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POLICY

Relevance of Quality Measurement to Integrative Healthcare in the United States

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Abstract

With the advent of new models for payment and delivery of healthcare services, the use of quality measures for continual improvement of clinical healthcare is now an integral feature of medical practice in the United States. However, quality measurement and quality improvement activities are not common practice among integrative health providers. This article discusses the import and application of quality measurement to the practice of integrative healthcare. It reviews developments in the healthcare quality improvement movement, explores the relevance of quality measures to integrative healthcare, describes examples of the current use of quality measures in integrative health practice, discusses discriminatory policies that may prevent participation in quality improvement by integrative health practitioners, and makes recommendations for practice and policy.

Keywords: quality indicators, quality improvement, integrative medicine

Introduction

Quality healthcare is ''safe, effective, patient-centered, timely, efficient and equitable.''[1] Delivering quality healthcare means ''doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.''[2] Recent evaluations of healthcare in the United States have illuminated a critical need for system reform, including aggressive efforts to improve the quality of clinical healthcare.[3,4] Due in part to policy changes embodied in the Affordable Care Act, the standardized measurement of quality and the application of quality improvement principles to clinical healthcare has become an integral component of standard practice in many medical clinics and most hospitals throughout the United States. However, clinicians, educators, and thought leaders in the field of integrative healthcare (which for purposes of this article includes integrative care provided by both conventional and complementary practitioners) appear to have had little involvement in the published dialogue about healthcare quality, and the systematic measurement of quality does not appear to be a common practice among integrative health providers in the United States. This article reviews developments in the healthcare quality improvement movement and discusses their import and application to the practice of integrative healthcare.

Evolution of quality improvement

Shewhart and Deming pioneered the science of improving quality in management and industry. The Shewhart cycle, one of the first processes of statistical control and continuous improvement, was further developed by Deming into the Plan–Do–Study–Act cycle of quality improvement that is widely used today in healthcare. Deming also applied statistical control processes to ongoing improvement measurements, pioneered the use of run charts, and advocated for transformative management.[5,6] Donabedian applied the principles of industrial quality improvement to pioneer quality improvement in healthcare,[7,8] and identified three categories of quality measures: structure, process and outcome.[9] Efforts in the United States to improve the quality of healthcare accelerated with the establishment in 1989 of the Agency for Health Care Policy

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and Research. The following year saw the founding of the National Committee for Quality Assurance (NCQA), a non-profit organization dedicated to improving healthcare quality. The NCQA works with public and private organizations, doctors, and patients to define, measure, and improve quality in U.S. healthcare. In 1999, the Agency for Health Care Policy and Research was reauthorized by Congress and renamed as the Agency for Healthcare Research and Quality (AHRQ), establishing AHRQ as the lead Federal agency on quality of care research. The Centers for Medicare and Medicaid Services evaluate the quality of care delivered under the Medicare and Medicaid programs, and the National Quality Forum promotes patient protections and healthcare quality through measurement and public reporting. University-based research institutes such as Harvard's Institute for Healthcare Improvement and Dartmouth's Institute for Health Policy and Clinical Practice continue to investigate the quality of U.S. healthcare and inform its evidence-based improvement (Table 1).

Recent developments in quality improvement

Efforts to reform healthcare quality in the United States were energized by two groundbreaking reports from the Institute of Medicine (now the Health and Medicine Division of the National Academy of Sciences). Released in 1999, ''To Err is Human: Building a Safer Health System''[10] issued a call action for safer healthcare, based upon the finding that 44,000–98,000 hospital patients die needlessly every year due to preventable medical errors. In 2001, ''Crossing the Quality Chasm: A New Health System for the 21st Century''[1] provided a blueprint and specific recommendations for changes needed in U.S. hospitals and healthcare organizations to ensure the reliable delivery of quality healthcare.[11] The ''Quality Chasm'' report identified six attributes of quality healthcare: effectiveness, efficiency, equity, safety, timeliness, and patient-centeredness (Table 2). All six of these aspects of quality are applicable to the practices of integrative healthcare.

