Steering Quality Improvement in Healthcare

by Suzanne Schoenfelt

"Quality" is a multi-industry buzzword, but what does it really mean in today's healthcare climate? We asked the experts for their views on the state of quality improvement in healthcare and what lies in store for HIM professionals as QI evolves.

For decades, healthcare has concerned itself with quality—the ability of clinical and health services to achieve health outcomes. During those years, regulatory conditions have shifted, competition has increased, and economic tides have ebbed. These forces have overturned the industry, leading to increased focus on quality evaluation and improvement to better deliver services, increase customer satisfaction, improve health, and reduce costs.[1]

Quality improvement (QI) evaluation techniques have gone through many evolutions, and the industry has acquired much knowledge. Measuring QI is complex; each generation of methods provides inroads about affecting healthcare quality. The *Journal of AHIMA* asked five experts to comment about the state of QI in healthcare, future industry trends, and opportunities for HIM professionals as QI evolves.

The panelists are:

- **Viola (Vi) Griffin**, RHIT, CPHQ, director of the health information department and QI coordinator, Craig Hospital, Englewood, CO, and chair of AHIMA's Quality Management Section
- **Maulik Joshi**, MHSA, principal and chief quality officer, doctorquality.com, and former senior director of quality at the University of Pennsylvania Health System
- **Charles Kilo**, MD, MPH, vice president and director of idealized design at the Institute for HealthCare Improvement, Boston, MA
- **David Lansky**, PhD, president of the Foundation for Accountability, an organization based in Portland, OR
- **Cary Sennett**, MD, PhD, healthcare consultant, former executive vice president of the National Committee for Quality Assurance, an organization based in Washington, DC

Q: How would you summarize the "state of the art" today in healthcare quality evaluation?

Griffin: QI measures are dependent on resources and attitudes; consequently, the state of the art ranges from elementary to sophisticated. A facility typically will not expend limited resources beyond those required to meet minimal standards. Current QI standards are set by the Joint Commission for the Accreditation of Healthcare, the National Committee for Quality Assurance (NCQA), and the Health Care Financing Administration (HCFA). Institutions whose QI efforts are more extensive voluntarily excel. Institutions just meeting minimal standards have a long way to go.

Lansky: We know how to evaluate quality. We have well-developed tools, and the issues are clear; the problem is we're not doing it. Within the industry, there is no general will to evaluate and communicate about quality. Quality evaluation is a threat to current dominant institutions in healthcare: purchasers, providers, and health plans. Such institutions are not well served by thorough evaluation, because the marketplace does not economically reward quality care. From a business viewpoint, to invest in functions that increase reimbursement and market share is wiser than investing in health outcomes.

Even though patients report anecdotal incidents of poor care, poor quality is hard for patients to detect. Patients don't know whether care is good or consistent.

Joshi: I agree. Healthcare does not properly measure quality due to lack of adequate resources, leadership, and quality expertise. The industry has made attempts at QI, but these have been largely ineffective in changing outcomes and results and in impacting the culture toward improvement. Resistance to change abounds. Many institutions simply pay lip service to measuring quality.

Other industries, such as manufacturing, have embraced QI, providing good examples of best-practice standards. Measuring quality of service when it comes to human life is undoubtedly different from other industries, but that does not mean it cannot be done.

Kilo: Yes, the value of human life is unique, an element that sets apart healthcare from other industries. Healthcare is also unique because we are both a service and a manufacturing industry—our product is health that is delivered and created in a service environment. It's the only industry where the product and the customer are the same.

QI development in healthcare lags behind because of the complexity of the industry and because of our diffuse power structure—independent practitioners (physicians) control what they do, even when they are employed by an organization. We're ruggedly independent, and that independence, while at times an advantage, can be a disadvantage as well. Appropriate leadership is often inhibited in healthcare by this diffuse power network. Not that a lack of independence would be better—rather, what we need is participation for the benefit of an organization and its customers.

