



NIQIE 2009: Mastering Continuous Performance Improvement Conference Highlights

This year's NIQIE conference focused on mastering continuous performance improvement (CPI). It used the NIQIE CPI framework integrating Quality Improvement, CME, Informatics and Research as the structure for the conference content.

[See photos from the conference](#)

The following are highlights from each presenter.

Pre-conference: Healthcare Quality Improvement Basics—September 10, 2009

What is Healthcare Quality Improvement?

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The Evolution of Medical Quality

- Shewhart - Bell Labs 1920's & 30's
 - Deming/Juran - Industrial Quality Management Systems - CQI/TQM and the movement from QA to QI.
 - Crosby -- Conformance to requirements
 - Donabedian – Early basic thinking in medical QI
 - Couch – Quality = The attribute of a product, service, or outcome that is the extent to which achievable value is actually achieved. Value is usually defined in terms of consumer expectations, whether explicit (i.e. wants), or implicit (i.e. needs)
 - Eddy – Attributes of quality indicators and HEDIS
 - Berwick – Institute for Healthcare Improvement (IHI) Provider participation, continuous improvement. The IOM report.
 - Six Sigma, Toyota Production System, ISO9000 and others
 - ACMQ – Core Curriculum for Medical Quality Management
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- Stage 1: Quality Assurance, The Era of Inspection
 - CPCs, sentinel event monitoring, outlier review, inspection
 - Stage 2: Statistical Quality Control and CQI
 - Deming tools, control charts, multivariate normal distributions
 - Stage 3: Outcomes Focused Analysis

- Prevention, functional status, patients perceptions,
- Stage 4: Big Management
- Rise of the QI bureaucracy: NCQA, JCAHO, URAC, CMS
- Stage 5: Fluid Change, a Cacophony of Quality

The Era of Inspection

- Physician Credentialing
- Institutional Credentialing
- Procedure Specific Credentialing
- UM/QI Process Adequacy
- Technology Assessment Process Adequacy
- Adverse Occurrence Monitoring
- Sentinel Event Monitoring
- External Accreditation

The Era of Statistical Quality Control

- Diagnosis-Specific Admissions Variations
- Targeted Surgical Variations
- Targeted Ambulatory Surgery Variations
- Physician Statistical cost/mortality profiling
- Pharmaceutical Profiling

The Era of True Outcomes Measures

- Selected Claims-Based Outcomes
- Member Satisfaction/Perception of Health
- Clinical Outcomes Measures
- Disease Specific Patient Perceptions
- Linkage to Disability/Absenteeism
- Life Event Risk Intervention Analysis
- Conventional Medical Outcomes
- Social - small area analysis Dartmouth Study
- Functional Status and Well Being
- Health Risk Appraisal
- Cost Effectiveness Analysis (CEA)

The Era of Big Management

- Big Systems
 - Integrated Care Management Delivery Systems
 - Multispecialty Group Practice
 - PHO, PHCO, IPA, CHIN, and Others
- New Methods, Tools, and Concepts
 - “Data Driven” Information Systems
 - Statistical Quality Control - Shifting the Bell Curve
- Comparing Across Plans, Hospitals, Companies and Individuals
 - Best Practice Analysis

The Era of Confusion and Cacophony

- Government Agency Participation
 - CMS, AHRQ, State DOH, State DOI
- Pseudo-governmental Participation
 - NQF, IOM, PROs, QIOs
- Accreditation Bureaucracies
 - JCAHO, URAC, NCQA, AAAHC
- Integrated Care Management Delivery Systems
 - PHO, PHCO, IPA, CHIN, and Others
 - Health plans, HMOs, Group practice.
- Other Players
 - Consultants
- Accenturisms -- Buzzwords and Buzzwords for The Next Big Thing
 - P4P, Transparency, Accountable Networks, EMR, Medical Home
 -

Making the Business Case

- Making the business case to someone or some entity that you should be paid for your valuable services is difficult for anyone. Money is tight everywhere.
- You were trained as a clinician, not a business person. So, how do you put a price on quality or clinical improvement? What is the strategy to convince a potential nonclinical payer of diabetic education services that they are worth it?
- Do your services create a “value proposition” for your services? How do you construct the approach and the arguments for the government, health plans and clinics that create a compelling case in your favor in the mind of a business person?

