

TOBACCO CESSATION PERFORMANCE IMPROVEMENT PROJECT

By Kathleen Davis, MD, FAAFP and Jeanette Dunn, RN, EdD

In this article we report on barriers and successes in implementing a PI-CME project in rural hospitals and small practices in the Pacific Northwest.

BACKGROUND

The incorporation of baseline assessment and measureable practice change that positively impact patient outcomes is a growing component of successful continuing medical education (CME) program design. In February 2007, the Agency for Healthcare Research and Quality reported that CME “appears” to be effective in the acquisition and retention of knowledge, attitudes, skills, behaviors, and clinical outcomes.ⁱ It has been noted, however, that traditional CME activities lack the ability to assess the clinical impact of this improved knowledge on practice change and patient outcomes.ⁱⁱ The integration of this improved knowledge into clinical practice requires the practitioner’s consideration and self-assessment of their practice patterns before, during, and after the educational activity to improve their delivery of care and provide measureable patient outcomes.ⁱⁱⁱ The development of Performance Improvement (PI) - CME activities has emerged as an approach to incorporate the measurement of practitioner practice patterns linked to education and process interventions to improve care and patient outcomes. The American Medical Association defines PI-CME activities as a structured, long-term three-stage process by which practitioners learn about specific performance measures; retrospectively assess their practice using the selected performance measures; implement interventions/practice changes to improve their performance; and re-evaluate their performance.^{iv} The AMA and the American Academy of Family Physicians (AAFP) as evidence of evaluation of performance in practice that can be used as verification of learning used for the recertification of a practitioner’s credentials adopted this educational format in 2004.^v

CHALLENGES

Several challenges have been identified in the development and delivery of PI-CME programs. One of the principle barriers is changing the educational habits of the practitioners and the organizations. Steven Weinberger, MD, FACP, Deputy Executive Vice President and Senior Vice President, Medical Education and Publishing of the American College of Physicians noted that medical education providers must establish an educational culture in which practitioners examine their performance and measure patient outcomes, with the ultimate aim of continually improving the quality of care they provide.^{vi} This recommendation is supported by data from Garrard and colleagues who noted organizational change improved the impact of education and the management of Hepatitis C patients. Garrard documented that while practitioner knowledge following the CME program increased significantly, practice change and improvements in patient outcomes were noted in the facilities that made organizational changes. These data showed that 93% of the 23 participating sites implemented organizational changes. The major barriers to organizational change that were identified were a lack of administrative support, funding limitations, staff shortages, and difficulty collaborating with colleagues.^{vii}

Maintaining practitioners engagement in PI-CME programs has also been identified as a challenge due to the length of time required to complete the three stages of the programs. A study by Shershneva evaluated the challenges and barriers encountered in a PI-CME program, and the requirements for successful academic-community partnership to achieve practice change. They identified that the reinforcement of shared goals and commitments among the participants and planners; agreements on the process of change to be accomplished; and clearly defined roles when conducting the PI-CME activity improved the success of the program and participant completion. The necessity for organizational support was also noted. They specifically identified the need for collaboration between the CME planners and the quality improvement stakeholders as a requirement to facilitate changes in clinical practice.^{viii}

THE TOBACCO CESSATION INITIATIVE

In 2009 – 2010, Foundation for Care Management, a nonprofit CME accrediting organization, collaborated with Free and Clear, a for-profit tobacco cessation company to offer a PI-CME tobacco initiative funded by Pfizer, Inc. The initiative consisted of a one hour to 1 ½ hour lecture on tobacco cessation and offered a free 6-month PI-CME to the attendees.

Foundation for Care Management lecturers presented the program at 22 different sites in Alaska, Washington State, and Oregon. Lectures were based in hospitals, most of which were small Critical Access Hospitals, for grand rounds or as a dinner CME. The lectures were offered to hospital clinical staff as well as practitioners from small area practices in the hospital catchment area. These sessions were open to all specialties working with patients including respiratory therapists, nurses, physician assistants, nurse practitioners, mental health workers, pharmacists as well as physicians. Hospital administrators were also encouraged to come. The lectures included a discussion of behavioral and pharmacological techniques to help patients quit tobacco. It concluded with the description of the PI-CME.

To participate in the PI-CME, each site was required to form a 2 to 3 person team and commit to spending about a one hour per team member per week on the project for six months. That hour was spent in a conference call with Free and Clear one week alternating with the team members working on the project in the alternate weeks. Timing of the call was flexible to accommodate the practitioners’ busy clinical schedules.

The first step in the project was to develop indicators for doing a baseline chart review. A minimum of 30 charts were reviewed per team. Based on the data retrieved, the practice team decided which indicators needed to be improved. The team members with Free and Clear consultants and with their practice colleagues, then developed an implementation plan which was adjusted as needed during the six months. At six months the team reviewed a second set of randomly selected charts to evaluate if the indicators had improved. The team members with the practice also evaluated the process to see if it was deemed helpful. Practices completing all of these steps received the \$500 honorarium and each team member received 20 hours of continuing medical education units.

