

# The Quality Connection

## Chapter FastFACTS

- 1. Collecting data and measuring progress toward goals are critical for quality improvement efforts.**
- 2. Measuring and improving quality will help you qualify for federal stimulus dollars and earn quality-based financial incentives from payers.**
- 3. It may be counterproductive to set a quality improvement goal before you tackle workflow and practice management systems issues.**
- 4. A quality initiative for your practice can be as simple as developing and implementing a paper-based checklist and reminder system.**
- 5. While staff members are often blamed for them, most mistakes actually can be traced back to underlying system problems.**

**D**r. Smith, a general internist, is conducting a routine checkup on a patient with diabetes. She checks the patient's blood sugar, measures his blood pressure and cholesterol, and performs a foot exam. In the few minutes remaining, she answers the patient's questions about medications and reminds him to make an appointment in three months. Both physician and patient feel good about the visit; so why does it fall short on quality?

The answer lies in what *wasn't* done. In the rush of this hypothetical visit, for example, the physician forgot to tell the patient



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to get a flu vaccine and didn't ensure that he had made an appointment for an eye exam. Such lapses are not surprising in a busy primary care practice, where visits are limited to 15 or 20 minutes; but they can be prevented. The key is to have systems and processes in place that measure and track care by relying on evidence-based practices. If you're engaging in this type of qual-



**“The increasing use of electronic health records is moving us away from reliance on claims data for quality measurement.”**

**Yul D. Ejnes, MD, FACP**

Internist

Chair-elect

American College of Physicians Board of Regents

ity improvement (QI) effort, experts say, you not only feel you're providing good care, but you can also prove it with data. That's more important than ever as Medicare and major private insurers begin to reward physicians for collecting data, measuring progress, and achieving quality benchmarks—and, eventually, they will penalize those who fail to do so. (Medicare's Physician Quality Reporting Initiative [PQRI], for example, will reduce payments to physicians who do not participate starting in 2015.) “Quality improvement is a science that we didn't learn in medical school,” says Manoj Jain, MD, MPH, an infectious disease specialist in Memphis, Tenn., who has written and lectured extensively on QI issues. “We can make a meaningful difference in patients' lives by quantitatively looking at the quality of care we deliver.”

The transition to QI methods isn't always easy, Dr. Jain acknowledges. Many physicians initially feel defensive when presented with numbers showing, for example, that a significant percentage of their patients are not getting recommended mammograms or pneumonia vaccines. These physicians are used to thinking of quality in a subjective way rather than as something that can be quantified. “We need to take those subjective feelings and supplement them with quantity and quality measures,”

says Dr. Jain, who also serves as a faculty member for the Institute for Healthcare Improvement's (IHI) National Forum on Quality Improvement in Healthcare. "Numbers may not paint a complete picture, but they show a broader picture of quality."

Think of data and measurement as the "necessary starting blocks of quality improvement," says David Meyers, MD, director of the Center for Primary Care, Prevention, and Clinical Partnerships at the Rockville, Md.-based Agency for Healthcare Research and Quality (AHRQ). "If we don't know how we're doing, we don't know where to improve; and we don't know if we have improved."

This issue of *Doctor's Digest* will prepare you to become what Dr. Meyers calls a "reflective practitioner," to create a practice environment in which you constantly question whether what you're doing is working and alter your practice in order to get better results. Knowing how to measure and improve quality is key to qualifying for federal stimulus dollars through meaningful use of electronic health records (EHRs), earning quality-based financial incentives from payers, and, ultimately, transforming your practice into a fully functioning patient-centered medical home (PCMH). Changes can range from tweaking the way you order prescription refills to streamlining your workflow to reorganizing your billing system.

"The reasons for doing quality improvement are very broad and go beyond specific goals of an incentive [payment] program," says Karen Boudreau, MD, medical director for IHI's portfolio of work across the continuum of care, based in Cambridge, Mass. "The goal is really to help your patients achieve better outcomes and to help your practice function in a way that is more efficient and more satisfying to you and your staff."

