

# Quality of Care

## IN GENERAL

As managed care became vogue, the buzz words were discounts, cost-effectiveness and utilization control; but not much about quality of care. This is not rapidly changing. The current prevailing point of view is this: quality care is cost-effective care.

Increasingly with direct provider contracting, three questions are asked by the employer of the provider:

- What are discounts, per diem, etc.?
- Is there a fit geographically?
- Is there quality of care?

*Measuring Quality.* These are the traditional objective measures of an *input* nature:

- Extent of credentialing and/or certification?
- Extent of technology?
- Is there a quality assurance review program in place?
- What research is there?
- What is client base of provider?

Overall, there are two methods to measure quality of an *output* nature:

- **Process**  
Is good protocol followed?
- **Outcomes**  
Are results acceptable statistically?

*Dimensions of Quality.* There are basically four dimensions that must be considered.

Access. Care must be available.

Structure. Equipment, staff, systems, etc. must be in place.

Process. Proper protocols must be followed.

Outcome. These must meet norms and minimums.

Overall, such care must be efficient, effective, appropriate and executional.

## Outcomes Management

Outcomes management involves developing measures to assess which types of treatment work best and using these measures to manage and improve the quality and efficiency of care. Practice guidelines or treatment paths, provider profiling, continuous

quality improvement and patient and provider education are all components of outcomes management. Outcomes management requires teamwork among patients, providers and payers and provides a rational basis for decision making among the three groups of constituents. However, outcomes management is complicated by the many perspectives on outcomes and quality and how to define them. These include direct and indirect measures; process, structural and outcomes measures; and cost utilization measures. There are also concerns about whether outcomes management is actually *medicine by the numbers*; whether it involves rationing of health care; or whether it will or should result in savings. There are also questions about the ownership of the outcomes management data; whether the data can meet rigorous scientific standards; and the availability of sufficient resources to develop effective approaches to outcomes management.

## **Employer Resistance to Quality Control**

Employers, traditionally, have not been in the lead in pushing for quality control of physicians. There are several reasons for this:

- Belief that provider price is sufficient criteria; that is, only being *bottom line* in attitude.
- Employers are in an area in which their knowledge is limited.
- Employers *scoff* at the idea of measuring quality of care.
- Employers are convinced their local health care is already high quality with little prospect for improvement.
- Traditional aversion to challenging the quality of medical care
- Corporate benefit/risk managers are hesitant to *rock the boat*.
- Employers want a *hands off* posture on the sensitive area of health care.
- Employers do not feel qualified to enter into the area of questioning physicians on their quality of care.

## **Why is Quality an Issue?**

As employers steer their employees to use or avoid certain providers, such employers wish that quality of care not be sacrificed. Employers expect managed care networks to measure and maintain quality of care programs. In fact, quality of care, and its sister, outcomes management, are becoming recognizable cost containment programs. Whatever works is the most cost containing.

## **Cost and Quality Work Together**

It must be initially understood that quality health care is not an easy item to measure. As health care is transformed from a *cottage* industry to a business, the need to hold on to quality is critical.

Generally accepted criteria of quality are these:

- Efficiency
- Appropriateness
- Accessibility by patient
- Competence
- Efficacy
- Continuity.

The toughest of the quality questions will always be these:

- Too little care is bad.
- Too much care is bad.

What is the correct amount? That is the goal. In fact the problems attendant with providing such care must be measured:

- Nosocomial – hospital-acquired (staph, e.g.).
- Iatrogenic – caused by physicians (surgical complications, e.g.).
- With undertreatment, the results may be complications of a far worse nature or even death. Thus, we are faced with trade-offs.

## **Should Quality Be Measured at All?**

Many physicians say no. Yet, the mainstream of thought is the medical profession should be held accountable. In arriving at the measure of quality, the factors of interest to the employer are these:

- Inherent excellence of the product
- Measurable features of the product
- Consumer general satisfaction
- Meeting certain production standards
- Price in relationship to value.

Each of these five factors must, somehow, be measured.

## **Improvement Should Be Continuous**

By relying on assessment, observation, analysis and result application, the quality of care, in theory, should be ever improving.

## **Indicators of Quality and Its Improvement**

Generally, such indicators are of the following types:

- *Rates/Number of Occurrences.*  
Examples: death, C-sections, delivery complication, e.g.

