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Toward Effective Enhancement of Clinical Quality

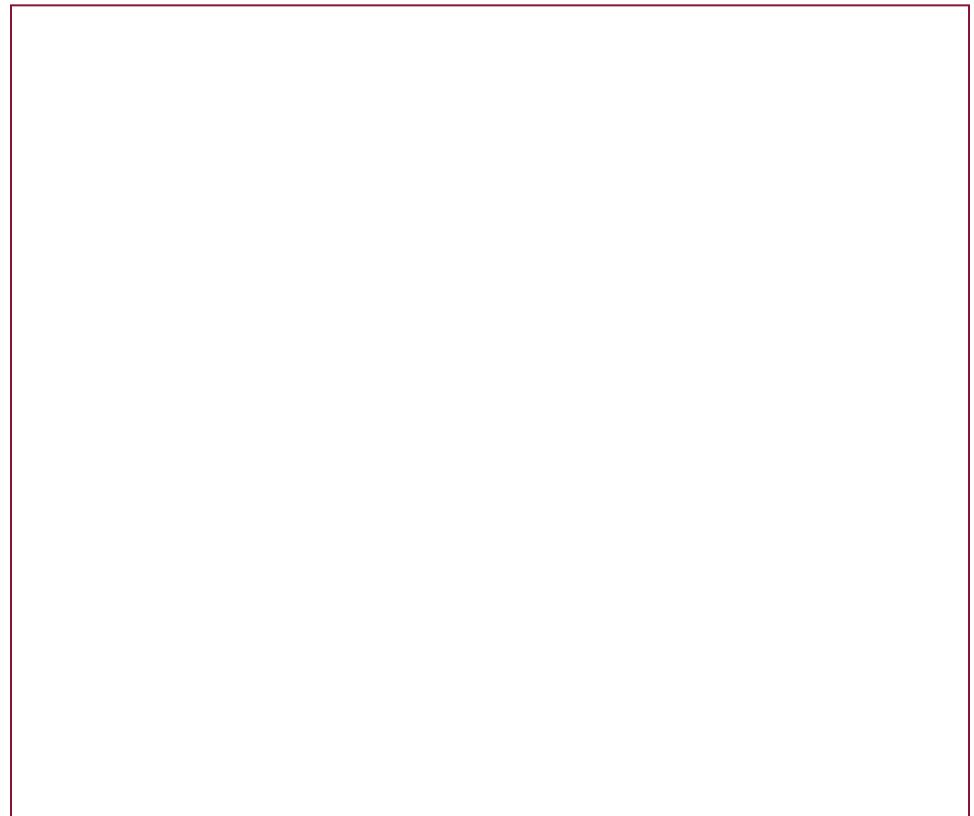
Based on the Second Group Discussion of Medical Executives in Managed Care at the Cambridge Healthcare Summit, March 20-22, 2002.

“Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”
—*Institute of Medicine*

Medical directors are the gatekeepers of clinical quality within their respective managed care organizations (MCOs) and are placed in the awkward position of managing “from the middle” as they strive to bridge two worlds—the business world and that of clinical medicine. This inevitably raises issues of trust or credibility vis-à-vis their MCO and its providers that are directly related to one’s ability to influence clinical quality matters within the organization.

Identifying opportunities for effective improvements of clinical quality requires thinking “out of the box” while navigating within the objectives of the system. In a market-driven healthcare delivery system, developing evidence-based clinical performance measures to foster accountability and enhance quality of care becomes increasingly important.

(Continued)





WHAT IS WRONG WITH OUR QUALITY OF CARE?

The current US healthcare system is exposed to serious gaps between the desired and actual levels of care, which are especially evident in certain populations (eg, the elderly, patients with chronic diseases) and resulting in great lapses and increased dependence on the individual physician, regardless of the specific MCO. Problems regarding quality of care evident in the current healthcare system, as perceived by MCO executives, are summarized in the Table.

POSSIBLE CAUSES

Identifying main causes for the less-than-acceptable quality of care is a necessary first step.

