
GAINING THE COMPETITIVE EDGE: WHY QUALITY COUNTS

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Quality measurement and improvement programs are vital components of all health care organizations, which can reach their maximum potential only if physicians accept a major role in shaping them. In the course of their careers, physicians almost certainly will participate in health care organizations. To contribute meaningfully to quality programs, physicians need to understand the nature of health care organizations and appreciate where quality fits within the complex organizational structure as well as the priority placed on it.

Where Quality Fits

Health care organizations have become prominent players in health care delivery in the United States largely due to explosive growth of managed care entities such as staff- and group-model health maintenance organizations (HMOs) and the more loosely affiliated independent practice associations (IPAs). The Balanced Budget Act of 1997 created physician-sponsored organizations (whose majority owners are the physicians who provide care) to contract directly with the Health Care Financing Administration (HCFA) for total health care for Medicare members, and states are increasingly using managed care models for their Medicaid-eligible health care populations. Also on the rise are integrated delivery systems consisting of hospitals, multispecialty medical groups, and ancillary and home care providers, which directly contract with large employers to deliver health care to their employees.

All health care organizations, regardless of size or type, are required by statute or contract to provide quality assurance programs that are monitored or audited in some fashion. These programs must demonstrate the organization's ability to identify and study quality of care issues at the individual practitioner level (eg, member satisfaction surveys) as well as across the plan population (eg, immunization or

mammography rates). Quality assurance programs also include credentialing standards, access and availability standards, and guidelines for clinical resource management. Whereas clinical resource management programs can show efficiency and cost reduction, quality assurance programs can demonstrate improvement in the quality of medical care or services delivered by the health plan and its network of practitioners.

Health plans view quality in terms of appropriateness of care (ie, what is done to or for members) and adequacy of customer service. Quality programs include surveys to determine whether members believe the care and services they receive meet their needs and is of good quality and surveys to determine what consumers feel is important. Health plans also study patterns of complaints and grievances, conduct demographic and disease prevalence analyses, and collect data to help focus their quality improvement efforts on specific care or services.

Why Quality Counts

In recent years, increased competition among health plans has lessened the difference in cost to members and employers, and state and federal regulation has made benefits increasingly similar. As a result, quality (including member perception of quality) has become an important tool for differentiating among health plans. Quality measurement and improvement programs are becoming as critical to a health plan's success as premium cost, physician selection, and administrative efficiency. Large employers and public purchasers have begun to ask for and evaluate quality data from individual health plans, and they provide this information to their employees and enrollees to help in plan selection.

The Health Plan Employer Data Information Set (HEDIS) currently is the best source for data on health plan quality performance. Developed under the auspices of the National Committee for Quality Assurance (NCQA), HEDIS includes information about such broad aspects of care as immunization and mammography rates, follow-up care for patients with major affective disorders, access to prenatal care, and

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utilization for common medical disorders. HEDIS data is scored and disseminated by large employer groups and HCFA for enrollees to use in selecting health plans. HEDIS scores also are published on the Internet and in national magazines. The data currently is not population- or risk-adjusted for severity of illness, making it better for internal quality improvement than for meaningful public comparisons. However, in 1999, all HEDIS data will be independently audited, allowing the information to be used as benchmarks for quality improvement efforts nationwide. Also in 1999, HEDIS quality performance measures will be incorporated into NCQA's health plan accreditation process and will represent 25% of the score required to pass.

How Good are Today's Tools for Measuring Quality?

Process and Outcome Measures

Although it is actively debated whether outcome or process is more important in quality of care measurement, the truth is that both types of measures are important for different purposes.

Process measures evaluate the manner in which care is provided. These measures are designed to demonstrate that variations in the attribute measured (eg, hemoglobin A_{1c} level in diabetic patients) lead to differences in outcome (ie, better or worse glucose control, which has implications for development of diabetic complications). Other examples of care process measures include health screening rates (eg, lipid screening, Pap testing) and follow-up rates for abnormal diagnostic test results. Compared to outcome measures, process methodologies are easier to measure and apply to individual practices; they also are more timely and useful in providing data that will lead to medical practice improvement initiatives. Process also may be a more sensitive measure of quality, considering that poor outcomes do not occur every time there is an error of care and, in chronic conditions, may occur long after the care process (eg, foot amputation in a diabetic patient with poor care).

Outcome measures evaluate the outcome of care. These measures are designed to show that alterations in care processes under the control of health professionals lead to differences in outcome [1]. Outcome measures are effective tools for demonstrating improved health status of important segments of a health plan's enrolled population over time. For example, many health plans use maternal health care outcome measures (eg, gestational age at the time of

delivery, birth weight) to demonstrate effectiveness of maternal care programs. Such programs typically ensure that pregnant women receive prenatal care during the first trimester, that high-risk conditions are identified through an intake interview, and that case management programs are in place to provide specialized care for high-risk patients. Other examples of outcome measures include functional status for patients after undergoing elective surgery and mortality rates following coronary artery bypass graft surgery.

