Chapter 23

Entering the Health Care Crossroads

By Michael Dowling

Unlike any time in the history of the nation’s health care system, we are at a crossroad that will likely determine the future of how we provide medical care and improve the health status of Americans for decades to come. With political winds swirling around us, we are crossing the threshold of the status quo into a new era of health care delivery that will require courage, agility, and focus. For the heads of health care organizations, it is an exhilarating time, especially for those who:

• Want to lead, not just follow;
• Believe in change and transformation;
• Believe in carefully managing the present but selectively forgetting the past, and who are not preservers of tradition;
• Believe in creating a new future, not because we are mandated to but because we know it is the right thing to do;
• Understand that the current trajectory of health care usage and spending is unsustainable; and
• Are optimistic and positive.

Negativity does not inspire confidence, yet it is the prevailing attitude at far too many national and state meetings of health care leaders. There’s an ancient proverb that reads: “Just when the caterpillar thought the world was over, it became a butterfly.” Leaders recognize reality, take risks, inspire, and see a greatly improved future built around the needs and desires of the customer and the patient.

Celebrate Progress

Despite misgivings about the rate and pace of changes in health care delivery, as well as the quality and safety of the services we deliver, we should recognize the
enormous progress we have made. We have built significant momentum and a sturdy foundation on which to expand our efforts. Right now, our nation’s health care system and consumers are benefitting from:

- Greater acceptance of performance measurement, transparency, and public reporting;
- Improved oversight and regulatory processes instituted by government agencies to monitor and evaluate quality;
- General acceptance that the traditional fee-for-service payment system, in many instances, impedes the quality movement and the introduction of new, innovative payment methodologies; and
- Ongoing restructuring, consolidation, and integration by many hospitals and health systems, making them more viable financially, improving quality outcomes, and enabling them to lead in this new health care environment.

Many good things are happening. Leading organizations have demonstrated sustained improvements. It is almost universally accepted that the delivery of health care must move in a new direction.

**Figure 1. A view of the changing landscape**

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<tr>
<td>Provider Centric</td>
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<td>Value Blind Reimbursement</td>
<td>Value-based Reimbursement &amp; Accountability</td>
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The trends outlined in Figure 1 are at the core of current policy and legislation, including the federal health reform law—the Patient Protection and Affordable Care Act. They are not totally new or recent—in fact, they have been discussed in policy circles for more than a decade. The good news is that, finally, they are getting universal acceptance and better traction.

**The Journey Ahead**

Legendary football coach Vince Lombardi once said, “Perfection is not attainable, but if we chase perfection we can catch excellence.” The pursuit of excellence in health care has a multiplicity of components, many of which have been adequately discussed in previous chapters. However, we need to focus on, and continue the progress we have made in a number of key areas.

My perspective is shaped by my role as the president and CEO of one of the largest health systems in the U.S. and by my ongoing communications with middle managers, clinicians, nurses, and front-line staff. My views are also guided by my previous role in the New York State government as a policymaker and regulator. Outlined below are several underlying issues that we must address:

**Quality Metrics: The Need to Focus**

Because of the increased attention dedicated to the quality agenda, an entire subset of health care-related businesses have cropped up over the past decade to rate and compare hospitals, nursing homes, and other health care providers. Companies such as HealthGrades, Hospital Compare, *U.S. News and World Report*, Press Ganey, J.D. Power & Associates, National Research Corporation, and numerous others produce their own versions of hospital report cards and develop their own set of quality measures and oversight procedures. Often, hospitals must enter into marketing agreements with the companies performing these quality assessments in order to promote positive findings.

