ABSTRACT

This paper discusses the needs for future education in quality assurance, assessment and improvement, particularly in relation to managed care. The pressures for increased education about quality are derived from different components of the health care system; e.g., regulatory and governmental agencies, purchasers of care, and competitors of health institutions. The content of future education in health care quality is defined in six areas: (1) organization and management; (2) health systems; (3) quality theory and methods; (4) management information systems and research; (5) governmental policy; and (6) economics and finance. Education in health care quality in these content areas is delivered at both the primary and continuing education levels by universities, professional associations and private training and development corporations.

Future oriented, strategic thinking education in health care quality is needed. The pressures for education about quality, including traditional concepts of quality assurance, methodologies for quality assessment and the newer approaches to continuing quality improvement, are clearly growing stronger. This article discusses the need for education in health care quality, the content areas and levels of education and the delivery system.

Introduction: The Need for Quality Education

Quality has entered center stage in health care system reform. If regulators, consumers, payers and professionals all recognize that quality is important, why do they need to educate themselves? What is driving the interest for education in health care quality among the many stakeholders?

First, it is clear to the hospitals that the Joint Commission on the Accreditation of Health Care Organizations has created a strong push for continuous quality improvement (CQI) nation wide. The attention to quality assurance in past years has been accelerated with the regulatory interest in CQI. Health care institutions that receive regulatory reviews must educate clinical and administrative personnel about modern approaches to quality improvement, particularly the potential these approaches offer for institutional development. There is a dual incentive in the regulatory push for quality improvement education with the first incentive to insure that your institution is able to meet the accrediting requirements. Another incentive, organizational development, will be addressed as the final point in this rationale.

Second, there is an economic reason to be educated about quality. It is news to no one that the economics of health care are commanding priority attention. As restraining cost increases becomes the priority agenda, simultaneously there is a concern for negative impact on quality. Therefore, the linkage between cost and quality is important, especially if there is potential to realize quality gains at lower cost.

Third, many health care institutions are already paying attention to indicators of quality and to their own quality positions. Administrative and clinical leaders are seeing the quality question in a competitive sense, asking how can health care quality be used to gain competi-
tive advantage. Your institution may not be competing with an institution that is already engaging quality improvements. There is still time for education, otherwise the delay may be at the peril of competitive disadvantage.

Fourth, an issue that everyone talks about but follows with little action—demographics—is pushing the quality question as well. With the aging of the population in the United States we must address the questions of what is quality care, and how do we deliver services to a broad range of citizens as those citizens age, comprising a much larger group in need of care.

Fifth, purchasers of care are beginning to ask questions about the quality of services. Third party payers and corporate clients now query clinical and administrative leaders about the quality of their individual and organizational services.

Sixth and last, the interest in quality education is driven by questions of how to continuously develop our health care organizations. This is the opposite side of the regulatory incentive which demands we be interested in quality because we have to be. This most important reason suggests that we continuously seek higher quality organizations and higher quality services, because we value constant improvement. Modern methods of quality improvement may help us get there, transforming our institutions. Importantly, this means that clinical and administrative leaders want to be educated about quality improvement philosophies and techniques because they think patients will benefit. We may be forced to address quality by some of the regulatory agencies but we are interested in quality because we think it may help our organizations.

What is clear from the stakeholder groups pushing for quality and from the issues and trends forcing us to pay attention to quality is that education in health care quality is required. What are the content areas of that education?

Content of Education on Health Care Quality

Having determined our interest in quality, what is it we need to know about? In previous writings we have explored the topics of health care quality assurance education in, for example, fellowship programs and through educational opportunities offered by professional societies. From my perspective there are at least six major areas to be addressed in educating clinical and administrative leaders about quality:

- organization and management thinking
- health systems design and redesign
- quality theory and methods
- management information systems and research methods
- governmental policy
- health care economics and finance.

Each of these areas is outlined in content and with a specific application to health care quality.

1. ORGANIZATION AND MANAGEMENT THINKING

Managed care means managing both clinical and organizational behaviors and structures. Decision making that maximizes cost conservation and quality requires that administrative and clinical leaders and quality specialists understand the theory of organization. How do the essential elements of organization, culture, technology, structure, psychology and management, contribute to managing care with both cost control and high quality as outcomes? Managed care requires participants to act in an organizational system that requires baseline measurements of care and service, feedback on practice activities, control actions which modify individual and organizational behavior and broad based accountability (clinical and administrative).

