

# Building on Your Success

## Chapter FastFACTS

- 1. QI agencies, regulatory bodies, and hospitals are driving changes to quality and safety efforts in ambulatory care.**
- 2. Patients and even some providers may resist the culture changes needed to improve patient safety.**
- 3. Training in basic business practices and business management will help you meet best practice goals.**
- 4. Taking advantage of content services and clinical decision support in health information technology is more important than ever.**
- 5. There are steps you can take today to build best practice and improve patient safety.**

Once you've made a start to review and enhance the quality and safety efforts within your practice, you'll find plenty of incentive to build on your successes. Such changes are being driven not only by QI agencies and regulatory bodies, but also by hospitals that are inspired by the fact that their quality information is publicly reported.

A physician who thinks he has little to contribute—because his practice is running smoothly and his error rate is at an acceptable level—is actually in a good position to provide best practice examples, Dr. Lambert says. Just as physicians would publish the results of a study in which nothing went wrong, so should they share their best practices with their professional col-



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leagues. “That’s the kind of person who can [help others] by sharing his or her best practices” at, for example, local chapter meetings, he says.

Although there are some physicians with whom Dr. Lambert has worked for 25 years, he says, “I [can’t] tell you what their style of practice was, what their particular antibiotic use was, or what their protocols for this or that were, because none of that information was shared.”

### Handling Resistance

Openly discussing best practices and patient safety often calls for a change in office culture that can make some medical professionals uncomfortable.

“It’s a change in practice in expectation, in social hierarchies, and in power dynamics, . . . so I think it’s a completely natural consequence that at any time you have change, you [also] have

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resistance to that change,” according to Dr. Letourneau. “At the same time we have seen a lot of great successes in Maine and . . . nationally in terms of physicians taking leadership for that change.”

Some resistance might result from the fact that some of the changes were imposed by outside organizations or the government and were not physician led. “In Maine,” Dr. Letourneau points out, “we’ve had a very strong appreciation and reliance on the value of physicians leading that charge. . . . [They’ve said this] is about improving care for patients. Yes, this is the right thing to do. No, we don’t always like it. No, it’s not always easy, [but] we are going to do it anyway because it’s the right thing for our patients.”

That message is reinforced by AF4Q, the Robert Wood Johnson Foundation program. One of this program’s goals is to make sure physicians, patients, insurers, employers, and nurses come together to improve quality in their community. “Physicians can-

not be tag-along players,” says Bruce Siegel, MD, MPH, and director of the AF4Q program. “Measuring quality is only going to matter if physicians are full partners in it.” (For more information on AF4Q, see <http://www.forces4quality.org/>.)

Patients will experience a culture change, too, as quality care means even more reliance on using a healthcare team. That means that patients can’t always demand to see a specific doctor, Dr. Letourneau says. Instead, practices can help patients make that shift by reassuring them that their usual doctor is still active in their care and is consulting with other providers who are seeing the same patients. In the case of patients who are apprehensive about seeing non-MD staff, doctors can reassure them of that provider’s skill set and explain that this new approach doesn’t reduce quality but actually improves it.

## A Different Hat

Stepping up to best practice mode means learning how to be a businessperson as well as a medical expert. In medical school, nobody taught you how to bill, how to collect, how to run a practice, or how to schedule patients efficiently, Dr. Brazina points out. Instead, physicians often get used to medical staffing companies that take the business part of the practice off their hands. “And you know how that runs,” Dr. Brazina says. “Nobody is going to look after your dollars better than you are.”

He urges physicians to get trained in basic business practices and business management, then to train their staff in how to follow those good practices, “the old four A’s of medical practice—affability, availability, ability, and attitude.”

## Health Information Exchange

Even in the presence of well-meaning doctors, the literature shows that patients “receive the right care for their problem only

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50% of the time,” Dr. Taffel says. Not only that, he adds, but emerging new best practice information needs to be vetted before it can be disseminated to physicians—a process that can take years.

