Evaluating Quality - Redefined Under Health Care Reform

You have to know only one thing to understand health care reform to put together an appropriate plan for your office to prepare. Quality first. That is all. If every time you think about your practice, or anything regarding health care reform, and believe in “Quality first”, you will likely make the correct decisions. However, there is one important caveat: you must think quality first in relation to the patient, not in relation to yourself or any other provider.

Health care reform is about altering the way providers and patients think about quality, shifting a provider-focused system to a patient-focused system. This change is what is commonly referred to as the “transformation” that all health care practices have to undergo in order to prepare for the new emerging health care system. This transformation affects every aspect of every practice in the country, including yours. If you want to see a model organization that is leading this transformation among primary care physicians in medicine, take the time to Google search TransforMed. It is a non-profit organization created in 2006 by the American Academy of Family Physicians and is the leading organization assisting physician offices to prepare for care delivery based on the Medical Home and Coordinated Care models. The core to their approach is to help medical offices look at delivery as a “total patient experience” with quality in every step of the experience defined in relation to the patient.

A common misconception of providers is that it is difficult and/or impossible to accurately assess the quality of care provided in a primary eye care practice. That misconception only occurs if you continue to define quality in relation to the provider. If you understand what quality is defined in relation to the patient, it becomes very easy to assess. We all practiced the majority of our careers in a health care climate where quality was all about the provider. We were all taught to consider “quality” indicators in relation to things that the provider did. What kind of education does he or she have? Are they current on their CE credits? Is the equipment that they use up-to-date and modern? Did the provider do a thorough exam? Was an appropriate plan presented to the patient?

All of these things are important to delivering quality care. No one is questioning that. The problem is that there is one important missing element: the patient! None of these things, which are now being looked at as “assumptions of quality”, consider what happens to the patient. Did the patient get better or not? Is the patient changing his or her lifestyle to promote a healthier life? Did the treatment work and was it the most effective that could have been delivered? Was the care delivered during the exam coordinated with all other aspects of the patient’s health care so the combined messages delivered to the patient are consistent? Is this care being included in the overall health plan for the patient and known to the other providers caring for the patient? Is anything being done to track the outcomes of the patient? Is there an active process in place to constantly improve care, based on the measured outcomes of the patient?

The new concept of quality does not replace or eliminate any of the previous considerations. All of the traditional quality items are important, just as important as they always were. Payers are now recognizing though, that they don’t go far enough. In the new system, everything you did and
considered before, you will need to continue, but now you have a whole new level to meet in order to deliver quality care.

There is one other concept to understand to begin your transformation path. It relates to how you value the care you deliver, compared to how the architects of health care reform value the care you deliver. There seems to be a generalized fear among providers that the emerging health system is somehow going to tell providers how to practice, or control the decisions they make with their patients. It is a “big brother” view that the new system is designed to control providers’ care and diminish their value in the system. Nothing could be further from the truth. If you think that way, you will miss the tremendous opportunity that health care reform is opening to you.

The framers of health care reform recognize that there is a big difference in assessing patient outcomes in acute or episodic care than there is in assessing care in long-term chronic conditions. Acute care outcomes can be directly measured. An example would be if an incision is made this way in the cornea for cataract surgery, does it affect the anterior chamber reaction on the first post-surgical day? Or, does the number of days a patient is symptomatic with episcleritis decrease if a topical steroid is added to the treatment regimen? Those are all easy things to track and analyze directly. So, the approach of the health care reform quality assessment is to directly measure patient outcomes for acute or short-term health conditions.

For chronic care, the approach is completely different. In primary eye care, the vast majority of care delivered falls into the category of long-term chronic care delivery. When providers say that most patient outcomes can only be measured through very long-term, multiple-year studies, the architects of health care would agree. Providers often respond that there are so many variables in long-term studies that many are actually meaningless, especially when studies take several years to complete. Again, the framers of health care reform would completely agree. So, how can quality be assessed for chronic care?

If you make two assumptions, you can then see how to assess chronic-care quality. The first assumption the framers of health care reform make is that you are already making the best decisions possible and that your recommendations are the very best possible for each patient. The second assumption is that you are well informed and keep current on the literature that drives quality of care. If that is true, you are already quite familiar with the overwhelming body of evidence that patients who receive care for chronic conditions through a coordinated care system, where providers share patient health information and coordinate the overall care plan for the patient, consistently get better patient outcomes. If you combine those two assumptions, you arrive at a formula to create chronic care assessment tools. If the first assumption is correct, that what you are recommending to the patient represents the best care possible, then the patient outcome is going to be dependent on how well the patient follows what you have recommended. So, patient compliance becomes the measure to watch. If the second assumption, that you are aware coordinated care delivery improves outcomes, the measures would then look at how engaged you are in delivering coordinated care.
From a payer standpoint, if you want to assess provider quality for chronic care, the answer is simple. Put together analytical tools that look at these two issues. All they have to do is “ask the patient”. Payers don’t have to ask you anything to assess your quality. In fact, you are likely seeing patients every day in your practice who are engaged in assessment activities which are already profiling the care you deliver in relation to the care delivered by other providers. The results of these assessments are being used nationally to formulate regulatory changes to drive patients toward providers who score well on the new definition of quality, and drive patients away from providers who score poorly. They are being used locally to identify providers who will be invited to continue to provide care to patients, as well as to identify providers who don’t score well. This is so patients can be encouraged through a variety of methods to select higher scoring providers.