Strategies to advance health care quality

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Overcoming the quality crisis in American health care is an enormous challenge. Despite a large cadre of individuals committed to improving quality, progress is stifled by the multiple ways in which issues central to quality care are conceptualized. To realize bona fide improvements in care quality, it is essential to understand the dominant conceptualizations driving quality efforts. Steps must then be taken to revise those conceptualizations that are obstacles to advancing health care quality. In this paper, four strategies are proposed for refocusing quality initiatives: (1) Looking at quality from the clinicians' eyes, (2) moving beyond physician care as a synonym for quality, (3) expanding the triple typology used to classify quality, and (4) enriching the evidence base for quality. The paper concludes with a call to action for nurses to exert stronger leadership to advance quality.

Several landmark reports conclude that health care in America is in a quality crisis.[1-4] Important commentaries are surfacing, however, regarding obstacles in the path to achieving better quality.[5,6] Not yet mentioned, however, are concerns about how key features of quality are conceptualized. Unaltered, these conceptualizations serve as additional obstacles to advancing health care quality. In this article, therefore, strategies are considered to refocus conceptualizations of quality: (1) Looking at quality through the clinicians' eyes, (2) moving beyond physician care as a synonym for quality, (3) expanding the triple typology used to classify quality problems, and (4) enriching the evidence base for quality care. Along with mobilizing leadership efforts around these issues, nurses need to decide whether, as a profession, we want to seriously engage in the work of improving health care quality. Presuming we want to be active participants, this article concludes by proposing strategies for the nursing profession to implement as active participants who can influence quality endeavors.

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LOOKING AT QUALITY THROUGH THE CLINICIANS' EYES

There are many stakeholders involved in the provision of quality care—patients, providers, purchasers, payers, policy makers, and researchers—each of whom may have a slightly different view about quality. The definition of quality care illustrates these variations. Researchers, policy makers and accrediting bodies typically define quality care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".[7] From the clinician's view, this definition is often regarded as vague and fuzzy. It fails to convey the essence of quality. A more suitable definition might be one that considers quality "as something that has to do with how well patients are cared for".[8]

The impact of differing stakeholder views is depicted in a national survey of physicians and the public regarding medical errors. Of the 831 participating physicians and 1207 members of the public, 35% and 42% respectively reported errors in their care or the care of a family member. Neither group, however, viewed medical errors as a prominent problem in health care.[9] This finding is in startling contrast to the policy and research initiatives that are targeting medical errors and patient safety to improve quality.

Which stakeholder views should drive quality initiatives is a thorny question. It is also a question that requires frequent revisiting. For the efforts of researchers and policy makers to realize bona fide improvements in quality, views of quality expressed by patients and clinical staff must be taken into account. Otherwise, improvement strategies may clash with patient expectations and experiences. They also may not survive the scrutiny of clinicians in the practice setting who turn ideas into actions as well as interact with patients.

Better aligning quality initiatives with the views of patients and clinicians can accelerate progress in advancing quality. Although a huge literature has amassed regarding patients' views of quality, there is much lesser understanding about quality from the view of those who deliver care. Herein lies an enormous challenge, because patients' views of quality may differ substantially from clinicians' views. For example, in two multi-site studies, important discrepancies were uncovered regarding how nurses, physicians, and pa-

tients viewed quality.[10,11] Nurses tended to undervalue aspects of care that were important to patients, while physicians had a higher view of both unit quality and patient satisfaction than either patients or nurses.[11]

Despite these incongruities, clinicians' views of quality cannot be ignored. The clinical staff is the linchpin for achieving success when implementing quality initiatives in the practice setting. It remains particularly important to consider how even well-intentioned organizational efforts might hinder care delivery rather than help it. Sometimes, for instance, attempts to improve quality actually result in more cumbersome care delivery processes. Regulatory requirements may pull clinicians away from patients to complete voluminous pages of documentation. In such circumstances, improvements in quality may be only cosmetic. The quality reflected in the paper trail may not translate into meaningful improvements for patients. Changes in care delivery intended to improve quality need to be considered from the view of the clinical staff who are at the crux of quality reform.