The driving needs in healthcare are for better clinical outcomes, more patient and staff satisfaction, and enhanced financial performance. The science of improvement is rooted in systems theory. The science behind systems (how to test and measure changes to achieve improved system performance) is the foundation of quality management.

The first rule of improvement is that all systems are perfectly designed to produce the results they produce. In other words, if you want to change the output of the system, you have to change the system itself. It is not sufficient to encourage individuals to try harder within a difficult system. The focus has to be on changing the system itself. QI aims at scientifically testing and measuring the effects of changes on the system itself to achieve better performance.

Q: What are the important lessons we've learned in recent years about measuring and improving healthcare quality?

Sennett: We've learned that measuring healthcare quality outcomes reliably and validly is possible. The first lesson—a surprise to no one—is that quality is not easy to measure. QI is also not cost-free; the improvement process requires considerable investment.

Lansky: Investment is not only financial. We must invest in a different approach to quality. Professionals and patients view improvement differently. Experts in QI suggest that customers be closely involved with the QI process, but on most QI teams, patients are nowhere to be found—and the professional is assumed to be right.

Until we place consumers at the center of planning, we will continue to alienate them. To populate QI teams with patients and consumers would change the way business is done. Without this integration, meaningful improvement is difficult to achieve.

Griffin: We need to accelerate the QI process at the hands-on level. To effect change, we need to use—not merely collect—data. Many of us have adopted a system called the Plan-Do-Check-Act (PCDA) system, which was innovated by W. Edwards Deming, a leader in the field of QI. This method can be time-consuming because so much time can be spent on collecting and analyzing data before developing corrective action plans. A rapid cycle process could be considered to accelerate the improvement process.

Q: What are some of the key elements for successful QI in a healthcare organization?

Sennett: There are three. One is will. One does not see improvement until there is significant will to improve. This requires external pressure. The second is focus. To maximize success, an organization should focus on a limited number of efforts. If the force of will is distributed across too many activities, efforts will be ineffective. And finally, there's capability. The world is littered with organizations that have will and focus but don't understand systematic processes. This leads to frustration.

Some requirements for QI are technical. People need to understand how to evaluate a process and how to measure and manage process capability and process control.

Joshi: QI takes leadership. We need champions to take responsibility clinically and administratively. Organizations outside of healthcare have strong leadership in quality, and consequently they embody that strength.

We need accountability built into the system, whether for financial or nonfinancial incentives. We must take a balanced, comprehensive approach to data, to financial matters, and to clinical matters. Quality viewed as separate from an organization's mission is bound to fail. When it is incorporated into the mission and the daily work, QI will succeed.

Kilo: Toyota—a great example of a continually improving organization—understands that a focus on the quality of its products and services drives the long-term success of the company. In healthcare, leaders tend to focus on financial performance without understanding or improving the quality of their products or services. The key to the future is to drive financial performance by creating fantastic performance around clinical outcomes and patient satisfaction—but few, if any, healthcare leaders have made that their strategic priority. Few leaders even know what the quality of their outcomes are. The literature demonstrates that we have a long way to go before healthcare performance is as good as it could be.

We spend an incredible amount of money to obtain health services in the United States. We've seen some improvements in the past few decades, but most of those improvements have been innovations in medical science. The basic systems in which we deliver care, however, have changed little and leave much to be desired. We know that from the literature and our own personal experiences. Real improvement will occur when healthcare leaders and clinicians begin to see improvements in the delivery of products and services as their strategic priority. Real improvement will occur when we become accountable, when we drive measurement internally and use it for real-time improvement—not when we perform measurement begrudgingly. There's still a tremendous gap looming between knowledge and practice. We cannot allow that gap to persist, and the science of improvement aims to close it.

