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Improving the Quality of Care — Can We Practice What We Preach?

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It has been 30 years since Wennberg and Gittelsohn published their landmark article demonstrating substantial variation among different geographic areas in the provision of medical services.[1] Since then, investigators have found variation in the delivery of virtually every aspect of health care that has been examined. From the perspective of the quality of care, the variation that is the greatest cause for concern is that between actual practice and evidence-based "best practice."

Over the past 30 years, progress has been made in several areas that are vital to quality improvement. Practice guidelines have become more rigorously evidence-based and are now packaged in ways that make it easier to put them into practice. Tremendous progress has been made in the development of valid, reliable, and practical measures of the quality of care[2] that are now applied in managed care[3] and fee-for-service settings.[4] There are many indications of an increased focus on quality, and we have made great progress in our understanding of factors that contribute to substandard quality[2] and of interventions that do (and those that do not) improve the quality of care.[2,5,6]

In this issue of the *Journal*, McGlynn and colleagues[7] report the results of a large national study of the content of care provided to adults between 1996 and 1998. Although the "headline" finding of the study is that adults received 55 percent of recommended care according to 439 process-of-care measures, the most enlightening findings are those in the measure-specific results. The biggest limitation of the study derives from the likelihood that documentation was poor in the charts that were used to determine what care patients had received. Because of this limitation, along with the focus on compliance with multiple recommendations for the management of a given clinical condition rather than on how well the condition was controlled, it would not be appropriate to interpret the findings of this study as showing that a typical adult in the United States has a 50–50 chance of receiving adequate care of a particular clinical condition. Nonetheless, the study adds detailed information to a substantial body of research that shows that the quality of the care delivered in the United States is considerably lower than it should be.[8]

What will it take to do better? Four actions are likely to have the greatest effect. First, quality of care should be measured and reported routinely at both the national and provider-specific (e.g., hospital and physician) levels. In September 2003, the Agency for Healthcare Research and Quality will publish the first annual National Healthcare Quality Report, which will include 150 measures. A separate effort is needed, however, to report on the quality of care delivered by individual facilities and physicians. Such an effort would benefit from the involvement of professional societies in measurement and quality-improvement activities.[9] Both types of activities are consistent with the missions of professional societies. Examples of such leadership, as well as the benefits of it, can be observed in the Dialysis Outcomes Quality Initiative of the National Kidney Foundation,[10] the End-Stage Renal Disease (ESRD) Clinical Performance Measures Project,[11] and the Guidelines Applied in Practice Initiative of the American College of Cardiology.[12]

Problems with the quality of data and statistical challenges will need to be overcome in order to assess quality at the level of the provider,[13] but these problems and challenges are surmountable. Incentives can be put into place for physicians and hospitals to improve the completeness and accuracy of their data. The number of observations available for analysis of a single physician or group of physicians can be increased through the aggregation of data from different health plans and insurers and through the combining of data for different measures of clinical performance.

Second, we must make greater use of information technology. Given the rate at which diagnostic and therapeutic advances are being made, the number of data elements pertinent to the provision of high-quality care, the dispersion of those data elements throughout a highly fragmented delivery system, and the increased number of patients to whom many physicians now provide care, it is ludicrous to expect physicians to comply consistently with hundreds of practice guidelines without the support of a computerized infrastructure. Decision-support tools, including reminders, improve the quality of care.[6,14] I reliably receive reminders when my dog needs a vaccination and when my car is due for maintenance. Physicians and patients should also receive computer-driven reminders.

For financial and practical reasons, during the next decade, we should increase the use of comparatively inexpensive decision-support tools that are applied to data already being collected in computerized form, rather than expect the widespread installation of computerized patient records or incremental data collection. Because decision support is likely to be most effective at the time when decisions are being made, payers should experiment with inexpensive electronic techniques for transmitting relevant information to physicians on the day a patient is to be seen, and hospitals should install computerized ordering systems that are integrated with decision-support tools. Over the longer term, a significant investment needs to be made in an infrastructure for quality improvement. Since Medicare is the payer that will benefit the most financially from quality-improvement efforts focused on chronic disease, it is in the long-term interest of the federal government to invest in the development of information technology and a care-support infrastructure that will facilitate quality improvement.

Third, in addition to capitalizing on the power of computers, we should draw on the power of patients to improve the quality of care they receive and their health outcomes. We cannot achieve meaningful "consumer-driven health care," however, simply by increasing consumers' financial stake in the cost of that care. To engage consumers and empower them to take increased responsibility for their health and health care, we need to provide them with information about the care they should receive and consider receiving. To be effective, that information needs to be authoritative, easily accessible, easy to understand and to act on, timely, and personalized.

The fourth and biggest problem that must be addressed is the fact that current financial incentives often discourage quality improvement.[15] Improved compliance with some of the quality measures used in the study by McGlynn et al.[7] will require investments and increased health care expenditures in the short term, without any compensating cost savings over the long term. Improved compliance with other measures will yield savings that exceed the cost of achieving them, but those savings may not be realized for 5 to 10 years. In a market in which people often change health plans every year or two, health plans lack an economic incentive to invest in quality-improvement initiatives that will require 5 to 10 years to achieve an economic return on investment.[15] Physicians and hospitals often face an outright economic disincentive to invest in infrastructure that will improve compliance with best practices.[15] The challenge, therefore, is not to demonstrate that there already is a "business case" for quality improvement in health care; rather, it is to establish new incentives that will create such a case. Potential strategies for creating this case include tying incremental payment to improved clinical performance or investment in information technology designed to promote quality improvement; providing economic incentives for patients to use providers with profiles of high-quality care; providing grants to health plans and hospitals, and creating tax incentives for physicians, to invest in information technology that will support quality improvement; and reducing malpractice insurance premiums or lowering ceilings on potential claims for providers that use certain types of quality-improvement infrastructures, or both.

Underuse and overuse of care, and errors that occur in the course of providing services that are appropriate, are a predictable result of our current system of care. Thus, although many of the findings reported by McGlynn et al.[7] may cause concern, they are not surprising. We can and should take concert-

ed action to ensure that future studies document substantial improvement.

Dr. Steinberg reports having equity interests in Resolution Health.

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