SPRING 2001

ARIZONA HEALTH FUTURES

IN THIS ISSUE:

SLHI
A Catalyst for Community Health
St. Luke's Health Initiatives

Got Quality?

THE SEARCH FOR PERFECTION IN AN IMPERFECT HEALTH CARE SYSTEM

Item: John Hall, a Professor of Public Affairs at ASU, had the decided misfortune to be mugged in broad daylight in downtown Phoenix in January. Then he had the misfortune to wait in a local emergency room for six hours before being treated.

Item: Ann Ronan, attorney for the Arizona Center for Disability Law, reports an even bigger challenge than those faced in the recent settlement of the Jason K lawsuit to provide services to children with serious mental and emotional disorders: There aren't nearly enough trained case managers to provide the quality care these children so desperately need.

Item: Dr. Chris Shearer, Director of Baptist Hospital's Family Practice Residency Program, tells of seeing JA, a man who shows up at the clinic with tremors and an unsteady gait. It turns out to be lithium toxicity, caused by taking a combination of non-steroids for intense back pain and a number of medications for chronic bi-polar disease. But another doctor in another system treats JA's mental illness. If Dr. Shearer hadn't gone "outside" the system and tracked down JA's psychiatrist to work together to solve his problem, he could have been another medical "error" in the making.

Wrenching Social Change

Isolated incidences? Hardly. They are representative of serious structural dislocations that compromise the ability of health professionals to deliver a high quality of care to patients. This isn't a story about identifiable bad guys – incompetent physicians, greedy insurance companies, plodding bureaucrats – but rather a tale of misaligned incentives, unrealistic expectations, fragmented systems and colliding market forces.

Mostly it's a story about wrenching social change, and how it usually takes a crisis to get people to cooperate for the greater public good.

In this issue of Arizona Health Futures, we map out the concept of quality in health care: What is it, how do we know it when we see it, and how do we get more of it. Quality is not an easy concept to define, nor can it be deconstructed without exploring its relationship to issues of access and cost – the other two legs of the health policy stool that were subjects of the two preceding issues of AHF.

We hope to bring these issues into sharper perspective by providing relevant information and analysis, sampling the views of people in health care, and suggesting strategies for action in Arizona.

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Defining Quality: H

Trying to define quality in health care is a little like trying to define pornography: There's little agreement on exactly what it is, but you know it when you see it.

Lawrence Shapiro, M.D., President of Health Services Advisory Group in Phoenix, puts it succinctly: "It will take the rest of our collective lifetimes to define exactly what quality in health care is."

But why is this? Surely we can all agree that when a person goes to a doctor complaining of a sore throat, gets a proper diagnosis and intervention, and is markedly improved within a few days, that's a "quality" outcome, right?

Well, yes and no. Perhaps the patient had to wait two hours for an appointment. Perhaps the physician was rude and arrogant. From the customer's perspective, the "total package" may have been a disaster, even though the "technical" outcome was good.

Conversely, Suzie Ingersoll, R.N., Director of Quality Improvement at UnitedHealthcare in Arizona and a former staff nurse, remembers a particular doctor who was a favorite of patients because of his interpersonal skills. Yet none of the nurses liked to work with him because, in Ingersoll's words, "he didn't know what he was doing."

"What we might call quality, a patient might call satisfaction," Ingersoll says. "Where they pleased or not? That's often the chief criterion."

For Starters: A Definition

One place to start thinking about quality in health care is a definition that is widely accepted by many health professionals and organizations. This is the Institute of Medicine's (IOM) definition, developed in 1990:

"Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

This definition raises three key points:

Q The distinction between quality of care for individuals and populations. The U.S. offers the highest quality care in the world delivered to individuals by specific organizations, health plans and clinicians. At the same time, we have less impressive outcomes when looking at quality of care across the health care system from the perspective of populations, defined by cultural heritage, socio-economic characteristics, geography, etc. (See sidebar on the World Health Organization 2000 report).