Old Habits. Many physicians continue to manage patients according to outdated algorithms and old information learned during medical school or residency days, resulting in high variability in the level of patient treatment. Updated management guidelines for a broad range of disorders are widely available and are well publicized by the medical community, the government, and even by pharmaceutical companies. Nevertheless, routine use of most recent guidelines is often limited and slow to be implemented. Time limitation and the sheer amount of new information complicate the task of keeping up with new practice guidelines. Resistance to adapt new guidelines is another problem affecting level of care, stemming from personal reluctance to change or physicians' general dislike of clinical guidelines, which are some-

TABLE

Problems Influencing Quality of Care

- High variability/inconsistency of treatment
- Many patients not treated according to most up-to-date guidelines:
 - Undertreatment (major driver of costs?)
 - Overtreatment
- Poorly performing (“bad”) physicians remain in MCO
- Physician fraud
- Patient noncompliance
- Lack of industrywide standards

times perceived as interfering with one’s professional autonomy and the license to practice the art of medicine. All this underscores the need for the establishment of standards of medical care delivery and performance measurements.

Under/Overtreatment. Inappropriate treatment, undertreatment, and lack of long-term prevention strategies in chronic conditions as well as underuse of some drug classes (eg, angiotensin-converting enzyme [ACE] inhibitors for congestive heart failure [CHF] or statins for coronary artery disease [CAD]) are major contributors to poor quality of care and increased total healthcare costs. The opposite is also true. Overtreatment or unnecessary treatment (and diagnostic procedures), as well as overprescribing or inappropriate drug

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therapy (eg, prescribing long-term antibiotics for Lyme disease prevention) are also significant contributors to poor care, although their impact on total costs is likely less significant than undertreatment.

Poor Performance. Even when providers who fail to meet performance standards have been identified, removing them from an MCO is not simple. Curiously, many of those identified by their MCO as providing poor care are liked and defended by their patients. Many patients are poor judges of medical quality and cannot tell what constitutes good or bad care. The right to select a provider is also perceived by some patients as an index of high quality. Other patients resist provider changes due to personal loyalties or unwillingness to seek alternative providers. Therefore, patients indirectly play a major role in the retention of undesirable providers.

Employers, who do not want complaints from their patients (the “noise factor”), also contribute to the retention of questionable providers. In addition, removal of unwanted providers involves considerable legal expenses as well as marketing issues; it is the marketing personnel rather than medical directors who end up driving choice of providers in a plan.

Fraud. Most physicians can be expected to act with the best interests of their patients and are very honest, but they will sometimes lie to their MCO to get around the rules when deemed necessary. In addition, some fraud and abuse of the system are inevitable contributors to poor quality. Overuse of diagnostic modalities and costly treatments, which are often not candidates for MCO precertification, are sometimes used to further providers’ own financial needs.

Noncompliance. Even when the MCO and providers are doing all

they can to promote high-quality treatment, patient noncompliance and failure to follow treatment recommendations compromise the level of care. Noncompliance is associated with adverse drug effects, drug interactions, storage restrictions, dietary requirements, complex treatment regimens, and travel away from home. Although fewer tablets and simpler dosing regimens are associated with improved treatment adherence, a perceived convenience of a treatment regimen may have a greater impact on compliance than the actual number of daily tablets.

Inappropriate treatment, undertreatment, and lack of long-term prevention strategies as well as underuse of some drug classes are major contributors to poor quality of care.

Other determinants of adherence include alcohol and substance abuse, stress and coping mechanisms, perceived benefits of treatment, and patient-provider relationships. Demographic variables, including age, sex, race, education, employment, and socioeconomic level, may also factor in.

Lack of Standards. Lack of industrywide standards for formulary management, prescription documentation, performance measurement tools, and electronic medical record keeping is another factor affecting quality of care.

EFFECTIVE APPROACHES TO IMPROVING CARE

Incremental application of the following action points can have

significant impact on the level of care in the current healthcare delivery system.

Neutral Agency. Designation of a third-party neutral agency or group for promoting and educating physicians about current clinical guidelines may increase acceptance and implementation of updated management recommendations and help quell concerns regarding balance and credibility on the part of providers. Some possible neutral agents include the US Preventive Services Task Force, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), or a new entity especially created for this purpose.

