DOWNLOAD PDF CHANGING HEALTH-CARE SYSTEM AND EXPECTATIONS OF PHYSICIANS EDWARD H. ONEIL

Chapter 1 : Creating community-responsive physicians :

The Changing Health-Care System and Expectations of Physiciansâ€"Edward H. O'Neil Toward Building Communities of Commitment: Integrating Community-Oriented Primary Care and Continuous Quality Improvement Into Service-Learningâ€"Deborah Gardner, Andrew Schamess, Doreen Harper, Denice Cora-Bramble.

They can either establish minimum levels of performance or can establish consistency or uniformity across multiple individuals and organizations. Another purpose for standards is that they set expectations. The process of developing standards can set expectations for the organizations and health professionals affected by the standards. The publication and dissemination of standards additionally helps to set expectations for consumers and purchasers. Standards can be developed and used in public regulatory processes, such as licensure for health professionals and licensure for health care organizations, such as hospitals or health plans. Standards can also be developed through private voluntary processes, such as professional certification or organizational accreditation. Although there are many kinds of standards in health care, especially those promulgated by licensing agencies and accrediting organizations, few standards focus explicitly on issues of patient safety. Furthermore, the current lack of safety standards does not allow consumers and purchasers to reinforce the need for safe systems from the providers and organizations with whom they have contact. All existing regulatory and voluntary standard-setting organizations can increase their attention to patient safety and should consistently reinforce its importance. Expectations for the performance of health professionals and organizations are also shaped by professional groups, purchasers and consumers, and society in general. Professional groups and leaders play a particularly important role in establishing norms and facilitating improvements in performance through educational, convening and advocacy activities. Large public and private group purchasers and purchasing coalitions also have the opportunity to shape expectations through marketplace decisions. This chapter describes how performance standards and expectations can foster improvements in patient safety. Although this report has described the importance of a systems approach for reducing errors in health care, licensing and accreditation of individual practitioners and organizations can also play a role in reinforcing the importance of patient safety. The primary focus is on how existing models of oversight can be strengthened to include a focus on patient safety. In this report, the committee did not undertake an evaluation of the effectiveness of public and private oversight systems to affect quality of care. The committee recognizes, however, that as the organizational arrangements through which health care is delivered change, an evaluation may be appropriate since the existing models of oversight may no longer be adequate. Recommendations In the health care industry, standards and expectations about performance are applicable to health care organizations, health professionals, and drugs and devices. The committee believes there are numerous opportunities to strengthen the focus of the existing processes on patient safety issues. Regulators and accreditors should require health care organizations to implement meaningful patient safety programs with defined executive responsibility. Public and private purchasers should provide incentives to health care organizations to demonstrate continuous improvement in patient safety. Changes within health care organizations will have the most direct impact on making care delivery processes safer for patients. Regulators and accreditors have a role in encouraging and supporting actions within health care organizations by holding them accountable for ensuring a safe environment for patients. Health care organizations ought to be developing patient safety programs within their own organizations see Chapter 8. After a reasonable period of time for health care organizations to set up such programs, regulators and accreditors should require patient safety programs as a minimum standard. The marketplace, through purchaser and consumer demands, also exerts influence on health care organizations. Public and private purchasers have three tools that can be employed today to demand better attention to safety by health care organizations. First, purchasers can consider safety issues in their contracting decisions. Second, purchasers can reinforce the importance of patient safety by providing relevant information to their employees or beneficiaries. There is increasing