## Payment and Quality

The best reason to participate in QI is to improve the health of

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your patients. But, increasingly, measuring and reporting on how well you take care of patients is tied to the practice's bottom line as well as your own professional reputation. "While delivering quality care has always been important for all physicians, the expectations are much more explicit today," says Yul D. Ejnes, MD, FACP, an internist and chair-elect of the American College of Physicians' (ACP) Board of Regents. "Patients, payers, and regulators are more focused on quality, especially in light of the greater sensitivity to getting value from healthcare expenses."

Whereas the traditional fee-for-service payment model is based on volume, "new payment models will look increasingly at quality," Dr. Ejnes says. "Measuring quality, while still in the developmental phase, is becoming less complicated and less redundant as all the stakeholders adopt the same ways of measuring quality. Plus, the increasing use of electronic health records is moving us away from reliance on claims data for quality measurement." EHRs, not yet commonplace in primary care offices, will soon become indispensable if physicians want to participate fully in federal incentive-based payment programs, including the federal stimulus package that may pay up to \$44,000 over five years to practices that adopt EHRs, experts predict. Now is the time to take advantage of incentives for embracing technology or risk incurring penalties down the road, such as the scheduled payment reductions for not participating in electronic prescribing by 2012. (See "The Connection Between QI and 'Meaningful Use.'")

### **The Measuring Mindset**

A significant hurdle to improving quality is the pressure of the current payment system, which rewards volume, says Bruce Bagley, MD, medical director for quality improvement for the American Academy of Family Physicians (AAFP). "In order to make [their practices] work financially, [physicians] have to focus on getting visits; so the entire endeavor is centered on that," says Dr. Bagley, a family physician. "Things like quality improvement or non-visit-based care have to take a back seat because of the economics of running the office."

Indeed, research has shown that time and cost constraints are major reasons small practices find it difficult to try new initia-

## The Connection Between QI and ‘Meaningful Use’

Physicians must comply with recently issued criteria for “meaningful use” of EHRs in order to qualify for federal financial incentives. The rule includes five overarching healthcare policy priorities for meaningful use, all of which are related to quality:

- 1. Improve quality, safety, and efficiency, and reduce health disparities.**
  - Provide access to comprehensive patient health data for patient’s healthcare team.
  - Use evidence-based order sets and CPOE.
  - Apply clinical decision support at the point of care.
  - Generate lists of patients who need care and use them to reach out to patients (e.g., reminders, care instructions, etc.).
  - Report information for QI and public reporting.
- 2. Engage patients and families in their care.**
  - Provide patients and families with timely access to data, knowledge, and tools to enable them to make informed decisions and to manage their health.
- 3. Improve care coordination.**
  - Exchange meaningful clinical information among professional healthcare team members.
- 4. Promote population and public health.**
  - Healthcare team communicates with public health agencies.
- 5. Ensure adequate privacy and security protections for personal health information.**
  - Ensure privacy and security for confidential information through operating policies, procedures, and technologies and compliance with applicable law.
  - Provide transparency of data sharing to patient.

*Source: Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule. Federal Register/Vol. 75, No. 144; July 28, 2010.  
<http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>*

tives. A 2009 study in *Annals of Family Medicine* examined the cost of responding to payer requests for quality and performance data; it found that the smallest practices were the hardest hit by costs of planning, training, registry maintenance, visit coding, data gathering and entry, and modification of electronic systems.

Of the eight primary care practices studied, one solo practice reported a total of \$22,200 in implementation costs to participate in the Physicians Quality Reporting Initiative (PQRI), for example, compared with \$5,949 for an eight-physician group practice. The solo practitioner's costs were driven by expensive outside



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**Bruce Bagley, MD**

Medical Director for Quality Improvement  
American Academy of Family Physicians

consultants and extensive use of office and personal time by the physician to collect and report data, according to the study.