Appropriate starting points include guidelines that have widespread consensus regarding their applicability and adaptability, such as the management of patients with CHF, post-myocardial infarction administration of beta blockers, and similar relatively common and easy-to-follow guidelines. This will enhance universal adaptability before progressing to less widely accepted guidelines requiring more rigorous education and promotion.

Measurement Tools. Standardized software programs and information storage and processing technologies are necessary to document and evaluate standards of care, development of comparative models of disease management (DM) programs, and projection of patient population-based outcomes, with the end result of enhanced clinical quality. Identifying providers associated with poor clinical outcomes is based in part on assessment of clinical performance parameters and patient outcomes. The JCAHO and the NCQA, among others, have developed attributes of performance indicators that can be useful tools for measuring professional accountability and help



providers improve their patients' outcomes.

Compliance. Development of treatments with reduced toxicity and simpler dosing regimens is an effective approach to improving adherence. Educating patients and clinicians about their plan formularies and the introduction of standardized performance measurements will likely also contribute to patient compliance.

Tailored DM Programs. Uniquely tailored DM programs may be the most effective means of enhancing clinical quality in select patient populations. Those undergoing certain orthopedic or other surgical procedures, for example, will benefit from the establishment of mandatory medical clearance with their primary care or personal physician before surgery (to ensure they are stable enough), well-defined length of hospital stay, and timing and duration of postdischarge follow-up. Programs for patients with CHF utilizing extracorporeal counterpulsation will likely reduce the number of days in the hospital and may decrease total hospitalization events. Postdischarge telephone calls to all patients is another possible means to enhance quality and reduce total costs. A pain management program is another likely candidate.

Under such programs, relatively simple clinical issues with clearly defined outcomes may be effectively managed with minimal interventions, including targeted mailings and phone calls. More complex conditions and those with less well-defined outcomes may require more intensive interventions, including case management or office visits. Patients with CHF, asthma, diabetes, or CAD are the most common candidate populations recognized as those for whom intensive case management provides a high return on investment (ROI; ie, cost-saving associated with improved clinical out-

come). Less recognized groups include patients who frequent emergency departments for routine and non-emergency care, and patients with end-stage renal disease and other chronic conditions.

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may be the most effective
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cost-saving ability.**

ROI Strategies for Quality Improvement. Instituting a DM program based on anticipated or warranted intensity of intervention, ROI, or clinical outcomes may be an effective means of regulating resource allocation, saving costs, and enhancing clinical quality. Although intensity of care will increase initial costs, the ROI will follow the improvements in clinical outcomes.

A major challenge to implementation of such DM programs is delayed ROI. Expenditures associated with these programs can be substantial, and demonstrating the expected clinical and financial benefits may take a long time. Thus, it is best to begin with programs with a relatively rapid ROI, such as CHF—possibly the easiest one to demonstrate the ROI quickly. Beginning with a fast-track ROI program will also establish trust and confidence in the medical director's ability to cut costs and encourage allocation of resources for programs with slower ROI (eg, diabetes, women's health), or those with difficult-to-manage, asymptomatic, chronic conditions (eg, CAD)—which may take 3 to 5 years to demonstrate ROI. Conversely, beginning with a

slow ROI program is a sure way to limit the chances of instituting future DM programs. Carefully choosing the initial condition may mean the difference between success and failure of this approach.

Other strategies include choosing an initial DM program based on needs identified by the finance department or top management because of high expenditures, or one identified by marketing as a potential marketing tool. If improved clinical outcome can be used for marketing purposes, allocation of resources could come from marketing, not the medical director. Also, instituting a unique DM program will offer marketing a plan-specific tool for attracting buyers, especially self-insured ones.

Finally, using a pharmaceutical company to support a DM program with preferred-drug programs is another possibility, although ethical and legal issues may deem this prohibitive. A creative approach to DM programs can be a good starting point for demonstrating cost-saving ability as well as improving clinical outcomes. Using ROI creatively to influence outcomes may be an effective means of regulating resource allocation and enhancing clinical quality. ■