attention in providing information to aid in the selection of health coverage. Information about safety can be part of that process. Finally, purchasers can communicate concerns about patient safety to accrediting bodies to support stronger oversight for patient safety. Health professional licensing bodies should 1 implement periodic reexaminations and relicensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices; and 2 work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action. Professional societies should make a visible commitment to patient safety by establishing a permanent committee dedicated to safety improvement. For most health professionals, current methods of licensing and credentialing assess knowledge, but do not assess performance skills after initial licensure. Although the state grants initial licensure, responsibility for documenting continued competence is dispersed. Competence may be considered when a licensing board reacts to a complaint. It may be evaluated when an individual applies to a health care organization for privileges or network contracting or employment. Professional certification is the current process for evaluating clinical knowledge after licensure and some programs are now starting to consider assessment of clinical skills in addition to clinical knowledge. Given the rapid pace of change in health care and the constant development of new technologies and information, existing licensing and accreditation processes should be strengthened to ensure that all health care professionals are assessed periodically on both skills and knowledge for practice. More effective methods for identifying unsafe providers and better coordination between the organizations involved are also needed. The time between discovery of a problem, investigation, and action can currently last several years, depending on the issue and procedures for appeal or other processes. Efforts should be made to make this time as short as possible, while ensuring that practitioners have available the due process procedures to which they are entitled. Although unsafe practitioners are believed to be few in number and efforts to identify such individuals are not likely to improve overall quality or safety problems throughout the industry, such efforts are important to a comprehensive safety program. Finally, professional societies and groups should become active leaders in encouraging and demanding improvements in patient safety. Setting standards, convening and communicating with members about safety, incorporating attention to patient safety into training programs, and collaborating across disciplines are all mechanisms that will contribute to creating a culture of safety. As patient advocates, health care professionals owe their patients nothing less. Drugs may be prone to error in use due to sound-alike or look-alike names, unclear labeling, or poorly designed packaging. FDA standards for packaging and labeling of drugs should consider the safety of the products in actual use. Manufacturers should also be required to use proven methods for detecting drug names that sound or look similar. If necessary, Congress should take appropriate action to provide additional enabling authority or clarification of existing authority for FDA to implement this action. Since not all safety problems can be predicted or avoided before a drug is marketed, FDA should also conduct intensive and extensive monitoring to identify problems early and respond quickly when serious threats are discovered in the actual use of approved drugs. Current Approaches for Setting Standards in Health Care Generically, standards can be used to define a process or outcome of care. The Institute of Medicine defines a quality standard as a minimum level of acceptable performance or results or excellent levels of performance or results or the range of acceptable performance or results. The committee does not recommend one definition or type of standard over another, but recognizes that standards can be quite varied and that as standards specific to safety are developed, they could take multiple forms and focus. In health care, standards are set through both public, regulatory initiatives and private, voluntary initiatives. Standards can apply to health care organizations, health professionals, and drugs and medical devices. For health care organizations e. For health care professionals, standards are set through state licensure, board certification, and accrediting and credentialing programs. For drugs and devices, the FDA plays a critical role in standard setting. In general, current standards in health care do not provide adequate focus on patient safety. Organizational licensure and accreditation focus on the review of core processes such as credentialing, quality improvement, and risk management, but lack a specific focus on patient safety issues. Standards for drugs and medical devices concentrate on safe design and

production, with less attention to their safe use. Current standards in health care leave serious gaps in ensuring patient safety. Performance Standards and Expectations for Health Care Organizations Standards and expectations for health care organizations may be established through oversight processes, primarily licensing and accreditation requirements. Additionally, large public and private purchasers may also impose demands on health care organizations. Each is discussed in this section. Licensing and Accreditation There is a great deal of variation in state licensure requirements for health care organizations. Responsibility for licensure rests at the state level, with each state setting its own standards, measurement, and enforcement. Although standards and measurement can be made more similar, enforcement is always likely to vary to some extent depending on the level of resources devoted by a state to this activity. In many states, licensure and accreditation are intertwined. Some states may additionally require compliance with other standards related to building safety or medical care issues that are tracked in that particular state. The remaining states do not link hospital licensure and accreditation. Although the overwhelming tendency to use JCAHO increases the consistency of standards nationally, differences in application also contribute to the variation in ensuring patient safety. For licensure of health maintenance organizations HMOs , some states rely on private accrediting bodies, primarily the National Committee for Quality Assurance NCQA , to conduct reviews of health plans. One of the few mechanisms in place today that more broadly examines care in the ambulatory setting is managed care organizations. Three private-sector agencies play a role in organizational accreditation: Each effort, to some degree, encompasses aspects of standard setting and performance measurement. JCAHO accredits more than 18, health care organizations, including hospitals, health plans, home care agencies, and others. JCAHO accredits hospitals for three-year periods based on compliance with its standards in the areas of patient rights and patient care: Both Joint Commission-accredited hospitals and those accredited by the American Osteopathic Association are deemed to meet Medicare conditions of participation. JCAHO is incorporating performance information into the accreditation process through its Oryx system, in which hospitals will collect clinical data on six measures and submit performance data on these measures. This system was introduced in and is required by the Joint Commission for a hospital to be accredited. Eventually hospitals will have to demonstrate specific Oryx performance to maintain their accreditation status. NCQA accredits health plans for periods of one, two, or three years. Approximately 14 states incorporate accreditation into their licensure requirement for health plans; another six states require that health plans have external reviews, most of which are done by NCQA Steve Lamb, NCQA, personal communication, March 2, Purchaser Requirements and Demands Both private and public purchasers have the ability to encourage health care organizations and providers to pursue continuous improvements in patient safety. Large group purchasers, such as Fortune companies or the Health Care Financing Administration, and purchasing coalitions that provide insurance to large numbers of people are well positioned to exert considerable leverage in the marketplace. Private Group Purchasers There are numerous examples of large private employers that incorporate quality issues into their decision-making process when selecting health plans and providers to offer to employees. ARCO evaluates health plans based on 50 different quality and access criteria, and ties the employer contribution to the premium level of the highest-ranking plan. A survey of U. Health Care Financing Administration As a major national purchaser of health care services, HCFA sets standards through payment policies and conditions of participation for the organizations with which it contracts. HCFA provides health insurance for 74 million people through Medicare, and in partnership with the states, Medicaid, and Child Health Insurance programs. The peer review organizations PROs monitor the utilization and quality of care of Medicare beneficiaries through a state-based network. First, they conduct cooperative quality improvement projects in partnership with other quality-focused organizations. Among the current projects are programs on diabetes, end-stage renal disease, influenza campaign, and quality improvement systems for managed care. Second, PROs conduct mandatory case review in response to beneficiary complaints, as well as educational and outreach activities. Third, they oversee program integrity by ensuring that Medicare pays only for medically necessary services. Patient safety has not been identified as a priority to date, however, HCFA is giving serious consideration to