The lack of an objective source, and the disparities in findings, are confusing to consumers and frustrating for providers. Who should you believe? It is like a soccer game with a dozen referees, each using different rules to officiate the game. As Margaret O’Kane, President of the National Committee for Quality Assurance, once said, “The quality community has become a quality problem in its own right. Confusion is an impediment to progress. As the environment gets more confusing, we’re in danger of providers throwing up their hands in frustration.” (Figure 2, page 382)

If this is confusing for leaders in the field, imagine the impact on middle management, physicians, and front-line staff. The existence of so many different quality measures can easily lead to distraction, frustration, and “metric fatigue.” There is an obvious lack of clarity and standardization. What’s needed is a national consensus on a smaller, more manageable number of quality metrics that all parties believe are at the core of good patient care. While the National Quality Forum, the Institute of Medicine and the Centers for Medicare and Medicaid Services, and others have made some progress in developing unified standards on which all providers can be evaluated, much more needs to be done.
Despite the confusion and pressure to adhere to quality indicators developed by self-proclaimed quality consultants, every hospital and health system needs to stay focused on its own internal pursuit of clinical excellence. My advice is to prioritize by choosing a small number of key impactful areas that drive overall improvement. For our organization, we have chosen mortality, sepsis, and patient readmissions. This focus needs to be ongoing rather than a project of the month. All staff, especially those at the front lines, must be able to understand and describe the organization’s quality agenda and relate it to their own work and how they contribute each day. Such focus requires the setting of strategic priorities; the realignment of organization structures; and investments in education, training, and skill development.

**Creating a Learning Environment**

To advance an organization’s strategic and business goals, its leadership must foster growth and continuous learning among employees. Achieving that goal among health care providers requires investments in the workforce that will help transform the organization to meet the demands of the new health care environment. Organizations don’t change; people do. Making change happen and breaking down barriers to change requires system-wide commitment, from the corporate suite to the front-line staff, including physicians.
The objective is to build a “learning organization”—the creation of a workforce culture that is grounded in the desire to continually strive to do things better as part of an ongoing pursuit of excellence.

To make it happen, the commitment must be significant and ongoing. Otherwise, meaningful changes and cultural transformations will be unsuccessful. In our organization (North Shore-Long Jewish [North Shore-LIJ]), for example, we established a corporate university called the Center for Learning and Innovation in 2002. Now headquartered in a 45,000-square-foot facility in Lake Success, NY, the Center’s goals are to:

• Build a first-class organization of continuous learning.
• Build among employees the knowledge, attitude and skills necessary to support a reform agenda.
• Develop a cadre of leaders throughout the organization.
• Create and promote a culture that is consumer- and patient-centric and dedicated to excellence, teamwork, and continuous change.

Among the steps North Shore-LIJ has taken to achieve those goals are to incorporate courses on “fast-track” decision-making for solving organizational problems, “change acceleration” processes for breaking down barriers to change, and Six-Sigma and LEAN management processes for identifying and correcting errors in existing processes. By integrating these practices in our hospitals and facilities, we’ve been able to make measurable strides in driving quality, increasing efficiency and improving the environment for both patients and employees.

One of the centerpieces of our corporate university is a Patient Safety Institute that features sophisticated patient simulators with computer-based technology. Faculty in control rooms with one-way mirrors manipulate the patient simulators to mimic diverse medical scenarios found in all areas of health care. The simulation center is a resource for professionals at all clinical levels, and clinical teams from throughout our health system have regularly scheduled sessions. We built it on the premise that there must be a zero-tolerance policy toward medical errors and infections.

**Physician Education**

Improving quality and care delivery requires rethinking of how physicians are trained. For some time, there was much discussion on the need to reform medical education, but little changed. Most medical schools developed their curricula on principles and practices dating back to the 1890s. For much of the 20th century, medical education outside the classroom involved students accompanying an academic professor in a hospital, where the doctor would analyze, diagnose, and treat patients for however long it took before they were well enough to go home or they died.
Today, a patient’s care typically is delivered by a team of clinicians that includes multiple doctors, nurses, social workers, and specialists. Unlike years ago, the vast majority of care is delivered in outpatient settings; if patients do require hospitalization, they’re usually there for days rather than weeks.

