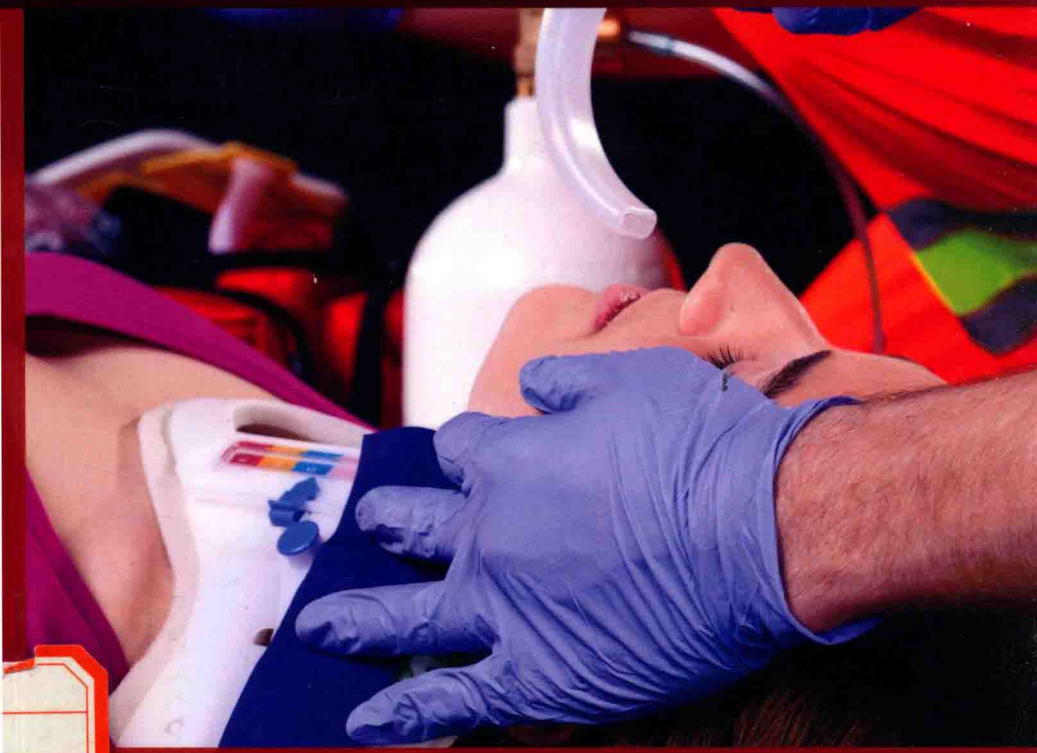
Assessment of Practice Performance in Emergency Medicine

A Clinician's Guide to Quality Improvement



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Assessment of Practice Performance in Emergency Medicine: A Clinician's Guide to Quality Improvement

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Assessment of Practice Performance in Emergency Medicine: A Clinician's Guide to Quality Improvement, First Edition

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Summary: "Improve patient outcomes and meet MOC Part IV requirements with this real-world guide to implementing quality assessment and practice performance in emergency medicine. Assessment of Practice Performance in Emergency Medicine delivers a comprehensive, engagingly written review of our current methods for outcome assessment and clinical efficacy. The author, an experienced Emergency Department physician, also offers an insightful, thought-provoking call for a more aggressive, comprehensive, and local process. Highlights of coverage include: The Standard Peer Chart Review Process, Sequential Clinical Auditing, Assessment of Practice Performance, Implementing a Sequential Clinical Auditing Program, Case Studies in Peer Review, Examples of Clinical Audits, Examples and Templates for compliance with the APP PCPI Component, Integration of these elements in a holistic physician performance program, How this process can be initiated within your organization, Essential for every medical director, chairperson, administrator, or physician who is searching for methods to raise and/or sustain their own technical quality or that of their group, Assessment of Practice Performance in Emergency Medicine provides a critically important tool in today's medicine and healthcare market."—Provided by publisher.
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Notice

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Preface

Like many young physicians in health care leadership, I started out wanting to change the activity of medicine and was quickly, ironically … promoted.

My first forays into physician performance were completing peer chart reviews and writing guidelines, then joining hospital peer review groups, then leading quality councils and health system committees. Along the way, I obtained many merit badges, CMEs, and some vision.

I see imbalance; a system shifting on a scale.