Because healthcare systems' payment structures affect the quality of care,[12] much of the effort to improve the quality of U.S. healthcare has focused upon reform of payment systems. Third-party payment for healthcare in the United States has been traditionally accomplished via the fee-for-service model through a conglomeration of public and private payers, and applied (with some exceptions such as the Veterans Health Administration) to a dispersed private enterprise model of healthcare delivery. With each iteration of state and federally mandated quality metrics, payment models move further from the fee-for-service model and closer toward reimbursement for prevention and value-based care. The costly fee-for-service model is being supplanted by a variety of innovative delivery and payment systems, including the Patient Centered Medical Home, Accountable Care Organizations, bundled payments, and Maryland's new Total Patient Revenue model.[13] Care coordination, community case management, and the National Council on Aging's Chronic Disease Self-Management Program[14] are being widely implemented. Accompanying the new models of payment is the concept of accountability: providers—whether public or private—are held accountable by the payer for the quality of care they provide.

In response to the need for standardized means of measuring healthcare quality, thousands of quality measures have been developed by numerous organizations, and AHRQ has established the National Quality Measures Clearinghouse,[15] which provides detailed information on quality measures by organization, domain, quality strategy, and other indicators. The NCQA established a set of healthcare quality standards in the form of the Healthcare Effectiveness Data and Information Set (HEDIS).[16] Used by >90% of health plans in the United States, HEDIS measures are categorized by domains of effectiveness, access and availability, experience of care, and utilization. HEDIS measures have also been developed specifically for wellness and health promotion. AHRQ has also developed its own standardized measures of healthcare quality known as Quality Indicators,[17] which are organized into four modules: prevention quality, inpatient quality, patient safety, and pediatric quality. The AHRQ Quality Indicators make use of hospital inpatient administrative data, and are based upon measures used in AHRQ's Healthcare Cost and Utilization Project,[18] a nationwide collection of U.S. hospital care data. The Centers for Medicare and Medicaid Services has also developed a set of quality measures that are applicable to the Medicare Shared Savings Program.[19]

Table 1. Selected Organizations Devoted to Improving the Quality of U.S. Healthcare

Organization	*Year founded*	*Purpose*
Centers for Medicare and Medicaid Services (CMS)—formerly the Health Care Financing Administration	1977	Government agency; evaluates the quality of care delivered under the Medicare and Medicaid programs
The Dartmouth Institute for Health Policy and Clinical Practice (TDI)—formerly the Center for Evaluative Clinical Sciences	1988	University-based research institute that investigates the quality of healthcare and informs its evidence-based improvement
Agency for Health Care Research and Quality (AHRQ)—formerly the Agency for Health Care Policy and Research	1989	Government agency created to improve the quality of healthcare in the United States
National Committee for Quality Assurance (NCQA)	1990	Non-profit organization; works with public and private organizations, doctors, and patients to define, measure, and improve quality in healthcare
Institute for Healthcare Improvement (IHI)	1991	University-based research institute that investigates the quality of healthcare and informs its evidence-based improvement
National Quality Forum (NQF)	1999	Non-profit organization that promotes patient protections and healthcare quality through measurement and public reporting

Table 2. The Six Domains of Quality Healthcare

Effectiveness	Providing services based on scientific knowledge to all who can benefit, and refraining from providing services to those not likely to benefit
Efficiency	Avoiding waste, including waste of equipment, supplies, ideas, and energy
Equity	Providing care that does not vary in quality because of patient personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status
Safety	Avoiding injuries to patients from care that is intended to help them
Timeliness	Reducing waits and sometimes harmful delays for both those who receive and those who give care
Patient-centeredness	Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions

It is not clear which, if any, of the emerging payment models and sets of quality measures will eventually become the dominant standards in U.S. healthcare, but the concept of accountability for the quality of healthcare is likely here to stay, regardless of the specific way in which the delivery of integrative healthcare is organized. Achieving quality goals means a shift toward care that is personalized, safer, and more effective for individuals, communities, and populations. The new medical models needed to effect these changes emphasize primary care, self-care, and preventive care to avoid or delay chronic disease. These emerging models appear to be well aligned with the principles and practices of integrative healthcare. However, the future role of integrative health practitioners in the development of new models of healthcare and in the improvement of healthcare quality is far from certain.[20,21]