making patient safety a higher priority.

Chapter 2 : The Workforce for Health | Vision: Health in the 21st Century | The National Academies Press

system and the relevance of community-oriented primary care and continuous quality improvement to service learning; titles are: "The Changing Health-Care System and Expectations of Physicians" (Edward H. O'Neil); and.

Figure 1 Health care in the United States, circa The final value involves improving the quality of patient care outcomes. The system is moving faster now than even the most aggressive prognosticators thought possible as recently as two or three years ago. By the end of this decade, I believe that in most major markets of this country, 90â€”95 percent of the population will be enrolled in some sort of integrated system, not owned necessarily all in a single place, but integrated in the sense of long-term contracts or exclusive contracts. Already, in northern California; Portland, Oregon; Seattle, Washington; and the Twin Cities, such patterns of organization are emerging. The nature of the integration is almost unimportant; horizontal or vertical integration is almost unimportant. However, the size of the system is critical. How the systems come together is something for consultants and attorneys to work on, not something that will have anything ultimately to do with the health of the nation. This integration is occurring in three phases. Let me focus on one dimension of each, because in each of the three phases there is a cost-control and system value-added dimension that presses severely on health professionals and their work. The first stage is assemblyâ€”the cobbling together of systems. That is going on right now. To try to make sense out of this and then project into the future is foolish because, next year, someone will buy the system on which that analysis is based and the analysis will be useless. In this first phase, limiting access and reducing fees are essentially the means of controlling Page 95 Share Cite Suggested Citation: Health in the 21st Century. The National Academies Press. This is what is pressing most on professionals as they take on the responsibility for that risk. The second phase sounds terrificâ€”the integration of this far-flung set of health care resources in management information and decision support systems. This is the promise, the upside. The downside in integration is having to remove excess capacity from the system. In independent hospitals it made sense to have an operating census of 20 percent. In putting together a system of four or five hospitals, it makes no sense to have each operating with that kind of enrollment. So that is where we remove perhaps 30â€”50 percent of the hospitals; maybe 40â€”60 percent of the hospital beds; from , to , of the physicians, all of them specialists; and perhaps ,â€”, hospital-based nursesâ€”not because we change the intensity of care delivered in the hospital, but because the hospital is not operating any longerâ€”the work force simply is not there. Finally, we arrive at a management phase. If there is a silver lining in this rather brutal process, it is in management. If there is an American genius in what we are about, it is bringing a brand new approach to the organization of health care. This not only will redesign the health production function to yield the higher value that has been discussed, but will also change the process by which we produce care. Determine what the inputs are, professional and other, that will actually produce a particular outcome, and then radically redesign in that context the practice of health professionals. Why the professions are key to this change is obvious, but let me mention a few reasons. Health care itself is a labor-intensive process: The professions control cost, waste, and innovation by how they work. The existing professional structures are not amenable to change. We have essentially a set of 19th-century work rules operating in a 21st-century institution. We have this system that has been dominated by supply. What is it that we want to provide? What is best for us? How do we want to array the community needs to increase demand? All of the professions are tied to this aging model. Medicine is overly focused on individual practitioners providing clinical service to individual patients who present with acute care treatment needs. Nursing is oriented to an undifferentiated practice across most ranges of nursing today, particularly within a hospital setting. By continuing to operate in this way, the emerging system is demanding different roles for nurses. Pharmacy is still focused almost exclusively on the physical delivery of a drug, even though we know that the guarantees of quality and other di- Page 96 Share Cite Suggested Citation: In allied health, the more than different allied health professions still define themselves by the technology or the therapy that created them