MOVING BEYOND PHYSICIAN CARE AS A SYNONYM FOR QUALITY CARE

Quality care is more than care delivered by physicians. To date, however, there is a strong tendency to assess quality based on the profession of medicine. It is possible that the word "medicine" is used generically to encompass all health care disciplines. However, indicators suggest quality care is currently conceptualized using a physician focus which leads to impressions of problems that are only partially correct. Moreover, the powerful potential in calls for collaboration and interdisciplinary work is seriously weakened when the boundaries delineating quality are drawn without regard for inclusion of all health care disciplines.

This emphasis on physicians is evident in the important recommendations of the Leapfrog Group. This consortium of corporations is committed to make health care purchase decisions based on principles that promote patient safety. To achieve a giant leap forward in quality, Leapfrog initially targeted three areas for improvement; one of these involved staffing intensive care units (ICUs) with intensivists—that is, physician critical care specialists. This focus on intensivists tends to ignore that care is delivered by a large group of health care personnel in the ICU. Along with examining the collective effects of the full complement of players needed to achieve desirable patient outcome, strategies for improving the quality of care for patients in ICUs would be enhanced if they were coupled with growing evidence regarding the importance of caregiver interactions.[12–16]

The emphasis on physicians as quality gate-keepers is also apparent in a recent report evaluating the quality of health care delivered to adults in 12 metropolitan areas.[17] Through telephone interviews and medical record reviews, preventive care as well as 30 acute and chronic conditions were evaluated using 439 quality indicators. The report claims it examined the quality of health care. However both the quality indicators used and the expert panels that assessed their validity were physician dominated. Health care is more than medical and physician care. Thus, to assess the quality of health care, evaluations need to expand beyond the medical profession.

Nurses are certainly among the many disciplines who deliver health care. The role of nurses in sustaining quality is highlighted by the recent emphasis on patient safety. Quite often nurses intervene proactively, closing gaps in quality before mistakes happen. Nurses, therefore, are the proximal link between patients and quality care. However, if quality care is equated with physician care, then the portrayal of quality will be inaccurate because studies will not be designed to detect the effects of nurses or other health professionals in achieving quality care.[18,19]

EXPANDING THE TRIPLE TYPOLOGY USED TO CLASSIFY QUALITY PROBLEMS

Health care quality problems are frequently classified using a triple typology related to overuse, underuse, and misuse.[1,2,6,20,21] These terms generally refer to the "dose" of care as being too much (eg, prescribing antibiotics when they are not warranted), too little (eg, not prescribing beta-blockers when they are warranted), or incorrect (eg, errors in diagnosis and/or treatment) respectively. This typology focuses on treatments and the technical aspects of care.

If the purpose of the typology is to reflect problems arising from poor quality, then it needs to be expanded to better reflect the universe of quality problems. This strategy is consistent with previous warnings that this typology is too narrow to represent the universe of health care quality problems.[1] For instance, Donabedian[22] considered interpersonal performance as the vehicle for achieving technical success. Similarly, assessing only technical aspects of care and complications misses the importance of patient-centered care to improve quality.[2,23–26]

Structural measures are needed in the typology. Some evaluations claim structural measures do not contribute meaningfully to differences in outcomes and quality.[20–22,27–30] It is possible, however, that past studies used weak structural indicators in their analysis. Nurse staffing and workplace issues represent two clusters of more robust structural measures that can be linked to quality.

The importance of nurse staffing as a component of quality is illustrated by its high priority in funding agencies such as the Agency for Healthcare Quality and Research (AHRQ) and accrediting agencies such as the Joint Commission on the Accreditation of Healthcare

Organizations (JCAHO). The focus on nurse staffing is driven by a view that nurse staffing has a direct impact on quality and safe care. Although findings are mixed, evidence reports conclude nurse staffing is linked to quality care.[31,32] The strength of the associations depends on the unit of analysis, which outcomes are examined, and which patient populations are studied.