Despite these legitimate concerns, physicians have to adapt to current changes and must prepare for potential payment system reform by developing a “measuring mindset,” Dr. Bagley says. “The fundamental change that has to happen is an acknowledgment that we have to measure what we do in order to show that we are providing quality care and have the foundation to improve quality.” That’s a change from many physicians’ current attitude towards measurement, he adds. “When I talk to physicians about measurement, they immediately think ‘payment and judgment.’ We need to change that to ‘how do I ensure I provide quality care, and how do I systemically improve so that when someone comes around with a measurement or payment system, I’ll be ready.’”

### First Steps

The need for QI does not reflect poor care on the part of physicians but rather a lack of organization, experts say. Doctors must learn to look beyond their interactions with individual patients to whole populations of patients in order to know



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whether they are providing consistent, evidence-based care across the board.

“There is increasing evidence that we need to be far more systematic in how we approach care,” Dr. Bagley says. “We’ve been winging it for a long time, and now it’s time to make sure the science is there ... and to make sure we are using computer systems and registries to increase the reliability of care. We do a pretty good job, but we don’t actually know because we’re not measuring.”

Setting a goal, such as improving diabetes care, before you’ve tackled practical issues like workflow and practice management systems can be counterproductive, he cautions. For example, if you’re staying late every night to finish up paperwork and callbacks, focus on what you could be doing differently during the day to improve efficiency and free up more time. “Focusing on that can have immediate payoffs and make you feel like tackling the next problem,” Dr. Meyers says. “Whereas if you tackle improving diabetes management first, it’s great; but you don’t feel the win there. You’re happy about improved care, but [you won’t be] as empowered and energized as if you were getting home at six instead of eight every night.” (See “Three Questions to Guide Change in Your Practice.”)

Launching a quality initiative can be as simple as introducing a paper-based checklist and reminder system, Dr. Jain says. For example, you can place a running checklist on the left side of patient charts to ensure that all patients are getting needed rou-

tine care such as flu shots and other vaccines, he suggests. Take advantage of data that already exist from major insurance plans or government agencies on best practices or benchmarks, he adds, so you can begin to gauge how your practice measures up.

These first steps can be significant in themselves. “Quality improvement isn’t all or nothing,” Dr. Ejnes says. “A practice that hasn’t done much formal quality improvement can start with a small project, like a patient satisfaction survey or limited chart audit on a specific topic, such as diabetic care.”

### **How to Measure Change**

Once you’ve decided on an initial area for improvement, the next step is to establish measurements in order to assess the impact of the changes you’re making. Physician practices generally use two types of measurement: process measures, which report on whether protocols and best practices are being followed; and outcome measures, which report on results.

Experts recommend following the Plan-Do-Study-Act (PDSA) cycle, which starts with planning the change, followed by testing it in practice, then observing the results, and finally acting on what you learn. The idea is to start with a small sample—as small as one patient—and refine the change before you expand it to an entire patient population or panel. “I always say start where it hurts,” says Dr. Boudreau of IHI. “It doesn’t have to be a huge problem; but begin to develop the skills around understanding the challenge, thinking of ideas to improve, testing, and refining them. It’s really a new kind of practice that develops as you have success.”

EHRs are not necessary to initiate change, she notes. In fact, there are advantages to starting out with a paper system. “With paper, you can work on your processes and figure out how you want to do things before you hardwire them into your computer,” Dr. Boudreau says. “Once the system is set electronically, it can be difficult to change.”

