

Topic	Take-Home Messages To Inform Future Research
<p>Disability Outcomes</p>	<p>More focused, narrow searches are needed in the future. As a starting place in tackling the topic of quality measurement for people with disabilities, this review was purposely broad in scope. However, this breadth resulted in search strategies that lacked sensitivity and specificity, yielding a sample rather than a comprehensive review of the available literature. The authors expect that literature could be identified to answer each of the Key Questions addressed by this review if more focused, narrow searches were undertaken. However, given the breadth of this field, several such reviews, each homing in on a separate area, would likely be needed.</p> <p>Further efforts are needed to assemble and assess measurement tools. This review identified several collaborative efforts to review large numbers of measurement tools, critically assess their applicability for research involving various disability populations, and assemble those tools into consensus-based core measure sets or databases. However, the efforts to date have focused either on narrow populations (e.g., patients who experienced stroke, frail elderly individuals, patients with spinal cord or traumatic brain injuries) or limited aspects of care (e.g., rehabilitation, developmental disability services). While these are important early steps, further work is needed to establish measure sets that address the full spectrum of QI and care coordination research related to people with disabilities. Further coordination among such efforts would also benefit the field.</p> <p>Support research that is inclusive and multidisciplinary. Researchers contribute to health care disparities for people with disabilities when they systematically exclude people with disabilities from research studies or use measures that do not capture the full range of outcomes valued by people with disabilities. Ideally, rather than isolating disabled populations in studies focusing exclusively on disability (the predominant disability-as-core-concern model) and excluding them from studies of the general population, future research incentives are needed for studies that include a mix of disabled and nondisabled people within study samples with appropriate adjustment for the disability as a complicating condition. Multidisciplinary research will help bridge silos and widen the range of measures used to include the full range of outcomes valued by people with disabilities.</p>
<p>Palliative Care</p>	<p>Key knowledge gaps require further research. Research funding is needed to support well-designed studies that evaluate QI and policy interventions, particularly in areas that are advancing rapidly in health care policy (e.g., audit and feedback and financial and regulatory interventions) but that have not been rigorously evaluated with regard to palliative care. Broadening research on palliative care interventions to a wider group of patients (current research being heavily focused on patients with cancer) and health care settings (beyond the intensive care unit) would yield valuable new knowledge. More research is needed to understand the effectiveness of both integrative and consultative palliative care models. This review found no studies that compared the two models directly.</p>

Note: HAI = healthcare-associated infections; PCMH = patient-centered medical home; QI = quality improvement.

Reference

1. Ranji SR, Shetty K, Posley KA, Lewis R, Sundaram V, Galvin CM, Winston LG. Prevention of Healthcare-Associated Infections. Vol 6 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under Contract No. 290-02-0017). AHRQ Publication No. 04(07)-0051-6. Rockville, MD: Agency for Healthcare Research and Quality. January 2007.

Appendix D. Taxonomy of Quality Improvement Strategies

In this methods report, we discuss results for intervention-focused topics with respect to the taxonomy of quality improvement (QI) strategies developed for the original Closing the Quality Gap series. Below, we provide details of that taxonomy, abstracted from the original series report. Further details, including examples of each type, may be found in the original Closing the Quality Gap series overview and methodology report.¹

1. Provider reminder systems—The investigators defined a reminder system as any patient- or clinical encounter-specific information provided orally, in writing, or by computer intended to prompt a clinician to recall information or intended to prompt consideration of a specific process of care (e.g., “This patient last underwent screening mammography 3 years ago”). The reminder also may include information prompting the clinician to follow evidence-based care recommendations (e.g., to make medication adjustments or to order appropriate screening tests). The phrase “clinical encounter-specific” in the definition serves to distinguish reminder systems from audit and feedback, whereby clinicians typically receive performance summaries relative to a process or outcome of care spanning multiple encounters (e.g., all patients with type 2 diabetes seen by the clinician during the past 6 months).

2. Facilitated relay of clinical data to providers—“Facilitated relay” is used to describe the transfer of clinical information collected directly from patients and relayed to the provider in instances where the data are not generally collected during a patient visit or using some format other than the existing local medical record system (e.g., the telephone transmission of a patient's blood pressure measurements from a specialist's office). The Effective Practice and Organisation of Care (EPOC) group uses the term “patient mediated” to describe such interventions,² but the authors regard the label “facilitated relay” as more descriptive. Some overlap with provider reminder systems was expected, but the strategies were kept separate at the abstraction stage. This decision allowed for the possibility that the data could be subsequently analyzed with and without collapsing the two strategies.

