From Washington

Quality and Health Care Reform

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It is safe to say that there are few subjects less exciting to the average family physician than quality assessment and measurement. Most of us define "quality care" as what we ourselves do every day in our practices and would consider any attempt on the part of some outside party to measure the quality of medical care we provide as intrusive and interfering.

With changes in the health care environment, however, we should view "quality improvement" as the system that puts new resources at our disposal to allow us to do things in our practices that we could never do in the past. How family physicians perceive quality measurement within this new environment will determine in large part whether these changes constitute a threat or a tool with which we can promote our own practice goals.

What Does "Quality" Mean?

We are asking questions about quality of care when we say such things as: "Was the care I gave that patient appropriate? Was it necessary? Did I adequately protect the patient from possible harm? Was my care consistent with the latest scientific evidence?"

"Quality" has a meaning for primary care physicians that is somewhat different from its meaning for specialists. Specialists tend to do a small number of procedures repeatedly, and data on the immediate outcomes of those procedures, such as mortality and complication rates following coronary bypass surgery, are more likely to be readily available. By contrast, the quality measure in family practice is more varied (Table).

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The world of medical quality management and monitoring is in flux. The old system, typified by peer-review organizations, was based largely on the philosophy of "get rid of the bad apples." It was assumed that the way to improve the quality of medical care was to eliminate the bad doctors and leave the good ones alone. This philosophy set an adversarial process in motion. The newer philosophy is one of continuous quality improvement, based on the idea that since there are many more good than bad doctors, overall quality of care will see the greatest improvement if each physician finds a way to do his or her job better, and if the system as a whole takes on more responsibility for assuring quality and encouraging this behavior in each member of the health care team. This philosophy has a nonadversarial posture in which physicians and health care plans are given a great deal of responsibility for measuring and managing their own quality of care. Different health reform proposals in Washington have varying proportions of both the old and the new philosophies.

How the Environment is Changing

Virtually all health reform proposals considered by Congress during 1994 promise to provide expanded access to affordable *quality* health care. Most establish some structure for quality monitoring at both the federal and local levels and call for more research. Even in the absence of federal health care reform, the managed care marketplace is moving in a similar direction, allowing us to predict with confidence the continuation of two trends: accountability and consumer choice. Quality will no longer be taken for granted. Physicians will have to demonstrate in some way that we are doing a good job. Consumers will expect adequate choices among both physicians and health care plans. To make reasonable choices, they will require information not only on the costs but also on the quality of care provided.

In this new environment, we will have to measure what we do in such a way that this information will ulti-

Table. Quality Measures Currently Feasible in Family Medicine

Access to preventive service
Screening mammograms
Pap smears
Blood cholesterol
Influenza vaccine
Other screening tests and immunizations
Patient reports of communication
Identification of consistent, responsible provider
Clarity of communication process
Clinical measures of process and outcomes
Preventable complications of disease
Follow-up of abnormal findings
Appropriate drug use
Appropriate use of procedures
Appropriate monitoring of safe use of drugs
Appropriate self-care instruction

mately be understandable and meaningful to consumers trying to choose a physician or a plan.

What Is a "Report Card"?

The policy planners involved in health care reform, especially the Clinton administration proposal, often refer to the "report card" as shorthand for the concept of expanded information for consumer choice. Imagine that there are four managed care plans for your city and that consumers can enroll in a different plan once a year if they choose. Just before open enrollment, a neutral party or the managed care plans themselves mail to each consumer the previous year's report card on the four plans. The report card lists perhaps 12 to 15 categories related to access to care, outcomes of care, and patient satisfaction. Examples might include the percentage of women over 50 years old who have had mammograms within the past 2 years; the percentage of children under age 6 who are up to date on immunizations; the number of days patients had to wait for a scheduled appointment; and complication rates following various types of major surgery. For each category, data for each of the four plans are listed side by side. An independent authority changes some of the measures used every few years, so that no plan can "game" the system by focusing only on the categories currently being evaluated and ignoring other equally important aspects of quality care. Ideally, consumers will then choose a plan on the basis of a combined assessment of the quality data on the report card and the costs of premiums and out-of-pocket expenses for each plan rather than depend on glitzy TV or billboard marketing campaigns.

Will consumers actually use the report card? We currently do not know how consumers make these decisions and what information would be most helpful, because this question has not yet been studied. Moreover, there may well be a "learning curve" phenomenon. During the first few years, consumers will learn a variety of useful ways to consider cost and quality information in making health care decisions. With time, data collection and measurement will be further refined so that information is more appropriately targeted toward consumer needs.

Although the report card has attracted much attention, it represents only a small portion of the quality of care data that will be gathered by the managed care system of the future. The report card should be considered primarily a means of ensuring informed consumer choice and only indirectly a means of improving quality. At least in the short run, physicians will be most influenced by quality reports that provide confidential feedback comparing them with their peers; and most of the quality data gathered by the plan will be used for that purpose. Over time, however, consumers will have access to increasing amounts of data that will allow them to choose among individual facilities and practitioners rather than simply among managed care plans.

How Can Family Physicians Benefit?