However, old systems and processes still persist, creating a chasm between what is done and what is required. Excessive specialization, autonomy, and memorization must give way to medical training in which the focus is on teamwork and collaboration. Given the amount of knowledge available as a result of scientific and technological advancement, physicians cannot be the only source of all patient health information. If our true goal is to deliver excellent care, it’s imperative for medical students to work with nurses and other patient caregivers—in essence, learning in a collaborative, interdisciplinary team environment.

Students admitted to the Hofstra North Shore-LIJ School of Medicine’s first class, in August 2011, are immersed in patient care from the beginning to help them develop an early medical skill set. In lieu of the traditional approach (i.e., one which separates the science from the practice of medicine by keeping students primarily in classes for the first two years and primarily in clinical settings for last two years) our curriculum integrates the clinical and the scientific. Within one month of their arrival, students are trained and certified as emergency medical technicians, and begin working on ambulances, and treating patients in their homes, communities, and medical facilities. By learning first to be EMTs and practicing emergency care from the start of their studies, students are exposed to patients in crisis situations as members of emergency-response teams—working not only with doctors and nurses, but also with police, firefighters, social workers, and other first responders. This reinforces the fact that the best medicine is practiced by caregivers working as a team, not individually. Also, by interacting with patients and their family members early in their education, students develop greater sensitivity and appreciation of patients as real people, with strong emotional and cultural ties to their families and communities.

Partnering with Patients/Consumers

A core value of the Patient-Centered Medical Home (PCMH) is its focus on engaging patients and families in the care process. This is also the subject of a wonderful new book entitled Your Medical Mind by Drs. Jerome Groopman and Pamela Hartzband. Discussions around patient engagement have been going on for decades, but health care organizations have not modified their operational or clinical processes, or changed their structures, to make it happen. Engaging patients and their families in the delivery of care is now a central task in the transformed health care landscape. It requires fundamental change in the historic roles of both patient and provider, and in the cultural mindset of the health care industry. Done properly, patient engagement improves the process of care and quality outcomes, has the potential to reduce cost, and promotes wellness and disease self-management. There are successful examples both here and abroad that attest to the benefits. The task is to create the environment in which such a partnership is allowed to blossom.
At the 2011 Institute for Healthcare Improvement (IHI) Annual Meeting, I met a young Swedish nurse. He shared his story of gaining greater autonomy with his kidney dialysis and paving the way for a change in Swedish hospital policy so other patients could follow his lead and receive their dialysis at home. He spoke about how leaders can remove barriers and create cultures in which patient engagement is not just possible but encouraged. Getting providers closely involved enables patients and families to learn how their behaviors affect their health.

**Metrics: From Medical Care to Health**

One of the overarching strategic imperatives of health reform is to change our primary focus from treating people who are already sick to preventing them from getting sick in the first place by promoting wellness and a healthy lifestyle. In other words, we’re shifting from a medical care delivery system to a health promotion system. Most agree that this is necessary and desirable, but it requires a new focus and the adoption of a different set of skills and relationships by hospitals and medical care delivery systems, as well as new forms of reimbursement.

Because medical conditions are primarily determined by environmental factors, lifelong behaviors, and lifestyle choices, this “new” focus is critical if we are to improve the health of individuals. Getting the “best” medical care will not, in and of itself, improve an individual’s overall health status, a fact recognized with the formation of the Community Health Center movement in the 1960s. A broad, holistic vision of health, this movement was based on the theory that social, environmental, and economic conditions need to be integrated with medical care.

The focus had been on illness metrics, such as rates of hospital-acquired infections and patient readmissions. This new view raised fundamental issues: How do we measure “health?” What are the metrics and who should be held responsible? If population health is a new domain, we need to develop the measures. How do we know if we’re successful? What is the responsibility of individuals? What is health quality? It is not sufficient to say we are reducing readmissions. After finally reaching a general degree of consensus on hospital-based or illness metrics, we now need the same for community and public health.