Lansky: From another point of view, the key to success is listening to patients. An institution that puts itself in patients' shoes can evaluate quality differently. We must suspend beliefs about care and focus instead on health. We view quality of care as optimizing delivery of technical services—like surgery or antibiotics. Patients view health as relief from pain, as a state of well-being.

In our current system, it's difficult to think of patients as customers because patients don't pay the bills—insurance does. Therefore, health plans are the customers. Until the QI movement focuses on the health outcomes of patients, improvement will be limited. Until we look at outcomes, QI becomes an efficiency process instead of a health improvement process.

Q: Let's take a look at a few healthcare trends and talk about how they've affected QI. For example, technology is changing very rapidly. What sort of effect does that have?

Sennett: Managing quality requires tremendous information. Information technology has the potential to enable QI efforts by increasing the amount of available information, reducing the cost of producing it, and accelerating the movement of information to users. Ongoing uncertainty about what technology will emerge as the standard has a lot of people sitting on the sidelines, waiting. Until organizations invest more in technology, we won't see any radical acceleration of QI.

Joshi: Technology has tremendously improved information capture and feedback. When it comes to quality measurement, we sometimes wait too long for perfect data. We shouldn't wait. We should make use of the most reliable and credible data we have.

Kilo: High-tech medicine, used appropriately, is a great benefit to healthcare and to humanity. However, "appropriate use" has not yet been clearly defined and is a slippery ethical slope. Technology sometimes leads to overuse, which is widely assumed but not widely studied.

Lansky: On the other hand, there's the argument that technology used in medical practice is a distraction. Institutions are spending money on advanced treatments when basic care delivery is inadequate. In our system, millions of people fail to receive rudimentary forms of care, while the business of healthcare commits dollars to technology. Technology adds to job requirements of physicians, nurses, and other health professionals, making their responsibilities more difficult when basic care is not properly delivered.

Q: What about the mergers and acquisitions we've seen in the last few years? What has their impact been?

Sennett: Mergers have the potential both to disable and to enable QI. On one hand, mergers consume a lot of energy, destabilize management systems and processes, and cause a lot of internal anxiety. These don't help the QI process at all. On the other hand, larger organizations have proportionally more resources to invest and can better afford to acquire necessary QI skills. They typically have multiple sites, creating opportunities for benchmarking. If the sort of large, multisite organization that typically emerges from a merger or acquisition in healthcare were able to standardize measurement, it would create unique opportunities to accelerate innovation. But the sad truth for the moment, is that mergers and acquisitions don't seem to have had much of an impact on QI, despite the theoretical possibilities.

Kilo: Mergers and acquisitions are driven by financial performance, not quality of care. One would be hard-pressed to find any evidence that one patient has benefited from mergers and acquisitions. The cost has been astronomical. No one has yet shown where the real benefit of these mergers lies.

Lansky: Trends in the industry in cost containment, mergers and acquisitions, and business in managed care have proven that the primary concern in the marketplace is not quality. The focus has been on many other issues; therefore, investments made in QI infrastructure, management, training, and measurement techniques have been steadily eroding. We've had a hard enough time implementing quality within a traditional structure, let alone within broader institutional arrangements. The growing openness of the infrastructure in healthcare in certain provider organizations has actually diminished the ability to implement information and management systems across a coordinated body.

Rather than committing dollars to reengineer a system, we should be focusing on QI. Healthcare has reorganized business units for greater effectiveness in the marketplace with no corresponding QI effort. There is no evidence that the market is rewarding better quality care.

Griffin: Typically, hospitals have individual QI departments. Mergers and consolidations potentially downsize or reduce QI staff. But what may be gained is a way of comparing best practices, so that facilities benefit from each other's ideas.

Q: We've heard a lot about managed care. What has its effect been on QI?

Kilo: There have been problems in the "managed care industry," but managed care is not one entity. Different people mean different things by "managed care." Despite some problems, in many respects, managed care has been a scapegoat. For decades, healthcare quality has been lower than it should be and costs have been too high. Instead of applying real leadership to this problem, either nothing was done or people pointed fingers. Managed care came along as a potential solution, but now many in healthcare spend their time criticizing these efforts instead of working to define other options. The problems, by the way, still exist.