Likewise, the effects of the workplace on health care quality are gaining attention.[33–36] "Health care workers' ability to execute the processes of care that will produce desired outcomes is either constrained or enabled by features of the system in which care is delivered".[36] Yet, the aspects of the workplace that most influence quality remain to be solidified. Possible features include unit size,[37] physical layout and work flow,[31,38] leadership,[35,39] caregiver interactions,[12–16] and attributes of Magnet hospitals.[34,40–43] Workplace factors, nevertheless, warrant inclusion in the typology.

ENRICHING THE EVIDENCE BASE FOR QUALITY CARE

Proponents of the quality movement correctly call for using knowledge as the foundation for practice as well as the basis for establishing sound environments of care. It is therefore disappointing to realize that scientific evidence has had only a modest impact on molding care delivery practices.[2,4] It is also disappointing to realize there are gaps in evidence that ". . .undermine efforts to improve the scientific basis of health care decisions. . .".[44] These gaps derive from a variety of sources including what constitutes evidence and the data infrastructure.

Certain rules governing the acceptability of evidence may be restrictive. The best evidence is often determined by applying evidence hierarchies that give preference to randomized controlled trials (RCTs). The consequences of favoring RCTs play out in systematic reviews where the quality of evidence is consistently found to be suboptimal.[44] More importantly, not all questions about quality care lend themselves to RCTs. External relevance—practical implications, the context of clinical practice, utility in decision making, and patient issues—is just as important as internal validity.[44–46] The best evidence in support of quality care will give equal value to clinical research, effectiveness studies, health services research, and outcomes studies.

Additionally, to develop and maintain an informed view of quality, efforts to synthesize existing knowledge need to include all relevant evidence. To illustrate this point, consider a review of the quality of health care that was first published in 1998,[20] and updated for inclusion in a highly influential Institute of Medicine (IOM) report.[21] The authors used the underuse, overuse, misuse typology as their framework, without considering its limitations. The search parameters further constrained the pool of acceptable evidence. For example, single site studies were omitted as were reports using structural measures such as staffing. As a consequence, the resulting evidence represented only a slice of the total evidence regarding health care quality.

The absence of a solid data infrastructure also limits available evidence and thus can compromise knowledge about quality. At present, because administrative and financial data are readily available, they dominate quality assessments. Yet, clinical measures remain limited and data about nurses and nursing practice are even more sparse. Although the need for a nursing data infrastructure was first addressed more than 10 years ago,[47] data central to the practice of nursing remain largely absent. These deficits in available data create a conundrum for administrators and clinicians who are accountable for patient care. It is impossible to practice from an evidence base when salient data are unavailable to inform decision making.

To correct quality problems, a serious commitment is needed to develop an appropriate data infrastructure. There is a compelling need to determine which indicators best relate to, or better yet, predict variations in quality and patient safety. It would also be beneficial to consider how meaningful the indicators are across disciplines. Falls, for example, simply do not garner the same level of interest as mortality. Additionally, strong emphasis must be placed on designing the next generation of quality indicators. Ideally, this would serve to broaden and refine the quality paradigm for all disciplines with patients as the prime benefactors. Furthermore, because adverse events seem to be unrelated to how patients view quality care,[48] there is considerable merit to including the patients' view of quality among the indicators. And as a companion to the data, there is a need to institute standardized methods for risk adjustment to facilitate the accurate interpretation of findings about quality.

On a broader scale, both an infusion of money and a mandate from policy makers are needed to institutionalize databases that capture appropriately identified data elements that will inform quality care initiatives. This requires engaging individuals outside nursing to garner support for such a massive undertaking. A suggested interim measure is to enhance data collection by national entities, such as the American Hospital Association and the Centers for Medicare and Medicaid Services. For instance, staffing data need to reflect the various types of nursing personnel (Registered Nurses, Licensed Practical Nurses, Nursing Assistants), the settings where staff work (eg, inpatient, outpatient), the type patient care unit to which they are assigned (eg, medical, surgical), and whether they are full-time, part-time, or agency staff.[49]

NURSING LEADERSHIP FOR QUALITY: A CALL TO ACTION

Nurses are recognized as the backbone of the health industry[50] and the glue that holds hospitals together.[51]

Nevertheless, nurses and nursing remain conspicuously absent from influential quality initiatives. As a first step in changing this situation, nurses need to decide whether, as a profession, we want to seriously engage in the work of improving health care quality in America. If the answer is no, then we need to accept the status quo and cease voicing our concerns. If the answer is yes, then we must exert leadership by designing and initiating a focused strategy to influence the field of quality.

