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Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: Dennis S. O'Leary (1990) Improving Quality of Care in an Era of Cost Constraints, Oncology Issues, 5:3, 8-9, DOI: 10.1080/10463356.1990.11904840

To link to this article: https://doi.org/10.1080/10463356.1990.11904840

Published online: 19 Oct 2017.

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IMPROVING QUALITY OF CARE IN AN ERA OF COST CONSTRAINTS

Dennis S. O'Leary, M.D.

This article examines how the focus is shifting from negatively-oriented Quality Assurance models, which have tended to focus on identifying problems, to Continuous Quality Improvement, which stresses the need for organizationwide involvement in the monitoring and improvement of the quality of health care.

The health care environment today is characterized by growing tensions between cost and quality. As purchasers of care, including government, worry about the steady escalation of health care costs, pointed questions are being asked about the value of the services being provided to patients. Thus, providers of care are increasingly finding themselves accountable for measuring quality of care and for demonstrating that they are indeed providing value for the health care dollar.

This is a new and challenging environment for hospitals, physicians, and other health care providers. Although the dimensions of quality can be defined (e.g., appropriateness of care and effectiveness of care), measurement tools are still in their infancy. Further, practitioners and other health care organization staff have little experience in interpreting performance data and using those data to improve their services. Nevertheless, progressive application of these evolving new tools and skills offers major opportunities both to improve quality and to contain costs.

The transition facing the health care field also requires attention to the conceptual framework within which quality of care is reviewed. In the late 1970s, the Joint Commission introduced a new model of quality assurance (QA). While that model has clearly proven its worth, it is now, quite appropriately, being overtaken by a more encompassing model of continuous quality improvement (CQI). Understanding the similarities and differences between QA and CQI is important to all who face the cost versus quality challenge.

In simple terms, CQI is built from the foundation of the positive aspects of QA, but it seeks to redirect the focus of organizational attention on quality of care issues. Both QA and CQI inherently require health care organizations to pay attention to what they are doing, but the terms convey different meanings.

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In retrospect, the word "assurance" was an unfortunate semantic selection. Quality, of course, could never be assured. Rather, it could, at best, only be improved. Over time, QA subtly became incorporated into the broader tide of unrealistic public expectations that often were reflected in external review processes, including that of the Joint Commission. Meanwhile, the emphasis of QA on identifying "problems" and "outliers" took its toll inside organizations. Not surprisingly, it was (and is) difficult for a negatively-oriented process to capture the support and imagination of health care professionals.

CQI originates from a different philosophy and a different set of assumptions. First, and foremost, it acknowledges the humanity and complexity of health care organizations. Although individual competence and performance remain important, good patient care and acceptable (or better) outcomes are viewed as the product of all individual actions and interactions that relate directly or indirectly to the care received by the patient. Performance is thus a reflection of a variety of internal organizational systems and subsystems that underlie essential day-to-day functions. Human error may occur within these often complex systems, but remedial actions are usually most appropriately directed to the system, not to the human.

Patient care systems, particularly because of their high degree of human dependency, can always be improved. This basic tenet of CQI suggests that the emphasis of monitoring and evaluation activities should progressively shift from individual "outlier" identification to ongoing assessment of the composite performance of key functions. Thus, attention becomes focused on improving the performance "norm," rather than dealing reactively with the symptoms of system failures. Hence, the recast axiom, "If it ain't broke, it can still be improved."

The intricacies and scope of activities that are necessary to support good patient care within an organization are impressive. The ostensibly simple process of ordering, preparing, and administering a drug for a patient is not simple at all, as attested by the substantial volume of medication errors, as well as the number of inappropriate medications administered in a typical hospital every week. Most of these errors are not life-threatening, but a few are. Similarly, the timely and careful admission and transfer of a critically-ill patient from the emergency unit to an operating room or a special care unit seems superficially straightforward—until something goes wrong. Despite the implied objective of QA, those who labor on the front lines know that perfection is not an attainable goal. By the same token, however, opportunities for improvement abound.

In a CQI context, certain truisms for health care organizations begin to emerge:

- While the direct care provided by physicians, nurses, and other clinicians are undeniably important, effective governance, management, and support services are equally important to the provision of good care. This perspective does not diminish the role of the practitioner; rather it emphasizes the pervasive responsibilities of all individuals throughout the organization.
- Opportunities for improvement can be identified only through effective performance monitoring. Drawing upon existing QA principles, this requires the prudent selection and application of good performance measures or indicators.
- Performance monitoring should be widely applied across the organization. Systems do not run themselves; they are managed. Good performance measures have the ability to address issues that cross internal boundaries. The care delivered to the patient is the end-product of how well individuals, departments, and management work together to do their jobs well.

The review and analysis of performance data should be a collective responsibility of those involved in the function that is being monitored. In the eyes of patients, the care provided by physicians, nurses, support services, and others are not discrete activities. Patients might reasonably expect that those who worked together in providing their care would also work together in reviewing that care. Issues arising from this initial process may lead to separate peer review activities.

Quality Assurance has come to be viewed as a "blame-fixing" activity. Continuous Quality Improvement represents the antithesis of this approach

Whether fairly portrayed or not, QA has come to be viewed as a "blame-fixing" activity. CQI represents the antithesis of this approach. QA has also tended to become a compartmentalized activity. Often it has been a segregated program in the organization, a set of specified requirements for individual departments, or, conceptually, a means of figuring out and providing "what they want" (they often being the Joint Commission). CQI, on the other hand, is an organizationwide way of life. The underlying philosophy of CQI is fundamentally helpful to, and good for, both the organization and the patients that organization serves. And CQI supports the organization in meeting its external accountabilities.

CQI has been portrayed as a management style, but it is more properly viewed as a management support. The challenge to health care organization leaders is to capture the attention and imagination of their staffs. CQI works best when everyone is involved and committed to the same goals. This end can be achieved in different ways, but it is an end that each organization should expect for itself. Just as clearly, it is an end that will be expected by others. ■

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This article is adapted from an article in the March-April, 1990, issue of Perspectives.

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