We don't need blame and finger-pointing. We need new, deep leadership. Fortunately, physician interest in leadership is growing. We hope these new leaders can help guide us toward a future we know is possible—a more reliable healthcare system, better clinical outcomes, lower costs, and improved patient and staff satisfaction because the system is easier to use.

As an industry, we are becoming sophisticated about improvement over time. Creating change in any complex system requires deep leadership. I believe that leadership is beginning to emerge. The answer is to work hard enough to come up with new alternatives.

Sennett: QI is a process requiring management and information systems infrastructure. Within managed care, there are unique opportunities to drive and enable QI that don't exist elsewhere. Whether managed care has capitalized on the opportunity is another issue. Fee-for-service care is not able to manage QI in the way a managed care system can.

Griffin: With rare exception, managed care has resulted in a reduction in reimbursement for healthcare providers. Even though many managed care contracts will stipulate that providers must show evidence of QI so that beneficiaries receive high-quality care, I question whether or not this is actually a priority, as opposed to reducing costs.

Q: Let's consider patient empowerment and its impact.

Kilo: The Internet is fundamentally changing the physician-patient relationship. Information access now allows patients to guide their care. The healthcare industry must take responsibility for directing patients to good knowledge sources.

Sennett: That's true. With information on the Internet of variable quality, consumers must sift through contradictory or incomprehensibly different information. Because of information access, the patient is better able to become a partner with the physician in healthcare. Patients are not adequately empowered yet, but their empowerment will be a driver of QI in the future.

Lansky: Healthcare has been slow to build effective information systems. So it's likely that consumers will begin to bypass "the system." Consumers will rapidly outpace the medical industry in the use of technology. Individuals are discovering that they can learn about and obtain care through technologies without relying on traditional institutions.

The term "patient empowerment" implies that patients will have more power in the future. The question is whether providers will resist the transfer of power. It would be a hopeful sign if the system embraced giving patients power. This would bode well for a creative redesign of healthcare in which patients and providers treat each other with respect. The successful provider of the future will help patients obtain more power.

Joshi: Consumers are starting to demand quality information for their own decision making. The number of hits logged by Internet sites that specialize in medical information is astounding. In the future, patients will become more involved in their own healthcare, and consumers will define healthcare quality. Patients will lose tolerance for industry resistance.

Q: What do you see in the future for the evolution of QI? Are any promising new approaches being tried?

Lansky: There are powerful trends, outside of major institutions and entrepreneurial efforts, that focus on quality, and patients' experiences are moving QI forward. Large institutions are not initiating these trends; organizations with a direct connection to consumers—that are driven economically to meet consumer needs—are the innovators. One example is chronic disease care organized out of easy-access sites, such as pharmacies or malls, where patients see appropriate professionals who perform routine procedures like drug dosage adjustment or blood pressure checks. This kind of innovation is from the private market.

Griffin: The Joint Commission clinical practice guideline standards could lead to a whole new approach for evaluating quality of care. This proactive approach to quality planning has been in place for years in other industries. Healthcare providers use a retroactive approach—meaning we wait until the problem is upon us, then decide to solve it.

Sennett: Progress is being made nationally with respect to measurement. This is critically important because that progress creates the pressure necessary to create the organizational will to improve. We will eventually see the growth of an infrastructure needed to enable QI, as well as more investment. This is not a qualitative change in the way organizations conduct QI—no one has invented a better way of doing it.

Joshi: New approaches are not the necessity. We generally know the best practices. We have the approaches. Execution of QI is 90 percent of the game. Today, there are really no comprehensive examples, but there is promise. The imperative to improve quality in healthcare is clear, as consumers, providers, and purchasers are dissatisfied with the current system and market forces are signaling a change. The evolution of these market forces will make quality the reason for being in the business of healthcare.

