In this article we report on barriers and successes and small practices in the Pacific Northwest.

BACKGROUND

The incorporation of baseline assessment and measurable practice change that positively impact patient outcomes is a growing component of successful continuing medical education (CME) program design. In February 2007, the American Health Quality and Reporting Group recommended that CME “apparently” be effective in the acquisition and retention of knowledge, attitudes, skills, behaviors, and clinical outcomes.1 It has been noted, however, that without protocols, use of assessment data is limited to the impact of an improved knowledge on practice change and patient outcomes.2 The integration of this improved knowledge into clinical practice requires the practitioner’s consideration of their assessment of their practice patterns before, during, and after the educational activity to improve their delivery of care and provide measurable patient outcomes.3 The development of Performance Improvement (PI-CME) activities has emerged as an approach to incorporate the measurement of practitioner patterns to determine the impact of continuing education activities on providers 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 using the PI-CME 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 education units.

CHALLENGES

Several challenges have been identified in the development and delivery of CME programs. One of the principle barriers is changing the educational habits of the practitioners and the organization. Steven Weinberger, MD, FAAP, Deputy Executive Vice President and Senior Vice President, Medical Education and Publishing of the American Academy of Family Physicians (AAP) 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.

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 in a one hour 1 ½ hour lecture on tobacco cessation and offered a free 6-month PI-CME at 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 CM E. The lectures were offered to hospital clinical staff and as practitioners from small areas offered in the hospital catchment area. These sessions were open to all specialties, working 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 Free and Clear distribution toolkits. To participate in the PI-CME, each site was required to form a to 2 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 week. Team members that worked one week 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 patients were offered pharmacological and behavioral interventions and referral to quit lines or other community resources as appropriate.

RESULTS

Evaluation of the sites that did complete the project showed that all 6 established improvements in 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 26% and 60% of practices with compliance with smoke tobacco cessation interventions. 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.

TOBACCO USE DOCUMENTED IN CHART

- Baseline data: 20%
- 6-month data: 64%

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 agreed that she did not think there would be a priority given to ongoing reviews unless the Joint Committee for the Accreditation of Health Organizations (JCAHO) required it.

DISCUSSION AND RECOMMENDATIONS

These types of performance improvement projects are now becoming required components of the medical policies and Medical Home demonstration of the Performance Improvement 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 is an urgent need for a standardized for performance improvement platform to facilitate each of the 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 “to be a Robert Wood Johnson Foundation “near 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 nearly 3/4 of the health 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 (IPPI) 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 AIMS 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. Embedding 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 pro active care, and measured their own health outcomes, and lowered costs.

They concluded that coaches can help practitioners 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. It is clear that the small practices 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 nearly 3/4 of the health 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 (IPPI) 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 AIMS 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. Embedding 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 pro active care, and measured their own health outcomes, and lowered costs.

They concluded that coaches can help practitioners 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.

REFERENCES


