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From the Editor

Improving the Quality of Ambulatory Care

David B. Nash, MD, MBA*

* Thomas Jefferson University

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From the Editor

Improving the Quality of Ambulatory Care

Careful readers of this column know that we have periodically covered the important topic of measuring and improving the quality of medical care. We have focused on such topics as report cards in medicine ("Report on Report Cards," May 1998), the cultural barriers to quality ("A Health Care Tipping Point?" June 2001), and involving consumers in their own health care ("Just the FACCTs," September 1997). One arena at the national level that has not received comparable attention is the quality of care in the ambulatory setting. Why is ambulatory care different from inpatient care with regard to measuring and improving quality? What is Jefferson Medical College attempting to accomplish in this arena? And, what are some of the future forces impacting ambulatory care quality?

Astute observers of health care agree that "while most ambulatory care is less technologically complex than inpatient care, it is often more complex logistically. An episode of ambulatory care often requires communication and coordination among a number of clinicians, the patient, and family among several different sites. It frequently involves handoffs and transitions over time. Laboratories, imaging facilities, and other diagnostic services are often located in disparate sites, and communication of results back to the physician and the patient are subject to a variety of sources of failure. In addition, requirements by insurers force clinicians and patients to use particular laboratories, imaging facilities, and consulting physicians with which they do not have working relationships. As a result of the aforementioned, the coordination, management, and ability to measure and improve quality is difficult for physicians and their practices."[1]

In academic medical centers similar to the one within which our department resides, these issues are of particular concern. Our complex system involves multiple providers caring for patients oftentimes with multi-system illnesses. According to Dr. Mark Keroack,[2] the Senior Director of Clinical Practice Management at the University HealthSystem Consortium (UHC) in Chicago, academic medical centers lack a primary care model, and the links to community providers are often tenuous or non-existent, exacerbating the communication difficulties. Dr. Keroack has observed that there is generally little regulatory oversight in the ambulatory setting; and, research on the outcomes of ambulatory care remains at a relatively early stage as compared to inpatient care.

Indeed, research conducted by our own Department of Health Policy (DHP) in conjunction with the UHC demonstrated that most UHC members are still at an early stage in their approach to organizing the infrastructure necessary to improve ambulatory care quality.[3] In our survey of UHC members, we found that few members reported the regular collection and dissemination of either clinical process measures or clinical outcome measures from their ambulatory practices. Although we were hampered by a 33% survey response rate, we believe our findings are generalizable to most academic medical centers where, historically, the emphasis has been on measuring inpatient quality largely for accreditation purposes. UHC members cited many barriers that impede a faculty practice plan's ability to implement outpatient quality initiatives including a lack of resources, the lack of the

business case for quality and, frankly, the lack of interest from providers in the medical school setting. Clearly, more research is needed to describe the key ingredients of effective models to measure ambulatory care quality. We will return to this theme later.

Our survey research with the UHC was contemporaneous with the release of a strategic plan by the leadership of Jefferson University Physicians (JUP)—the 18-department, 480-physician strong faculty practice plan at Thomas Jefferson University. The strategic plan for JUP calls for the practice to be the gold standard of outpatient quality and makes quite explicit the need to create an infrastructure for measuring and improving the work performed by our large number of specialty-oriented physicians.

How is JUP poised to meet the challenge of improving ambulatory care quality? First, in our marketplace, there are few autonomous large, multi-specialty group practices that might be more prevalent elsewhere across the country. In fact, faculty practice plans are among the largest providers of ambulatory care in the tri-state Pennsylvania, New Jersey and Delaware marketplace. Therefore, understanding JUP's approach to ambulatory care improvement is vital.

I am very pleased to report that JUP has reconstituted its Clinical Care Committee (CCC) with representation from all 18 clinical departments. The JUP CCC has several standing subcommittees including risk management and credentialing. During the first part of calendar year 2003, the CCC heard a series of presentations from locally and nationally prominent leadership of quality measurement and improvement programs. These leaders emphasized the rationale for undertaking performance improvement activities across all JUP outpatient practices. Each clinical department has now identified at least one specific indicator relevant to its own practice for structured measurement and potential quality improvement interventions, such as education and feedback.

In addition, JUP has committed to a multi-departmental performance improvement demonstration project that will develop, implement, and evaluate a key clinical measure of quality across, at least, three departments. Specifically, the intent is to focus on an indicator for which national measurement standards and general consensus on importance to quality of care already exists. We have selected the National Committee for Quality Assurance (NCQA) HEDIS measurement set for controlling high blood pressure as our first multi-departmental performance improvement demonstration project. For more information about the NCQA's HEDIS measurement program, please visit www.ncqa.org. Finally, JUP has also committed to appropriately staff the work of the CCC through hiring 1.5 fulltime employees who will devote their energies exclusively to gathering and disseminating quality of care indicator-based measures across the participating departments.

As JUP begins to tackle the tough job of measuring and improving ambulatory care quality, many challenges will be faced. Fortunately, we will be able to call upon the resources of the UHC and, specifically, the Group Practice Council, Ambulatory Care Council, Medical Leadership Council and the Faculty Practice Solutions Center (FPSC). While a detailed review of all of the UHC activities is beyond the scope of this editorial, let me highlight the key attributes. The various councils bring together like-minded individuals with comparable levels of responsibility and expertise from across the entire membership of the UHC. Regular communication and in-person meetings will enable us to benchmark our performance against the "best-of-breed" within

academic medical centers. The FPSC is a special entity, which collects, compiles, and benchmarks academic physician productivity and financial statistics. The FPSC is a collaborative effort of both the UHC and the Association of American Medical Colleges in Washington, DC. JUP is committed to benchmarking as a primary strategic tool to assure operational excellence across all participating departments.

At the national level, public interest in quality and safety in all phases of medical care is growing. It is becoming increasingly apparent that the professional role of physicians in designing and improving complex care delivery systems is a critical factor in improving outcomes. Our ability to demonstrate accountability in our daily activities in the ambulatory setting is a core component of our professionalism. I am proud of the work of the Department of Health Policy, the JUP Clinical Care Committee, and all of the representatives across the 18 clinical departments making up our Faculty Practice Plan. We have much more work to accomplish together in the next year as we strive to meet the Dean's challenge of creating the gold standard in outpatient quality. As always, I am interested in your feedback. Please email me at david.nash@jefferson.edu.

References

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