Quality Care: Where We Came From and Where We Must Go

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The focus of this new column will be to showcase innovative work that has advanced quality in areas of practice and care delivery that are of interest to the practicing oncology nurse. Examples include, but are not limited to, practice environment innovation, patient outcomes and experiences of care, team effectiveness, and unit-based or institutionwide system changes.

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The editorial board’s decision for the Clinical Journal of Oncology Nursing (CJON) to place special emphasis on quality comes at an important time. Passage of the Patient Protection and Affordable Care Act (2010) expanded healthcare access to millions of Americans, mandating sweeping reforms to the current system. The goals of increasing access and decreasing cost, while maintaining or improving quality, are central to the mandate of this new law. These goals pose specific and important challenges to those in oncology care. How can healthcare providers give cost-effective care that produces reliable and consistent quality outcomes for patients with cancer and their families? How can healthcare providers ensure patients and payors that the interventions at the system, institution, and individual patient level produce outcomes that are of sufficient value (low cost and consistent, reliable quality) to garner their trust and payment? Some answers to these questions lie in the growing body of knowledge regarding the science and methods of quality improvement. In this article, the evolution of quality improvement in healthcare is examined, as are the implications for oncology nurses and oncology care.

History and Evolution

Healthcare quality improvement is focused on the design, implementation, spread, and sustainability of interventions that demonstrate measurable improvements in clinical care processes and/or systems supporting those processes. The objective is to deliver the highest quality care at the lowest possible cost. The Institute of Medicine (IOM) 1999 defined quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The IOM (2001) later expanded the definition by identifying six aims for improving the quality of healthcare to make it safe, effective, patient-centered, efficient, timely, and equitable. These aims have guided quality improvement work in health care for the past decade. In 2011, a working group called the National Strategy for Quality Improvement in Healthcare was formed with the passage of the Patient Protection and Affordable Care Act and charged with developing quality aims and priorities for health care in the United States. The group issued its first report to Congress in April, 2012 (Agency for Healthcare Research, 2013). The aims are similar to those identified by the IOM in 2001. However, emphasis is placed on improving population health, preventing disease, and the affordability of care (see Figure 1).

The evolution of quality improvement in health care has roots in the work of Florence Nightingale. Working in a Turkish Hospital caring for British soldiers during the Crimean War, Nightingale established the link between sanitation, hygiene, infection, and mortality rates. Informed by her observations of the practice environment and care delivery systems, she implemented interventions corresponding to emerging theories of the spread of infection-causing microorganisms. Her interventions put emphasis on hand hygiene, changing of bed linens, sanitizing surgical instruments, providing proper nutrition, and ensuring fresh, continuous airflow for patients. A forerunner in the measurement of patient outcomes, Nightingale examined the impact of these interventions on infection and mortality over time, demonstrating a decrease in mortality rates from 60% to 1% (Goldie, 1987; Kalisch & Kalisch, 2004). Spreading and sustaining these changes across the system, she used her own evidence to create a safer, more reliable practice environment for a patient population at high risk for infection. Nightingale’s work distinguishes her as a pioneer in developing the fundamentals of quality improvement methods and measurement. Her work leaves nurses and other healthcare providers a powerful legacy for continuously improving the quality of care for patients and families.

The focus on healthcare quality in the United States continued into the 20th century and was marked by the transformation of medical education, government funding of programs supporting maternal child health, and the creation of Medicare and Medicaid. At the same
time, quality experts in the business and manufacturing industries developed methods for improving efficiency and quality, concentrating on eliminating errors, increasing standardization of production processes, and using data-driven decision making. Those successful methods were subsequently adapted to health care and continue to inform many of the current approaches to improving systems and processes of care.

In the 1950s, regulatory and accrediting agencies were created, such as the Joint Commission Agency on Healthcare Organizations. They developed best practice standards for accreditation and regulation of healthcare institutions and continue to hold the industry accountable for the provision of quality care (Ranson, Joshi, & Nash, 2005). The introduction of the Donabedian model (Donabedian, 2005) for evaluating healthcare quality (structure, process, outcomes) provided an excellent framework for organizing the work of quality improvement.