Q The emphasis on current professional knowledge. The IOM definition of quality of care stresses mastery of an expanding knowledge base, evidence-based practice and the rigor of the scientific method. This often runs up against high quality of care ratings by consumers for certain procedures and remedies for which there is no persuasive clinical and scientific evidence, but often a great deal of anecdotal and cultural support.

Q The phrase desired health outcomes. This highlights the critical link between care and its effects on health. The issue, of course, is determining what the "desired" outcome ought to be, and the extent to which clinicians take patients' preferences and values into account in determining that outcome.

Q "It will take the rest of our collective lifetimes to define exactly what quality in health care is."

Lawrence Shapiro, M.D.
President of
Health Services
Advisory Group

Helpful or Hopeless?

More Questions Than Answers

The IOM definition of quality of care is useful. It illustrates the provisional nature of all definitions in something as dynamic, changing and contentious as America's health care system.

First, the definition raises questions about the clash of perceptions and perspectives: those of clinicians and patients, individuals and populations, traditional and "emerging" practitioners. It invites a critical examination of diverse and even divergent perspectives, and that is exactly where we need to begin in a concerted effort to improve quality of care on more than just a sporadic basis.

Second, the definition avoids tying quality to the issue of resource constraints, i.e., the relationship between quality and efficiency, or cost. Judgments about quality ought not to be made on the basis of what one can afford – although they often are. Instead, the issue of cost is related to quality through

the concept of value, expressed in the equation:

Obviously, our nation will be forced to come to terms with how much quality of care we can afford given demographic, economic and social trends. But that is not the same thing as coming to terms with what represents quality of care in the first place.

Finally, because the definition stresses the relationship between quality of care and the likelihood of good outcomes, it reminds us that quality is not the same thing as good outcomes. You can get the best possible care in the world and still have poor outcomes. Not only do we have to deal with the limits of science and knowledge – and just plain bad luck – but we also have to deal with unhealthy human behavior, which often has more to do with outcomes than medical interventions.

To no great surprise, quality health outcomes start with us.

"What we might call quality, a patient might call satisfaction."

Suzie Ingersoll, R.N.
Director of Quality Improvement
UnitedHealthcare in Arizona

Resources

- The Institute of Medicine's To Err is Human (1999) and Crossing the Quality Chasm (2001) provide a good overview of health care quality and safety issues. Visit www.iom.edu for more information.
- The Agency for Healthcare Research and Quality (AHRQ) provides a wide range of resources on quality issues for clinicians, consumers, organizations and researchers. www.ahrq.gov.
- Employers are becoming more active in demanding high quality and patient safety in health care. The Leapfrog Group for Patient Safety, part of the Business Roundtable, is one example. www.leapfroggroup.org.
- The Institute for Healthcare Improvement (IHI) is engaged in a number of quality improvement projects and related activities. See www.ihi.org.
- The National Committee for Quality Health Care (NCQHC) is an educational organization focused on improving health care quality. www.ncqhc.org.
- The Robert Wood Johnson Foundation recently initiated its Pursuing Perfection grant program to help hospitals and physician organizations improve patient outcomes. Learn more at www.rwjf.org.
- In Arizona, the Health Services Advisory Group (HSAG) provides quality improvement services to organizations and governmental groups. www.hsag.com. Phoenix-based IntelliMed maintains a web site that provides information on health care quality based on consumer feedback. www.myhealthscore.com.