The three indicators studied for improvement were documentation in the chart that:

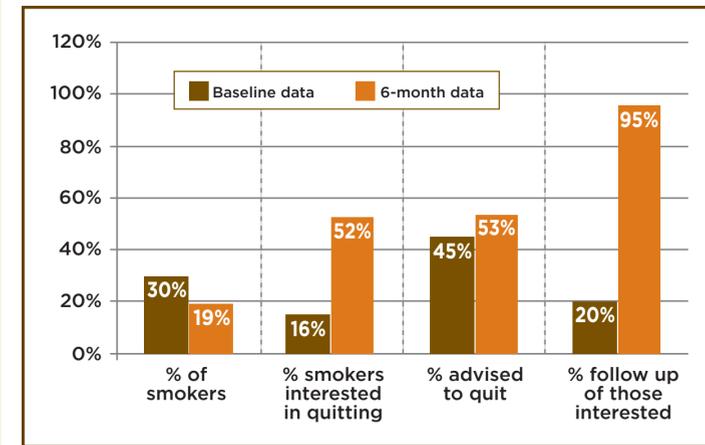
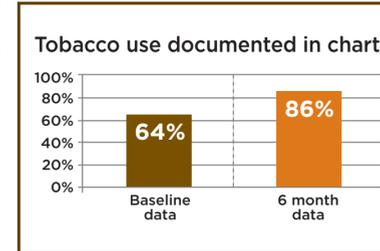
1. All patients were asked about their tobacco use.
2. All smokers were being advised to quit.
3. All the smokers were offered pharmacological and behavioral interventions and referral to quit lines or other community resources as appropriate.

RESULTS

Clinicians from 22 different Pacific Northwest sites requested that we offer this program. At 20 of the sites, clinicians from multiple practices or hospital departments attended. Two sites were each limited to a small office practice. After most of the presentations, several clinicians expressed a desire to be involved with the practice improvement project and filled out interest forms. On follow-up, however, only eight practices decided they were able to participate because of time/staffing restraints. Of those eight practices, only five were able to complete the project.

RESULTS (continued)

Evaluation of the sites that did complete the project showed that all 5 had established improved systems to increase compliance with all three indicators. All five sites felt that the collaboration with the Free and Clear consultants was valuable and worth the time spent. The guidance given was relevant to their practices and their practices had made improvements in achieving compliance with smoke tobacco cessation guidelines. When asked about their ability to sustain the program, some sites felt that some of the improvements would persist, but it was unlikely they would have enough resources to episodically review their charts to be sure they continued to meet their goals or improve further.



BARRIERS

Limited staffing was clearly the biggest barrier identified by the small practices’ ability to complete and sustain practice improvement projects. These practices do not have quality assurance, medical record, or technology staff to assist with routine chart reviews as do bigger institutions. Unless required for accreditation or licensing, a small monetary award and 20 units of CME hours was clearly not enough. One practitioner simply stated that she did not think there would be a priority given to continuing reviews unless the Joint Committee for the Accreditation of Health Organizations (JCAHO) required it.

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DISCUSSION AND RECOMMENDATIONS

These types of performance improvement projects are now becoming required components of the Patient Centered Medical Home designation, Pay-for-Performance insurance schemes, Center for Medical Services performance improvement projects and to qualify for Maintenance of Certification part 4 board reaccreditation in 26 medical specialties. Unfortunately the criteria for performance improvement projects differ among these and other agencies. There’s an urgent need for a standardized performance improvement platform to fulfill the criteria for each of these organizations in order to make periodic patient care evaluations part of the standard of care in small medical practices.

As large patient care committees and academic institutions set the standard and requirements for performance improvement projects, it is important to remember that according to the Robert Wood Johnson foundation “nearly 3/4 of all US physicians work in office-based practices rather than a big institutions and nearly 60% work in offices with fewer than 10 doctors. These small practices deliver a nearly 3/4 of the country’s ambulatory care in the United States.”

To target these concerns, the Robert Wood Johnson Foundation, the American Board of Medical Specialties and state specialty boards together are developing models appropriate for small practices.

The Michigan Improving Performance in Practice (IPIP) demonstration project is a good example. It involved:

1. Coordination of requirements from various payers to show outcome focused improvement in chronic care, qualifications for the Patient Centered Medical Home designation and ABMS Maintenance of Certification part 4.
2. Training outside manufacturing quality assurance experts in chronic health care models to mentor practitioners learning how to use quality improvement methods to improve chronic disease care outcomes.
3. Imbedding these volunteer coaches in specific clinics under the guidance of a physician champion from each office. They facilitated initial data collection and analysis followed by ongoing progress reports. The practice teams also received training on tools to implement more proactive care, and measured if they were achieving improved health outcomes, and lowered costs.

They concluded that coaches can help practices learn to apply the tools for quality improvement but, to sustain their successes, the coaches would have to be employed on an ongoing basis for monitoring and improving outcomes in chronic care.

In our project we were able to show that consistent telephone coaching by consultants well-trained in the subject was effective in changing practices to achieve guidelines for asking, assisting, advising and referring patients using tobacco. The IPIP initiative was established to address the same concerns. Telephone consultation from the private sector may be useful to very small practices for which on-site coaches would not be cost-effective.