Discussion

Relevance of quality measures to integrative healthcare

Central to all of the licensed integrative health disciplines is a common set of values, including the importance of the bond between practitioner and patient, a focus on the whole person, clinical practice informed by evidence, and the use of all appropriate therapeutic approaches and professions to achieve optimal *health* and healing.[22] Integrative health practitioners envision care that is effective, patient centered, focused on health creation and healing, and readily accessible to all populations.[23] The Project for Integrative Health and the Triple Aim[24] has called for the implementation of these values to achieve the goals of healthcare reform. The following paragraphs explore how integrative healthcare relates to quality in two of the six domains of healthcare quality: equity and patient-centered care.

Equity. Equitable access to all of the healthcare services that people need and want has been described as a moral imperative.[25] In the United States, this humanistic value was codified into law by Section 2706 of the Affordable Care Act,[26] which mandates equitable access to integrative health services. However, the law also allows insurers to establish varying reimbursement rates based upon quality measures. If integrative healthcare is to realize full integration in practice—with unrestricted patient access to integrative health services provided in harmony with conventional medicine—adherence to standardized quality measures will likely be necessary to satisfy the requirements of third-party payers. The inclusion of integrative health services under new payment models will require integrative practitioners to be accountable for the quality of care they provide.

Patient-centered care. The importance of providing patient-centered care is a core value of integrative healthcare.[22] The patient may be given a diagnosis, but the typical intent of integrative healthcare is not only the treatment of the diagnosed condition, but also the co-creation of health and well-being. The diagnosis is secondary in importance to the primary focus on the whole and unique individual, whose care need not be limited by standardized approaches to the treatment of disease. Given such a strong patient-centered orientation, many integrative practitioners are unlikely to embrace quality measures with a disease-oriented focus. Examples of quality measures more likely to resonate with the values and clinical practices of integrative health practitioners medicine might be oriented toward lifestyle (e.g., smoking cessation), function (e.g., vision testing), body systems (e.g., blood-pressure monitoring), or biopsychosocial considerations (e.g., weight-loss counseling).

Given the growing prevalence of multimorbidity, clinicians are recognizing the necessity of shifting their focus away from single diagnoses and toward the health goals of individual patients.[27] Furthermore, many integrative health practitioners tend to place little value on diagnosis-oriented protocols and guidelines,[28] which apply to populations but not necessarily to any given individual. The clinical expertise and sensitivity required for personalized care and attention to subtle, hidden, and unmeasurable human factors are unlikely to be reflected by quality measures,[29] which mandate standardization and objectification of both the patient and the clinician. Quality measures may be perceived by integrative health clinicians as a detriment to quality—a ''cookie-cutter'' approach to healthcare that actually results in lower not higher quality of care.

Impact of quality measurement on health outcomes

The Centers for Medicare and Medicaid Services assessed the quality, efficiency, and impact of use of specific endorsed measures for the years 2006–2012 and publicly reported the results.[30] Measures that addressed clinical guidelines for patient care were most likely to be high performing (i.e., measure rates >90% in each of the most recent three years), but few measures that addressed clinical outcomes were high performing. High performance correlated with positive patient outcomes for a limited number of measures; use of process measures related to heart and surgical care were associated with improved patient outcomes.

A progress report on quality measurement by Oregon's coordinated care organizations showed improvements in numerous areas in 2015, including reductions in emergency department visits, decreased hospital readmissions, decreased

hospital admissions for short-term complications from diabetes, increased access to primary care for children and adolescents, and increased member satisfaction.[31]

Destroying quality by measuring it? Iona Heath, a former physician and prominent critic of overmedication of patients and overprescription of drugs, notes that with modern quality improvement, numbers have replaced words, and computerized statistical analyses of adherence to quality measures have taken the place of human understanding: ''At the moment we waste effort, money and time, collecting data and pursuing quality targets, so that we have less time to listen and we risk losing sight of the suffering human subject. And we risk destroying quality in our attempt to measure it.''[32] Perhaps the most important contribution that integrative health professionals can offer the field of healthcare improvement is the development of measures for the personalization and humanization of healthcare.