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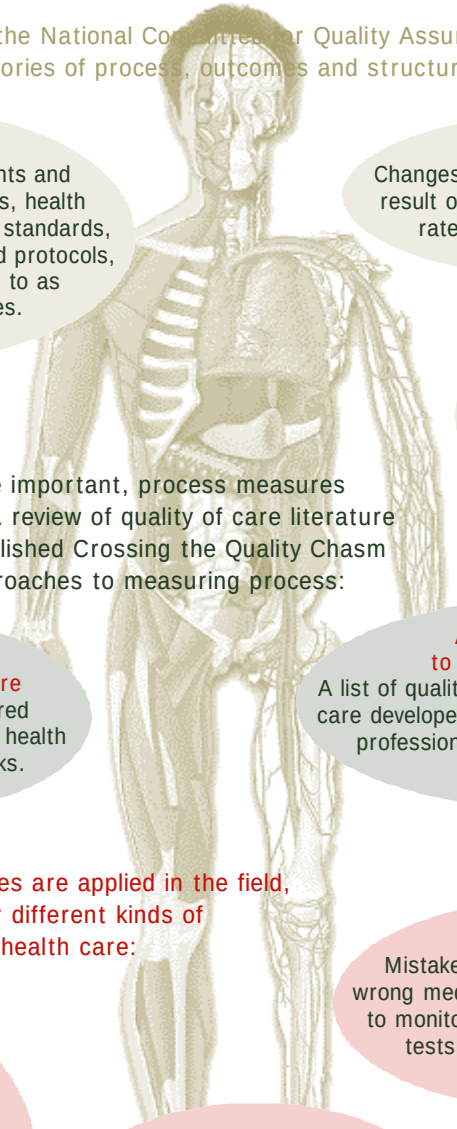
The Anatomy of Quality

Organizations like the IOM and the National Committee for Quality Assurance (NCQA) break the evaluation of quality into the familiar categories of process, outcomes and structure:



Process Measures
Interactions between patients and clinicians (immunization rates, health screening rates, best practice standards, compliance with evidence-based protocols, etc.). This is also referred to as performance measures.

Outcome Measures
Changes in the patient's health status as the result of health care interventions (recovery rates, mortality, health status, etc.).

Structural Measures
The capacity of health systems to deliver care (staffing, equipment, output measures like the number of heart surgeries performed annually in a hospital, board certification, etc.)

While all of these measures are important, process measures receive most of the attention. A review of quality of care literature by the IOM in their recently published Crossing the Quality Chasm (2001) revealed two major approaches to measuring process:

Assessing appropriateness of care
The process is considered appropriate if the expected health benefits exceed the risks.

Assessing adherence to professional standards
A list of quality indicators based on standards of care developed through evidence-based practice, professional medical associations, expert panels, etc.

When these approaches are applied in the field, the results reveal four different kinds of problems in quality of health care:

Misuse
Mistakes in care. Prescribing the wrong medication, misdiagnosis, failure to monitor or follow up abnormal lab tests, surgical mistakes, etc.

Underuse
Too little care. Serious depression is under diagnosed, not enough people get screening and preventive services such as mammography and immunization, people fail to visit a doctor and get effective medications until the problem has reached the critical stage, etc.

Overuse
Too much care. The overuse of antibiotics, unnecessary surgery, excessive use of x-rays and other diagnostic tests, etc.

Variation in Use
Variations in medical practice in different regions and communities, i.e., higher hospital discharge rates in the East than in the West, etc.

As useful as these categories of assessing quality are, we might note the following:

- Process measures are useful only insofar as they can be linked to outcomes that people actually desire and care about. A health plan may have the best "report card" in Arizona based on established HEDIS measures (Health Plan Employer Data and Information Set), but it may not measure what's important to consumers, such as whether doctors are available on evenings and weekends.
- Outcome measures are useful only insofar as they can be linked to health interventions that actually have a demonstrated impact on the outcome. We cannot hold the health system accountable for outcomes that may be more a factor of behavioral, environmental and genetic causes than the "quality" of medical interventions.
- Quality measures are designed with specific audiences in mind: health plans, providers, consumers, payers. Some want neatly arranged tables of clinical outcomes, others might want information on patient-provider communication. Part of the difficulty in both defining and assessing quality in health care lies in trying to meet the expectations of different audiences.

LIVE AND LEARN: Measuring Quality in Mental Health

St. Luke's Health Initiatives knows firsthand how hard it can be to measure quality, let alone define it. We learned this through the aborted launch of our Mental Health Outcomes Indicator Project.