**The Challenge of Information Management**

The worlds of health care and information technology (IT) are coming together at a warp speed to create an aligned, integrated galaxy unlike any other in the universe of high-tech businesses. For decades, health care has evolved to feature enhanced technology equaled by few other industries—just observe all the advanced diagnostic equipment, robotic surgical devices, and countless other gadgets used by hospitals and physicians. Technology has advanced our ability to do wondrous things in the treatment of patients and the curing of disease. Yet, health care has lagged behind other industries in the technology that manages knowledge, communication, and information.
That’s changing now with the advent of sophisticated electronic health record capabilities. The reasons are obvious: the collective goals of enhancing quality, managing patient care, monitoring and influencing population health, and reducing cost growth are unachievable if information cannot be shared, tracked, and used.

While the benefits are well-documented, the implementation is not easy. Bringing the worlds of IT and health care delivery together is much more than a technical challenge—it requires major cultural change, ongoing training, and structural transformation. But there is a bigger potential problem—data overload. In other words, how do we understand and make intelligent use of all the data at our disposal?

The analytical resources necessary to decipher such growing supplies of data are enormous and costly. Many health care organizations simply do not have the financial wherewithal to manage such a Herculean IT challenge. It is becoming increasingly clear that our ability to collect data is surpassing our ability to absorb and understand the data. Just as we have become overwhelmed in trying to review and respond to all of the paperwork, emails, text messages, phone calls, voicemails, and other communication that preoccupy our personal lives, we are being drowned in the seemingly endless volume of data that gives us the capacity to deliver the highest level of care to our patients. Organizations need to develop the analytical capacity to evaluate and convert all of these data into information that can be understood and used by the practitioners who are diagnosing and treating patients.

**Conclusion**

The drivers of health care transformation in what promises to be an exciting decade ahead must come from the provider community—the administrators, physicians, nurses and others who understand the uniqueness of health care delivery and its potential better than any distant policy maker. It’s their obligation and responsibility to identify and implement solutions. The alternative is a bureaucratically driven and micro-managed scenario that will, over time, stifle innovation and creativity.

My experience working in the regulatory, policymaking, insurance, and provider worlds has provided me with a unique perspective on the issues facing health care. After 16 years on the provider side, I clearly understand the degree of caring, compassion, and professionalism that exists among the thousands of caregivers with whom I regularly interact. It’s a reservoir of talent, and, as leaders, it’s imperative that we tap into it and let it flow throughout our respective organizations.
Nursing Credentialing — Raising the Bar on Clinical Excellence

By Karen Drenkard, PhD, RN, NEA-BC, FAAN

“Credentialing is a mode of self-regulation in which interests of the professions, industries, academia, or other fields of endeavor band together to establish quality and performance standards for their own constituencies and to measure performance against those standards for the betterment of society.”

As a form of self-regulation in a discipline, credentialing offers a means for a profession to set standards for both individuals and organizations and to measure the qualifications, knowledge, skills, and outcomes that indicate excellence. Credentialing is a complicated arena with many laws and requirements of its own. The combination of regulatory requirements and voluntary credentialing services can work together to protect the public and ensure competence of individual practitioners and organizations. In addition, voluntary credentialing can raise the bar on practice by setting standards for excellence. As individuals and organizations work to meet these high standards of practice, patient care and outcomes can improve.

There are several types of credentialing, including licensure, registration, accreditation, certification, recognition, approval, and endorsement.

- **Licensure** is a process by which an agency of a state government grants permission to individuals accountable for the practice of a profession to engage in the practice of that profession and prohibits all others from legally doing so. It permits use of a particular title, and its purpose is to protect the public by ensuring a minimum level of professional competence.

- **Accreditation** is the process by which a voluntary, non-governmental agency or organization appraises and grants accredited status to institutions and/or programs or services that meet predetermined structure, process, and outcome criteria.
• **Certification** is a process by which a non-governmental agency or association certifies that an individual has met certain predetermined standards specified by that profession for specialty practice. Its purpose is to assure various publics that an individual has mastered a body of knowledge and acquired skills in a particular specialty.

• **Recognition** is formal acknowledgement that a program, institution, or service has met a set of criteria promulgated by an official agency.