As more and more family physicians join managed care plans, as the environment calls for increased accountability and consumer choice, and as new research demonstrates better methods, managed care plans will approach physicians with various means to measure quality in individual practices. At this point, family physicians' understanding of quality measurement will be crucial. First, family physicians will have to adjust to the idea that they must organize their practices so that data which traditionally may have been ignored is routinely collected. Next, recognizing that what will be measured and how it will be measured will be dictated to some extent by outside forces, family physicians must be poised to take advantage of whatever flexibility exists at the local level. As part of negotiating a contract with any plan, family physicians will have some and perhaps a great deal of leeway to demand a quality improvement system that works for them, ie, one that is adequately financed by the plan; is maximally user-friendly for patients and for office staff; provides timely, understandable, and useful feedback; and above all, measures what family physicians themselves consider to be the important indicators of quality.

For example, most of us believe that it is very important that the majority of our patients feel satisfied when they leave the office, but few of us know how to design and use a patient-satisfaction questionnaire in our offices:

how many patients need to be sampled at which intervals to produce reliable data and how to tabulate results quickly and accurately. Even if one of us had the know-how and resources to do so, the results would have little meaning unless compared with those of other offices in the community. The same is true of measures of more technical aspects of care, such as number of mammograms ordered or appropriateness of drug prescribing. A properly designed and financed quality program within a managed care system could resolve all these issues.

The ideal quality monitoring system within a managed care plan is a win-win situation. Because of government regulation or market pressures or both, the plan must report quality data to the outside world; therefore, gathering data is simply one of the costs of doing business. The only way physicians can gather large volumes of accurate, useful data without interrupting the flow of their office practices is to use the most effective available tools, such as automated records and other office information systems. Compared with individual physicians, a managed care plan has much more financial capacity to develop and disseminate these tools among participating physicians. If a given plan measures the areas physicians really want to know about in a way that is least intrusive on their office routines, the physicians in that plan will be happier, which will give it a competitive advantage over other plans eager to sign up primary care providers. If its physicians take an active role in designing the quality system and monitoring the feedback it provides, the plan will have greater assurances that its member physicians will be motivated to provide high-quality care, and therefore, that the resulting report card will be attractive to consumers.

Where's the Action?

Most of the media attention regarding health care so far has focused on federal activities. The various bills before Congress all have somewhat different provisions for setting up some national standards for quality monitoring. A great many of the most important decisions, ie, those that have the most direct impact on the daily work of the participating physician, will end up being made at the local level. The message gleaned from these facts is clear: family physicians who want to be sure that quality monitoring in the new health care environment works *for* them and not *against* them should become active right away in the local systems that already exist, assuming that many of them will be incorporated into the new environment. Given the rate of change and the relative novelty of many of these tools, a local plan with an impressive quality-improvement system already in place may well find its methods serving as a template for the local authority or marketplace that will be used by other plans in the area.

What About Practice Guidelines?

Most proposals Congress considered in 1994 call for increased development of clinical practice guidelines as a means of containing costs while assuring quality. In general, practice guidelines are viewed as tools rather than rigid standards. They are carrots rather than sticks and should be considered as an effort to create a provider-friendly environment. Guidelines are currently popular in Congress and have received no serious objections from any group, including physicians.

The consensus about the potential of guidelines has led to unrealistically high expectations on how they will save money while improving quality. No one has yet devised a good method to make busy physicians who are already content with how they are practicing alter their behavior to conform to the guidelines, even when they are well designed and contain clinical "truths." The danger is not so much that guidelines will be used to make things more difficult for the primary care physician, but rather that they will not have nearly the economic impact that some of their strong supporters have taken for granted.

Family physicians interested in research can contribute by studying the appropriate interface between published guidelines and actual clinical practice, but *all* family physicians have a part in the process. While we are learning how best to use the guidelines, we can also work to assure that the guidelines are being developed according to a credible process. Guidelines should be based on an accurate analysis of the existing medical literature and should take into account the experience of the family physician in addition to that of the subspecialist. In particular, family physicians should work to challenge proprietary guidelines whose methods of development are hidden in a black box as "trade secrets." Until now, the average family physician asked to review a guideline generally first asks, "Do the recommendations seem reasonable?" We can improve our future practice environment if we ask instead, "How was this guideline developed, and did the process include all of the proper steps?"

Goals for the Future

Family physicians will be challenged in the future to pay increased attention to measuring quality of care. This can be a win-win situation for physicians, patients, and systems managers if we can keep several issues in mind: how to

incorporate into our practices improved methods of routine data collection; how to design continuous quality-improvement systems that meet our practice goals in a minimally intrusive fashion; and how quality monitoring from the primary care perspective differs from that of the specialist.

One aspect of measuring quality that will require more research in the future is the differing perceptions of "quality of care" from the perspective of the patient and that of the physician. Patient expectations frequently deviate from scientifically based practice guidelines. Therefore, the physician delivering high-quality care, as measured by patient satisfaction, could be providing care that, based on appropriateness and adherence to scientific standards, is of lesser quality. The current trend in quality research is to attempt to integrate patients' values and preferences in the measurement and monitoring process.

In the future, if our system of quality management and consumer accountability results in patients being better informed and having more realistic expectations of the medical system, physicians will likely find that patient satisfaction can be compatible with adherence to scientific standards of quality care.

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