Improving the quality of medical care essay

A patient or family may not always agree or like what their provider is telling them, but they deserve to have honest, excellent skilled, excellent bedside manner very day and every time. So how do measure “ good care” in a system that is not always black and white? The importance of measuring and monitoring healthcare quality is no longer in doubt.

Yet quantifying healthcare quality is a complex and challenging process for which public and payer demands clearly exceed current capabilities.

According to the document, Quality of Care: A process for making choices in health systems, there are six areas or dimensions of quality, These dimensions require that health care be; effective, efficient, accessible, acceptable and patient-centered, equitable, and safe. These six areas are retry common sense thinking. As a provider if were rating myself as a provider that delivered “ good care” all six of these would be on my list (WHO, 2006).

Instead of focusing on “ doctor knows best” our focus on improving the quality of medical care in the through initiatives like public reporting and pay for performance is based on the belief that measuring quality of care is an essential first step in improving quality of care. Without measurement, it is implored; it will be impossible to know if the care clinician’s deliver is good or bad. As a result, quality measurement has flourished and has been the inundation for quality improvement initiatives.

Quality measures are publicly reported and perhaps influence consumer choice of physicians and hospitals and, therefore, create incentives to deliver high-quality care (Werner and Uncut, 2009). Public reporting is a strategy to

address quality and cost in the health care system by providing consumers, payers, and health care providers, such as doctors and hospitals, with information about the performance of these providers and insurance plans.

It can include such tools as “ report cards” on hospital performance.

Public reports can allow for the imprison of costs, quality (such as rates of hospital-acquired infections), and how satisfied patients are with service. I do believe that customers have the right to be informed of hospital, service or provider reputation, but I worry about perspective. As manager I take multiple patient complaint calls. Though it is our duty to see everything from the patient’s perspective, it is hard to take some complaints seriously.

I know it sounds wrong, but patients expect a lot from a profession that is humanly run.

We offer the very most professional care to the very best of our ability, UT we still fall short of some patient’s expectations. Public reporting is the best system We have to measure quality of care, but like everything it is not perfect. Quality in medical care may be defined as achieving the greatest benefit at the lowest risk.

How have the priorities of our health care system and the allocation of resources addressed this goal? Health care systems, like any business are confronted with budget constraints every day. Priority setting in resource allocation has to be addressed.

Quality in medical care can be defined as achieving the greatest benefit at the lowest risk, but how about the sweets cost? In this essay we will look at

how the priorities of our health care system and allocation of resources have addressed this goal. Addressing pronunciation of spend there needs to be a balance between prevention and intervention. In most countries, health care is managed and administered by health organizations that have the responsibility to meet, as best they can within a limited funding envelope, the health needs of a pre- defined population.

This worldwide phenomenon has been brought into focus by various health care reforms and other system-level developments (Farad, Ryan, Ross, and Ludicrous, 2000).

Meaning there are more claims on resources than there are resources available, some form of priority setting must occur. This making resources are scarce and there is a need, regardless of how many resources are available in total, to make choices about what to fund and what not to fund. After being in management for several years you gain a new perspective of the movement of monies and the allocation of resources.

An example we are currently facing is that we have a small department within our department, the Fetal Diagnostic Treatment unit (FAT). Historically three nurses, a Nurse Clinician Specialist, and a secretary staff the mall unit. As of late the secretary quit and the nurses are doing the duties of the secretary.

Since it is a small area and extremely specialized, their calls are few and very screened. They only receive information and calls about very sick babies who are in need of diagnostic testing and advanced treatment. The nurses have picked up the slack and are doing her duties.

The unit is functioning and the nurse’s workload is not overwhelming. So when we went to the hiring board and asked for another secretary, we were told that if they gave us a secretary line, we would have to give back part of a nurse’s line cause we are functioning adequately without the secretary.

This was maddening at the time, but after thinking about it and looking at it from the hospitals financial view, I saw their point. According to an article in Health Service Management Research, there are two key economic principles that underlie health care priority setting.

The first is that of opportunity cost, which carries with it the understanding that in investing resources in one way, some opportunity for benefit, through investing those resources elsewhere, has been lost. One of the keys in setting priorities, then, is to measure or sigh out the costs and benefits of what is being done (Mitten 2003).

Another principle is that of the margin, which is about shifting or changing the resource mix. If the budget increases, we could ask how best the additional resources should be spent. Conversely, if the budget decreases, one would likely want to take resources from areas that are producing the least benefit.

Lastly, if the budget was neither increasing nor decreasing, at least not continuously, the question remains as to whether resources should be re-allocated (with some areas cut back so that others can expand) so as to improve benefit to the population being served (Mitten, 2003).

The concept of the margin is crucial to the development of an economic approach to priority setting. Health care is backed into a corner and it is our duty to educate others and ourselves about what we can do to reduce spending while still giving top-notch care to our patients.

Nursing may not understand the financial aspect of health care and why changes are being made, so we have to step up and realize that when people look from another person’s perspective they may be more willing to help make changes instead of to fight he system entirely. Contrast the definitions of implicit and explicit criteria in assessing health care quality. How is each type of criterion useful in quality assessment? Assessing health care quality is often based on a review of the process of care in the medical record.

Looking at the quality or the degree to which the process Of care conforms to accepted standards or norms is important.

Even though we use medical records every day they are sometimes unreliable methods for identifying quality. In this essay we are going to contrast two criteria useful in quality assessment In the implicit review the reviewer judge’s quality by comparing the actual process of care against his or her own knowledge, opinions, and beliefs about what the process of care should have been. Implicit review is, therefore, highly individual and reviewer dependent.

If the reviewer is clinically proficient, has at least moderate experience in treating patients with the disease in question, and has up-to-date knowledge of diagnosis and therapy, then that reviewers internalized standards are

likely to approximate those of normative care. If he or she is attentive and unbiased during the actual view, the findings should be accurate.

However, most reviewers do not meet all these qualifications, and it is easy to see how two or more reviewers working independently can come to different conclusions about the same case (Gaston, C. Kendall, David H. , Johnson, Michael M. , 1999). In explicit review, the reviewer compares the actual process of care against a set of statements or criteria, sometimes differentially weighted that spell out what the elements of adequate process should have been.

As consequence, explicit review can be very nearly reviewer independent (Gaston, C. , Kendall, David H. , Johnson, Michael M. 1999). To compare, implicit criteria are adaptable to the precise characteristics of each case, making possible the highly individualized assessments that the conceptual formation of quality.

Explicit criteria are costly to develop, but they can be used subsequently to produce precise assessments at low cost, although only cases for which explicit criteria are available can be used in assessment.

Two major challenges in quality assessment and improvement are the development and testing of quality indicators. To be useful, an indicator must reliably identify subjects at risk for poor quality care, taking into account lineally appropriate deviations from the indicator. If it is to be used in routine quality measurement, the indicator must be simple and relatively inexpensive to apply, and provide meaningful information.

It may not be appropriate to use as a stand-alone external quality indicator for reporting and accreditation purposes until we can identify a more specific way to identify the patients at greatest risk of poor quality care (Hoofer, Bernstein, and Hayward, 1997). I believe a combination of explicit and implicit review would be most useful for improving the quality of care in health care.