Several organizations are actively working to overcome the lack of nationally accepted medical guidelines and standards for quality measures, including NCQA, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Foundation for Accountability, the Preventive Services Task Force [2], and the Agency for Health Care Policy and Research (AHCPR). In addition, recent reports of collaboration among competing developers of standards (ie, JCAHO, NCQA, and the American Medical Association's American Medical Accreditation Program) [3] indicate a trend toward developing greater consistency across accrediting organizations. If successful, this collaboration of organizations that accredit health plans, hospitals, and other health care facilities with an organization that accredits individual physicians could promise great improvements in the development of quality of care measures.

Physician Profiling

Physician profiling is a common method used by health plans to evaluate practice patterns in their networks. Profiles look at both care (quality) and cost (utilization) measurements for an individual physician and compare them to those of like specialists. Examples of quality measurements used in physician profiles are the proper provision of preventive health care, documentation of continuity of care in the medical record, and patient satisfaction (**Table 1**). Sample cost measurements include average number of visits per member, referral rate, number of hospital days per 1000 members, and number of prescriptions per member. Many health plans are moving toward a reimbursement model that rewards physicians who meet certain quality and utilization standards within a given year [4].

A major weakness of physician profiling has been the inability to adjust data adequately to reflect the case mix and severity of illness in an individual physician's practice, particularly where overutilization is concerned. Critics fear that health plans will use

utilization data to limit appropriate care. However, plans use the data to identify underutilization as well as overutilization, as both can negatively impact health care; for example, good quality programs will increase utilization of appropriate preventive services. A danger in overutilization profiling is inappropriately sanctioning a practitioner who is providing appropriate care to a sicker population. Quality profiles generally are less controversial and better accepted by physicians than utilization profiles, because they relate more directly to the medical care provided to patients and how satisfied those individuals are with that care.

It is important that any actions taken as a result of a profile analysis undergo peer review to ensure they are fair. This is an opportunity for practicing physicians to have an impact on health plan decisions and to learn more about quality processes at the same time.

Translating Theory into Practice

Comprehensive quality programs have the ability to evaluate and act on a broad range of quality concerns. Individual quality issues usually are identified through member complaints or medical management care tracking and are addressed in peer review processes where sanctions are imposed. Quality studies of specific medical conditions usually involve disease management programs that identify affected members, evaluate care against defined standards, and attempt to reduce variability of care toward best practice to improve outcomes. Population-based quality efforts address many of the same issues as public health entities, such as improving preventive care and improving access to care. Priorities for all quality efforts within a health care organization are established using demographic, epidemiologic, and disease prevalence studies.

Critics within the health care field often charge that health plans design quality programs primarily to reduce costs. However, as the examples below illustrate, the implementation of quality programs can improve medical care. Although it is difficult to prove by formal cost-benefit analysis that quality improvement efforts reduce costs, it is generally accepted in managed care that quality improvements do not lead to increased health care costs but—like preventive health care—will lower them in the long term.

Asthma Education Program at Oxford Health Plans

In 1991, an expert panel convened by the National Heart, Lung, and Blood Institute (the National

Table 1. Measurements Used by Oxford Health Plans to Develop Physician Profiles in Various Specialties

Quality of care

- Sentinel events
- Medical record review
- Site visits
- Quality Management Committee actions
- HEDIS indicators
 - Childhood immunization (Peds)
 - Adolescent immunization (Peds)
 - Influenza vaccine (IMs/FPs)
 - Mammography (IMs/FPs/Ob-Gyns)
 - Cervical cancer screening (IMs/FPs/Ob-Gyns)
 - First trimester prenatal care (Ob-Gyns)
 - Low-birth weight infants (Ob-Gyns)
 - Otitis media treatment (Peds)
 - β-Blocker treatment post-AMI (IMs/FPs)
 - Diabetic eye examinations (IMs/FPs)

Quality of service

- Member satisfaction
- Member complaints
- Enrolled member growth
- Disenrollment/PCP changes
- Next available appointment—urgent
- Next available appointment—not urgent
- Total hours per week
- Evening hours per week
- Weekend hours per week

Cost of care

- Hospital days per 1000 members
- Average LOS
- Admissions per 1000 members
- Emergency room rates
- Percentage of patients seen
- Costs per episode of care
- Utilization Review Committee actions

AMI = acute myocardial infarction; FPs = family physicians; HEDIS = Health Plan Employer Data Information Set; IMs = internists; LOS = length of stay; Peds = pediatricians; PCP = primary care physician; Ob-Gyns = obstetrician-gynecologists.