• **Approval** is a process by which a school and/or a program has met the prescribed minimum standards set by the appropriate regulatory body.

• **Endorsement** is an expression of support or approval by an authority in the field of a product, program, or service. Credentialing serves to protect the health, safety or welfare of the public by establishing standards for professional knowledge, skills, and practice and assuring consumers that professionals have met standards of practice.

Benefits of credentialing include meeting the requirements of governmental regulators, advancing the profession, providing a sense of pride and professional accomplishment, and demonstrating commitment to a profession and to life-long learning. Maintaining the credential of a professional certification requires renewal by continuing education, examination, and self-assessment. The nursing profession includes parallel and overlapping systems of both voluntary and mandatory credentialing. In the U.S., there are two types of credentialing—one at the individual level and one at the organizational level. Individual credentialing includes certification of providers, such as nurse practitioners and specialty nurses. Organizational credentialing accredits organizations—for example, educational institutions or health care organizations such as hospitals, long-term care facilities, and other care centers.

**Individual credentialing**

Within the profession of nursing, individuals receive credentials at the advanced practice and specialty level through examination that validates nurses’ skills, knowledge, and abilities. At the American Nurses Credentialing Center (ANCC), a commission of experts and nurse peers constitutes the Commission on Certification. This commission oversees examination eligibility requirements and test parameters that ensure legally defensible and psychometrically sound examinations. Nurses who are deemed eligible may sit for an exam and, upon passing, are conferred the credentials “board certified.” At many certifying agencies, such as ANCC, the process, structure, and content of exams are also accredited by external credentialing organizations. The Accreditation Board for Specialty Nursing Certification (ABSNC) is the only accrediting body specifically for nursing certification. ABSNC accreditation is a peer-review mechanism that allows nursing certification organizations to obtain accreditation by demonstrating compliance with the highest quality standards available in the industry. In addition, certification exams and programs can be credentialied by the National Commission for Certifying Agencies (NCCA). The NCCA helps to ensure the health, welfare, and
safety of the public through the accreditation of a variety of individual certification programs that assess professional competency. In this way the certification exams being offered are also externally reviewed for high quality and compliance to external standards. NCCA credentials certification exams in any field and is not specific to health care.

**Trends in individual credentialing:**

In the 1990s, it became clear that the definitions and the coordination between licensure, accreditation of curriculum programs for schools of nursing, and certification eligibility requirements were not aligned. An alliance of over 40 nursing organizations worked collaboratively to represent the stakeholders of licensure, accreditation, certification and education in creating a Consensus Model for APRN Regulation. This transformative model will provide needed uniformity for the advanced practice registered nurse (APRN) profession. The consensus model was designed to align the inter-relationships among licensure, accreditation, certification, and education to create a more uniform practice across the country. The resulting consistency and clarity will take advanced practice nursing to the next level, benefiting individual nurses and enhancing patient care. Full implementation of the consensus model, anticipated in 2015, will require coordination between the involved stakeholders. Key changes include clear alignment of advanced practice nurses into four roles: nurse anesthetist, nurse midwives, nurse practitioners, and clinical nurse specialists. Once roles are determined, populations of study will be aligned, including neonatal, pediatric, adult-gerontology, women’s health/ gender-related, family/individual across the lifespan, and psychiatric mental health. Further specification of knowledge would occur at the specialty level (e.g., areas such as oncology, palliative care, and forensics) and would include a focus of practice beyond the role and population linked to the health care needs of individuals.

As a result of the consensus model, changes are happening across regulatory arenas to protect licensure for advanced practice RNs as well as aligning certification exams with educational requirements for these roles and populations. This model will align the interlocking pieces of educational preparation and licensure and certification across the nation, allowing advanced practice nurses to have mobility in their practice and for the public to have assurance that competent, qualified advanced practice nurses are caring for them.