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- *Unexplained practice variations.*
- *Event Statistics.*
- *Length of stay, e.g.*

## **Medical Appropriateness**

This involves the use of practice protocols and standardized procedures.

## **Medical Information**

The difficulty is that data for an indemnity plan is generally ill-suited to data for a managed care program. Integrated and coordinated data is badly needed.

## **Medical Technology Issues**

Medical technology is growing exponentially. This drives up costs, increases malpractice suits, puts stress on the providers and may be counter-productive. The majority of technological advances only marginally expand life and often detract from the quality of life.

## **Case Management**

Much attention has been given to working on the 10% of the population that cause 65% of the costs - namely the problem claimants. This technique is large case management. It deals with the catastrophic (severe burns) and the chronic illnesses (AIDS, e.g.).

## **MEASURING MANAGED CARE QUALITY**

### **In General**

The general trend in measuring managed care quality is to seek both cost (quantitative) and value (quality) measurement.

*One.* Quality, in terms of any single good or service, has a number of dimensions. Health care is a complex bundle of services, and each component service within an episode of care affects the other components and the patients differently. Moreover, patients differ in numerous ways, which means that similar symptoms may require different services if care is to be effective. Measuring quality of health care services requires accounting for all of these factors.

*Two.* If quality assessment is used as a rationale for allocating health care resources across a population, whether it is the population of the United States or the enrollees in an

HMO, the criteria for evaluating quality differ from those intended to measure the quality of care received by individuals. It is important to understand the underlying aggregate measures of quality of care. Many of these measures may place implicit values on quality of life and other factors that affect the ranking of alternative practices, providers or sites of care.

## **Key Issues in Measuring Quality**

- Emphasis on cost must not lead to undercare.
- Overstressing cost containment may put the employer at risk.
- Quality should translate into economic value.

## **Managed Care Quality**

### **Is the Service Good?**

Convenient and accessible?  
Is the service sufficiently broad?  
Is it consumer friendly?  
Are systems workable?

### **Is Clinical Care Good?**

Are providers good?  
Are providers credentialed?  
Is care subject to audit and review?  
Is liability to all parties minimized?  
Is system in place to make corrections?

## **Other Measures**

**Structural Measures.** These measures of quality have historically been employed in the various accreditation processes used by both private agencies and public agencies.

**Process Measures.** These measures are used by peer review organizations in reviewing the quality of care received by Medicare recipients and by organizations that perform utilization review. The creation of practice guidelines, the utilization of total quality management methodologies, utilization review and reviews of medical necessity and appropriateness are all examples of process measures of quality.

**Outcome Measures.** These measures have intuitive appeal in that they can be relatively inexpensive to collect and appear to be easy to interpret. The most commonly used outcome measures have been mortality, morbidity and patient satisfaction.

## **CRITIQUE OF MANAGED CARE QUALITY**

## **Provider's Point of View**

These factors are significant to the physician:

- What latitude does the physician have?
- What is the extent of the hassle factor?
- Is network loose or integrated - or - unclear?
- Is emphasis on cost or quality by the network managers?
- Is time between the patient and physician limited or controlled?
- Is pay capitated; does pay involve a withhold?
- Are quality guidelines and protocols promulgated?

## **Patient's Point of View**

These factors are significant to the patient:

- Is hospital on the high mortality list of CMS?
- Does physician offer amenities (nice office, e.g.)?
- Is physician credentialed?
- Is physician a specialist?
- Is physician connected with the patient's choice of hospital?
- Is physician's reputation generally good?

## **Employer's prospective**

These factors are significant to the employer:

- Is the physician cost-effective?
- Is the quality of care reasonably good?  
When the National Committee on Quality Assurance reviews an HMO, it looks for certain needed programs/activities, etc.:
- HMO-sponsored quality control programs.
- Care in physician credentialing.
- Good utilization review program.
- Written contracts with physicians.
- Preventive care services.
- Maintenance of proper records:

This review is carried on by the Committee in three steps: preassessment; on-site survey; post-survey review.

*Role of HEDIS.* This statistical measuring system examines aspects of quality  
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of care:

- *Access*  
To what extent is needed care urgent - or not urgent?
- *Appropriateness*  
Is care needed at all; may it be outpatient rather than inpatient?
- *Efficiency*  
Was provided care given without needless delay?
- *Outcome*  
Was expected outcome achieved without mishap?
- *Patient Response*  
Was patient satisfied with care?

