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Quality of Care and Healthcare Reform
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The use of the word "Quality" in the healthcare creates as many questions as any other word in the medical lexicon. The reality is that there is not a universally accepted definition or even description of what quality healthcare looks like, or what elements make up quality.

In fact, the discussion of "quality healthcare" has multiple end points depending upon the perspective of the one examining quality. Among these unique perspectives are:

1. Providers who want to be assess whether they are performing their work well.
2. Patients who want to know whether they are receiving excellent care.
3. Payers who want to know whether what they are paying for is worth the price.
4. Politicians who want to have a standard by which to judge whether the healthcare system is providing a "quality" service and who want to know how the healthcare system can be changed in order to control costs without compromising "quality."
5. The public, which differs form patients as a population differs from a patient, who wants to know if they can trust the council and advice of the healthcare industry.
6. Public Health officials who want to know if the outcomes of healthcare delivery are providing the improved health required for public policy initiatives.
7. Professors of medicine who need to know what quality healthcare looks like in order to better prepare healthcare students to provide and to produce quality care.

Whatever the perspective, each stakeholder in the healthcare-quality debate wishes to improve healthcare and to advance excellence in its delivery.

Quality Measures and Legislation

Just as we begin to discuss quality, it is important to acknowledge the active discussion of real and potential problems. In the April 9, 2009, *Wall Street Journal* this was heralded in an article entitled, "Why 'Quality' Care is Dangerous." In part that article stated:

"The Obama administration is working with Congress to mandate that all Medicare payments be tied to 'quality metrics.' But an analysis of this drive for better health care reveals a fundamental flaw in how quality is defined and metrics applied. In too many cases, the quality measures have been hastily adopted, only to be proven wrong and even potentially dangerous to patients.

"…In Massachusetts, there are not only carrots but also sticks; physicians who fail to comply with quality guidelines from certain state-based insurers are publicly discredited and their patients required to pay up to three times as much out of pocket to see them. Unfortunately, many states are considering the Massachusetts model for their local insurance.

"…One key quality measure in the ICU became the level of blood sugar in critically ill patients. Expert panels reviewed data on whether ICU patients should have insulin therapy adjusted to tightly control their blood sugar, keeping it within the normal range, or whether a more flexible approach, allowing some elevation of sugar, was permissible. Expert consensus endorsed tight control, and this approach was embedded in guidelines from the American Diabetes Association. The Joint Commission on Accreditation of Healthcare Organizations, which generates report cards on hospitals, and governmental and private insurers that pay for care, adopted as a suggested quality metric this tight control of blood sugar.

"A colleague who works in an ICU in a medical center in our state told us how his care of the critically ill is closely monitored. If his patients have blood sugars that rise above the metric, he must attend what he calls "re-education sessions" where he is pointedly lectured on the need to adhere to the rule. If he does not strictly comply, his hospital will be downgraded on its quality rating and risks financial loss. His status on the faculty is also at risk should he be seen as delivering low-quality care.

"But this coercive approach was turned on its head last month when the *New England Journal of Medicine* published a randomized study, by the Australian and New Zealand Intensive Care Society Clinical Trials Group and the Canadian Critical Care Trials Group, of more than 6,000 critically ill patients in the ICU. Half of the patients received insulin to tightly maintain their sugar in the normal range, and the other half were on a more flexible protocol, allowing higher sugar levels. More patients died in the tightly regulated group than those cared for with the flexible protocol."

Healthcare Reform Act and Quality

Nevertheless, the ideal of quality and concepts about the elements of quality are integral to healthcare legislation. The Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010, contemplates the establishment and ongoing maintenance of quality-related initiatives and metrics in almost every aspect of health care. In their summary of the bill the international law firm of McDermott Will & Emery give the following analysis of the law, the future and quality metrics.

"What's Quality Got to Do With It? In a word: everything. The PPACA requires health plans and insurers (§§2717-2718), insurance exchanges (§1311), Medicaid and Medicare programs (§2701, 3§001), hospitals and other health care facilities (*e.g.,* §3001), and physicians (§3002) to compile, report and receive payment adjustments related to quality metrics. Concerns regarding the quality of health care provided in the United States have been cited as a key driver of health care reform, and the manner in which quality initiatives and impact have been interwoven into the PPACA bears this out.

"Quality Initiatives Within Health Care Reform Legislation Affect All Stakeholders: Examples in the PPACA Physicians and Physician Groups "Physician quality reporting is to

be expanded under the PPACA to affect payment rates for physician providers, with incentive to make quality reports in order to obtain favorable reimbursement (§3002).

"National Quality "Strategy" The PPACA contemplates the establishment of a national strategy to improve the delivery of health care services, patient health outcomes and population health. The data-driven strategy would also identify "gaps" in quality and report strategic plans for health care quality improvement on a health care quality website accessible to the public (§3011). Working group activities to align efforts in this regard are expected to begin reporting to Congress by December 31, 2010 (§3012).

"Quality's Role in New Patient Care Models Health reform legislation includes formation of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models with the goal of reducing program expenditures while preserving or enhancing the quality of care furnished to Medicare and Medicaid beneficiaries (§3021).

"The PPCA also anticipates the development of a Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality to use research from a variety of disciplines to help establish best practices for quality improvement in the delivery of health care services; propose changes to the processes of care and redesign of systems to improve patient safety and reduce medical errors; identify high-performing providers across the health care spectrum; and create strategies for quality improvement through tools, methodologies and interventions (§3501).

"Health Professional Education The PPACA includes provision for grants to fund a demonstration program to integrate quality improvement and patient safety training into the clinical education of health care professionals, including medicine, nursing, pharmacy, social work, health care administrators and other health professional programs (§3508).

"Next Steps for Stakeholders Stakeholders should assess the impact of PPACA provisions on existing quality processes and determine where additional risks may arise once the legislation is fully implemented. The establishment of quality measures and criteria referenced in the PPACA will be a significant undertaking for the federal government, and will serve to both clarify the extent of the impact of quality on the health care system and better identify the potential burdens and benefits of the legislation for the key players in the health care marketplace."

Conclusion

Quality in healthcare will never be a destination at which we arrive because our knowledge will never be perfect. Quality metrics will always be changing, not rapidly, but surely. It is probably unrealistic to imagine that a single provider can pay attention to all quality metrics at one time.

Electronic systems will aid in this process, but energy and attentiveness are more problematic than even time in attending to hundreds of quality metrics simultaneously. If the patient is to be an active part in the advancement of quality, and they should be and must be, it is not possible to imagine that a single patient can successfully relate to hundreds of quality measures at the same time.

To expand and sustain the use of multiple quality metrics is going to require automation. It is going to require all participants to know that this is what we will do today based on our best knowledge. We may change soon when evidenced-based medicine gives us new insights into a disease process, or its treatment. Those changes are not a failure or prima fascia evidence of incompetence. They are our commitment to excellence, which means as we learn; we change.

It is probable that excellent providers will be relatively slow to accept the innovations proposed by the rapidly moving pioneers. The latter are necessary for learning; the former are necessary for stability. Everyone will be committed to learning and to changing but only in the context of our ultimate responsibility which is foremost to do the right thing for the patient.