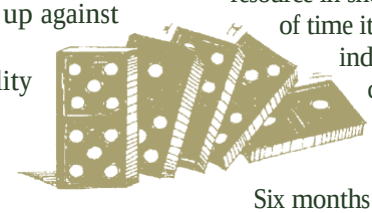
Defining and measuring quality of care in mental health makes physical health look like a walk in the park. There are huge definitional and boundary issues, stigma issues, lack of integration with necessary medical and social services, lack of resources and, until recently in Arizona, an appalling lack of public attention.

In 1998 SLHI issued its Into the Light study of Arizona's public mental health system. It concluded, among other things, that Arizona spends too much time and resources assessing process and structural indicators of quality (wait time before seeing a doctor, credentials of case managers, etc.) and not enough on assessing outcomes (do people get better and go back to work, do they find stable housing and employment, etc.).

To give the system a little "push," we initiated an outcomes indicator project. The idea was to convene the stakeholders, see if we could come up with a core set of manageable outcome indicators that we all could agree might serve to measure whether the system was successful, populate the indicators with data from the various parts of the system, establish some baselines, measure performance over time, issue public "report cards" comparing different geographical regions of the system, and provide ongoing technical support and training in best practices to improve performance over time.

The Real World

It sounded good. But we soon ran up against all the real world issues that plague everyone who works to improve quality in health care:



The BLAME Game. Quality issues are always someone else's fault: incompetent doctors, rigid bureaucracies, not enough trained staff, stifling rules and regulations, not enough money, not enough time, legislative inertia, for-profit companies, etc.

The ACCOUNTABILITY Game. Some of the key stakeholders didn't think it was fair to rate their performance for, say, safe and secure housing for seriously mentally ill persons when there wasn't adequate low income housing in the community, and public reimbursement rates were below market rates. Publishing report cards on outcomes that are significantly impacted by forces beyond the control of providers and public systems raises false expectations, invites disappointment and fuels the continuing blame game.

The RESOURCE Game. It takes significant management information resources, both in terms of data systems and trained staff, to add muscle to outcome indicator bones. Our biggest hurdle proved to be getting assistance on data collection from a state system sorely understaffed and underfunded. Time was the other resource in short supply. We underestimated the amount of time it would take to mount an outcomes indicator project of any significance, especially considering the public system's preoccupation with immediate contractual, legal and funding issues.

Six months into the project, we made the decision to reassess the strategy. The good news is that Arizona's public behavioral health system is moving forward with work on developing outcome quality indicators that was started before SLHI entered the picture, and there is a strong commitment among all stakeholders to participate in that process – all the "games" mentioned here notwithstanding.

Our own take-home lesson is that assessing and improving quality in something as contentious and complicated as mental health requires long-term involvement in social and cultural change that extends considerably beyond linear systems thinking and tidy categories of data.

Quality starts with thoughtful and persistent communication. That's also where it ends.

THE TOTAL PACKAGE: How Much Quality Can We Really

R. Scott Gorman, M.D., Medical Director of Mayo Health Plan Arizona (MHPA), tells the story of sending out cards to members on their birthday and reminding them to get checkups. One woman called to complain, "How dare you remind me that I'm getting older and need a mammogram?"

For Gorman, the story illustrates the relation between quality improvement and patient compliance, and the need to develop health systems that make it easy for people to get preventive and primary care.

The traditional 8 a.m. to 5 p.m., Monday-Friday office model doesn't always make sense in a changing consumer demographic. Gorman asks, "Does the public really see the difference between a service provider and a professional?" He points out that physicians are more aware of the customer service dimensions of their work than even a decade ago.

"For the patient, quality is the total package," Gorman says. "It's how they're treated in the office, whether someone sees them in a timely manner, how the office functions, as well as the clinical expertise and health outcome."

