Chasing Our Tails

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Consider for a moment the systems we have in place in American health care to assess quality and efficiency. A national commission, now called the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), has evaluated hospitals since 1951.[1] In 1979, the National Committee for Quality Assurance (NCQA) was constituted to assess managed care health plans.[2] Both the JCAHO and NCQA were built on the principle of establishing a baseline standard for quality and safety and then using this standard as a benchmark to assess performance. Their focus is on evaluating organizations. In contrast, the quality of care provided by physicians in the ambulatory setting historically has been assured by the state physician licensing process, the accreditation of graduate medical education programs, and by the process of specialty board certification. So while health care organizations have been evaluated in comparison to a performance standard, the quality of physician care has been evaluated by assessing the physicians' training and competence, not by assessing the care itself.

Over the past three decades, much time and money has been invested in efforts to change this by promoting continuous quality improvement in ambulatory care. These efforts have been driven by growing frustration with the high costs and poor quality of health care in America as compared with other health systems in the developed world. Initially, this took the form of voluntary efforts within individual clinical practices. Eventually, regional and national organizations mobilized to assess and improve practices. The JCAHO developed quality improvement standards for ambulatory practices that were part of integrated health systems. The NCQA was reorganized in 1991 and eventually expanded its focus to include disease management programs, wellness and health promotion programs and, more recently, patient-centered medical homes.[3] Also in 1991, the Institute for Healthcare Improvement (IHI) was incorporated and national meetings and training programs were developed to advance the science of clinical quality improvement.[4] This created a cult of passionate quality improvement disciples and the movement was embraced by medical specialty societies including the American Academy of Family Physicians, and by certifying boards including the American Board of Family Medicine. More recently, there has been much excitement about the possibility that large data sets extracted from electronic health records might finally create the long-awaited tools needed for such efforts to achieve their potential.

In this issue of *Family Medicine*, Donahue and colleagues have provided us with a detailed report from the I3 residency collaborative about quality improvement efforts in 23 primary care residency programs in North Carolina, South Carolina, and Virginia.[5] Their paper offers a fascinating look into the progress being made by those seeking to improve measures of all three domains of the triple aim in the primary care residency practices. The triple aim—improving patient experience, lowering cost, and improving population outcomes—is now the accepted goal of our health care system[6] and has been specifically embraced by the discipline of family medicine in

the Family Medicine for America's Health Project.[7] Because Donahue and colleagues included only residency practices, their study provides us with valuable insight into what residents are learning in their respective communities. And the picture is not encouraging. One in five of the residencies was not able to get enough data from their own electronic health records to participate in the analysis. Overall, there was no significant improvement in any of the quality or cost measures being assessed across the entire collaborative. Only a quarter of the practices demonstrated significant improvement in each of the three domains of the triple aim and in only two cases was this improvement over 10% better than baseline. It should be noted that the I3 collaborative has been a national leader in efforts to learn about population health improvement in primary care residency education. The collaborative includes family medicine, internal medicine, and pediatric residencies in three states and has already produced important publications including four previous papers in this journal.[8-11] Because the I3 residencies have agreed to participate in the collaborative, it is likely that they have expertise in quality improvement beyond the average program. So the results reported in this study are probably better than what we would find in the typical family medicine program.

It seems axiomatic that all of us should care about improving the quality and efficiency of our clinical practices and that we should embrace the task of teaching these skills to students and residents. But there is a wide chasm between theory and reality. We need to have these skills ourselves before we can teach them, and we are not yet sure how to measure quality in a way that captures the full richness of primary care. So, in the absence of knowing how to measure what matters, we are left with working on what we can measure. This usually means crude quantitative measures of process outcomes like hemoglobin A1C levels and hospitalization rates and surveys of patient satisfaction with individual visits. Too often, our efforts lead to a frustrating whack-a-mole phenomenon in which short-term improvements are not sustained as we move our attention from one measure to the next. When we also consider the workload and burnout rate in primary care, it is hardly surprising that our lofty goals too often fade into efforts to get home on time at the end of each hectic day.

