Understanding Quality Patient Care and the Role of the Practicing Nurse

Laura D. Owens, PhD, RN[a], Robert W. Koch, DNSc, RN[b,*]

KEYWORDS

- Health care quality • Affordable Care Act
- Center for Medicare and Medicaid Services (CMS)
- Institute of Healthcare Improvement (IHI)
- The Agency for Healthcare Research and Quality (AHRQ)
- National Database of Nursing Quality Indicators (NDNQI)

KEY POINTS

- Understanding the history of the quality initiative in health care is important in understanding the directions for the future.
- Health care quality is closely monitored by both private and public agencies charged with ensuring safe and efficient delivery of health services.
- Measuring quality in health care is the key to determining if desired outcomes are achieved.

INTRODUCTION

Nursing today requires more than caring for patients. Nurses must provide, manage, and document quality patient care measured within the patient care setting. This article discusses the history of the quality movement, key quality health care organizations, various measures of quality care, and the financial and professional practice implications for quality patient care.

HISTORY OF QUALITY MOVEMENT

Quality management in the United States can be traced to the 1920s and the work of Edward Deming, Walter A. Shewhart, and Joseph Juran.[1] All 3 laid the groundwork for current quality health care initiatives with their work that began in American industry.

Disclosure: The authors of this publication have not received any support (financial or otherwise) in the preparation of this article.
[a] Loewenberg School of Nursing, University of Memphis, Memphis, TN 38152, USA; [b] The West Cancer Center, Memphis, TN 38120, USA
* Corresponding author.
E-mail address: rkoch@WESTCLINIC.com

Nurs Clin N Am 50 (2015) 33–43
http://dx.doi.org/10.1016/j.cnur.2014.10.003 **nursing.theclinics.com**
0029-6465/15/$ – see front matter

Deming's work in Japan during their postwar reconstruction led to significant industrial gains and business success in that country. Later, as the United States recognized his work, it became the turning point for quality control in the United States.[2] By the time of Deming's death in 1993, he had seen quality management efforts move from manufacturing to service industries, and finally, to health care.[3,4]

Dr Avedis Donabebian also contributed to the quality movement in the 1960s with his research on quality and outcomes research in medicine. His model used the aspects of structure, process, and outcomes to examine health care quality. Structure indicates the context in which the care is given, such as a hospital; process is the interaction between patients and providers, and outcomes are the effects of health care on patients and the population. The Donabedian model continues to influence health care quality evaluation today.[5,6]

In 1966, Medicare was signed into law under Title XVIII of the Social Security Act to provide health insurance to people 65 years of age and older and for those with certain disabilities and chronic diseases. Medicaid was signed into law as Title XIX of the Social Security Act to provide medical assistance for certain individuals with low income and resources. Both programs have undergone changes and expansion over their years of existence.[7] Measures to address quality in these services were established at the onset and have also changed over the course of time. Initially, in 1965, a set of conditions called "conditions of participation" were developed that addressed matters such as nursing services, staff credentials, and utilization review. Utilization review committees were established to identify whether hospitals and providers were meeting the conditions for participation. These committees were not considered successful partly because of a lack of means to identify ways to improve care.

In 1972, "Experimental Medical Care Review Organizations" were established by Congress and given the responsibility of reviewing both quality and appropriateness of care being delivered. These organizations were able to develop improvement strategies based on the findings of a quality review. The Experimental Review Organizations were more successful than the utilization review committees and led to the development of Medicare's Professional Standards Review Organizations (PSROs), which were charged with ensuring that hospitals and providers met Medicare guidelines for quality care. In 1983, the PSROs were replaced with Peer Review Organizations (PROs), which led to success in achieving goals of cost containment and quality improvement (QI). PROs continue to function as a Quality Improvement Organization under the current Centers for Medicare and Medicaid Services (CMS).[8]

Quality assurance (QA) models were the models initially used by hospitals as a method to maintain quality in the institution. In the 1980s, the approach of QI or quality management was added and used alongside QA models to improve the process of identifying root causes of poorer quality care and prevent future problems. Koch and Fairly[9] described some differences in QA and QI models of quality. QA activities tend to be inspection oriented to detect problems, whereas QI models are planning-oriented and focus on prevention. QA models tend to have a narrow focus, be reactive, and correct special problems, whereas QI models tend to have a cross-functional focus, are proactive, and attempt to correct the common causes of quality concerns. QA "models seek to ensure that current quality exists, whereas QI models assume that the process if ongoing and quality can always be improved."[10]

In the 1980s, the Healthcare Quality Improvement Initiative, developed by the Health Care Finance Administration (HCFA) and implemented as an effort to maintain QI in Medicare, allowed PSROs to apply a patient algorithm to data sets and claims history to identify how well care conformed to guidelines.[11] In the late 1980s, the Institute of Medicine (IOM) conducted a study commissioned by Congress to evaluate QA for