Different customers expect different things. A younger person might want the doctor to cut the social chatter and get on with the evaluation and diagnosis. An older person might want to chat longer and visit the gift shop afterwards.

"From what we see, quality and service are usually conflated in the public's mind," Gorman says.

"I tell them that medicine is an art as well as a science."

The Latest Issue

Like others, Gorman notes an increased interest in patient safety and medical errors, which he describes as the "latest issue of the day." Safety issues have always been with us, he points out, but with the conflicting trends of higher medical costs, higher expectations on the part of the public, and declining resources – especially trained staff – they have a sense of urgency that wasn't apparent before.

MHPA, which covers 43,000 members through a network of more than 2,000 community-based physicians, has a continuous improvement committee that uses the HEDIS measures and other indicators of quality to monitor plan performance. In addition to working to increase patient safety, reduce medical errors and improve clinical outcomes, Gorman reports that some of Mayo's primary care clinics are moving to drop-in medical services and same-day appointments – all in an effort to improve customer service.

"Years ago there were physicians who actually took pride in not providing timely appointments," Gorman says. "Two or three month wait times indicated their services were in demand. But increasingly the public equates quality with access – often immediate access."

The quality-as-access equation is not limited to primary care clinics. Gorman says that hospitals may well have to find ways to employ an entire cadre of physicians to staff emergency rooms, as more and more people – many of them uninsured – are showing up there for basic medical care and demanding timely access.

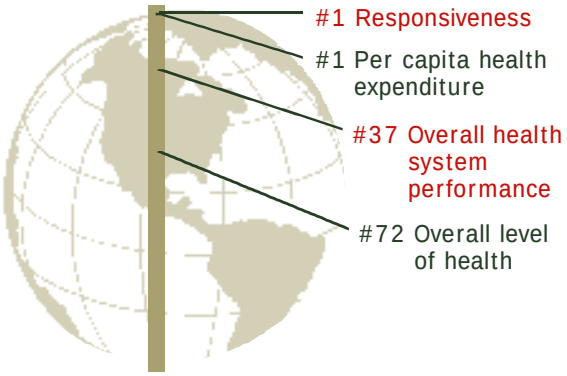
More Than an Algorithm

Gorman spends a fair amount of time managing MHPA, but he also is a clinician and helps to train residents. Sometimes he sees young physicians who view their profession as a "lifestyle" choice, the "I'm-going-to-work-for-a-plan, work-just-40-hours-a-week, make-decent-money-and-not-get-hassled" types. But he also sees many young physicians who still enter the profession for what he thinks are all the right reasons: they want to help, they want to heal.

(Continued on page eleven.)

When Ideologies Collide: The Politics of Quality

In 2000 the World Health Organization (WHO) issued The World Health Report 2000 – Health Systems: Improving Performance, which ranked the health systems of 191 countries across a wide range of indicators. In the publicity that followed, much was made of the U.S. rankings:



Predictably, critics turned out on both the left and right to illustrate the politics of trying to determine the "quality" of the nation's health care system. Here's one overview:

ON THE LEFT

The WHO report confirms what we've known for quite some time: you can get high quality health care in the U.S. if you've got the bucks or insurance, but you're out of luck if you have neither. The U.S. has too many people without health insurance; a fractured, uncoordinated and inefficient system of care that overemphasizes acute, high tech intervention at the expense of prevention and public health; and a hidden system of health care rationing that masquerades as free choice and personal responsibility.

ON THE RIGHT

How can it be that thousands of foreigners flock to the U.S. for superb health care if the U.S. ranks near the bottom of the heap for quality? The WHO has its own global agenda of mandatory universal health insurance coverage, health care rationing, and the continuing redistribution of wealth from richer to poorer countries. The WHO report villianizes the U.S. for allegedly lousy health care value (high expenditures, mediocre population outcomes) but fails to mention our #1 ranking on responsiveness to patients' needs for choice of provider, dignity, autonomy, timely care and confidentiality – not to mention some of most skilled physicians and best patient care in the world.