To understand the quality mechanisms in managed care is to understand that quality is organizational in nature. Clinical activities and decision making are embedded in complex systems of financing, organizational structure, team relations and values. Structure, process and outcome are organizational level targets, not just individual ones.

2. HEALTH SYSTEMS DESIGN AND REDESIGN

The concept of managed care implies an extended boundary for the control and development of our local and regional health systems. Rather than the narrow focus of traditional quality assurance, the clinical activities of physicians and nurses, managed care quality improvement implies knowledge and control of the whole system of care. Integration and continuity are two key objectives but the requirements for achievement are expanded.

Quality in managed care demands knowledge of the design and flow of the whole health system (in the
locale or responsible region). Leaders must be educated about the diverse stakeholders: physicians, nurses, administrators, consumers, payors, corporate customers. Quality is driven by the capability to conform to the multiple requirements of this broad array of stakeholders. Leaders therefore must have an understanding of the full range of elements of the health system and management and clinical policy making in order to "manage" the shifting demands and relationships of payors, providers and patients.

3. QUALITY THEORY AND METHODS

The educational base for quality certainly requires knowledge of modern quality theory and methods. An outline of the major areas of knowledge would include:

- historical and current theory and technique - early efforts to define, assess and assure quality (e.g. structure, process outcome distinctions, health accounting, practice parameters, small area analysis). \(^2^3\)
- computer applications - the design, development and operation of computer systems that support the management of care both at the individual and organizational levels.
- organizational behavior - concepts of individual and group behaviors contributing to quality; problem solving, power and authority, decision-making and culture change.
- leadership and competitive contribution - the role of leadership in developing and maintaining quality and the contribution of quality to competitive position.

To achieve quality in managed care, administrative and clinical leaders and quality specialists must understand the shift in philosophy and values, from the "bad apples" searches of historical quality assurance to the continuous improvement of all processes (total quality management). \(^4^9\)

4. MANAGEMENT INFORMATION SYSTEMS AND RESEARCH METHODS

Managing care is based on two underlying assumptions: (1) that those in charge have the information to truly manage the system; and (2) that changes in the managed care system are systematically tested and adjusted via feedback and control processes. What are the educational needs?

The first is for administrative and clinical leaders to be able to design and develop information systems that support clinical and administrative decision-making. Identifying data needs, establishing a system for data collection, and most important, developing and supporting the actual use of the data are the tasks for which leaders must be educated.

The second need is for an understanding of research methods: Methodologies relevant to assessing changes in the care system that affect clinical decision-making, care system policy and financial reimbursement. If the care system is to be truly managed, current operations and innovations must be rigorously evaluated as they are practiced and tested in actual care and delivery transactions.

5. GOVERNMENTAL POLICY

One advantage of managed care is that the concept rests on recognition of diverse stakeholders and influences. Managed care leaders recognize the demands of government and corporate customers and seek designs that represent all interests. In the quality arena it is not news that government has begun to demonstrate interest with activities ranging from a national data bank on physician practices to state level councils that collect and distribute cost and quality data. Administrative and clinical leaders must be aware of the emergence and requirements of federal and state policy initiatives.

The learning agenda is to develop capability for making policy recommendations. When we are proactive we are helping to create policy that makes sense to those delivering care. Managed care leaders want to position themselves as best they can, so that they are not living with bad policy, but creating good policy to support quality improvement. In order to be proactive, clinical and administrative leaders must know how the policy process works.

6. HEALTH CARE ECONOMICS AND FINANCE

Managing quality in the managed care system requires educational activity in several areas:

- relationships between cost and quality
- balancing financial and patient service issues
- understanding how to calculate the gains from quality improvement.

First, we are still unclear about the relations between cost and quality. As resources are constrained do we
automatically find quality reduction? Or through redesign with cost reduction can we actually achieve quality improvement?

Second, how do we balance the tradeoffs inherent in restraining resource usage? What are the financial issues that are inextricably linked to ethical considerations (from "appropriate utilization" to rationing)?

Third, the move to continuous quality improvement calls for (in one model) calculations of the return on investments in quality improvement. Leaders must be able to understand how to estimate the cost of poor quality and the subsequent gains from improvement. Crosby's contribution to quality improvement requires that clinical and administrative leaders understand the financial aspects of quality.

With these content areas in mind, we can consider how and when leaders may be educated and by whom.