**Organizational credentialing**

Certifying agencies have the capability to credential health care organizations. While there are credentialing programs that recognize subsets of whole organizations (e.g., the Beacon Program that recognizes critical care units), perhaps the best known organizational credentials in health care are The Joint Commission accreditation and certification programs and the Magnet Recognition Designation program.
As described in previous chapters, The Joint Commission, an independent, not-for-profit organization, accredits and certifies more than 19,000 health care organizations and programs in the U.S. Joint Commission accreditation and certification reflects an organization’s commitment to meeting certain performance standards. The accreditation of hospitals and health care organizations by the Joint Commission is also recognized as having met the CMS Standards of Participation by the federal government.

The Magnet Recognition Program, an organizational credentialing program managed by the ANCC and the Commission on Magnet, requires organizations to demonstrate excellence in nursing care and provide written evidence of meeting standards (called sources of evidence) for structures, processes and outcomes of patient satisfaction, nurse satisfaction, and clinical outcome measures of patient care. A rigorous process of review includes a multi-day site visit of the organization to validate, clarify, and amplify the results of the written study. At present, there are almost 400 Magnet®-designated hospitals around the world. The designation period is four years, with requirements for interim monitoring and reports. Nearly 98 percent of all magnet-designated organizations work to become re-designated, and several magnet organizations have been re-designated four times, demonstrating their commitment to excellence in nursing and patient care. A growing body of evidence also has linked Magnet designation with improved clinical outcomes. The original and ongoing research represents the implementation of evidence-based practice in nursing services and hospital administration. Another organizational credential that is growing in importance is the Pathway to Excellence™ designation. This credential recognizes 12 practice standards of a positive practice environment at the organization level.

**Issues and trends in organizational credentialing**

One of the key areas for future consideration is a growing need for research that links standards for credentialing to improvement in patient outcomes. This relatively new field is growing swiftly, and the ANCC is leading the way by exploring the research questions and providing guidance for methods and analysis. With most credentialing, whether individual or organizational, the designation is voluntary. It is a major challenge to compare credentialed versus non-credentialed variables, because many non-credentialed organizations and individuals share the same characteristics but chose not to go through the credentialing process. Rigorous research methods, sound design, and large enough sample sizes are required to ensure the growth of a scholarly evidence base regarding the merits of credentialing and its link to outcomes of care.

Another area of exploration is the link between credentialing and competency. Does certifying an individual ensure competence? Is there an improvement in patient outcomes? For organizations being credentialed, both for education and practice, does the credential link to improved systems of care that produce competent health care providers and result in improved patient outcomes? For example, individual activity outcomes are evaluated in continuing education for nurses, but
few linkages have been made between the educational activity and the outcomes of patient care. The linkage to patient care outcomes is clearly the direction of the future. In terms of both reimbursement and spending on health care infrastructure, there must be a clear return on investment.

When standards are set, organizations and individuals work to meet the standards. If the bar is set high, the level of effort and results will be high as well. Credentialing is a powerful lever to improve patient care knowledge of caregivers, continuing education, and organizational systems. Knowing which standards impact outcomes will be key to improving quality. Future improvements in credentialing science research methodology; analysis of existing data; and conceptual models of competency, quality, and excellence will all contribute to the creation of the best outcomes in patient care.

**Suggested Reading**


**References**


The Future Is Now

By David E. Longnecker, MD, FACP
and Dave Davis, MD, CCFP, FCFP

Perhaps the most important message regarding future directions is the realization that the future is now. Never has the health care delivery environment been more dynamic than it is today. Some have described it as “constant whitewater” characterized by rocks, eddies, whirlpools, and waterfalls with labels such as payment reform, risk-based reimbursement, bundled payments, public reporting, accountability, transparency, meaningful use, team-based care, maintenance of certification, maintenance of licensure (MOL), OPPE, FPPE, etc. While we recognize that significant challenges face today’s practitioners, we also embrace these changes because we envision a future that is focused on quality as defined by the Institute of Medicine (IOM) (i.e., safe, timely, effective, efficient, equitable, patient-centered) and the Centers for Medicare and Medicaid Services (CMS) (i.e., better health for individuals, better care for populations, and lower costs through improvement). Together, these approaches are facilitating a transformation in care delivery that is unprecedented in American history.

