

Quality of Care & Patient Safety: Measurement and Improvement

Introduction: *Quality of care is:*

1. "Evidence-based medicine."
2. Central to lifelong learning, certification, and licensure.
3. At the center of health care reform.
4. Increasingly about accountability.
5. Drives health care system improvement.

Why Are There Concerns About Quality?

Poor quality includes: **1.** unsafe practices, **2.** ineffective therapies, **3.** wrong therapy to the wrong patient, **4.** delayed care delivery, **5.** use of resource intensive care for marginal benefit, **6.** differential care based on age, gender, race, or ethnicity.

What Is High Quality Health Care?

- 1. Safe:** Avoiding harm to patients.
- 2. Effective:** Providing services based on scientific knowledge.
- 3. Patient-Centered:** Respectful/responsive to patient preferences, needs, & values.
- 4. Timely:** Reducing waits & harmful delays for those who receive & give care.
- 5. Efficient:** Avoiding waste, including equipment, supplies, ideas, and energy.
- 6. Equitable:** With regards to gender, ethnicity, geographic/socioeconomic status.

How Should We Assess Quality?

- 1. Structure:** Resources (personnel, equipment, facilities, labs, training, protocols).
- 2. Process:** "Right thing for the right patient at the right time."
- 3. Outcomes:** "end-results" of care delivery with regards to morbidity & mortality.

What About Cost?

Higher care costs & resource utilization do not translate into higher quality of care: Quality improvement efforts are focused on *efficiency of care* (cost per outcomes).

A Systems Problem, A Systems Solution

Quality improvement (QI) is achieved through a systems approach that provides a supportive environment for the delivery of health care.

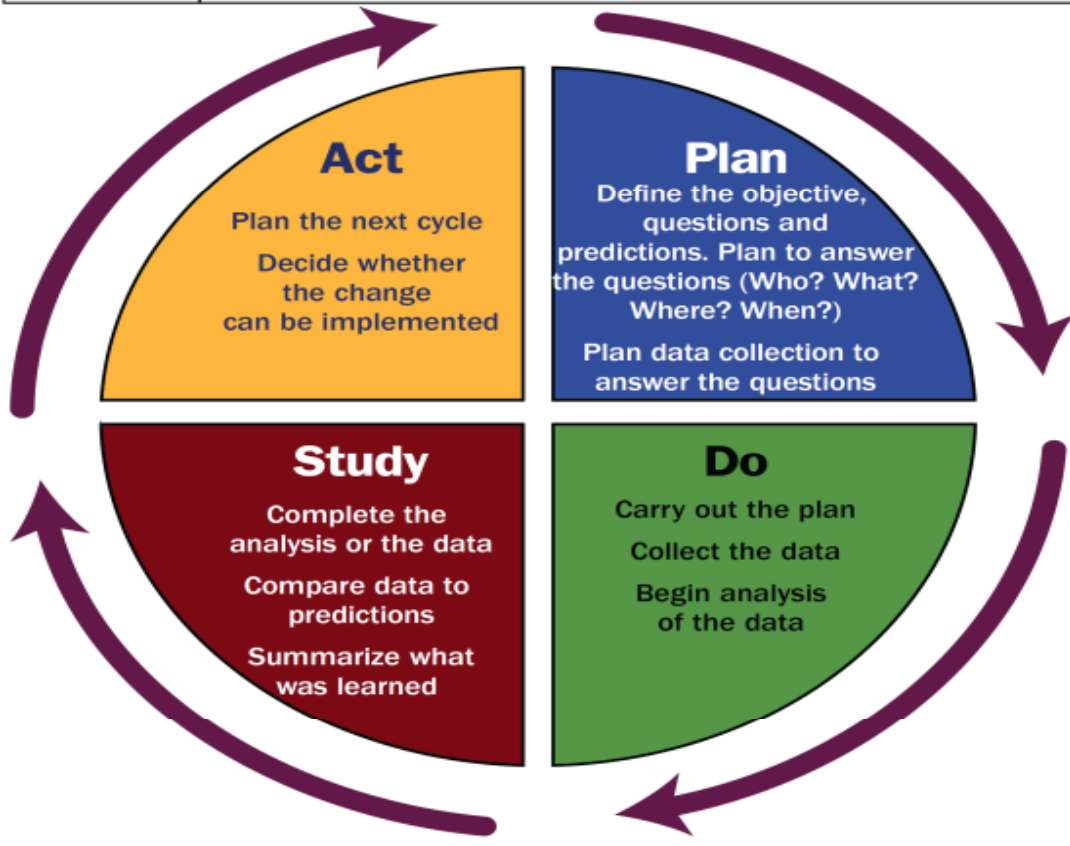
Continuous quality improvement (CQI) is an organized, scientific process for evaluating, planning, improving, and controlling quality.

Patient Safety: includes opportunities to report errors, unsafe conditions, and near misses, & participate in inter-professional teams to promote and enhance safe care.

Near Miss: "Any event that could have had adverse consequences but did not and was distinguishable from fully fledged adverse events in all but outcome."

Tool	Definition / Purpose
Evidence	Data on associations between actions and outcomes; derived from a hierarchy of scientific research: <ul style="list-style-type: none"> • Unsystematic clinical observation • Physiological experiments • Expert opinion • Case series • Cross-sectional studies • Case-control studies • Retrospective observational cohorts • Prospective observational cohorts • Randomized controlled trials
Data Standards	Agreed upon definitions, nomenclature, and data elements; facilitate accurate communication and fair comparison
Clinical Practice Guidelines	Detailed summary of the body of evidence-based medicine for a given disease process or clinical content area; includes specific recommendations for standards of care, graded on level (I, IIa, IIb, III) and type of evidence (A, B, C)
Process Performance Measures	Discrete processes of care that imply that clinicians are in error if they do not care for patients according to these clinical standards; must also allow for practical identification of those patients for whom a specific action should be taken (a clear denominator), easy determination of whether or not the measure has been performed (a clear numerator), and opportunities for timely feedback
Appropriate Use Criteria	Identify common, prototypical patient subgroups for which expert clinicians assess the benefits and risks of a test or procedure on patient outcomes (score 1-9); primary goal is to reduce overuse, thereby improving safety and efficiency
Outcomes Measures	Measures of health that are important to patients and are through to be affected by processes of care; generally require risk-standardization to account for case mix

The Toolkit of Quality Improvement



The
**Plan-
Do-
Study-
Act**
(PDSA)
Model
for Improvement