The real tragedy in this process is what we give up when our attention is focused on traditional quality improvement activities. We stop visiting patients in hospitals and nursing homes. We stop performing common procedures and our referral rates to specialty care soar. All of us are vaguely aware that this does not make sense, but we feel powerless to stop whacking the mole. In fact, it is often hard to question these activities as the management culture of those leading our practices insists on ever-increasing levels of conformity from us. And the frustration gets worse when all of our efforts fail to make care safer or less expensive. The care fragmentation resulting from what we give up too often overwhelms any short-term improvements we achieve.

So what are we to do? First, it is long past time for us to rethink a clear and measurable definition of quality in family medicine. This definition would start with strong, trusting relationships between patients and those who care for them. It would include competent comprehensive clinical practice, around-the-clock availability, care coordinated based on the individual needs of each patient, and care focused on families and communities. The I3 collaborative is on the right track by measuring continuity and specialty referral rates in their work. These core principles need to be the foundation of what we do clinically, of what we measure and hold ourselves accountable to, and of what we teach to the physicians of the future. We cannot improve care for a population by shortchanging the individual people who make up that population. Nor can we improve what matters in primary care by driving those who provide it crazy with an endless array of minutiae. An entire industry has been built on evaluating our practices, but that industry is largely based on the priorities of those who pay for the care rather than those who receive it. Solving this problem starts by empowering patients and providers at the level of individual practices. We will not accomplish the triple aim by whacking moles to impress those we never actually get to meet.

References

1. The Joint Commission. Facts About the Joint Commission. https://www.jointcommission.org/about_us/fact_sheets.aspx. Accessed December 13, 2017.
2. McPartland G. Birth of the National Committee for Quality Assurance. A History of Total Health Blog. Kaiser Permanente; 2012. https://kaiserpermanentehistory.org/latest/birth-of-the-national-committee-for-quality-assurance/. Accessed January 14, 2018.

3. National Committee for Quality Assurance. http://www.ncqa.org. Accessed December 13, 2017.
4. Institute for Healthcare Improvement. http://www.ihi.org/Pages/default.aspx. Accessed December 13, 2017.
5. Donahue KE, Reid A, Baxley EG, et al. Triple aim is triple tough: can you focus on three things at once? Fam Med. 2018;50(3):179-187.
6. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. Health Aff (Millwood). 2008;27(3):759-769. https://doi.org/10.1377/hlthaff.27.3.759.
7. Puffer JC, Borkan J, DeVoe JE, et al. Envisioning a new healthcare system for America. Fam Med. 2015;47(8):598-603.
8. Newton W, Baxley E, Reid A, Stanek M, Robinson M, Weir S. Improving chronic illness care in teaching practices: learnings from the I^3 collaborative. Fam Med. 2011;43(7):495-502.
9. Reid A, Baxley E, Stanek M, Newton W. Practice transformation in teaching settings: lessons from the I^3 PCMH collaborative. Fam Med. 2011;43(7):487-494.
10. Donahue KE, Reid A, Lefebvre A, Stanek M, Newton WP. Tackling the triple aim in primary care residencies: the I3 POP Collaborative. Fam Med. 2015;47(2):91-97.
11. Gwynne M, Page C, Reid A, Donahue K, Newton W. What's the right referral rate? Specialty referral patterns and curricula across I3 collaborative primary care residencies. Fam Med. 2017;49(2):91-96.

Family Medicine Call for Submissions: The Outcomes of Family Medicine for America's Health

The Family Medicine for America's Health (FMAHealth) Board of Directors and the journal *Family Medicine* announce our intention to publish a theme issue of *Family Medicine* to highlight the lessons learned and accomplishments of FMAHealth's 5-year collaborative effort to drive improvement in American health care, demonstrate the value of primary care, and reform the specialty of family medicine. The purpose of the theme issue will be to provide an assessment of the project and to update the journal's readers about FMAHealth's progress in achieving its goals.

Papers for the theme issue will be considered if they are submitted to the journal by July 1, 2018. All submissions should comply with the journal's Instructions for Authors and must be submitted into the journal's electronic manuscript management system. Further details regarding submission requirements, and types of articles sought, can be found at https://journals.stfm.org/media/1367/fmahealth-call-for-papers.pdf.