Not all ideas work, but every test is a step toward improvement. “Quality improvement is a journey,” Dr. Boudreau says. “Start with something that is driving you crazy, and build on your successes. Use your front-line staff and listen to your patients. It can be very exciting—it’s hard work and hard to get

### Three Questions to Guide Change in Your Practice

Regardless of the scope or nature of your planned quality initiative, take a moment to ensure that you're on the right track. IHI's approach is based on *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, which starts any improvement effort with the three fundamental questions of the Model for Improvement:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

These questions should guide any change, but experts suggest working on practice issues first. Any clinical goals you decide to tackle later will become easier to implement if your office is running smoothly and efficiently. "The end goal is to improve patient care, but getting there for many small practices is about improving the workflow in the office and the practice management systems," Dr. Meyers says. "The great news about that is that it can save the practice money and give back the time that will make [the physician's] life better."

started; but as soon as you start to see things getting better, it builds momentum."

### It Takes a Team

Wherever you decide to start with QI, success hinges on how well you and your staff work as a team. That can be a shift in mindset for physicians who are used to working independently and shouldering most or all of the responsibility for patient care. "The model of [having] the doctor and patient in the room and everyone else's work being superfluous to that is just not tenable anymore," Dr. Bagley says. "Every single member of the office team that touches the patient in any way should agree on a game plan, have a common goal, and hold each other accountable."

A recent analysis, published in the *Annals of Family Medicine*, reported on a two-year trial of the PCMH initiated in 2006 in 36 volunteer practices by the AAFP. The results highlight the difficulty many physicians have with shifting to a team mentality. Those physicians "who had deeply held beliefs that primary care doctoring was based in a strong, trusting relationship between a patient and a physician" had perhaps the most diffi-

culty with the transition, the authors say.

“Permitting other practice staff members into meaningful patient interactions for team care meant expanding that special relationship; and for many physicians, doing so required a substantial change in their identity as a physician,” the authors note. “This shift required not only a change in roles of both physicians



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Director, Center for Primary Care, Prevention, and  
Clinical Partnerships  
Agency for Healthcare Research and Quality

and staff, but also substantial changes in the way physicians thought about themselves.”

In order to work effectively as a team, physicians must “shift from a blame mentality to a systems-thinking mentality,” Dr. Meyers says. “A lot of the time, quality improvement will start when there is a bad event,” he says. A common reaction is to blame a staff member, but most mistakes can be traced back to underlying system problems that can be resolved. “People see a problem; so they add more work to fix it, and that almost always fails,” Dr. Meyers says. “The real solution is the one that figures out how to get rid of the problem by doing something differently [with either] the same amount of work or maybe even less. The process often leads to understanding the value of [contributions from] everyone on the team.”

Another adjustment for many physicians is thinking of the patient as a member of the care team. It’s no longer enough to dispense advice or hand-printed information to patients as they walk out the door; physicians need to act as coaches in helping the patient achieve goals that you set together. “Many physicians feel as if they engage their patients already; but sometimes those

relationships are on our terms, our agenda, and our understanding of the disease and what the patient needs to do,” Dr. Boudreau says. “Partnering with patients puts us in a different role as physicians, more of a coaching and collaborative role.”

Dr. Bagley explains what comprises patient self-management support: “motivational interviewing, patient shared-goal setting, follow-up, encouraging, and coaching.” Is this too much to accomplish in a 15-minute visit? That’s where team care plays a role. Much of what’s involved in engaging the patient can be done by staff members, leaving the physician free to handle more complicated issues in the exam room.

“If a patient comes in with diabetes, before the physician even sees him, the team should have done motivational interviewing or goal setting,” Dr. Bagley advises. “Then the doctor might say, ‘Look, I understand you’ve committed to walking around the block three times over the next week; let me know how you do.’ That could be the total involvement of the physician—recognizing that patients are committed, holding them to the commitment, then moving on to something more difficult that only the physician can provide.”

Engaging in QI takes time, especially under a payment system that does not yet reward physicians for coordinated, comprehensive care. But experts say the process is worthwhile, not only for improving care, but also for your own career satisfaction. “The bottom line is that it’s no fun to work in chaos,” Dr. Bagley says, “whereas an organized, well-managed, reliable practice is a high-quality practice that people enjoy working in and gets better results for patients.”

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