Mind the gap: where quality measures fall down

Physicians today are navigating a complex health care environment where our practices are being scrutinized by competing interests.

As one colleague described it to me, “I can’t win; if I give antibiotics to the patient [with a viral illness] to improve satisfaction scores, I’m also dinged for poor antibiotic stewardship.”

This is a familiar story to clinicians, especially those within large health care organizations, where often we feel like providing the best care is not only difficult, but inevitably prone to criticism. This hopelessness is a primary contributor to burnout, succinctly highlighted in the movie Office Space (1999), where the protagonist describes his reaction to draconian administrative oversight: “My only real motivation is not to be hassled.”

How can we provide quality care in a practice environment where we are doomed to failure, knowing that quality is being further entwined with reimbursement as medicine shifts towards value-based care?

Health care quality has been defined by the Institute of Medicine as “the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” This definition has been reiterated by the World Health Organization, the National Committee for Quality Assurance, and by the Agency for Healthcare Research and Quality, at times with somewhat different verbiage.

These same organizations likewise agree on the domains in which quality must be pursued: safety, effectiveness, efficiency, equity, patient-centeredness and timeliness. Four of these six parallel the four basic principles of medical ethics—the exceptions being efficiency (benefit relative to cost) and timeliness.

The domains can be at odds with each other. Explaining why overprescribing increases the patient’s and the population’s risk of harm can help satisfaction, but comes at the expense of efficiency, since educating each patient increases time and reduces patient volumes. The same is true when a patient needs a medication, but timeliness is sacrificed to the gods of insurance prior authorization, an administrative barrier completely outside of our control.

Rather than viewing quality domains or individual measures independently, we need to see that they work in concert to contribute to a complete picture of quality for each patient in each instance of care. If we view these quality domains as a map of individual islands in an ocean, the interactions of these domains sink in the water between them. We must close these gaps and envision quality as a dynamic continent in which various countries are competing for resources, with the most influential aspects of our work occurring at the shifting international borders.

Imagine evaluating diabetes care by glycosylated hemoglobin (HbA1c) alone, instead of by several quality domains in parallel, where a poor HbA1c may be related to patient not starting it immediately (patient-centered), despite the most effective treatment (insulin) being prescribed at the right time. In diabetes management, we must consider the balance of safety, effectiveness, efficiency and equity, as impacted by patient preference, insurance coverage and the high cost of insulin to patients.

We must advocate within our institutions, our specialties and our regulatory frameworks for a balance of measures in the context of whole-person care, as opposed to an independent evaluation of quality in each domain. Only when the sum of these domains is viewed as greater than any of its parts will physicians be able to comfortably practice medicine as partners in—rather than hostages to—quality measurement.

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