Q: In light of what we've discussed, what are the opportunities for professionals who specialize in HIM in the quality arena in the future?

Lansky: Our most important asset is medical information. The shifting paradigm that millions of people will eventually manage their health records on the Web is common knowledge. If patients control their own medical information, add to it, remove from it, and grant and provide permission to access it, this empowers consumers, creating a universal information repository, a one-person health plan.

That model, if it comes to pass, will challenge the job security of HIM professionals but will, in the process, create a dynamic environment for them to be on the side of patients managing their own healthcare. Healthcare is an information-driven business; information is the dominant service. If people can reimagine their jobs and roles as being patient information advocates, there is incredible opportunity. This is central to what healthcare is becoming.

Griffin: Based on the new innovations, HIM professionals can move into advanced quality planning that involves data management and data quality. They also will have opportunities to assist with the development of clinical practice guidelines. I would like to see a stronger motivation among HIM professionals to deal with QI. We need knowledgeable HIM professionals to educate people and facilitate these efforts.

Sennett: Healthcare, as an industry, is tremendously information-intensive. This creates demand for people who understand data, data management, and the technical side of information management. Great opportunity is available for people who understand hardware and software as well as for people who understand the business of healthcare.

Kilo: Information technologies hold tremendous promise and hope. But in other industries, advanced technology has led not to improved products and services, but to higher costs. We should not make that mistake in healthcare. Instead, we need to understand the technology as such and how it fits into the system to advance care. Information management specialists have a key role in healthcare's future. Those who will help the most will be those who understand information management in its broad sense within the complex system of healthcare. The tools are only as good as those who use them and the system in which they work.

Joshi: QI in healthcare is starting to recruit people from outside the industry. People with the skill set for quality are in demand. The fundamental building block for quality is information. Without data, there's no real understanding, nothing to feed back, no goals to target, and no quantifiable objective. That's the focus for HIM professionals.

Quality Classifications

From 1996 through 1998, the Institute of Medicine (IOM) convened the National Roundtable on Health Care Quality. The group succinctly defined three quality problems in healthcare: overuse, underuse, and misuse of technologies, procedures, pharmaceuticals, and other medical practices. The following information was adapted from a consensus statement from the roundtable published in the Journal of the American Medical Association in 1998.[2]

Underuse: failure to provide service (e.g., childhood immunization) when that service would have led to a favorable outcome for a patient. (Underuse is not confined to managed care plans that provide incentives to physicians to reduce care. Underuse problems are exacerbated when people lack health insurance.)

Overuse: service provided under circumstances in which its potential for harm exceeds the benefit (e.g., use of antibiotics [at an expense] for viral infection when there is no proven efficacy)

Misuse: when appropriate health service has been selected but a preventable complication occurs and the patient does not receive the full potential benefit of the service (e.g., avoidable complications of surgery or medication use or administering a drug to which a patient has an allergy)

The group also explored the relationship between quality and cost:

- decreasing overuse improves quality and decreases cost simultaneously
- correcting underuse usually results in increased costs and increased quality
- clarifying misuse improves quality and reduces cost (Minimizing complications also minimizes the need to treat complications)

By correcting these problems, we reduce costs.

To learn more about quality improvement, here are a few useful Web sites:

Foundation for Accountability—www.facct.org

Institute for Healthcare Improvement—www.ihi.org

National Committee for Quality Assurance—www.ncqa.org

Notes

1. Abdelhak, Mervat, et al., eds. "Quality Assessment and Improvement." Chapter in *Health Information: Management of a Strategic Resource.* Philadelphia: W.B. Saunders, 1999, p. 321.

2. Chassin, M.R., R.W. Galvin, and the National Roundtable on Health Care Quality. "The Urgent Need to Improve Health Care Quality." *Journal of the American Medical Association* 280, no. 11 (1998).

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