Your Business “Go Bag”

- You will need to collect all that you will need to have for a rapid, no thought needed response when you encounter:
 - Takeover of your company/hospital and a sudden visit by the new CEO
 - Sudden loss of your job and the need to find a new one
 - Talking your boss into a 10% increase in your budget so you can “improve the quality of care”
- So, what’s in your go bag?
 - A brief powerpoint overview of your area and span of control
 - Microsoft project plan for creating impact in the next 12 months
 - An economic impact analysis of your area on the corporate functions and/or your customers
 - Your budget and financial plan for next year
 - Samples of achievements in the past 12 months
 - Your CV

Practical Approaches to Healthcare Quality Improvement

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Value Based Purchasing

Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care

- Improve clinical quality
- Reduce adverse events and improve patient safety
- Encourage more patient-centered care
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in effective structural components or systems

PQIR

- Established by the Tax Relief and Health Care Act of 2006
- Pay-for-REPORTING program
 - Incentives for reporting on quality metrics; not performance
 - Performance on quality metrics not publicly reported
- Eligible professionals select the measures and method to report
- Number of measures and reporting options change each year

EPrescribing

Incentive program modified by American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5)

- Established by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L.110-275)
 - Removed e-prescribing from Physician Quality Reporting Initiative (PQRI)
- Encourages use of e-prescribing through incentives and penalties
 - 2009 incentive: 2% of total Medicare Part B charges
 - Penalties do not start until 2012

Goals for Reform

- “Alignment”: payments should be considered as a whole across the spectrum of care and setting, includes payments by episode of care
- “Value” & “Quality”
- “Comparative Effectiveness”: target care where the evidence base is lacking
- Non-profit status questioned
- Accountability

All with limited resources to enact change

Practice Redesign-Learning and Improving At The Point Of Care

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Patient Centered Medical Home:

- provides a **Vision** for the future practice of family medicine.
- is a **Guide** for office redesign that promises better results for patients and physicians
- provides a **Path** to fortify primary care and establish its value in our health system

Quality measures

- Culture of improvement
- Practice performance measures
- Reliable systems

Patient experience

- Access to care
- Personalized care
- Care coordination

Efficient Practice Organization

Financial management

- Personnel management
- Efficient clinical systems

Health Information Technology (HIT)

Business and clinical process automation

Connectivity and communication

Evidence-based medicine support

Clinical data analysis

Physician Consortium for Performance Improvement (PCPI) Performance Measures: Who, What, Where When, Why & How?

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PCPI Mission

Improve patient health and safety by:

- **Identifying and developing** evidence-based clinical performance **measures and measurement resources** that enhance quality of patient care and foster accountability
- **Promoting the implementation of** effective and relevant clinical **performance improvement activities**
- **Advancing the science** of clinical performance **measurement and improvement**

Current PCPI Membership

- More than 100 national medical specialty and state medical society representatives
- Council of Medical Specialty Societies
- ABMS and its member boards
- Experts in methodology and data collection
- *10 Health care professional organizations (NEW)*
- Agency for Healthcare Research and Quality
- Centers for Medicare and Medicaid Services
- Individuals/organizations committed to health care quality improvement and/or patient safety, and participants in the development, review, dissemination or implementation of performance measures and measurement resources

Convened and staffed by AMA

PCPI Strategic Priorities

Measure development (new and updates):

- adult diabetes, chronic stable coronary artery disease, hypertension, heart failure, prenatal testing, dementia, pediatric topic, and overuse (back pain management, percutaneous coronary intervention, appropriate maternity care, sinusitis, diagnostic imaging)

New measure analyses:

- measures of overuse
- New levels of measurement:
- episodes of care; physician, team, care setting

Specifications for Electronic Health Record Systems and Quality Improvement registries

Implementation of PCPI Measures

- More than 100 are NQF-endorsed™ and/or AQA selected
- More than 70% of the measures in the CMS PQRI program
- Integrated into the ABIM practice improvement modules
- Used in AAFP METRIC® program

Organizations Using PCPI Measures

Companies with license to use measures

EHR systems – 5

CME providers – 96 with point/click licenses

Other – 6 (eg, Ingenix, VIPS, AAFP)

Registries – 12+

ABMS member boards – ABIM, ABFM, ABP

CMS Demonstrations

7 testing projects in progress

Hospitals/academic medical centers, national medical specialty societies, state medical societies, community health centers, health plans, group practices, QIOs

Local, regional QI collaboratives

Contact PCPI

www.physicianconsortium.org
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Performance Measures: Who, What, Where, When, Why and How?

