

Implementing Quality Improvement (QI)

Chapter FastFACTS

- 1. You're not alone—specialty societies offer tools and resources to help your QI efforts.**
- 2. Your front desk can be the front line of safety.**
- 3. Programs that handle scheduling headaches can forecast appointment demand, reduce delays in getting appointments, and cut rates of “no shows.”**
- 4. Office efficiency can be increased by moving nonclinical work away from clinical staff.**
- 5. Practicing techniques via simulation can improve patient safety.**

Are you and your practice providing high-quality care that ensures patient safety? Find out by becoming part of an existing QI project or developing one of your own. By doing so, you'll be able to evaluate your present practice in order to determine what areas need improvement.

If your practice is hospital owned or part of a larger medical group, those organizations may already have projects of their own. For example, a chronic disease improvement project might track patients with diabetes, cardiovascular disease, depression, or asthma. Or those organizations might be working on QI by transforming primary care practices into patient-centered medical homes.

Your practice may choose to initiate its own QI projects for any number of reasons—for example, to improve diabetes care or to develop a patient registry. But because such efforts invari-

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ably take resources and time, Dr. Letourneau says they would be more likely to succeed if they had some ongoing support from outside the practice. If applicable, look to your parent organizations for guidance, and consider national trends (see “Quality Care at a Glance,” below).

Finding Outside Resources

If you’re not part of a larger organization, contact your specialty societies like AAFP, ACP, or the American Academy of Pediatrics (AAP), in order to get involved with their QI projects or to get information about others that might work for you. Following are some examples of what they offer:

AAFP:

<http://www.aafp.org/online/en/home/practicemgt/quality.html>

The AAFP’s Website offers a special section devoted to clinical quality improvement and practice management. Here you’ll find updated information on QI, plus education, tools, and resources to help physicians prepare for the future and redesign their practices “for optimal patient care.” Selections include choosing a QI program, instructions for implementing a QI project in your practice, registry tools and resources, performance measurement and pay for performance, and resources for redesigning your practice.

Quality Care at a Glance

The Agency for Healthcare Quality and Research, Rockville, Md., identified the following trends, as published in its National Healthcare Quality Report:

1. Most measures of quality are improving, but the pace of change remains modest.
2. Quality improvement varies by setting and phase of care.
3. The rate of improvement accelerated for some measures while a few continued to show deterioration.
4. Variation in healthcare quality remains high.

For the full report, go to: <http://www.ahrq.gov/qual/nhqr07/nhqr07.pdf>.

ACP:

http://www.acponline.org/running_practice/quality_improvement/

The ACP Website provides QI information in the “Running a Practice” section and includes information on QI programs, such as an adult immunization program in which participants qualify for continuing medical education (CME) credits and maintenance of certification (MOC) part 4 credit with the American Board of Internal Medicine (ABIM); ACP’s quarterly QI newsletter; information about ACPNet, a Web-based QI program; Closing the Gap, a free program that puts QI into practice; and satisfaction surveys to use in your practice.

AAP:

<http://www.eqipp.org/>

The AAP’s QI resources include education in QI in a pediatric practice; information about AAP’s safer-healthcare-for-kids program, medication reconciliation, and other topics; and QI programs such as its Quality Improvement Innovation Network.

Where Safety Starts

Once you have gathered all the resources and background information you need, it’s time to get started on the actual QI project. Even if you’re not part of a larger project, you can still make changes in your own practice that can make a significant difference in quality and patient safety.

“I think safety in the practice really starts with your front desk,” says Gary Brazina, MD, FACS, an orthopedic surgeon with Diagnostic & Intervention Spine and Sport Center in Marina Del Rey, Calif. He says it’s a mistake to fill that position with the new person on the block or the lowest-paid employee.

Instead, he says, practices should work with this high-profile

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position to take the small steps that can produce big changes in quality. To do so, he offers the following tips:

- Use duplicate-sheet message pads so that every message automatically generates a copy.
- Make sure the receptionist smiles when answering the phone, answers promptly, and does not allow the call to be forwarded to voicemail.
- Pick up your messages at least twice a day (e.g., before lunch and when the receptionist leaves in the afternoon).
- Have the receptionist document each message, including information about what the problem is, whether it is about a medication refill, and whether it is urgent.
- Ensure that the receptionist notes the disposition of each call, marking the message appropriately (e.g., left message, contacted), and has it initialed by the physician.
- If you handle a phone call, dictate it as a chart note.