- Education Levels and Delivery

There are two levels of education regarding health care quality that will be needed across the country. On the primary level we need to educate administrators, physicians and quality specialists in the theory and concepts. On the continuing education level we need to insure that professionals from all of the health and medical care disciplines have an opportunity to be updated on the newest quality initiatives and methodological developments. Each level has somewhat different requirements.

**Primary Education Level:** We have discussed in other publications the fellowship program model for creating physician leadership in health care quality. This primary education effort is directed at developing institutional leaders that are able to foster the quality movement in administrative and policy positions in community health care institutions, government agencies, and governmental hospitals for example.

Interest is now emerging in developing quality assurance education in primary professional training programs including medicine, nursing, and health administration. The objective is insuring that all health care professionals have some introductory knowledge of the relationship between their individual clinical and administrative services and the quality of the health care service product. But for primary education in quality to move forward several considerations remain.

- How much health care quality should be part of the core curriculum?
- What should be the course content?
- Should quality be distributed throughout the curriculum or identified as a separate course requirement.
- What is the mix of theoretical and practical experience to be presented?
- What is the resistance to education on health care quality within the institution?

**Continuing Education In Health Care Quality:** Continuing education initiatives in the health care quality area have been vigorous over the last several years. They are likely to go even further as the quality question remains high on the political and administrative agenda. Many providers and clinical and administrative leaders are interested in continuing education regarding quality, but they are confronted with several major problems.

- There is a diverse delivery system for education which is uneven and organized in no special way.
- There is no program continuity that presents a graduated learning process that allows the learner to move from one workshop to another (even with providers from diverse organizations). Professionals interested in creating their own individual learning program must organize it themselves.
- From the continuing education perspective there is no whole sense of what a curriculum on health care quality would look like. How do organization and management, health systems design, quality theory, information system and research methods, governmental policy and economics and finance fit into a conceptual scheme that would make sense to professionals?
- Finally, there are professional organizations such as the American College of Medical Quality that are developing credential programs which recognize the need for substantial education in different aspects of the discipline of clinical quality management, such as quality assessment, utilization management, risk management, governmental issues, statistics, epidemiology, etc. There is no certification process that recognizes the continuing education that professionals have engaged in. While there are individual certificates there is no way of pulling together this information in a coherent fashion and certifying the learning achieved.
In order for us to address the strategic need of reeducation in health care quality we must address these primary and continuing education problems. Certainly a part of those problems involves addressing the delivery system organizations.

**Delivery System Organizations:** The institutions currently providing education in health care quality include universities, professional organizations and individual training and consulting organizations. Currently, they have not addressed in any planned or purposeful way the integration of health care quality into curricula, the diversity in training capabilities and the need to have some conceptual base that will drive professionals interested in this quality business.

**Summary**

It is hardly news that health care quality is an agenda item at many hospital, regulatory and governmental meetings. Even a few university medical and health administration schools are talking about quality. There appear to be three forces pushing the interest in health care quality and the parallel discussions about education. Interest in quality is coming from four groups: regulatory agencies, consumers of services, payers of services and professionals through their various societies.

**Regulatory agencies** have decided that health care quality is of sufficient concern that it now must receive methodological attention; i.e., how to measure and improve quality. Government is beginning to release data related to quality. And certainly regulatory groups such as the Joint Commission On The Accreditation of Health Care Organizations are interested in the quality improvement potential in new approaches.

Second, **consumers** are pushing for attention to quality both directly and indirectly. Some advocacy groups have long expressed concern about the quality of health and medical care particularly in terms of the return on
resources invested. Consumers have expressed dissatisfaction through rising medical malpractice litigation.

Third, payers have entered the quality field searching for ways to guarantee that they are reimbursing for quality care and that corporate clients are receiving a legitimate return on their investment in care. Third party payors must carefully monitor the costs but are pressed by professional groups concerned that constrained resources will negatively affect quality.

Finally, professional associations and societies are concerned that we are not recognizing the substantial investments of professional physicians, nurses, and allied health workers. As a part of their natural professional lives, they have been concerned with quality and with continuous quality improvement. Professionals see the cost threats to quality levels, and simultaneously they are interested in showing how they might continuously improve their quality levels in their clinical work and their organization.

These four stakeholder groups illustrate that quality has forced its way to the top of the health care agenda and that the diversity of the interest insures that it is unlikely to go away quickly. We need now to continue the strategic development of education on quality addressing issues of content, levels of delivery and the providing organizations.

References