Letters to the Editor

Comment on "Quality indicators for psoriatic arthritis"

Sirs,

Kavanaugh *et al*. (1) have outlined potential quality indicators (QIs) for psoriatic arthritis (PsA) based on a systematic literature review. Defining health care quality for this condition is important, and the authors should be commended for their efforts. However, we wish to point out that many of the QIs that they have listed in their manuscript more closely resemble clinical guidelines.

Although clinical guidelines and quality indicators are related in that they both aim to improve the quality of medical care received by patients, the distinction between the two concepts is a critical one (see Table). The definition of a clinical guideline developed by the Institute of Medicine (IOM) states that guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances (2). In this way, guidelines can define *optimal* care for a condition, assist clinical decision-making, and thereby improve quality of care. They intentionally leave room for clinician judgment and are applied prospectively.

In contrast, a quality indicator defines a *minimal* acceptable standard of care, and may be used for accountability. As such, QIs set a "low bar" for the care expected from clinicians and health systems (3). In this way, QIs are distinct from guidelines as care not meeting the minimal standards set by QIs clearly represents poor quality. Based on these definitions, several of the QIs developed by Kavanaugh *et al*. may better serve as guidelines. For example, as written, in order to "pass" the third QI in the article, a physician would need to document not only joint counts, pain assessments, acute phase reactants and radiographs in the evaluation of patient with suspected PsA, but also physical function with an instrument such as the HAQ, health-related quality of life with an instrument such as the SF-36, and a measure of fatigue. This specification, if applied as a measure of quality, implies that failure to perform any one of these assessments would result in a designation of poor quality. This may represent a high rather than a low bar, especially since even for widely studied conditions such as rheumatoid arthritis, incorporation of instruments such as the SF-36 has not widely been accepted in routine clinical practice. While we agree that such assessments would certainly represent optimal are for patients with PsA, this QI may not represent a minimally acceptable standard of care.

Table. A comparison of key characteristics of clinical guidelines and quality indicators[4].

Clinical guidelines	Quality indicators
Comprehensive: Cover virtually all aspects of care for a condition.	**Targeted**: Apply to specific clinical circumstances where there is evidence of a process-outcome link.
Prescriptive: Intended to influence provider behavior prospectively at the individual patient level.	**Observational:** Measure performance at an aggregate level; generally applied retrospectively.
Flexible: Intentionally leave room for clinical judgment and interpretation.	**Precise:** Precise language that can be applied systematically to ensure comparability.

Another important characteristic of QIs that distinguishes them from guidelines is that they are extremely precise. QIs define specific structures, processes or outcomes of care that are necessary for specific patient populations under specific circumstances. While some guidelines may likewise provide specific recommendations, most are less specific and provide a range of possible processes that might be implemented over a variety of circumstances. Several of the QIs proposed by Kavanaugh and colleagues provide such broad recommendations and hence are more aptly characterized as guidelines rather than QIs. One such example is the statement "IF a person with PsA has active skin psoriasis, THEN treatment options include: 1) first line (phototherapy, methotrexate…)". This statement, and others like it in the article, leaves room for clinical judgment in that multiple options are listed, and the precise action to be taken by the provider is lacking. In practical terms, it would be impossible to determine whether this standard had been met because the numerator (*i.e*., the patients who received the recommended care) is not precisely defined. The statement describes which therapies *might* be used but does not define which therapies *must* be used to attain a minimal standard of care.

Finally, because quality indicators are often the basis for assessing health care quality retrospectively, they must be feasible to measure. This means that the information necessary to determine adherence is likely to be found with available data sources, such as medical records or administrative data sets, and that the estimates of adherence to the QIs are likely to be reliable and unbiased. In the article, as written, QI 2 ("IF a person has PsA, THEN the health care provider should consider all of the following individual aspects of disease…"), would not be feasible to measure. Determining whether a physician considered various things would only be feasible if the QI specified that certain items should always be clearly documented in the medical record, and a time interval for such documentation defined.

We agree with Kavanaugh *et al*. that developing QIs for chronic conditions such as PsA is an important step in measuring and eventually improving quality of care. Attention to the technical aspects of QI development is a critical aspect in achieving this important goal.

J. YAZDANY, *MD, MPH*
C. MACLEAN, *MD, PhD*

[1]Division of Rheumatology, Department of Medicine, and [2] Programs in Clinical Excellence, WellPoint, USA & David Geffen School of Medicine, University of California, Los Angeles, CA, USA.

Address correspondence to:
Dr. Jinoos Yazdany, Division of Rheumatology, Department of Medicine, University of California, Los Angeles, CA, USA.
E-mail: Jinoos.Yazdany@ucsf.edu

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