QUALITY DEVELOPMENT IN HEALTH CARE PRIMARY CARE REFLECTIONS ON THE INSTITUTE OF MEDICINE'S INITIATIVE

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ABSTRACT

Beginning with the shocker to the Americans and the world that some 44,000 to 98,000 people die yearly in the United States of avoidable medical accidents, the Institute of Medicine (IOM) in the United States has been pushing for the issue of quality development in health care as a necessity for sustainability of modern health care. 'To err is human: building safer health care systems', published in 1999, focused on the need for a mindset change in viewing medical accidents as a systems problem (blunt end) rather than the individual's problem (the sharp end). It is with such thinking that action will begin to be focused on patient safety as a system property and not just the actions of individuals. This publication was followed in 2001 by another, titled 'Crossing the Quality Chasm: A new health system for the 21st Century', in which IOM addressed the need to consider safety from errors as part of a systems quality improvement. There are six service aims and ten rules to bridge the quality gap that now exist in many healthcare systems. In its most recent publication released on 7 Jan 2003, IOM recommended a list of 20 priority areas that as a group provide a starting point to fix the American healthcare system. The ideas have application to the whole medical world, primary care included. The three publications provide family medicine practitioners worldwide with a robust agenda to work towards meaningful healthcare, satisfying patient care and a means to earn better recognition from the patient for the work done.

PROBLEMS OF TODAY'S HEALTHCARE SYSTEM

The modern health care delivery system worldwide modelled after that in Western countries has made a great transformation in our ability to cure, relieve and comfort those suffering from disease and illness. It has also created great complexities in health care delivery and dissatisfaction in practitioners and patients.

Just like the counter-culture that led to the formation of Family Medicine because the founders of that discipline felt that the person dimension was being neglected with too much attention was paid to diseases and organs and not the person behind it, the world led by America is spearheading yet another counter-culture which promises to fix the healthcare system and bring back the satisfaction that is now slowly being lost as we become caught in administrative and technical aspects of medicine to the neglect of once again, the person behind the disease and illness.

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Today, many healthcare organizations are more concerned about cost-containment to the extent of being at the expense of quality. More attention is being paid to form rather than the substantive raison d'etre of healthcare, which is the reduction of disease burden. Too many healthcare organizations have become a business with the bottom-line being the prime raison d'etre rather than the reduction of disease burden. Patients feel cheated and behave aggressively to their doctors, good or bad. Doctors become dissatisfied and distraught, particularly those who join the profession with a good heart. The quality initiative from the Institute of Medicine in the United States therefore comes at a timely moment to the world's medical stage.

SYSTEM FAILURES AS ROOT CAUSES

The Institute of Medicine (IOM) Report in 1999 titled "To err is human: Building a safer health system" draws the attention of the American public and worldwide to 44,000-98,000 hospital deaths from preventable medical errors per year in the United States, calculated from the rate of 3.7 per 1000 hospital admissions in the Harvard Medical Practice Study reported in 1991. The central thesis of the Report is that system failures are often the root causes of medical errors and the current mindset of name, blame and shame of the individual addresses only the sharp end of the problem but does not address the system deficiencies. System improvement does not take place and medical errors will continue to occur. The IOM Report has resulted in a positive Federal Government response including the setting up of a research centre in the AHRQ. The medical profession in the United States has also rallied to look into patient safety measures.

Specific measures can be introduced to reduce medical accidents. Those arising from medication errors, operating on the wrong site, wrong connection of gases, fluids or medications to the patient, and wrong routes, could be reduced by systems engineering measures. Further, the mindset change towards a culture of continuing education and self-enforcement of best practices directed at preventable errors for all healthcare staff, supported and led by healthcare administrators will propel healthcare providers and the systems that they work in towards zero defects. The result is a win-win-win situation for the patient, provider and organisation.

QUALITY GAPS

In the follow-up IOM publication in 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the continuing thesis of a systems approach addresses the need to consider safety from errors as part of system quality improvement. It enunciates six service aims and ten rules to bridge the quality gap that now exist in many healthcare systems.

The six service aims are that health services provided must be safe, effective, patient-centred, timely, efficient, and equitable. The ten rules in the mindset change to meet the six aims of service delivery are shown in Table 1.