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The Pharmacy Quality Alliance

- Established in April 2006, as a public-private partnership. Drs. Mark McClellan & Carolyn Clancy - Inaugural PQA Steering Committee members.
- Consensus-based, membership alliance with over 50 members.
- PQA is a 501 C-3, nonprofit organization.

Mission: *Improve the quality of medication use across health care settings through a collaborative process in which key stakeholders agree on a strategy for measuring and reporting performance information related to medications.*

Current Pharmacist Performance Metrics

- Number of prescriptions filled/day
- Generic conversion
- Prescriptions filled per unit of time
- Labor Cost per prescription
- Rx sales
- New/Refill prescription ratio
- Customer Satisfaction – convenience oriented

Future Performance Metrics

- Compliance rates
- Optimal asthma management
- Optimal diabetes care management
- Appropriate medication use in the elderly

Expanding pharmacy performance measurement will assist in promoting the pharmacist as a key player in assuring appropriate medication use by consumers.

PQA develops measure concepts that are:

1. Meaningful--to purchasers, consumers, and pharmacies
2. Feasible-- most organizations able to implement them now
3. Valid
4. Reliable
5. Broadly applicable

PQA Roadmap for Pharmacy Measure Development

Phase 1: Measure concept generation through approval of measure concept

Phase 2: Measure concept refinement through selection of measures for further development

Phase 3: a) Creation of technical specifications through endorsement of validated measures

b) Further development process

Phase 4: Submission for NQF endorsement

Current PQA Endorsed Measures

Proportion of Days Covered and Gaps in Therapy (10 in total):

1. Beta Blockers
2. ACE Inhibitor/ARB
3. Calcium Channel Blockers
4. Dyslipidemia Medications
5. Diabetes Medications

Diabetes Measures:

6. Excessive Doses of Oral Medications
7. Suboptimal Treatment of Hypertension

Asthma Measures:

8. Suboptimal Control
9. Absence of Controller Therapy

High Risk Medication Measures:

10. High Risk Medication Use in the Elderly

PQA Demonstration Projects: June 2008-November 2009

- Determine resources requirements for collecting/aggregating prescription claims data and calculating the 15 quality measure scores
- Collection of patient experiences with pharmacy services using the PQA-sponsored survey
- Generate/test models of providing pharmacy performance reports
- Get feedback from pharmacists on the reports' accuracy, user-friendliness and value in improving quality

PQA: www.pqaalliance.org

Integrating Planning and Assessment throughout Learning Activities

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Achieving Desired Results and Improved Outcomes: Integrating Planning and Assessment Throughout Learning Activities

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Most physicians believe that to provide the best possible care to their patients, they must commit to continuous learning. For the most part, it appears the learning activities currently available to physicians do not provide opportunities for meaningful continuous learning. At the same time there have been increasing concerns about the quality of health care, and a variety of groups within organized medicine have proposed approaches to address issues of physician competence and performance. The authors question whether CME will be accepted as a full partner in these new approaches if providers continue to use current approaches to planning and assessing CME. A conceptual model is proposed for planning and assessing continuous learning for physicians that the authors believe will help CME planners address issues of physician competence, physician performance, and patient health status.