## **MODEL QUALITY ASSESSMENT PROGRAM**

These are the primary measurements:

### *Review of Medical Records*

- Implicit (impressions, e.g.)
- Explicit (statistical measures, e.g.).
- Potential problems (red-flags).

Review of Patient Satisfaction

## **National Committee for Quality Assurance**

This committee came into being as follows:

1. *Two organizations*  
Group Health Association of America  
American Managed Care and Review Association.
2. Formed the National Committee for Quality Assurance.
3. Financed by a grant and monies from HMOs and PPOs.
4. Using Health Plan Employer Data and Information Set (HEDIS).

This Committee basically measures the quality of HMOs or all types and to a lesser extent PPOs.

Eligible organizations must meet certain minimums:

- Provide both inpatient and outpatient care
- Been in business for at least 18 months.
- Been active in quality control
- Have an acceptable data system.

## **The *Dumb* Side of Care Standards**

A physician, attempting to measure up to HMO-demanded quality of care standards, was disturbed by these alleged infractions:

1. Alcohol sponges with no expiration date even though they were changed daily.
2. Biohazardous items not in a red bag or in plain view, but rather under lock and key.
3. Not having beginning/ending temperatures on refrigerator holding serums; not having open dates on multiple-purpose vials.
4. Having a right angle measurement on weighing machine and not freestanding.
5. Not having office hours prominently posted.
6. Not having all machines calibrated by outside professionals.

## **MEDICAL PRACTICE PARAMETERS**

### **What Are They**

Practice guidelines are *checklists* to be followed in the diagnosis, care, and treatment of certain medical conditions. Their purpose is to improve care, reduce variations in practice, eliminate inappropriate procedures, and cut costs.

The present difficulty is that without such checklists it is not possible for the physicians to keep up with all of the information needed to make clinical decisions. The knowledge explosion has engulfed the physicians - even in a very specialized practice.

### **Federal Involvement**

The federal government, through the Department of Health and Human Services of the Agency for Health Care Policy and Research, has already released ten guidelines. More are scheduled for release. One of the discoveries of the federal studies is that guidelines will eliminate overtesting with dramatic reductions in costs; also found was that having guidelines is no guarantee they will be followed.

### **Practical Application**

There are firms that have a library of practice guidelines either in book form or on computer that may be accessed by insurers, payers, etc.

Often practice guidelines are used as part of the payer's precertification process. Because of the complexity of the guidelines, they are helped by being computerized. One of the corollary advantages of practice guidelines is that they permit the patient and provider (often a nurse practitioner or physician's assistant) to be proactive in the treatment

choices. Several areas that guidelines target as being overused and/or not cost-effective are:

- PSA tests for prostate cancer
- Use of lipid-lowering drugs that are both expensive and slow to be effective
- Use of less expensive antibiotics.

Blue Cross is now requiring practice guidelines to be followed by Illinois specialists in general surgery, **oncology**, cardiology, and orthopedics.

## **Building Practice Guidelines**

The evidence should be as scientific as possible but comes primarily from these sources:

- Review of existing medical literature
- Opinions of experts in the field.

## **Future of Guidelines**

These trends will accelerate the popularity of practice guidelines:

- Shift from fee-for-service to capitation
- Proliferation of computerized provider offers.

Expected practical fallout from continued popularity of practice guidelines should be:

- Reduction of defensive medicine
- Lowering of malpractice premiums.

Observers expect practice guidelines to be part of the final federal health reform package. Medicare and Medicaid are moving steadily into practice guidelines.

These are basically guidelines in protocol, to be followed in the diagnosis, prevention, treatment or managing a disease or condition; such guidelines are based not only on facts and figures but also are the composite of the best medical judgment possible.

- Practice parameters are consistent with quality.
- The American Medical Association is the primary creator of such parameters.

Following such guidelines will be generally a safe harbor against malpractice complaints.

## **MEDICAL INFORMATION**

## **Present Status**

The present status is a hodge podge and unintegrated; it is indemnity plan oriented.

## **Needed Status**

Managed care brings with us a host of data challenges not presently being met. From a practical point of view, an entirely new family of data must be created.