangements, in which payers reward physicians and hospitals for meeting evidence-based standards, have been proliferating. Unfortunately, this system might actually work against high-quality care, which requires a balance of specific risks, benefits, and patient preferences and not simply following general guidelines.

The question to ask is how the quality of care is measured and evaluated. The 2 most common methods are process and outcome measures. Process measures, such as those established by published clinical guidelines, can be relatively easily assessed and compared and can be based on scientific evidence. However, on the one hand, most clinical

care is not evidence based, and physician judgment might not agree that a specified process is best for a particular patient. On the other hand, outcome measures are more aligned with what is expected in clinical care. However, many outcomes depend on patient mix and the number of patients included in the measure.

Many hospitals and other health care organizations rely on administrative databases to determine the quality of care rendered, but anyone who has used such databases realizes the limitations. For example, there is little relevant clinical data in many such databases, so how are a patient's actual clinical well-being and satisfaction measured? The universal complaint I hear from patients and physicians is that there is simply not enough time spent in which there is a real interaction. Many physicians are limited to 10 minutes or so per patient encounter, and much of that time is spent completing forms on the electronic health record. Is this quality improvement?

Finally, there has been a proliferation of so many, sometimes confusing, performance measures that the IOM published a recent report, *Vital Signs: Core Metrics for Health and Health Care Progress*, which highlights major opportunities and problems in the current health care enterprise. The IOM committee identified 15 measures that comprise the core metrics for better health at a lower cost: life expectancy, well-being, overweight and obesity, addictive behavior, unintended pregnancy, healthy communities, preventive services, care access, patient safety, evidence-based care, care matched with patient goals, personal spending burden, population spending burden, individual engagement, and community engagement.⁴

Clearly, there is no perfect way to measure quality because so much is left to the person or persons setting the rules and making the determination. However, one way to determine whether and for whom there has been quality improvement in health care would be to repeat the study described in the 1999 IOM report. It has been almost 2 decades since those quality measures were implemented. At least for those measurements, we need to establish how much quality improvement has occurred and exactly who has benefited.

References

1. Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academies Press; 2000.

2. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.
3. Accenture. Many U.S. doctors will leave private practice for hospital employment, Accenture reports. 2015. <https://newsroom.accenture.com/news/many-us-doctors-will-leave-private-practice-for-hospital-employment-accenture-reports.htm>. Accessed June 12, 2016.
4. Institute of Medicine. *Vital Signs: Core Metrics for Health and Health Care Progress*. Washington, DC: National Academies Press; 2015.

Address correspondence to: Catherine D. DeAngelis, Johns Hopkins University School of Medicine, 3704 N Charles St, Unit 105, Baltimore, MD 21218 (email: cdeange1@jhmi.edu).