Commitment is the first element required for nurses to be strong players in health care quality. Quality is a concept around which all members of the profession can mobilize. It covers all specialties and all delivery settings. As a profession, however, we tend to be very diverse in our interests. To achieve success in creating a nursing presence in quality circles, it is imperative that we optimize the strength that comes from solidarity. A united stance regarding quality care needs to be constructed that covers professional nursing organizations, schools and universities, as well as clinical settings. Then, alliances need to be built with key players outside of nursing.

Improving communication is a second essential ingredient because language is a problem. To nurses, for example, interdisciplinary refers to the entire array of professions involved with care delivery—physicians, nurses, physical therapists and nutritionists to name only a few. To some physicians, interdisciplinary means the collection of medical specialties—radiologists, pathologists, internists, and surgeons—nothing more. However, capturing the attention of individuals outside nursing goes beyond differences in terminology. We need to conduct a thoughtful assessment of why nursing messages tend to remain unheard. Colleagues from other disciplines as well as communication experts can offer assistance in helping us identify which communication techniques are most effective for which audiences. We need to carefully construct a message that better resonates beyond nursing.

A final element is the need for a carefully crafted, focused agenda to guide a well-defined, proactive, profession-driven approach to quality. This agenda would be used by researchers, educators, clinicians and professional nursing organizations. Of the many possible agenda items, three are addressed here to get the discussion underway.

First, a coalition needs to be appointed to speak for the profession when high impact initiatives are being developed. Individuals simply do not have the same influence as a group speaking on behalf of the 2.2 million Registered Nurses (RNs). For example, the National Healthcare Quality Report[27] is moving forward with little nursing input. Nurses can not afford to allow this in the future. There are two emerging initiatives that demand nursing's attention. One concerns establishing a single level of quality for all Americans.[52] At present, quality covers a broad spectrum and there is no composite measure. An appointed coalition of nurses needs to influence the product of this endeavor. Likewise, nurses need to actively engage in the efforts to create a National Outcomes Database,[53] an idea for which there is already considerable momentum.

A second agenda item would have nurses taking the lead to move examinations of quality beyond acute care settings. Staffing and care processes are very different in long-term care, home care, and outpatient care. As the population ages and care continues to shift to these settings, it would be advisable to garner public support for advancing the understanding of quality across all aspects of the care continuum.

Addressing questions about staffing is potentially a third agenda item. This would require an ambitious and complicated effort given the numerous care settings as well as the variety of health care personnel involved. However there is an urgent need to determine the optimal skill mix of nursing personnel to achieve cost effective quality care. Concurrently, the balance of nursing personnel to other health care staff remains to be established.

CONCLUSION

Bold strategies are needed to initiate the sweeping changes necessary to radically reform the quality of care in America. These strategies will meet with only modest success unless the conceptualizations underpinning current quality initiatives are identified and changed. Clinicians' views about quality need to become more dominant because their actions determine whether quality is really improving. The physician-oriented assessments of quality need to be replaced by genuine collaborative efforts derived from the united expertise of the many health care disciplines. The typology used to reflect quality needs to expand to capture the array of issues that contribute to quality problems. Otherwise, unidentified quality problems will stifle attempts to advance quality. The evidence base for quality will be richest when it is derived from the full complement of research strategies, and when it evolves from a more complete data infrastructure. Finally, as a profession we must decide whether we want to seriously engage in the work of improving health care quality in America. If we do, then nurses must initiate leadership strategies to influence quality initiatives.

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