The terms 'right' and 'left' are rhetorical poles along a continuum of political and cultural positions. Nevertheless, they serve to frame some key distinctions related to determining quality in health care:

The tension between freedom and justice. The language of individual freedom and choice on the right is balanced by the language of justice and the "public good" on the left. How individuals and countries define quality in health care is driven to some extent by where they place greater emphasis.

The definition of health care systems. A perspective on the right might tend to view health systems in more restricted terms – doctors, clinics and hospitals, for example – while a perspective on the left might be more inclusive, such as government oversight functions, public health activities, etc. Whether the U.S. health system is No. 1 or No. 37 depends on where one starts.

The centrality of value. The right might tend to emphasize individual quality outcomes in the value = quality / cost equation, while the left might tend to emphasize population costs. This is not to say that the right de-emphasizes cost and the left de-emphasizes quality. It is to say that "value" can mean something quite different at each end of the philosophical continuum.

How we approach and define quality in health care depends to some degree on our politics – not conceived in terms of political affiliations and buzz words, but in terms of how we choose to assign our rights and responsibilities in the public realm.

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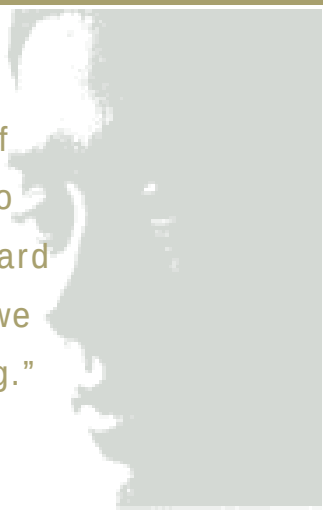
Safety First



"Safety is the bogeyman of health care. We've been so focused on quality that it's hard to acknowledge it's safety we really need to be addressing."

Fran Roberts, R.N., Ph.D.
Vice President, Professional Services
Arizona Hospital and Healthcare Association

"It's absurd to talk about quality if we can't provide acceptable levels of patient safety and risk," says Fran Roberts, R.N., Ph.D., Vice President of Professional Services at the Arizona Hospital and Healthcare Association (AzHHA).

Ever since publication of IOM's 1999 report, To Err is Human: Building a Safer Health System, there's been renewed interest, even a sense of urgency, in reducing medical errors and improving patient safety. IOM's new 2001 report, Crossing the Quality Chasm, lays out some goals and a roadmap for how to go about it.

AzHHA, the Arizona Medical Association (ArMA) and other state health groups – like their national counterparts – have taken steps to improve patient safety and reduce risk at the local level. But as Roberts points out, it can be an uphill battle.

"Safety is the bogeyman of health care," she says. "We've been so focused on quality that it's hard to acknowledge it's safety we really need to be addressing."

Getting on the Same Page

Roberts gives the example of "best basic practice" programs focused on improving the handwriting of physicians and other clinicians to reduce errors resulting from illegible prescriptions, lab tests and the like.

"This is something simple to change and easy for everyone to understand," says Roberts. "We've all looked at our prescriptions after a doctor's visit and wondered who could ever decipher the handwriting."

AzHHA and ArMA considered an educational project to address the issue, but it never went anywhere. A leading Arizona physician suggested to Roberts that an educational program aimed at improving physician's handwriting might be seen as "insulting." So instead, Roberts says, "we bring in expensive technology in the form of palm pilots and such, which also involves ramp up education."

Similarly, AzHHA participated in a quality initiative program with the American Hospital Association to gauge patient perceptions of care on a statewide level instead of focusing on traditional patient satisfaction surveys solely for individual institutions. That, too, didn't go far because most hospitals and health care systems were invested in their own measurement tools, making it nearly impossible to aggregate information to effect policy changes.

"You can have conferences and work groups until you're blue in the face, and still you won't get anywhere until people agree there's a serious problem," says Roberts. "There are ways of dealing with quality and patient safety issues that are more effective than others. We need to agree on what those ways are and get on the same page in changing our collective work."