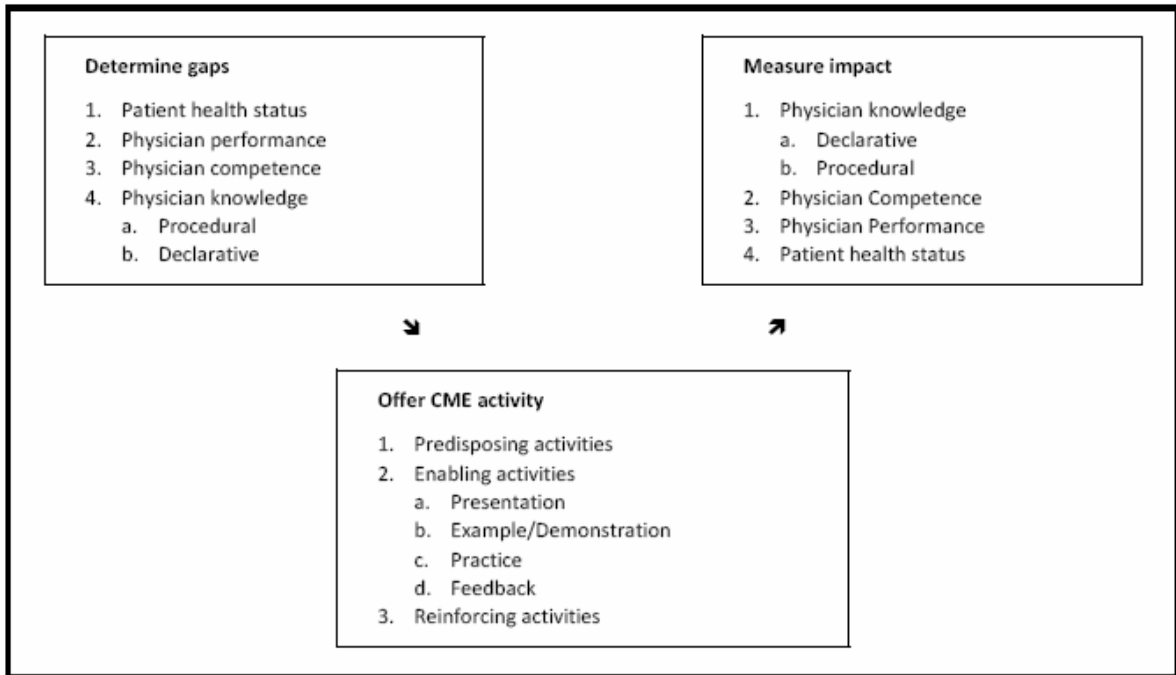
Key Words: education, medical, continuing, physician learning, planning, assessing, formative assessment, physician competence, physician performance

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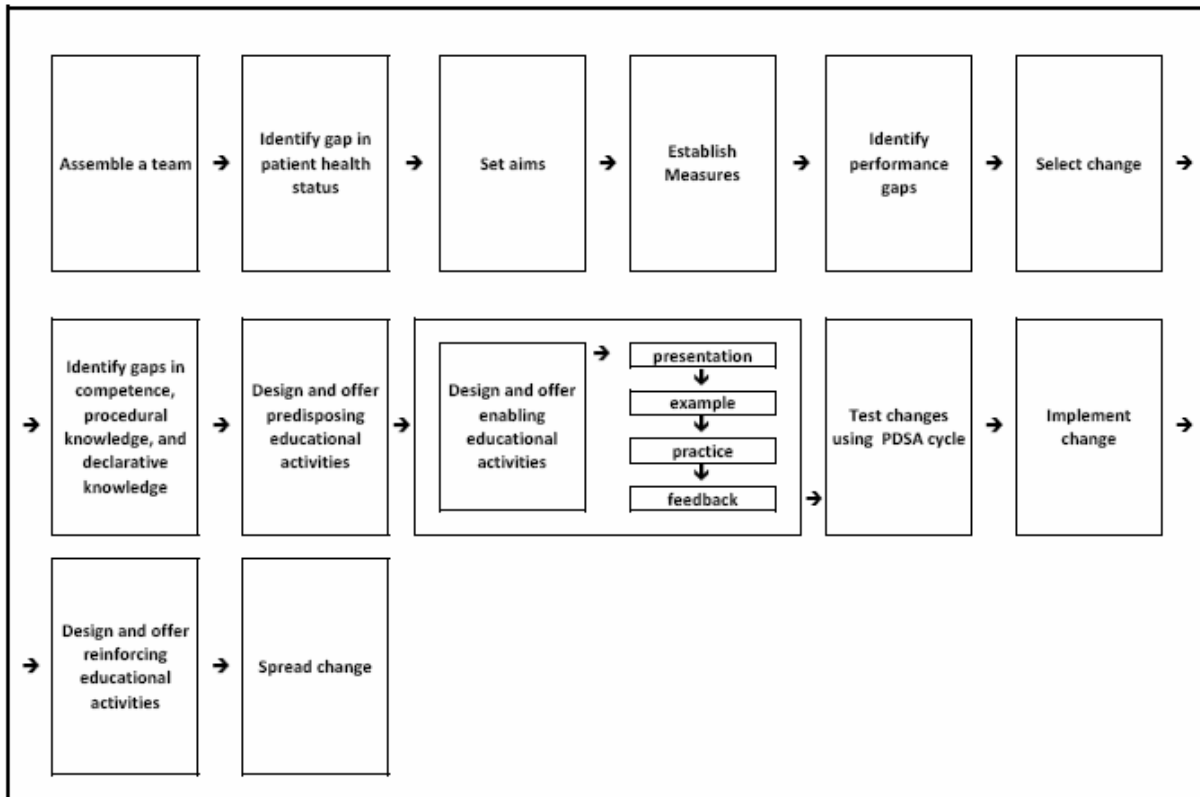
Summary:

- Planning for and assessing outcomes must go together.
- Start with the end (outcomes) in mind.
- Formative assessment: practice and feedback.
- Predisposing-enabling-reinforcing.
- Continuum of assessment.
- More than clinical content.