In this era of quality and patient safety in health care, I have marveled at the added complexity of the quality and patient safety effort brought to the system but was not surprised when the outcomes were not statistically affirming. I have watched the well-meaning core measures overshoot the evidence and the reactive response of a health system to a Joint Commission visit or waning Hospital Compare score.

I have been subjected to the drive of health care business and customer satisfaction goals. I found myself explaining to nonmedical personnel why I refused to prescribe 40 tablets of Percocet to a drug-seeking patient. I had naïvely considered our goal was limiting community drug addiction and not an unacknowledged method of customer retention.

Working within employed health systems, contract management groups, private practices, as well as academic institutions, I learned much about the physician perspective and behavior. Within those groups, I suffered some challenges developing this model but I was also encouraged with the hopefulness and patient alignment that our profession has retained.

This book offers one answer to correct the imbalance between the current quality and patient safety system, the business of health care and patient satisfaction metrics, and technical medical care. It tries to reduce activity to the local level and empower physicians to manage their craft, outcomes, group, and career.

Anthony Ferroggiaro, MD
May 4, 2015

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CHAPTER 1

The Assumption of Clinical Quality

Brothers and sisters,

One evening, I entered an emergency department to start a night shift. The day physician, signing out to me, was quite pleased with himself. He said,

I saw about 30 patients in triage in 2 hours… I bet I missed something.

The emergency department leadership had developed a policy of treating and discharging patients from the waiting room. Understanding that this department is much like others in which patient satisfaction has been aggressively promoted and operationally processes had been developed to achieve this interpretation of patient value, it did not shock me that this physician had given up on accuracy or correctness and had just focused on speed. Ironically, he was achieving a skewed interpretation of the Institute of Medicine aims.[1] I wondered how many patients would be harmed through his "efficiency," his "timeliness," his "concern" for the patient, for "his patient centeredness," and how the patients' "perception" of care would change when they found out their renal function was compromised from a quickly prescribed drug, a missed diagnosis or that they started bleeding from a toxic INR level. I doubted that the administration was monitoring the "return to the ED" rate.

I no longer work there…

As I started writing this appeal I realized that the term, assumption, with its dual meaning had strong linkage to our concerns.

Out of the dictionary,[2] "assumption" is the "thinking that something is true such as a fact or statement" and "taken for granted." A good example in today's health care world is the assumption that physicians provide highly accurate and precise care. People, patients, and families hope, believe, and delude themselves with this idea; physicians often do as well. Rarely do emergency physicians know whether they are 80% successful managing this process or another; the fact is that they might or might not but usually we do not have data to support any conclusion—good or bad.

Another assumption is that physicians are constantly improving their care, technique decay is minimal, and they do not need or they already have adequate programs or processes to assist with improvement. The current processes for

maintenance of practice quality are mostly self-directed and have minimal thresholds for compliance.

A third assumption is that patients cannot determine technical quality and that patient satisfaction is a reasonable surrogate marker for technical accuracy and ability.

Still, assumption can be positive.

As this book provides, we can "take [the responsibility of clinical accuracy, outcomes and improvement] to or upon oneself" especially since we are primarily if not solely responsible for these results and can be the only authority for review and action. Similarly, assumption is "the act of laying claim to or taking possession of something" and in this case, as I advocate in the text, we as physicians must continue to "lay claim" to clinical outcomes due to our technical nature and role in health care.

This book is about "hard" quality; the aggressive, at times, uncomfortable look at our practice, our knowledge, our outcomes, and our true technical quality. The currently used hard components of clinical quality do not achieve the goal of assessing overall technical physician performance; there is an incomplete, imbalanced description, review, and management of physician practice (Figure 1-1). Today this void has been filled with assessments of personality and soft quality not to be equated with professionalism or technical competence.

A simple overall view of emergency department activity includes operational management, clinical technical accuracy and effectiveness, and patient satisfaction (Figure 1-2). None of the three foci function in isolation and often overlap with activity. Operational management is about connecting the patient to and from the physician and enacting the physician's decision making. Patient satisfaction activity is about assessing the service delivery with the visit and whether the patient will promote the physician and facility to future patients. Clinical technical accuracy and effectiveness is the activity of those providing care; knowledge base, decision making, and technical ability; represented as practice performance. As stated, there can be overlap; the operational goal of timeliness to cardiac catherizations is linked to effective treatment in STEMI patients. Clinical accuracy and effectiveness, such as a properly anesthetized digit, that results in a pain-free repair is more satisfying to the patient with a finger laceration.