Burnout and Time

Roberts echoes the view of the IOM and other leading health organizations that patient safety and medical error problems are symptomatic of larger systems issues.

Workforce training and preparedness is just one example. Roberts points out that if you don't have enough trained staff to begin with, it's hard to deliver a uniformly high quality of care.

"The employees' own exhaustion is a major issue," she says. "If you can't adequately staff emergency rooms, ambulance services, patient wards and nursing homes, and if you work people too hard and too long, safety will always be compromised."

Another problem is the time it takes to research safety and quality issues, and to develop effective protocols and constructive regulations. Ironically, says Roberts, the rush to develop standards, procedures and regulations to meet safety and quality criteria can result in impediments to care.

"How many reports and forms do you have to fill out before you don't have time to see patients anymore?" Roberts asks.

Still, she's optimistic that the timing is good for seeing marked improvements in patient safety, and then in quality of care. Consumers will continue to push these issues. "It's on the radar screen now," she says. "Both patients and providers see we have to do better, and we are."

More Efficient Care: SEVEN KEY AREAS

HEALTH FUTURIST RUSS COILE identifies seven key areas for performance improvement in health care that link quality control, disease management, clinical efficiency and patient satisfaction:

1 ERROR REDUCTION
No-fault reporting systems, computerized databases of clinical performance, management processes for disseminating information.

2 ELECTRONIC MEDICAL RECORDS
Much more than just an automatic paper record. Allows organizations to collect data and analyze performance over time.

3 PATIENT-CENTERED IMPROVEMENT PROGRAMS
Designed to respond to the needs and preferences of consumers.

4 MEDICATION ERROR REDUCTION
Electronic monitoring of medication dispensing, electronic prescriptions.

5 RESEARCH ORGANIZATION
Creation of a dedicated research unit that relies on information systems to a much greater extent than traditional quality improvement efforts.

6 FOCUS ON CHRONIC ILLNESS
Early identification and management of patients with chronic diseases substantially improve quality of life and reduces cost of care.

7 LINK TO FINANCIAL PERFORMANCE
Clinical quality and efficiency contribute directly to an improved bottom line.

From Russ Coile's Health Trends, December 2000.

Consumers

Only 1 in 10 have used information that compares quality among health plans and providers.

61% don't trust their employer to provide them with information on health quality because they feel the employer's first concern is saving money on health benefits.

Kaiser Family Foundation 2000 survey

PHYSICIANS

More than half of physicians in the US believe that their ability to provide quality health care has deteriorated over the last five years. Although doctors don't view the situation as irreversible, many fear that the decline in quality will continue. At least half the doctors surveyed believe that technology – particularly electronic prescribing and electronic medical records – will improve the quality of care. They are less apt to believe that medical outcome comparisons, treatment protocols, and physician profiling are effective.

Commonwealth Fund 2000 International Physician Survey, Medical Economics, February 19, 2001.

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IOM REPORTS AND OTHER RESEARCH CONFIRM that the way our health care system is organized – not individual mistakes and lack of knowledge – is responsible for the great majority of medical errors and other adverse outcomes compromising quality. IOM's 2001 report lists four underlying reasons for inadequate quality of care:

A poorly organized delivery system. Highly decentralized, with "layers of processes and handoffs that patients and families find bewildering and clinicians view as wasteful."

Growing complexity of science and technology. "More to know, more to manage, more to watch, more to do, and more people involved in doing it." As knowledge and interventions become more sophisticated, our delivery systems haven't kept pace.

Increase in chronic conditions. Nearly 70 percent of the personal health care dollar is for persons with chronic conditions. As we live longer, we have more opportunities to become chronically ill. Unlike much of acute and episodic care, treating chronic conditions is usually a collaborative process across providers and among families, with more monitoring and case management. This adds layers of administrative complexity that we're just now beginning to sort through.