CME Outcomes Model



Combining Model for Improvement and CME



Maintenance of Certification: Current Status and Future Directions

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ABMS Background

- ABMS is largest self-regulatory group of physicians in the United States
- ~ 725,000 practicing physicians are certified by one (or more) of the 24 ABMS Member Boards
- General certificates = 38 / Subspecialty certificates 111 (many shared by two or more boards)
- ~ 65% have time-limited certificates (93% projected by 2020)

Maintenance of Certification is:

A lifelong learning process designed to document that physician specialists, certified by one of the Member Boards of ABMS, maintain the necessary competencies to provide quality patient care.

Initial Four Components of MOC--2001:

1. Professional standing (licensure)

- Hold a valid, unrestricted medical license
- 2. **Lifelong learning and self-assessment**
 - Evidence of participation
 - Diplomates are expected to conform to general and specialty-specific standards
- 3. **Cognitive expertise (examination)**
 - Covers the scope and range of the discipline
 - Is clinically relevant
- 4. **Practice performance assessment**
 - Proven scientific, educational and assessment methodology
 - Reflects patient care and should result in quality improvement

Changes to MOC March 16, 2009:

Part I

Add:

Patient survey
Peer survey
Public reporting

Part II

Add:

25 CME credits per year
1/3 involving self-assessment
+
Patient safety foundations curriculum

Part IV

Add

Practice assessment and QI:
Registry with learning collaborative
Self-administration module
Quality measurement / improvement

ABMS announced addition of Mellie Pouwels as new MOC Program Director. Contact her at:

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ABIM's Part 4 Program: Early Experience & Lessons

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Board Certification is Correlated with Higher Quality Care

Evidence that initial certification correlates with better quality of care (15 studies):

- Outcomes

- Certified physicians had better outcomes on 15 of 23 measures compared to non-certified physicians
 - E.g. 15% lower mortality for AMI (Norcini et al, 2002)
- Processes of care
 - Certified physicians performed better on processes of care on 14 of 29 comparisons
 - E.g. Higher rates of screening mammography and colonoscopy (Pham, et al, 2005)

ABIM Practice Improvement Modules Available:

- Asthma
- Care of the Vulnerable Elderly
- Clinical Prevention
- Colonoscopy
- Communication – Primary Care
- Communication - Subspecialists
- Communication with Referring Physicians
- Diabetes
- Hepatitis C
- HIV
- Hospital-Based Care
- Hypertension
- Osteoporosis
- Preventive Cardiology
- Self-Directed
- Clinical Supervision
- ACQI pathway

ABIM Alternative Pathways for MOC, Part IV

Self-directed PIM

Allows use of performance data from external sources or generated by a group
 QI activity

Health plan and PQRI data

IHI and NQF measures not yet in PIMs

Accepted Continuous Quality Improvement (ACQI) pathway

Physicians can get credit for meaningful participation in an institutional or organizational level project

PIM Information On-line

- PIM demonstration modules:
 - All modules in complete form for review
 - 15 PIMs; most condition specific
 - www.abim.org/online/pim/demo.aspx
- Annotated bibliography available
 Contact Eric Holmboe at eholmboe@abim.org

MOC in Surgery

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Associate Executive Director, American Board of Surgery

Evolution of MOC at American Board of Surgery

- Began certifying surgeons in 1937
- Required recertification beginning in 1976
- Required MOC starting 2005

Transition to MOC

- Diplomates are automatically enrolled in MOC once they certify or recertify in any ABS specialty after July 1, 2005
- Until then, the traditional recertification requirements for that specialty apply
- MOC runs in three-year cycles. At the end of each cycle, diplomates submit information online about their MOC activities
- The ABS will contact diplomates when submission of information is nearing due

Part IV

- Participation in a national, regional or local outcomes database or quality assessment program
 - Information regarding participation to be submitted every three years
- Evidence of evaluation of performance in practice, using tools such as outcome measures and quality improvement programs, and evaluation of behaviors such as communication and professionalism