Perhaps the most significant impact on the quality movement in the healthcare system in the United States in the past 50 years was the publication of two seminal reports, To Err Is Human: Building a Safer Health System (IOM, 1999) and Crossing the Quality Chasm: A New Health System for the 21st Century (IOM, 2001). These reports called attention to the unprecedented number of serious medical errors, as well as gaps in quality across the U.S. healthcare system. Both publications made a powerful case for making clinical care safe and for improving the reliability and quality of clinical outcomes in U.S. hospitals. This call to action is considered by many to have launched the transformation of the U.S. healthcare system that is currently underway.

Quality Oncology Care

The IOM published a report on cancer quality in the United States, concluding that oncology care, although excellent in many respects, continues to be inconsistent in its use of known best practices and evidence, is fragmented and lacking in coordination, and is inefficient with respect to resource use (Hewitt & Simone, 2009). The undisputed findings of this report, the National Quality Forum workgroup whitepaper on cancer quality measurement (Hassett & Bach, 2008), and outputs from various other groups are now driving the agenda for cancer quality. Examples of current priorities include the establishment and use of clinical guidelines and established best practices in cancer treatment, engagement of patients and families in their care, organization of services around what patients determine to be important to them, efficiency in models of care delivery, and use of practical methods for implementing quality measurements, such as the Quality Oncology Practice Initiative (Neuss, Gilmore, & Kadlubek, 2011).

Oncology nurses work separately and in teams to care for patients and their families. How have best practices and evidence been implemented into care models and where do gaps continue to exist? How well have oncology nurses educated themselves in quality improvement methods and applied the tools of improvement to make practice environments efficient and conducive to delivering high-quality care? What innovative methods have oncology nurses used to implement standards and guidelines that eliminate practice variation and improve safety and quality, such as the new Oncology Nursing Society (ONS)/American Society of Clinical Oncology chemotherapy guidelines (Neuss et al., 2013), and the existing ONS Putting Evidence Into Practice cards for symptom management (ONS, 2013a)?

Recommendations from the IOM (2011) report on the future of nursing call for nurses to redesign and improve practice environments and health systems in partnership with physicians and other members of the healthcare team. How and where have oncology nurses implemented established principles of positive practice environments and interventions to ensure positive care experiences for patients and families? How are oncology nurses ensuring the effectiveness of care models to support high-functioning teams delivering safe, effective care? How efficient are oncology nurses with resource use and what strides have been made to maximize the skills of each member of the clinical team?

Institute of Medicine, 2001
Six Aims for Improving Healthcare in the United States

Safe: Reducing medical errors; avoiding preventable injuries
Effective: Providing services based on scientific knowledge: evidence-based; clinical guidelines
Patient centered: Care that is respectful and responsive to individuals
Equitable: Consistent care and access regardless of patient demographics or characteristics
Efficient: Avoiding waste and other resources that increase costs of care.
Timely: Reduce unnecessary waiting time, improve practice flow and throughput

Agency for Healthcare Research, 2013
National Strategy for Quality Improvement in Health Care

Better care: Improving the overall quality of care by making health care more patient-centered, reliable, accessible, and safe
Priorities
• Make care safer by reducing harm caused in care delivery.
• Ensure that each person and family is engaged as partners in his or her care.
• Promote effective communication and coordination of care.

Healthy people/healthy communities: Improve population health by supporting evidence-based interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher quality care.
Priorities
• Promote effective prevention and treatment practices for leading causes of mortality.
• Work with communities to promote use of best practices for healthy living.

Affordable care: Reduce the cost of quality health care for individuals, families, employers, and government.
Priority
• Make quality care more affordable for all by developing and spreading new healthcare delivery models.

Comparative focus across studies
Comparative focus across studies
No comparable focus across studies

FIGURE 1. Comparing National Aims to Improve Healthcare Quality
Note: Based on information from Agency for Healthcare Research, 2013; Institute of Medicine, 2001.
Conclusions

In this new CJON column, we invite you to share quality improvement work from your practice settings with the readership, to disseminate the meaningful impact oncology nurses have in transforming cancer care and systems for delivering that care. Consistent with the mission of ONS (2013b) to promote excellence in oncology nursing and quality cancer care, it is fitting that at this moment of sweeping change and reform in healthcare, we open this formal dialogue on quality.

References


Do You Have an Interesting Topic to Share?

Quality provides readers with an update on innovative work in the area of practice and care delivery. Length should be no more than 1,000–1,500 words, exclusive of tables, figures, insets, and references. If interested, contact Associate Editor Anne H. Gross, PhD, RN, at anne_gross@dci.harvard.edu.