A Quality Model for Outpatient Medical Providers

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THE “ CULTURE” OF MEDICINE

- Authority
- Autonomy
- “Medicine is an in-exact science.”
- “ What ever my doctor says !”

EARLY ATTEMPTS AT PHYSICIAN QUALITY MONITORING

- Surgical review conferences
- Mortality review and evaluation
- Standard “questions posed”
  - ✓ “Was this patient expected to expired when admitted to the hospital.”
  - ✓“Would most practitioners have handled this case in similar way?”
  - ✓Was standard of care met?”

THE REAL QUESTIONS ARE:

WHAT IS STANDARD ??

WHAT WOULD "MOST" PHYSICIANS DO?

“THE BELL CURVE”

- Published in 2004 – New Yorker Magazine
- Atul Gawande, MD – thyroid surgeon
- Outcomes of 31 Cystic Fibrosis Centers in the USA
- Length of life varied in 2003 from 33 to 47 years depending on the center.
- All centers were treating the disease, “by the book”.

NEW YORKER
NEWYORKER.COM

HOW GOOD ARE WE ???

- Hernia repair recurrence 1:5 to 1:20.
- Colon cancer
  10 year survival
  21% to 63%
- New York State risk adjusted death rates for coronary surgery 5% to under 1 %.
- Health Grades (web based physician evaluation.)

WHY CARE ???

- Cost of health care is rising.
- Increased morbidity means increased cost.
- Hospitals are looking to margins.
- Competition is increasing.
- It is the right thing to do !

SIX SIGMA

MEASURE

ANALYZE

IMPROVE

CONTROL

PEDIATRIC CLINIC: A PLACE TO START

- Small number of high volume diagnoses.
- Full time staff.
- Data retrievable.
- Some Benchmarking available.

SIX SIGMA

- MEASURE :Data collection available via electronic record and clear definitions of disease state.
- ANALYZE: Large volumes of patients with small number of “diagnoses.”
- IMPROVE: Clinical Guidelines found in multiple areas.
- CONTROL:(CQI) continuous monitoring and evaluation of MDs.

AMERICAN ACADEMY OF PEDIATRICS

- **Quality Improvement and Patient Safety**
- AAP resources on practice-based quality improvement activities, as well as networks that contribute to overall quality measures and improvement in pediatric care
- AAP Quality Improvement Initiatives
- Clinical Practice Guidelines
- Maintenance of Certification
- Patient and Family Centered Medical Home
- Patient Safety
- Quality Improvement in the Practice
- Tool Kits

EQIPP

Helping You Improve Care for Children

Education in Quality Improvement in Pediatric Practice (EQIPP)

Are you interested in identifying and closing gaps in your practice using practical tools? Are you interested in documenting improved quality care on a continuous basis while earning CME credit and meeting MOC Part 4: Performance in Practice requirements? EQIPP offers courses on topics such as Asthma, Immunizations, GERD, and Bright Futures.

SOURCES OF DATA

- National Guidelines Clearing House
- Corcoran Collaborative
- Medline Plus
- Vermont Oxford Data Base
- CDC

Quality Basics of an EMR

- Consistent terminology, standard formatting, and thus increased legibility of documentation;
- Tracking of data and management plans;
- Data analysis using built-in Query and Report modules;
- Support for billing operations;
- Guideline and protocol support.

PEDIATRIC OUT PATIENT DEPARTMENT AT A NEW YORK HOSPITAL

- 35, 000 visits a year.
- Full time staff.
- Computerized, “query-able” data base.
- Full Service (surgery, cardiology, ophthalmology etc.)
- Multiple Clinical Guidelines in place.

IMMUNIZATION RATE: MOST SIGNIFICANT PROBLEM

IMMUNIZATION 2011	HOSPITAL	BENCHMARK (CDC 2011)
DTaP	76%	85%
Hib	83%	80%
MMR	90%	92%
HepB	85%	91%
Polio	87%	94%

WHAT TO DO ??

- Stress increased vigilance and “push” staff to improve adherence to present clinical guidelines ?
- Review present clinical guidelines and fine tune where necessary.
- Create a “stakeholder group”
- Find a “ best practice” and review their clinical guidelines and adopt their practices.

Engage Physicians in a Shared Quality Agenda (IHI)

- Discover Common Purpose
- Reframe Values and Beliefs
- Segment the Engagement Plan
- Use “Engaging” Improvement Methods
- Show Courage
- Adopt an Engaging Style

“BEST PRACTICE”

- Contacted American Academy of Pediatrics.
- Obtained their guidelines for immunization including:
  - Medical reasons for delay or exclusion.
  - Guidelines for parental discussion.
- Adopted their clinical guidelines.
- Monitor and report monthly

IMMUNIZATION RATE: MOST SIGNIFICANT PROBLEM

IMMUNIZATION 2012	HOSPITAL	BENCHMARK (CDC 2011)
DTaP	87%	85%
Hib	83%	80%
MMR	93%	92%
HepB	94%	91%
Polio	94%	94%

INTERNAL BENCHMARKING

- What to do when no benchmarking data or clinical guidelines exist.
    1. Define the problem.
    2. Use evidence based medicine to:
        a. set internal benchmarks
        b. develop: “new clinical guidelines”
        c. internally monitor the system

DEFINE THE “PROBLEM”

- Children in the out-patient practice are being treated for initial (first time)otitis media using different antibiotics depending on the healthcare provider.
- While guidelines exist for antibiotic choice, the is no clear consensus in the literature.

WHAT IS A CLINICAL GUIDELINE ?

Clinical guidelines are systematically developed statements designed to help practitioners and patients make decisions about appropriate health care for specific circumstances.

DEVELOPING A CLINCIAL GUIDELINE

The methods of guideline development should ensure that treating patients according to the guidelines will achieve the outcomes that are desired

THE STEPS IN DEVELOPING A GUIDELINE.

- Identifying and refining the subject area is the first step in developing a guideline.
- Convening and running guideline development groups is the next step.
- On the basis of systematic reviews, the group assesses the evidence about the clinical question or condition.

THE STEPS IN DEVELOPING A GUIDELINE: continued

- This evidence is then translated into a recommendation within a clinical practice guideline .
- The last step in guideline development is external review of the guideline .

REMEMBER !!!

- It is always better, when dealing in a “local” setting, to search the “guideline” literature for established protocols which have proven to be valid across a wide range of clinical settings, both systemically and geographically.

SIX SIGMA – "CONTROL"

- All children with initial otitis media are tracked for efficacy of treatment.
- Outcomes are reviewed monthly.
- Outcomes are compared to historic data.
- Each provider (MD) is peer reviewed every six months for "guideline compliance."

“Focused Peer Review”

- Every six months each physician is reviewed.
- 50 patient encounters are examined via the medical record.
- Compliance with the “otitis guideline” is judged. (direct compliance or rational deviation is a positive score)
- Rational deviation is defined as non-compliance with the guideline linked to a documented reason for non-compliance in the medical record.
- Results of the review are placed in the physicians credentialing file.

Thanks to all those who aided in this Presentation !!