Quality measurement in integrative practice: the experience at the Casey Health Institute and the National College of Natural Medicine

The Patient-Centered Medical Home (PCMH) is an emerging model of healthcare delivery that is intended to improve the quality of primary care and patients' and providers' experience of care. To understand the implications of instituting quality measures in integrative health practices, two integrative health clinics are considered that are early adopters of the PCMH model.[33] Although there are hundreds of integrative clinics across the United States, there are few clinics that have achieved status as a PCMH and also incorporate the five licensed integrative professions: acupuncture and Oriental medicine, chiropractic, direct-entry midwifery, massage therapy, and naturopathic medicine.[34] The Casey Health Institute (CHI) and the National College of Natural Medicine (NCNM) are two such clinics pioneering the integrative PCMH movement, and for this reason, it is useful to describe from an ethnomethodological perspective how these clinics normalize quality measures. CHI, located in Gaithersburg, MD, is a free-standing, not-for-profit, integrative primary-care center led by a medical doctor who utilizes a team-based and collaborative staff model. Across the United States in Portland, OR, naturopathic physicians at the NCNM teaching clinic also provide primary care with naturopathic and Chinese medicine. The Oregon Health Authority recently awarded NCNM the highest level of recognition for a Patient-Centered Primary Care Home. Among the chief challenges of quality measurement that clinicians and administrators at CHI and NCNM have identified are (1) the difficulty of meeting structural standards required for accountability, and (2) a clash between the values of integrative healthcare and certain process measures of quality.

Challenge of meeting structural standards. Acquiring the capacity for systematic measurement of quality is likely to present a challenge for many integrative health providers. The NCQA assesses the structural capabilities and processes of PCMHs. Recognition as a PCMH by the NCQA requires a clinic to meet a minimum set of six structural standards for patient-centered access, team-based care, population health management, care management and support, care coordination and care transitions, and performance measurement and quality improvement. The NCNM also used Oregon Health Authority's self-assessment tool to determine PCMH readiness.[35] Some of the state's structural standards (in-person access, preventive services, and patient and family involvement) are congruent with the values of integrative healthcare as put into practice at the NCNM, but certain structural standards pertaining to data management, electronic health records, and empanelment (assignment of patients to specific providers) have illuminated the need for NCNM physicians to acquire new technical tools, knowledge, and skills.

As a strategy to reduce technologically based knowledge barriers, both CHI and NCNM have constructed organizational cultures that promote data use and quality-improvement processes. By intentionally promoting these concepts through regular meetings and e-mail exchanges, both clinics created active learning communities centered on quality-improvement processes. Through professional education programs, these clinics have emerged as leaders in the discussion on quality measures in integrative health, as they empower integrative health providers to engage with the rapidly changing healthcare landscape. At the NCNM, providers with enthusiasm for data and accountability procedures established learning communities and taught other clinicians how to use data to manage patient loads.

Need for patient-centered quality measures. Process measures are intended to gauge the quality of care by measuring adherence to standards for clinical processes. Certain process measures, particularly those concerned with medication management, are grounded in the premise that pharmacological treatment is the standard of care for certain chronic diseases. Examples of such pharmacocentric measures include the Centers for Medicare and Medicaid's ''Drug Therapy for Lowering LDL Cholesterol,''[36] and the NCQA's ''Antidepressant Medication Management.''[37] Many CHI and NCNM clinicians are disinclined to embrace quality measures that promote the use of pharmaceuticals as a first-line treatment for chronic conditions that may be addressed by more conservative approaches. Such measures are viewed as inconsistent with the principles and practice of integrative healthcare, and even as potential threats to quality. Integrative practitioners may be more likely to embrace patient-centered process measures that emphasize health creation, primary prevention, and upstream care of chronic illness. Integrative clinicians may also feel less constrained by quality measures that focus upon outcome goals rather than measures that mandate the approach to achieving those goals.