Table 1: The ten rules in the mind set change to meet the six aims of service delivery

Current Approach	Mindset change
Care based primarily on visits	Care based on continuous healing relationship
Professional variability driven by professional autonomy	Care as customized according to patient needs and values
Care controlled by professionals	Patient as the source of control
Information as a record only	Knowledge is shared and information flows freely
Decision making based on training and experience only	Decision making is evidence-based
Do-no-harm as an individual responsibility	Safety as a system property
Secrecy is necessary	Transparency is necessary
System reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continuously decreased
Preference is given to professional roles being a priority over the system	Co-operation among clinicians as priority

PRIORITY AREAS FOR NATIONAL ACTION: TRANSFORMING HEALTH CARE QUALITY

IOM's committee presented on 7 Jan 2003 a recommended list of 20 priority areas that as a group provide a starting point to fix the American health care system. The 20 areas not ranked in any kind of hierarchical ranking of the priority areas are shown in Table 2 and graphically in Figure 1. These 20 areas offer the greatest opportunities for rapid and substantial improvements in the quality of health care.

The fact remains that far too many Americans do not receive the high-quality care they deserve. For instance, we know that people with diabetes should have their blood sugar levels carefully monitored and should also receive annual eye and foot exams. Despite these proven interventions, recent data reveal that up to 75% of adults with diabetes do not receive this recommended care from their health care providers. As a result, tens of thousands of people with diabetes die prematurely, have their limbs amputated, or go blind. Much of this is preventable.

Another case in point is that of pain control in advanced cancer. Despite proven guidelines for pain relief, many suffer needlessly because of health care providers' ignorance of proper protocols for pain management or biases against the use of opioid medications. And finally, I turn to a disease that has long been overlooked and stigmatized: major depression. Due to a lack of aggressive screening for depression, less than half of individuals with depression are correctly diagnosed. Far too many people are not receiving the treatments they need to recapture a decent quality of life.

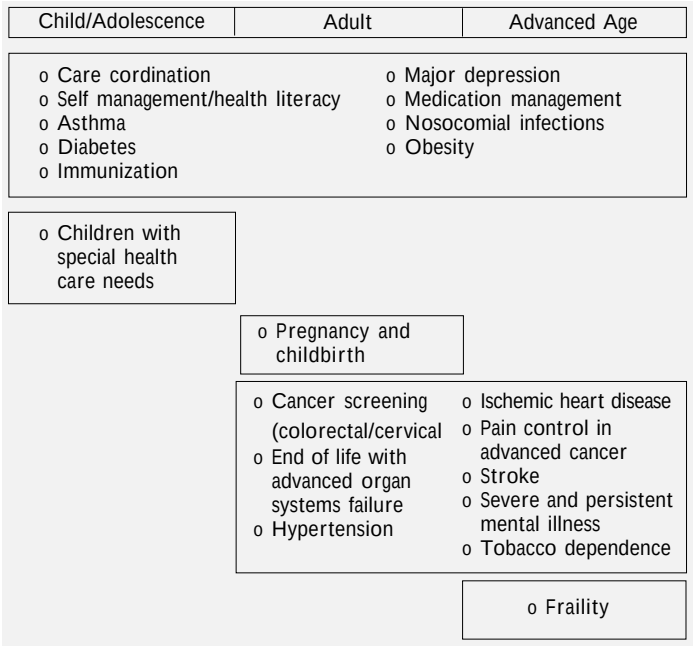

Fig 1: Priority Area for Quality Development

These failures are not happening because health care workers do not try hard enough, but rather because the systems of care that are in place are not adequate. As a result, patients, their families, and the health care professionals who care for them often become frustrated and overwhelmed.

So how is defining a set of priority areas supposed to help remedy this situation? The priority areas are a set of starting points to ignite the further transformation of health care. Addressing them will necessitate rebuilding the health care system's infrastructure so that it is better able to provide patient-centred, high-quality care. These 20 areas can be rallying points for alliances among individuals and organizations committed to improving health care quality. The priority areas could be used to develop models for better payment incentives that truly reward quality care and serve as the centrepiece of quality improvement initiatives. They could help to promote a culture of accountability in which we openly share results of our efforts to improve quality care with the public. And finally, the wellspring of information technology could be tapped to elevate care processes in the priority areas to a new level, with prompts and reminders for necessary services, and patients using the Internet in ways that empower them in the self-management of their care.

The twenty areas collectively represent four things viz.

- They reflect the full spectrum of health care, from preventive and acute care to chronic care and end-of-life care;
- They touch all age groups, from newborns to the elderly;
- They have impact all types of health care settings, from hospitals to ambulatory clinics to homes; and
- They engage a vast array of health care providers, including physicians, nurses, pharmacists, allied health professionals, social workers, and many others.