Many physicians are struggling with this health care model. They are trying to comply with the business side of this exchange but realize that the balance is hard

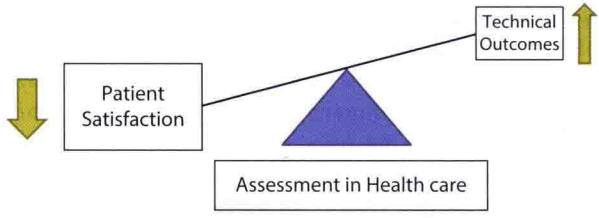

FIGURE 1-1. The imbalance in health care between patient satisfaction and technical outcomes.

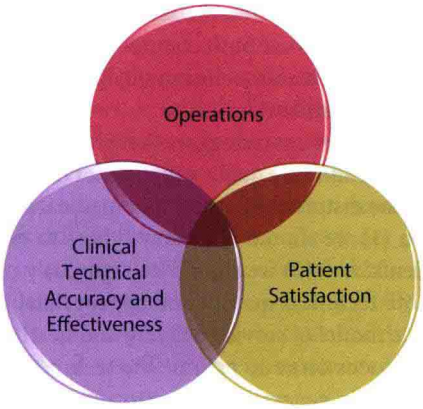

FIGURE 1-2. Simple view of emergency department activity.

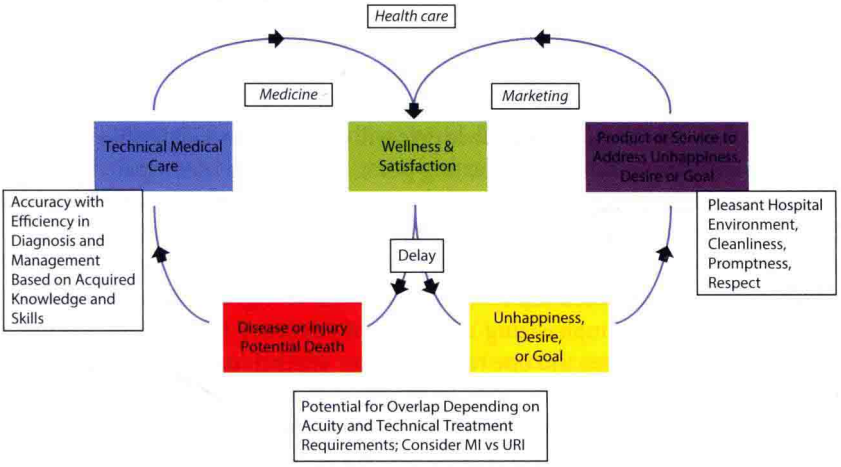

FIGURE 1-3. Simplified relationship between medical care and marketing—technical accuracy emphasis.

to achieve. Medical marketing and outcome medicine can be complementary and not antagonistic. Bowers and Kiefe[3] promote a model showing it is "conceptually feasible to integrate medical and marketing approaches to quality...." Within this model is technical quality associated with outcomes, "hard" quality, as a component *independent* to patient satisfaction and service delivery (Figure 1-3). Further the authors describe service delivery as based on the interaction between the physician and the patient (I would add the organization and the patient) and which contains elements—reliability, responsiveness, assurance, empathy, and the tangibles (physical environment). Bowers and Kiefe state that consumers attempt to assess technical quality but that technical quality may not be directly, overtly obvious to

the patient who then must use indirect measures of physician technical competency; "... consumers attempt to use both components when making quality judgments, but if lacking ability to assess technical quality the entire quality judgment is made on delivery quality elements."

If technical quality is not promoted aggressively but instead is a gap or vacuum in the overall concept of health care quality, then other factors of service dominate and the goals can become distorted. If no one but medical professionals can assess technical quality, then (1) we should not allow others to define it or proceed to assess, including patients, and (2) we should be vigorously pursuing systems and programs that promote technical quality and appropriately represent physician technical activity in the model of service delivery and health care process.