Although the pace may be dizzying for individual providers, the long-term benefits more than justify the effort. Further, we firmly believe that the changes occurring today will continue whether or not the Patient Protection and Affordable Care Act of 2010 is affirmed, rejected, or modified by the pending Supreme Court review. Put simply, the changes now occurring throughout health care have moved beyond the “tipping point”; they have gained so much support and momentum that a return to “business as usual” is simply not feasible. These views are also shared by keen observers of social trends.¹

For individual practitioners, three major quality themes will be especially prevalent in their future practice: 1) increased collection of quality data (“transparency”), 2) increased assessment of personal competence and practice performance, principally via the American Board of Medical Specialties MOC initiative (“accountability”),
and 3) the expectation that any gaps in performance will be corrected ("quality improvement" [QI]). The combined effects of transparency, accountability, and QI can have a profound effect on the quality of care offered by individual providers and by the health care “system” overall. We will address each of these areas below.

**Maintenance of Certification**

In the U.S., board certification by an American Board of Medical Specialties (ABMS) member board has long been considered the gold standard for documenting physician competence. For most of the 20th century this documentation was achieved by a single examination that resulted in a lifetime certificate. Maintaining that certification and maintaining medical licensure were generally simple, and mostly passive, processes that involved accruing a defined threshold of continuing medical education (CME) credits. CME credits were awarded for attendance at accredited CME courses and other less formal educational activities such as journal clubs, discussions with peers, and personal reading. There was little or no emphasis on actual clinical performance and quality of practice.

Over time, the medical profession began to recognize that knowledge alone did not ensure excellence in performance and that the standard, didactic CME model of passive learning was relatively ineffective. Additional evidence indicated that physicians were generally ineffective at assessing their own learning needs or their clinical care gaps. Thus, in 2000, the ABMS member boards adopted the concept of MOC, which involves four major components:

- Part I requires maintenance of licensure as a prerequisite to certification;
- Part II requires documentation of life-long learning and self-assessment;
- Part III requires a cognitive evaluation (i.e., evidence of current knowledge); and, notably,
- Part IV requires an assessment of actual practice performance, compared to standard norms and other practitioners.

Combined with time-limited certification (approved by all ABMS member boards in 2006), MOC is now the standard for evaluating the continuing competence of board diplomates. However, implementation of Part IV still varies among the ABMS member boards. Although all are working to achieve the desired goal, some (e.g., the boards for internal medicine, pediatrics and family medicine) have rather robust processes whereas others remain in earlier phases of implementation.

The moves to MOC and MOL represent dramatic changes in the way physicians are evaluated, and they provide greater assurance and validity to the board certification process. We believe that these changes are essential for improving the quality of care throughout the U.S., and we support them enthusiastically. The effectiveness of Part IV (practice assessment) depends greatly on the quality, extent, and timeliness of data gathered from physician practices—thus the current emphasis on implementing electronic health records (EHRs) that will facilitate data reporting.
Further, measurement of performance is a necessary, but insufficient, step toward improving performance. If gaps in clinical care are uncovered, clinicians must be competent in the discipline of QI to effectively implement corrective action.

**Quality Measurement and QI**

Americans have long been fascinated with performance measurement. We evaluate teams based on wins versus losses and athletes based on batting averages, home runs, goals scored, blocked shots, and an endless array of other measures. We evaluate financial performance by measures such as the Dow Jones Industrial Average® and the NASDAQ®. We evaluate thousands of products through rating systems such as Consumer Reports®. In short, we are obsessed with “keeping score,” yet performance in health care has been a notable latecomer to this process.