Table 2: Priority areas for quality development

- Improvement of care coordination, a cross-cutting area
- Self-management and health literacy, another cross-cutting area
- Appropriate treatment for persons with mild or moderate persistent asthma
- Cancer screening that is evidence-based, with a focus on colorectal and cervical cancer
- Improved processes of care for children with special health care needs
- Management of diabetes, especially early on
- Better care for those at the end of life with advanced organ system failure, with a focus on addressing congestive heart failure & chronic obstructive pulmonary disease
- Frailty associated with old age, with a focus on preventing falls and pressure ulcers, maximizing function, and developing advanced care plans
- Appropriate management of hypertension, especially early in the disease
- Immunization for both children and adults
- Prevention of ischemic heart disease, as well as reduction of recurring events and optimization of functional capacity in those who have suffered heart attacks
- Screening and treatment of major depression
- Medication management focused on preventing medication errors & overuse of antibiotics
- Prevention and surveillance of nosocomial infections
- Pain control in advanced cancer
- Appropriate prenatal and intrapartum care during pregnancy and childbirth
- Severe and persistent mental illness, with a focus on treatment in the public sector
- Early intervention and rehabilitation of stroke
- Treatment of tobacco dependence in adults
- Screening for and treatment of obesity, an emerging area.

In the words of the IOM Committee in their Executive Summary to the publication: "One of the unique features of the recommended set of priority areas is what is referred to as the 'cross-cutting areas.' These embody our firm commitment to the essential elements of system change that must traverse all conditions for care to be delivered in a patient-focused way. Another distinction of this priority set is what we refer to as an 'emerging area,' meaning that the evidence for effective intervention is not as fully developed as in the other priority areas. But nevertheless, the example included here – obesity – is one of the greatest health threats we face today."

Addressing the priority areas will require a broad-based effort on behalf of the public and private sectors in order to improve the quality of care. This includes primary care.

REFLECTIONS

The three IOM publications provide food for thought on how we can shape medicine in the next 10 years. The ideas are generic and applicable to Family Medicine too. The three publications provide family medicine practitioners worldwide with a robust agenda to work towards meaningful healthcare, satisfying patient care, and a means to earn better recognition from the patient for the work done.

The problems and solutions of primary care in the health care system

Primary health care systems around the world share common problems of poor recognition for the contributions made in the eyes of the patient, the healthcare system and many specialist peers. Worse of all, many of the practitioners have a poor regard for themselves.

All these can be improved by capacity building, given the will and the aligning vision. The IOM initiative gives the aligning vision. The quality development initiative is applicable to all. The twenty priority areas of quality development give all healthcare providers and people who are connected with healthcare delivery systems a new and important focus: reduction of disease burden.

Meaningful healthcare

Just like evidence-based medicine, where the driving force is to give greater attention to those items of care where there is compelling evidence while we look around to amass evidence of what is empirically good practice, we need to devote our energies and slender resources to greater attention to those areas of care where there is compelling evidence of reduction of disease burden. Suddenly, we move from form to substance.

However, like all new ideas, there is a need to persuade people to adopt these new ideas. The early adopters of such new ideas will need to lead the way.

Satisfying patient care

It is truism that we will continue to do something only if that activity is satisfying. The IOM initiative through its three publications – particularly the latest one – gives the family physician a way to provide satisfying patient care. There is a need to look further into the details of how we can work with patients, specialist colleagues and healthcare administrators on reducing disease burdens. If we could focus our energies on the chronic diseases, we will be able to reduce the morbidity and national health expenditure by a substantial portion. This will bring satisfaction to us as practitioners and to the patient because of a supra-ordinate goal. And because this will be satisfying, we will begin to enjoy our work.

Earning better recognition from the patient for the work done

This is sadly still a dream for many. However, as Rome was not built in a day, wishes and visions cannot move people in just a day. However, it is likely that persistence will pay off. Just as it is a fact that you can get water to move in the opposite direction if the tilt of the surface is reversed by a fraction of a degree, we can also earn better recognition once we get the vision set in the IOM initiative going. The counter-culture will be self-sustaining.

CONCLUSIONS

The IOM Initiative of quality development in healthcare is a timely vision. The vision is powerful because it is a unifying

one – we all in healthcare need to work towards cost-containment and quality. The three publications provide family medicine practitioners worldwide with a robust agenda to work towards meaningful healthcare, satisfying patient care, and a means to earn better recognition for the work done.

REFERENCES

1. IOM. Priority Areas for National Action: Transforming Health Care Quality. Jan 2003 (http://www.ahcpr.gov/qual/iompriorities.html/).
2. IOM. Crossing the Quality Chasm: A New Health System for the 21st Century. 2001 (http://www.nap.edu/books/0309072808/html/).
3. IOM. To Err is Human: Building a Safer Health System. Dec 1999 (http://www.nap.edu/books/0309068371/html/).

These three publications can be read on line at the IOM website. The website addresses for the three publications are in brackets.