This is an appeal to focus on or to assume the technical quality in emergency medicine and in medicine in general; to return to a focus on clinical outcomes, to emphasize that as a team player in a health system, as a physician, your main job is to be clinically the best technician with increasingly higher technical knowledge and skill. This is recognition of the priority function that no one else can do and is required to balance the health care quality process.

In the next five chapters, this book reviews our current methods for outcome assessment and clinical accuracy and advances a more aggressive, comprehensive, local process. In Chapter 2, the standard peer chart review (PCR) process for emergency medicine will be described. We will examine the TJC FPPE and OPPE requirements and structure as a starting point, leading to a more specific discussion on common emergency medicine peer review. I will present a comparison between isolated peer review and a group review process including the incorporation of EBM as a foundation for work comparison. There will be a description of a best method to approach the involved physician as well as a delineation of the "art" of peer review emphasizing a balance of advocacy for the physician and the patient. Several cases and one response letter are included as examples.

Chapter 3 will discuss clinical auditing and specifically sequential clinical auditing (SCA). The latter is work that I have provided to emergency medicine groups, both community and academic, for several years. In comparison to peer review, clinical auditing is disease-specific or chief complaint–specific comprehensive practice review, linked or grounded in evidence-based medicine, in which all the physicians within the group are reviewed simultaneously. Combined as a sequence of audits in a comprehensive program, audits provide a more holistic, accurate view of a physician's and a group's clinical performance. Sequential clinical auditing is one system answer that can be embedded within a larger effort of hospital, practice, and/or department quality improvement as a necessary complement to flow process improvement, patient safety measures, including a way to balance the focus on patient satisfaction. The discussion will show how core measure work, standard peer review, and the new ABEM requirements of practice assessment can be incorporated into this system. This chapter will provide the steps of the process, from selection of topics to the politics of intervention and provide many examples (potentially worth copying) of completed audits.

Chapter 4 will be a discussion on the fourth component of ABEM's maintenance of certification: the assessment of practice performance. This is a new requirement for board-certified emergency physicians and is composed of two sections: "The ABEM APP Patient Care Practice Improvement Requirement" and "The ABEM APP Communication/Professionalism Requirement." I will attempt to describe the components of the requirements with reliance on the ABEM sources in order to assist the curious or concerned emergency physician reader. The PCPI discussion will emphasize an individual clinical focus on the choice of review topics rather than the ABEM-advocated operational topics. Templates for individual completion are provided. In the Communication/Professionalism (C/P) Requirement section, I promote a separation of professionalism from patient satisfaction through a focus on technical quality. The focus will be on components of the physician-patient interaction that enable accuracy of diagnosis, relief of symptoms, and adherence to a treatment plan. The discussion's second half will break down the C/P requirement into categories with direction on methods of completion for the benefit of the individual physician practice.

Chapter 5 will describe how all of these elements can be linked within a physician performance process and how this process can be started within your organization. The emphasis of implementing a program in your group is based on the individual to group dynamic: The group must support the individual such that the individual can support the group. I will discuss different statuses of groups and their readiness for cultural change. Developing a coalition of key influential and power level physicians is invaluable to moving the audit program forward and we will explore which physicians in the group should compose the coalition. I present the mechanics of breaking inertia and monitoring the group process and rate of acceptance as well as the potential organizational impediments to program development and continuance.

This work is written for any medical director, chairperson, administrator, or physician who is searching for methods to raise and/or sustain his or her own technical quality or his/her group's technical quality. This text can be a platform for initiating your work or your program. Though all examples are for emergency medicine, the methods are universal. It is my hope that once you have completed your first read, you feel I argued well for our profession and for a better way.

Anthony Ferroggiaro, MD

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CHAPTER 2

Peer Chart Review

A 2009 survey of hospital leaders[1] on the process of peer review in US hospitals found that the majority of sites (96%) completed retrospective chart review. This was the most frequent and consistent method of peer review identified and probably is a response to regulatory demand and compliance. This chapter will describe the current requirements for and general technique of retrospective chart or case peer review as a comparative background for the clinical auditing chapter (Chapter 3).

HOSPITAL PEER REVIEW

Whether individual physicians are specifically aware, each medical staff at every hospital with The Joint Commission (TJC) certification and/or accreditation is required to have a structured peer review process for new applicant physicians requesting privileges and for established physicians requesting a change in or additional privileges. The hospital must have a similar process for ongoing practice evaluation in order to determine appropriateness of continuance of privileges.