Constraints on exploiting the revolution in information technology. Consumers are getting aboard the internet and related technologies in droves, but the promise it holds to improve health quality and efficiency is hampered by the health care industry's slow investment pace. Health care ranks 35th out of 53 industries in adoption of information technology.

GET INVOLVED: 5 ACTION STEPS

THERE ARE MANY THINGS Arizonans can do – and are doing – to promote a higher quality of health care in our state. Here are five areas where we can make a difference:

1 **Promote a culture of safety first.** Safety isn't the whole picture of quality in health care, but it's the cornerstone. Whether it's at the institutional level through rigorous clinical review and oversight; at the systems level through public policy, professional / consumer education and advocacy, or through market and regulatory strategies, we need to make safety a priority and align our objectives and rewards to foster it.

2 **Compete on excellence.** Ratings and rankings matter in a consumer-driven economy. Clinical care improvement and greater attention to customer needs, differences and preferences will result in a higher quality of care – and a healthier financial picture.

3 **Educate employers and consumers on quality issues.** Too few of us are asking hard questions about the quality of our care. Too few of us know what questions to ask in the first place. This is changing, but we can pick up the pace with more research, public / private partnerships, the use of more sophisticated and accurate quality indicators, and relentless public education.

In March / April, a Robert Wood Johnson Foundation survey ("Pursuing Excellence") of more than 1,000 health care providers, found that:

58% said that "health care in the United States isn't very good."

72% said that "fundamental changes are needed."

61% reported they "accept common (medical) errors as routine practice."

95% of doctors surveyed had witnessed a "serious" medical error.

29% indicated that they "believe they can provide leadership to change" the U.S. health system.

4 **Use the power of technology.** If ever an area was ripe for better information management technology – electronic medical records, prescriptions, state and national integrated databases, the internet – health care quality is it. There are major technical hurdles, but that doesn't mean we shouldn't press forward.

5 **Promote public health.** Our quality of health is much more than just the quality of health care. It's personal habits, the air we breathe, the food we eat, the quality of life in our communities. How much quality can we afford? Not much if we think only in terms of expensive high tech, acute health care. We need to promote a different agenda of prevention and personal responsibility, and invest in comprehensive public health and education activities.

THE TOTAL PACKAGE: (Continued from page six.)

Gorman encourages all his residents to expand their "differential diagnoses" and embrace the notion that not everything can be treated by a defined algorithm and strict clinical protocol.

"I tell them that medicine is an art as well as a science," he says. "The interventions you can make in the less precise dimensions of health – the emotional, social and psychological, for example – can often produce good outcomes where a medical procedure by itself may not."

Unrealistic Expectations

Despite recent public attention to safety and quality issues in health care, Gorman believes that overall quality of care is better than it's ever been before. Whether it's new technologies, better pharmaceuticals, improved clinical procedures – patients are healthier, living longer and taking better care of themselves.

In Gorman's opinion, perceptions of lower quality in health care today are more a function of unrealistic expectations than they are of declining standards and poor medical practices. Part of this he traces to unrealistic expectations, the attitude that perfection – even agelessness – is an option, when it clearly is not.

The other part Gorman traces to the way we finance health care itself.

"I really think managed care has improved aspects of quality by more monitoring and assessing of processes and outcomes," he says.

"But we let the cat out of the bag with first-dollar coverage. Patients want it all, they want it all now, and it's too easy to demand and get it when they're not paying for much of it themselves."

"Sure, quality is an issue. But the bigger issue is, how much quality can we really afford?"

AHF

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The purpose of Arizona Health Futures is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic; tap into the expertise of informed citizens, and suggest strategies for action.

Arizona Health Futures is available through our mailing list and also on our web site at www.slhi.org. If you would like to receive extra copies or be added to the list, please call (602) 385-6500 or e-mail us at info@slhi.org.

Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially our state's most vulnerable citizens.

SLHI
A Catalyst for Community Health

St. Luke's Health Initiatives

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