Discriminatory policies may prevent participation

Section 3502 of the Affordable Care Act specifies that chiropractors and other licensed complementary and alternative practitioners may be included as members of a PCMH healthcare team.[26] Section 2706 of the Affordable Care Act states that private health insurers may not discriminate with respect to insurance plan participation or coverage against any healthcare provider acting within their legal scope practice.[26] However, many insurers have delayed compliance with Section 2706, and complementary and integrative health providers who want to engage in quality improvement efforts may continue to encounter barriers to participation. The Centers for Medicare and Medicaid excludes and restricts the practice of integrative healthcare. Under Medicare, the only coverage

afforded for the services of a complementary healthcare practitioner is for spinal manipulative therapy provided by a chiropractor. Although chiropractors are designated as physicians by the Centers for Medicare and Medicaid Services, Medicare does not reimburse chiropractors for patient examinations.[38] Nevertheless, under Medicare's Physician Quality Reporting System doctors of chiropractic are held accountable for assessing patients. For 2015, chiropractic physicians were required to report two quality measures: pain assessment and follow-up and functional outcome assessment. Despite being fully qualified to do so, chiropractors are not required to report several additional measures related to prevention and screening that medical physicians must report.

Conclusions

The following recommendations are offered to help practitioners engage in quality measurement that will benefit patients:

Recommendations for practice and policy

(1) Integrative health clinicians, educators, and researchers should engage in a dialogue regarding the implementation of quality metrics appropriate for integrative healthcare. Inclusion and participation by all types of healthcare providers should be actively encouraged. The pros and cons of engaging in quality measurement should be examined in light of the principles and practices of integrative healthcare. One way to advance this objective would be to commission a task force charged with identifying appropriate existing measures and/or creating new measures that are aligned with the values of integrative healthcare.

(2) Conventional healthcare organizations should take steps to reduce barriers to participation in quality measurement by integrative practitioners. Remediation of barriers that restrict the ability of integrative practitioners to practice in conventional settings would lead to increased participation in existing quality-improvement efforts. For example, in the states of Vermont and Oregon, naturopathic physicians may lead PCMHs, and thus serve as primary-care providers directly accountable for the quality of the care they provide to their patients. Unnecessarily restrictive scope of practice laws, credentialing policies, and insurance coverage policies should be reformed to align with the level of training and expertise offered by integrative practitioners. The Academic Consortium for Integrative Health offers a toolkit to help hospitals and other health systems credential integrative healthcare practitioners. Insurance reimbursement for integrative healthcare services should be guided by Section 2706 of the Affordable Care Act, which prohibits discrimination by provider type. Significantly, insurance claims for integrative health services could provide a rich source of data for evaluation of the quality and value of these services.

(3) Integrative healthcare organizations should take steps to encourage clinicians and administrators to engage in quality measurement. For integrative clinics wishing to engage in quality measurement, three initial strategies are recommended:

- *Socialize the concept of quality improvement.* To develop organizational cultures that value accountability, the concept of quality improvement must be socialized. Because few providers have a background in quality improvement, the creation of expectations, norms, and behaviors to support continual quality improvement is essential for success. Use of a team-based approach and mentors can help facilitate the socialization process. Team-based models are inherently comprised of a multitude of dyadic opportunities, making this approach well-suited to establish and reify new expectations and behaviors. In this capacity, mentors or champions identify, model, and lead behaviors, while team members work collaboratively through everyday exchanges to adopt these new practices.
- *Identify realistic quality measures.* In transitioning to a culture of accountability, it is helpful to begin with quality measures that are readily obtainable. As quality measurement becomes established as part of the culture and daily routine, clinics can transition toward meeting more challenging guidelines.
- *Incorporate feedback loops.* Solicitation of feedback from providers and support staff promotes accountability, and feedback can help to demonstrate to patients, providers, and payers how well clinical behaviors align with the organization's goals and intentions. It is helpful to collect input from as many stakeholders as possible in order to assess progress toward meeting quality goals. In addition to seeking input from providers and support staff, clinics may also utilize patient satisfaction surveys and form patient advisory panels.

As the push for higher quality shifts healthcare in the direction of self-care, preventive care, and collaborative, patient-centered, and personalized primary care, an opportunity has arisen for the integrative healthcare community to offer leadership. Integrative health experts can help guide the development of new models of high-quality healthcare in the United States, and identify approaches to quality measurement that will facilitate the integration, personalization, and humanization of healthcare. Such leadership will require integrative health practitioners and thought leaders to become conversant with quality metrics and actively engage with the broader healthcare community in quality improvement efforts.

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