TABLE 2-1. The Joint Commission OPPE and FPPE Focus

Program	Focus
Focused Professional Practice Evaluation (FPPE)	Primary use: New MD privilege specific competence New or change in practice requests with established MD—new techniques, equipment, or provision of service Secondary use: Questions of quality and safety of care identified with OPPE
Ongoing Professional Practice Evaluation (OPPE)	Continue, limit, or revoke privileges

Data from Ref. 2.

TJC titled these processes FPPE and OPPE: Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).[2] (Table 2-1). Most frequently, the FPPE process is used when "the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization."[2] This is the expected process in which a medical staff evaluates a new colleague starting to practice at the hospital. The process is also inclusive of any new privilege requested of established physicians, in the case of new techniques, equipment, or provision of service. The secondary use of FPPE is "when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care." The secondary use of FPPE may also be in follow-up to questions of care as a result of the OPPE process.

Specific highlights of the FPPE requirement for the medical staff process are that (1) the policy is universally applied regardless of background or training, (2) triggers and evaluative criteria have been developed a priori, (3) only specific privileges be reviewed, (4) a period of review be defined, and (5) actions to resolve performance gaps are clearly defined and consistently implemented. The information for the FPPE "may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient".[2] These sources are also used for OPPE.

The OPPE "allows the organization to identify professional practice trends that impact on quality of care and patient safety".[2] The sources for criteria may be "review of operative and other clinical procedures..., pattern of blood and pharmaceutical usage, requests of tests and procedures, LOS patterns, M&M data, use of consultants, and other relevant criteria as determined by the organized medical staff." The OPPE requirements are somewhat different from the FPPE: (1) there is a clearly defined process, (2) the type of data can be determined by departments, and (3) the information from the OPPE must be used in the determination of continuing, limiting, or revoking existing privileges.

Ironically, the basis for peer review in most hospitals is now due to TJC requirement—connecting peer review with the request and maintenance of

privilege of practice. Whether peer review would be completed on an organizational level without this requirement is unclear. And to extend this haziness, it is unclear whether the form of "reviewing the practice of peers" would (or will) have evolved beyond what is now compliance with TJC requirements. After observing this culture for years, and typical of organizational behavior, once a compliance threshold has been established most organizations provide minimally beyond this mark (Figure 2-1). This is probably due to the lack of effective organizational vision and leadership and the resulting lack of linkage between peer review, performance improvement, and strategic positioning within a competitive marketplace with patient betterment as a goal. Still, some sites have experimented with modifications of the peer review process.[3]

TJC process is minimally about quality improvement and much more about quality control. TJC does not promote a requirement to raise quality beyond addressing performance where a gap has been observed. TJC could do more, promoting the concept of increasing performance as a goal; instead, TJC promotes a policing concept as the FPPE is a gatekeeping mechanism and the OPPE (with subsequent FPPE) works to identify outliers for mediation (revising or revoking privileges). As per TJC blog by Robert Wise, MD,[4] "it is important to emphasize that OPPE is not designed to identify clinicians who are delivering good or excellent care." In fact, he identifies how the policy, based on implementation, could result in negative outcomes, "the criteria used for OPPE may also identify some clinicians who have no quality of care issues (ie, identification of situations that turn out to be false positives)." This latter comment exposes the peer review policy as a disservice to physicians—the idea that insufficient compliance with some local, potentially non-EB standard or culture could result in being identified as an outlier. These physicians may actually practice beyond the state of the art, potentially better than the local standard of care, and whose practice should be viewed positively! This policy evokes the cultural issues within medical care that plague the evolution or innovation of practice. The system is set up to punish or reduce practice from objectivity and improvement to protectiveness and though the outcome may not be specified in the wording of TJC policy, the medical staff often interprets the policy as an effort to remove nonstandard practice without determination of whether it is evidence based. Indeed, within the policy there is no mention of "evidence-based" practice.

Despite its wording, current implementation, and functioning, within TJC OPPE/FPPE policy structure is opportunity. As mentioned above, TJC allows for compliance *and* opportunity for institutions/medical staff to develop more robust approaches to physician performance including a cultural aspect of continuous physician improvement and a forward vision of innovation. It is allowed and up to the medical staff at the institution to require more of its physicians, not

FIGURE 2-1. Methods of peer review—basic method.