3. Audit and feedback—The researchers defined audit and feedback as any summary of clinical performance for health care providers or institutions performed for a specific period of time and reported either publicly or confidentially to the clinician or institution (e.g., the percentage of a provider's patients who achieved or did not achieve some clinical target, such as blood pressure or HbA1c control over a certain period). “Benchmarking” is a term referring to the provision of performance data from institutions or providers regarded as leaders in the field. These data serve as performance targets for other providers and institutions. The authors included benchmarking as a type of audit and feedback, so long as local data were provided for comparison with the benchmark data.

4. Provider education—“Provider education” is used to describe a variety of interventions including educational workshops; meetings such as traditional Continuing Medical Education (CME); lectures (in person or computer based); and educational outreach visits (by a trained representative who meets with providers in their practice settings to disseminate information with the intent of changing the providers' practice). The same term also is used to describe the

distribution of educational materials (electronically published or printed clinical practice guidelines and audio-visual materials). The investigators further captured information about the intensity (i.e., duration and number of educational sessions) and format (i.e., lectures delivered live, via teleconference, or prerecorded) in a free-text mode for each of these substrategies. Early plans to capture these and other predictors in a structured form were abandoned after the authors and their technical advisors agreed the judgments were too subjective. This was due in large part to a relative lack of detail surrounding the interventions in the vast majority of studies.

5. Patient education—This strategy is centered on in-person patient education, either individually or as part of a group or community, and through the introduction of print or audio-visual educational materials. Patient education may be the sole component of a particular quality improvement strategy, or it can be one part of a multifaceted QI strategy. It should be noted that the authors evaluated only those strategies in which patient education was regarded as one component of a multifaceted strategy. A future volume in this series may address the topic of patient education as a single intervention, along with its relative effects on a variety of chronic diseases.

6. Promotion of self-management—This strategy includes the distribution of materials (e.g., devices for blood pressure or glucose self-monitoring) or access to a resource that enhances the patients' ability to manage their condition, the communication of useful clinical data to the patient (e.g., most recent HbA1c or lipid panel levels), or followup phone calls from the provider to the patient, with recommended adjustments to care. The authors expected some overlap with regard to patient education (strategy 5) and patient reminders (strategy 7). They elected to keep the strategies separate at the abstraction stage to allow for the possibility that the data could be analyzed after the fact, with and without collapsing the two strategies.

7. Patient reminders—This term is used to define any effort directed by providers toward patients that encourages them to keep appointments or adhere to other aspects of the self-management of their condition.

8. Organizational change—This strategy included any intervention having features consistent with at least one of the following descriptions, each of which represents a substrategy of organizational change that was abstracted for incorporation in the analysis:

(a) Disease management or case management: The coordination of assessment, treatment, and referrals by a person or multidisciplinary team in collaboration with, or supplementary to, the primary care provider.

(b) Team or personnel changes: Adding new members to a treatment team (e.g., adding a diabetes nurse, a clinical pharmacist, or a nutritionist to a clinical practice); creating multidisciplinary teams within a practice or revising the roles of existing team members (e.g., giving a clinic nurse a more active role in patient management); or simply adding more nurses, pharmacists, or physicians to a clinical setting.

(c) Communications, case discussions, and the exchange of treatment information between distant health professionals (e.g., telemedicine).

(d) Total Quality Management (TQM) or Continuous Quality Improvement (CQI) techniques for measuring quality problems, designing interventions, and implementation of interventions, along with process remeasurements.

(e) Changes in medical records systems: Adopting improved office technology (e.g., computer-based records, patient tracking systems).

Although the definition used for this strategy (organizational change) is consistent with prior reviews, the authors recognized the potential heterogeneity of included interventions and accordingly planned to analyze this strategy with respect to the aforementioned substrategies.

9. Financial, regulatory, or legislative incentives—This strategy encompassed any intervention having features consistent with at least one of the following descriptions:

- (a) Positive or negative financial incentives directed at providers (e.g., regarding adherence to some process of care or achievement of a target patient outcome).
- (b) Positive or negative financial incentives directed at patients.
- (c) Systemwide changes in reimbursement (e.g., capitation, prospective payment, shift from fee-for-service to salary).
- (d) Changes to provider licensure requirements.
- (e) Changes to institutional accreditation requirements.

References

1. Shojania KG, McDonald KM, Wachter RM, et al. Series Overview and Methodology. Vol. 1 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under Contract No. 290-02-0017). AHRQ Publication No. 04-0051-1. Rockville, MD: Agency for Healthcare Research and Quality. 2004. www.ncbi.nlm.nih.gov/books/NBK43908/.
2. Effective Practice and Organisation of Care Group (EPOC). The Data Collection Checklist, Section 2.1.1. <http://epoc.cochrane.org/sites/epoc.cochrane.org/files/uploads/datacollectionchecklist.pdf>. Accessed January 16, 2013.



“This course was developed from the public domain document: Through the Quality Kaleidoscope: Reflections on the Science and Practice of Improving Health Care Quality. Closing the Quality Gap: Revisiting the State of the Science - U.S. Department of Health and Human Services.”