In 2002, the CMS and the Hospital Quality Alliance collaborated to form Hospital Compare, which now provides publicly available quarterly reports on the performance of approximately 4,000 hospitals. Additional legislation, passed in 2006, prescribed the Physician Quality Reporting System (PQRS), which eventually will provide similar information on the performance of individual physicians and/or their group practices. The PQRS initiative is managed by CMS, but its goals are facilitated by policies generated in the Department of Health and Human Services’ Office of the National Coordinator of Health Information Technology (ONC), which provides financial incentives to clinicians for implementing health information technology in their practices and for reporting their performance data. Several of these initiatives are aligned to encourage physician quality reporting. For example, physicians who report their data via an EHR can receive additional incentives by also participating in MOC. Although still in the early stages of development, we see this convergence as an important catalyst for what we hope will become the standard of practice—i.e., timely reporting of performance data by all clinicians, with such information widely available to individuals and employers. Almost certainly, shining a light on performance will be a strong stimulus for performance improvement throughout the provider community, and we applaud this approach.

Keeping score alone is not enough. How does an individual clinician, or a group of practitioners, go about improving quality when gaps in clinical care are identified? All clinicians want what is best for their patients, but health care is now a complex process that often involves far more than an individual clinician working in a solo practice. For persons with advanced illness or multiple chronic conditions, the spectrum of providers includes primary care physicians, medical specialists, nurses, pharmacists, social workers, pastoral care workers, home health services, and more! Clearly, one needs an organized approach to manage and improve care in this system of care. Fortunately, there is a ready template for initiating such work—it is called QI.
W. Edwards Deming, PhD, an American statistician and process improvement expert, provided a framework for such efforts and demonstrated its effectiveness through his work in Japan in the 1950s. Japanese manufacturers were in a state of utter collapse following the massive destruction of their infrastructure during WWII. Deming led the redesign and rebuilding of Japanese industry using his now well-established Plan-Do-Study-Act (PDSA) cycle. Using this systematic approach, and incorporating the fundamental principle of team-based engagement, he not only revived Japan’s manufacturing but also created a standard of excellence that has served as a model for world-wide industry, including a growing number of health care organizations (e.g., the Virginia Mason Health System, Seattle, WA). But there are caveats to this approach.

Although the PDSA cycle provides a framework for QI, full effectiveness is achieved only when all providers involved in the delivery of care are equally engaged in the design (plan) and implementation (do) of that care. Further, the subsequent “study” phase must be supported by timely, reliable, and meaningful data. Finally, the resulting action must be effectively implemented, whereupon the cycle is continuously repeated. Experience reveals that such a process, taken seriously and with an emphasis on teamwork, leads to the development of a culture of quality in an organization that far exceeds the accomplishments achieved by simply expecting each person to “do their job well.” Humans are inherently error-prone, and they benefit greatly from the wisdom and watchfulness of engaged colleagues (the team) who are constantly checking for errors and opportunities for improvement. Indeed, highly reliable organizations are characterized by such approaches. But how does one learn the quality improvement methodology?

Medical schools and graduate medical education programs are now incorporating QI education and training into their curricula, and this bodes well for the future of the health care improvement initiative. In our experience, students and residents are literally “hungry” for the opportunity to make a difference by improving the quality, safety, timeliness, and efficiency of their practice. However, practitioners who received their training previously may need guidance and continuing education when seeking such knowledge. Several ABMS member boards and specialty societies provide access to online CME to guide the neophyte through this process. Examples include the American Board of Internal Medicine Practice Improvement Modules, the American College of Surgeons Division of Education, and numerous others. The respective ABMS member boards, professional societies, or a local CME provider can provide guidance for both individuals and group practices.

Summary

Beyond the ‘whitewater’ of health care change, we see a bright future—one not yet fully achieved but one that is based on the principles of safe, high-quality, person-centered, cost effective care delivery, guided by timely data that inform the practitioner and his or her care team of the effectiveness of their care processes based on meaningful quality metrics, and functioning collaboratively in a
QI framework. Selected health care organizations have implemented these approaches successfully, and the incentives for movement in this direction are increasingly attractive. While much remains to be done, the momentum for change suggests there is no turning back. Providers, educators, specialty societies, health insurers (both government and commercial), and the public increasingly expect such improvements and most are unwilling to tolerate the status quo—this alone is a strong impetus for action.

References