Asthma Education and Prevention Project [NAEPP]) released its first set of clinical practice guidelines for diagnosis and management of asthma, which have since been updated [5]. These guidelines establish a

single standard of care for all asthma patients and provide a standard of quality against which providers and health care organizations can measure their care processes. Among the recommendations of the NAEPP guidelines is a stepwise approach to using asthma medications that emphasizes early use of inhaled anti-inflammatory steroid medications. The NAEPP guidelines have been widely distributed to clinicians and other health professionals, including throughout the Oxford Health Plans system.

In 1993, Oxford implemented the Better Breathing[®] Program to improve the quality of care for asthma patients, who represent approximately 5% to 7% of its 21 million members. The program was instituted after Oxford found that physician prescribing patterns had not shifted toward a greater emphasis on the use of inhaled steroids, as is recommended in the NAEPP guidelines. In addition, Oxford found that physicians in certain specialties were much more likely to follow the guidelines than physicians in other specialties.

By focusing on physician education in the specialties with the least appropriate performance and providing feedback to individual physicians, Oxford was able to show a marked improvement in the prescribing pattern of target specialty physicians after 2 years. This effort coupled with asthma patient education helped to reduce emergency room usage and hospitalization, which led to a decrease in Oxford's overall costs of asthma care.

Diabetic Nephropathy Management at CIGNA HealthCare

End-stage renal disease is a complication that develops in 35% to 45% of type 1 diabetic patients by age 50 and in 20% of type 2 diabetics. Diabetic patients commonly have coexisting hypertension. Both systolic and diastolic hypertension greatly accelerate the progression of diabetic nephropathy, and several recent studies have demonstrated the benefits of using angiotensin-converting enzyme (ACE) inhibitors in preventing or reducing the progression of diabetic nephropathy. These studies are cited in a consensus statement of the American Diabetes Association on treatment of hypertension in diabetes [6].

In partnership with their practitioners, CIGNA HealthCare of Southern California is identifying diabetic patients with hypertension and/or microalbuminuria who are not receiving an ACE inhibitor for targeted intervention. Additional actions being taken to help reduce the risk of developing diabetic nephropathy include tight glycemic control, dietary

protein restriction, and correction of lipid abnormalities, all of which are included in CIGNA's Clinical Practice Guideline on Diabetes Management. Primary care providers with diabetic patients not being treated with ACE inhibitors receive a letter with patient information, a management recommendation guide, and a feedback survey. In addition, targeted diabetic patients receive a letter encouraging them to discuss this category of medications with their physician. Using these quality improvement interventions, CIGNA increased the use of ACE inhibitors in its diabetic population by 78% in the past 2 years.

The Physician's Role: Ready or Not?

In the *New England Journal of Medicine's* recent Quality of Health Care series, David Blumenthal sounds an alarm to physicians and asserts that they "owe it to themselves and their patients to master the substantive issues that underlie current discussions about the quality of care" [7]. Currently, most physicians lack the knowledge and skills they need to contribute meaningfully to quality programs within health care systems. Much of the terminology and concepts of quality improvement processes—observed and expected mortality, SF-36, case mix and case severity adjustment, HEDIS performance measures, control charts, critical pathways, and total quality management—were absent in past general medical training.

To a large extent this gap still exists. In a national survey of 91 deans of U.S. medical schools to help define a core managed care curriculum, most (70%) recognized the need to revise their institution's curricula and had or were developing programs to train students for practice in managed care settings [8]. About 95% had curricular components for epidemiology, about 50% had components for quality assurance, and about 67% had integrated managed care material into some courses. In only 43% of programs did any training occur in a managed care setting.

In addition to lacking technical knowledge about quality, physicians tend to resist getting involved with quality initiatives. Paul E. Morrison, operations management professor at Boston University's School of Management, observed several reasons for this resistance, including a fear of blame for incompetence or errors, a concern for confidentiality, a belief that medicine is different (ie, widget theory cannot be applied to human beings), and a concern that active participation in quality management programs leads to loss of control over the care one delivers [9]. Recognizing that outcomes are difficult to define, measure, and control, leaders of quality programs

can confront physician resistance by gathering and using data to openly discuss problems, by sharing information and findings, and by fixing the process instead of fixing the blame.

In the future, most physicians likely will be involved in some quality management processes, such as defining criteria for guidelines, simplifying national standards for local adoption, or peer review. Opportunities are expanding, as accrediting agencies require physician involvement in health plan quality programs and as legislation mandates external review of cases involving denial of care. Quality management has moved away from finding bad apples and imposing sanctions to changing practice patterns through collaborative education efforts developed by recognized physician leaders. With active involvement of practitioners, it should be possible to design and implement quality management programs within health care organizations that are acceptable to physicians, that reduce variation in clinical practice, and that bring local practice into closer conformation with national or best practice standards.

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