and build walls around those technologies and therapies to protect themselves. The transition that is likely to occur over the next decade is one from protectionism, to use a very stark and harsh word, to pragmatism for the professions: These values involve particularly, a capacity to lower costs, to deliver health quality at a higher outcome, and to enhance patient satisfaction. This may or may not have anything to do with the scope of practice. The health system itself increasingly has the power to make those decisions and looks to the professions to assist it. Professions have been unwilling or unable to capture or control quality. There is nothing in 40 years of the literature to indicate that the professions have been up to that task, unless the violation of quality was so egregious as to involve the criminal justice system. Then and only then do the professions have a record of actually policing their own in any effective way. So now we have quality standards not only developed from the system but demanded by the purchasers of the system. That power shift, more than anything else, will drive and create the new reality. Controlling information and access to that information has been central since the Middle Ages to the definition of what a profession is about, but we now know that information is abundant, cheap. The first step is the redesign of the health workplace. This is going on right now with little, if any, public discussion. The market-driven changes are pushing faster and deeper into reform than anything proposed by the Clinton administration. The next step is reregulation of professional practice, not its deregulation. We do not need to leave the professions or the public out in the cold against these terrible mechanisms of the marketâ€"the profit-driven managed care systems. What we need is a set of regulations that serve the public interest at the end of this century, not the end of the last century. Then must come right-sizingâ€"the politically correct word. There is some upsizing necessary in certain professions, but for a couple of important professions, there must be some downsizing. Finally, there is the restructuring of education. Redesign of the workplace focuses on outcomes, quality, cost, and the information base. It is performance driven. We have touched on all of these. Flexible, innovative, and adaptable are not words that have been hall-marks of the health professions. We must recognize those professions that once were viable but are no longer useful, and we need to get on with the process of team-oriented education and training. Then costs can be determined. Practice acts must be based on demonstrated initial competence, and professional boards must focus on changing Page 97 Share Cite Suggested Citation: The role of the consumer in all of this must be enlarged. Continuing competency requirements must be required as a part of that. The entire process must be focused on quality performance, or it simply will not be worth the time invested in it. Right-size the professions or reduce the number of physicians produced. Too many physicians are being produced by both the graduate and the undergraduate medical education systems. This number cannot be sustained in the system as it is now, much less as it will become. Reduce and redirect nursing practice toward four-year and advanced practice programs. The size of nursing programs at the diploma and associate degree level must be reduced. Reduce the number of pharmacists produced. In a system that will rapidly take advantage of information, communication, and transportation technology to distribute drugs, we simply do not need pharmacists handling drugs unless you like the opportunity to visit your local drugstore. Expand public health programs and increase the number of public health professionals. Several others have said that this is a great day for public health. In the evolution of the management phase, we eventually move to management of the health of populations. We do not have them integrated enough into clinical disciplines. The number of multiskilled allied health workers must increaseâ€"not the number of technically driven allied health workers, but the number of allied health workers who are multiskilled. Make education accountable for cost, time, and performance. If you liked managed health care, you are going to love managed education, because it will be in terms of performance and accountability standards. New skills must be created and offered for professional education. Remove time and place boundaries. It makes no sense to have a resource tied up in an institution. Move it to an ambulatory community setting. Clearly, we have made major strides in that direction. Merge with integrated care systems. It makes no sense to affirm a department of community and family medicine today but build it like a department of medicine in That was the wrong image: To build a primary care department today, build it at Kaiser Permanente; then figure out how to appoint the faculty back to your

academic health center. Then create a funding-based educational mention not to research, not to service, not to indirect recovery. To speak specifically about a few professions, physicians are oversupplied. Figure 2 is a picture of one estimate of specialist positions from the Pew Health Professions Commission. If we continue in this way until , there will be perhaps , too many specialists for that environment.

Chapter 3 : Enhancing Professionalism | Annals of Internal Medicine | American College of Physicians

This volume is part of a series of 18 monographs on service learning and the academic disciplines. Essays in this volume focus on understanding how service-learning in medical education differs from traditional clinical medical education.

Chapter 4 : Creating Community-responsive Physicians : Kris Hermanns :

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Chapter 5 : Creating Community-responsive Physicians PDF Sarena D. Seifer, Kris Hermanns, Judy Lewis

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