American College of Surgeons' National Surgical Quality Improvement Project (NSQIP)—most popular database used by board certified surgeons

- Assess programs, not individuals
- Information gathered independent of surgeons (although surgeons enter initial data)
- Verified by non-surgeons
- Expensive
- Requires institutional buy in, not individually accessible
-

Potential MOC Menu Items

- Credit for teaching in a surgical environment (Part II)
- Credit for teaching non-surgeons (Part I and II)
- Credit for volunteerism (Part I and II)
- 360 evaluations (ABOS) (Part II)
- Peer referral Experience (ABIM) (Part II)
- Performance Improvement modules (ABIM) (Part II and IV)

Integrating Quality Improvement and Education: Skill Sets for a New Breed of Healthcare Professional

Nancy Davis, PhD

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MP3 audio and PowerPoint™ presentation available [click here]

Registries: How do they fit into the future of health care and medical education?

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Definitions of Registry

1. Technology to collect and integrate data into a database that can sort patients.
2. Business entity that serves as a third party reporting entity for quality.
3. Performance evaluation or scoring tool for measuring quality.
4. Database for longitudinal patient tracking and quality analysis.
5. Comparative mechanism for seeing across practices with different systems.

Registries state of development

- Registries are at a relatively early stage of development
- The rules and roles for Registries are being defined
- There is no common “standard” for a Registry
- But, there are good models to use as springboard for development
- Data capture challenges require flexibility and persistence

Electronic Medical Record vs. Registry

Usage

- EMR is transactional and collects data at point of care, later incorporating some additional data, especially lab
- Registry is not transactional – it collects and integrates more points of data than an EMR

Focus

- Patient care encounter is the focus of the EMR
- Registry purpose is population measurement and comparisons

Scope of Data and Functionality

- EMR is generally limited to practice boundaries
- Registries allow collection of clinical data in multiple practice settings

Reporting

- EMRs are currently trying to handle reporting to CMS as a “Registry” function, but are not neutral
- Registries, depending on entity, are neutral third party reporters

Purpose / Business Model

- EMR is designed to capture patient data for point of care management and data sharing with other providers also delivering care
- Registry is designed for multiple purposes in different settings – integration of data across practices, clinical research, quality measurement, reporting, clinical integration

Registry Components

- Dashboard of measures
- Individual patient view with data entry
- View across the organization
- Specialty-specific registries, identify high-risk, tracked patients, overdue patients, point-of-care tools
- Analytics

Role of Registries in the Future

- Will help physicians measure quality and better control their clinical reputations and revenues
- Will eliminate the limitations of a single-practice clinical system by spanning multiple practices
- As a neutral third party, will aid the “believability” of Pay for Performance data between payers and providers
- Will serve as the integrator for multiple sources of quality information – from physicians, hospitals, laboratories, and patients
- Will be a critical tool for Accountable Care Organizations, where review of outcomes will take place

Translating PI Research Findings for Decision-Making to Improve Performance

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PI-CE Research

Uses a rigorous analysis of the requirements of the healthcare organization, its process, and human performance for identifying the causes for performance gaps.

Provides recommendations as to solutions to improve and sustain performance, and directions as to how to evaluate the results against the requirements.

PI-CE Research Methodology

Appreciative Inquiry: A particular way of asking questions and envisioning the future that fosters positive relationships and builds on the basic goodness in a person, a situation, or an organization. In so doing, it enhances a system's capacity for collaboration and change, focusing on:

DISCOVER: The identification of processes that work well.

DREAM: The envisioning of processes that would work well in the future.

DESIGN: Planning and prioritizing processes that would work well.

DELIVER: The implementation (execution) of the proposed design

Gap Analysis: Bridges the space by highlighting which requirements are being met and which are not. A gap is sometimes called "the space between where we are and where we want to be."

Key Messages

1. PI-CE research produces evidence based upon naturalistic clinical settings
2. PI-CE is driven by:
 - Evidence of the naturalistic clinical settings' practices issues and challenges

AND

- Evidence Based Medicine (including EBM, guidelines, "best practices")
3. PI Interventions require transitional and operational plans, in order to effectively facilitate change process

NIQIE introduced its new **Community of Practice**, professional networking for continuous performance improvement. Two work groups include Education and Research.

Join the NIQIE Community of Practice by registering at www.niqie.org

Mark your calendar for **NIQIE 2010, September 12-14, 2010**, InterContinental O'Hare, Rosemont, IL. Information will be posted as it is available at www.niqie.org