File every message in the chart. This will go far enough for documentations and, he says, may prevent a lawsuit in the long run.

It's worth the expense and time to manage phone messages efficiently, Dr. Brazina says. "I think. "The most important instrument in a physician's marketing and patient practice is the 500-pound telephone sitting on the side of his desk," he says. "It is imperative that he return calls in a timely manner."

Best Practice Office Organization

Improving the quality of your office also means finding the perfect schedule template that puts the right patient in the right slot. This can be a frustrating task (see "How Does Your Office Measure Up?," p. 64.)

Some patients may overstate their need in an effort to bump themselves higher on the priority list. Others may understate their problem. Still others are passive and may simply give up if they encounter obstacles, even though they know they should be seen if they have certain symptoms or if they are due for a test or check-up. These patients would benefit if the practice could say, "Yes, we can see you today," but that's not always possible.

If every day is booked to maximum capacity, the practice has no flexibility. But full schedules don't stop patient demand. That means practices wind up overbooking, which leaves both patient

and providers feeling they don't have enough time. Your staff may try to cover the gaps by skipping lunches or working late, but that doesn't solve the problem.

"As patients want and need to be seen, there is a constant struggle to figure out where we can fit them in each day," says Catherine Tantau, BSN, MPA, office practices advisor for the IHI and president of Tantau & Associates, a healthcare consulting company based in Chicago Park, Calif.

There are many scheduling programs and approaches available. One example of a best practice to manage and successfully schedule patients so that everyone's days are better organized, efficient, and meaningful is the Advanced Access approach, which Tantau & Associates developed 14 years ago. The system analyzes the practice; forecasts the actual demand for appointments on a daily, weekly, and seasonal basis; then deploys the supply of appointments based on the patterns that emerge. Because the Advanced Access model measures how many patients seek care on any given day of the week, the practice can plan to use its supply of appointments to meet that demand. "In this model, physicians come to work each day with sufficient appointments to meet today's forecasted demand. Practices find that patients are delighted with the offer of an appointment today with their provider of choice 70% to 90% of the time. For those patients preferring a future appointment, the practice has the option of offering them a future appointment at a time that is convenient for them," Ms. Tantau says. That results in dramatic reductions in delays for an appointment, she adds, and cuts the rate of "no shows." It also decreases patients' use of the emergency department and improves continuity with their primary care physicians.

For example, Mondays are very busy in most practices because of pent-up demand from the weekend. Your practice can use this forecasting model to predict high demand days, such as Mondays, and alter your supply of appointments accordingly.

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Ms. Tantau says a number of community health centers have used the program to track shifts in their demand patterns that often reflect changes in the economy. The results have helped them anticipate and prepare for an increased demand for their services as people who have been suddenly deprived of insurance coverage turn to help from their community health center.

A similar forecast helped a gastroenterology practice in Ann Arbor, Mich., stay “very nimble” by anticipating changes in the demand pattern and adjusting their supply accordingly. The practice was located in an area where unemployment was rising.

“If you’ve got one nurse in the practice, you’ve got four hours a day during which, frankly, someone earning far less money could be accomplishing those [clerical] tasks. That nurse could be freed to support patients and providers in more clinically relevant ways,” says Catherine Tantau, BSN, MPA.

That meant many patients were losing their health insurance coverage. “[The practice] was very concerned,” Ms. Tantau says. It used the Advanced Access model to measure “in a real way, day to day and month to month, what was happening with their demand patterns, [and this measurement] enabled them to adapt to current demand, to forecast future demand, and to adjust scheduling to the projected need.

The cost for this program varies depending on the size of the group, organization, or practice for which it is being customized, and the intensity of training desired—from one-day workshops to long-term implementation projects.

Similar approaches include Open-Office Scheduling, a program introduced by Marvin Smoller, MD, in the 1990s to improve patient satisfaction by arranging the schedule to allow patients in to be seen when they want to be seen, even if their need for care may not be urgent, because doing so provides excellent customer service that also improves patient satisfaction. (For more information about this program and how one practice employed it, see: <http://www.aafp.org/fpm/990400fj/38.html>).

Another similar approach known as modified-wave scheduling was created by M. Kyu Chung, MD, a family practice physi-

cian with Cooper University Hospital in Moorestown, N.J. In a Family Practice Management article, he described the system as “a simple technique where patients are purposely double-booked at the front end of each hour, and the end of the hour is left open for catch-up.” And, he added, “I’ve used this system with much success for 19 years. It has increased my bottom line by almost 15 percent without increasing my overhead.” (See <http://www.aafp.org/fpm/20020100/41tuni.html>.)