Technology may be the key to accelerating that process. You can take advantage of content services and clinical decision support in health information technology, which are constantly

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researched and updated by experts. “That information can be brought to bear on electronic medical records [to] inform physicians very quickly about best practice and allow them to implement it in real time,” Dr. Taffel says. “That’s a huge advantage over using a typical paper record where physicians have to thumb back through page after page of data to say, ‘Well now, did I order this? What medications?’” he says.

Because electronic records accelerate the process, physicians can see more patients instead of spending time searching the office for missing lab reports or other printed portions of the patient record.

How can physicians apply health information exchanges for best practice and patient safety? Consider this example for a diabetes patient. Best practices indicate that in a well-controlled patient with diabetes, you should obtain a hemoglobin A1c value twice a year, Dr. Taffel says. “Well, not all physicians do that. It’s easy to forget,” he says.

If a physician has access, not only to his or her own information on that patient, but also information from other practices within “the community of data,” he or she will know what other doctors have ordered and whether they have any clinical decision support to recognize a gap in care, Dr. Taffel explains.

### **What You Can Do Today**

No matter how well you think you’re doing, there’s always room for improvement. Elaine Fantle Shimberg, healthcare

author, past chairman of the hospital, and current chairman of the hospital foundation at St. Joseph's Hospital in Tampa, Fla., offers suggestions on what physicians can do to build a best practice and ensure patient safety:

■ **Let your patients know *in writing* how you want to be contacted.** “My internist prefers e-mail,” Ms. Shimberg says. “If your preference is phone calls, specify your phone hours so that a patient doesn't sit home all day waiting for your call; then, just as they run for the carpool, your office calls.”

■ **Consider patient literacy.** If patients don't understand you, they're not getting all the help they need. Even if they nod and say yes, they may have no idea what you said or what they're supposed to do.

■ **Learn to write legibly.** The credentialing committee of St. Joseph's Hospital insists that any physicians who apply to the hospital must write out a paragraph so that committee members can see their handwriting. If the handwriting is not legible, the applicant is required to take a handwriting course. Even though the hospital has electronic medical records, Ms. Shimberg explains, nurses still have to read physicians' handwriting.

### Does It Really Work?

Two years ago, Kenya Sekoni, MD, FAAFP, an East Lansing, Mich., family physician, used the AAFP's METRIC program as her practice's QI tool to improve quality of care for asthmatic patients. The goals were to ensure that every asthmatic patient in the practice was receiving the same high quality of care and received the same education about the disease, including use of medications, an asthma action plan, spacer and peak flow meter, and vaccinations. METRIC gave her a way to approach those tasks by evaluating the quality of patient care and enabling her practice to make measurable improvements.

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One result is that her practice now has an asthmatic patient registry. “This has proven useful for contacting patients during flu season,” Dr. Sekoni says. The patient registry also helped the practice quickly identify patients for other studies regarding asthma. For instance, Dr. Sekoni says, some patients participated in a study examining the use of cell phones, which patients used to input peak flow readings and to send the readings to their primary care physician. If the patients were beyond cell phone transmission range, a special alert message was delivered to Dr. Sekoni to notify her that she needed to contact the patient and might need to make adjustments. She adds, “More importantly, I reminded them to check their peak flows occasionally.”

The practice also created a tool that helped track measurements of quality, such as having an annual pulmonary function test (PFT) and filing an asthma action plan in the chart, as well as documenting whether the patient was given a spacer/peak flow meter. “This tool was especially useful for doing quick chart reviews for insurance companies and our own hospital,” Dr. Sekoni says. “Now nearly every asthmatic patient has an action plan, spacer, peak flow meter, annual PFT, [and can] state their triggers, and proper use of meds,” she says.

In addition, the practice gives a packet of information to patients newly diagnosed with asthma. The medical assistants, who are educated about the materials in the packet and review it with the patient, receive refresher classes including how to properly administer an in-office spirometry test. The physician is still responsible for educating patients about the asthma action plan and triggers.

The bottom line? “We are more confident about the care our asthmatic patients receive because we have measurements that show we are delivering the same quality of care each time, regardless of which physician they see,” Dr. Sekoni says.