Your Care Team

Best practices for office efficiency call for doing the most with your existing care team. “The provider simply can’t do everything. . . . How do we make the best use of all members of the care team, whether they’re a receptionist, medical assistant, RN, or anyone else?” Ms. Tantau asks.

Providers tell Ms. Tantau that they typically spend about 30% of their day doing clerical tasks because their support staff members are constantly busy with other tasks. Nurses report that nearly one-half of their day is spent in almost purely clerical work. “If you’ve got one nurse in the practice, you’ve got four hours a day during which, frankly, someone earning far less money could be accomplishing those [clerical] tasks. That nurse could be freed to support patients and providers in more clinically relevant ways,” she says.

Start with one key office process such as prescription refills or lab results; map out the current process you use. It’s helpful to have several members of your staff contribute to this mapping to get a full picture of the process as it is currently being done. This will help you to see the bottlenecks, rework, and redundancies. Finally, work with your staff to find new ways to make that process as simple as possible with fewer steps and fewer hand-offs. Move nonclinical work away from clinical staff, Ms. Tantau advises.

“Why hire more people to support broken, bulky processes?” she asks. “I call it feeding the monster.” Instead, look for ways to streamline and even eliminate tasks. Always examine the workflow of key office processes, and look for opportunities to streamline them—especially before you hire an additional provider or staff member.

How Does Your Office Measure Up?

Catherine Tantau, BSN, MPA, office practices advisor for the IHI and president of Tantau & Associates, a healthcare consulting company based in Chicago Park, Calif., suggests that you take a fresh look at your key office processes by seeing if what you do is optimal:

- How does your practice answer the phones?
- How do you send messages?
- How do you track lab results?
- How do you renew prescriptions?
- How do you notify patients of imaging results?

Learning Through Simulation

Imagine going to a facility where you can earn CME credits by participating in simulation exercises covering a range of health conditions common in the primary care setting. Maybe you would be videotaped, then broadcast to colleagues who will observe in another location, and finally, evaluated by peers in order to highlight areas of competence and those in need of improvement. That scenario may be unrealistic today, but it is not impossible. There is wide agreement that practicing techniques via simulation can improve patient safety by giving you a chance to perform a procedure or conduct a patient interaction in a risk-free environment where you can receive feedback to improve care.

Such simulations are already happening in other healthcare environments. For example, courses at the Israel Medical Simulation Center, located at the Sheba Medical Center at Tel Hashomer in Israel, include not only subspecialty areas such as gynecology endoscopy, but also primary care topics in such areas as clinical and communication skills, management of asthma patients and diabetic patients, recognizing signs of abuse, and identifying and reporting child abuse.

Simulation is making inroads in medical education, too. For example, this year Tulane University in New Orleans, La., opened a \$3-million, 14,000-square-foot advanced medical simulation and team training center to help residents learn more

about safety in a realistic environment. In addition to replicas of facilities such as fully equipped emergency and operating rooms, residents train in replicas of clinical exam rooms. Participants work on their interpersonal skills with either robotic mannequins capable of mimicking symptoms and speaking, or standardized patients. The training sessions are recorded—with both audio and video—then are reviewed by instructors and students. (For more information, see <http://tulane.edu/som/sim/>.)

The Boston College School of Nursing has a simulation lab with a model that can replicate changes in vital signs, pupil size, breath sounds, laboratory values, and EKGs. It can deliver verbal cues such as complaints of pain or changes in mental status, says Judith Shindul-Rothschild, PhD, RNC, DPNAP, a certified psychiatric nurse clinical specialist and associate professor at the college.

Eventually, participating in a simulation program may become even more useful. ABIM has introduced a certification maintenance program that requires interventional cardiologists to be recertified every 10 years; 20% of this process can be achieved by going through simulation evaluation, according to William E. Younkes, president and CEO of Medical Simulation Corp. in Denver, Colo.

Many others across the country may have warmed to the idea of simulation when Captain C.B. “Sully” Sullenberger, the U.S. Airways pilot who made a safe emergency landing in the Hudson River in January 2009, talked about his training, preparation, and teamwork in the cockpit. “Sully goes back ... for simulator training in an airplane he’s been flying for years—the same airplane,” Mr. Younkes says.



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