NIQIE 2011: Moving from Performance Measurement to Continuous Performance Improvement
September 14-16, 2011, Alexandria, VA

Conference Highlights

The NIQIE 2011 annual conference was held September 14-16 at the Hotel Monaco in Alexandria, Virginia. The focus was the integration of healthcare quality improvement and continuing medical education. New, this year, was a presentation on value based payment and an emphasis on practice based learning and improvement.

PI CME/MOC Workshop
The pre-conference workshop featured practical information for developing PI CME activities for ABMS Maintenance of Certification (MOC), Part IV. Mellie Pouwels, Director, ABMS MOC Support provided an overview of MOC including detail about requirements for Part IV, emphasizing that each certifying board has their own specific criteria and policies regarding acceptance of other organizations’ activities for Part IV credit. Nancy Davis, PhD, presented practical information on performance measures and developing interventions for Improvement. Andrew Rabin, CTO, CE City provided general information regarding data collection and analysis for performance measurement for use in MOC Part IV. Participants had the opportunity to plan out their own activities using a NIQIE template and advice from the expert faculty.

Conference
J. Larry Holly, MD, CEO, Southeast Texas Medical Associates, kicked off the meeting with Moving from Quality Measurement to Continuous Quality Improvement, an example of practice based learning and improvement using data collection, reporting, on-going performance improvement and suggestions for using SETMA’s techniques for CME. Dr. Holly emphasized the need for clinical decision support at the point of care; relevant data collection that makes a difference in practice; and aligning performance measurement with incentives such as pay for performance, maintenance of certification and CME credit.

Putting the Value into Value Based Purchasing. Laura Long, MD, VP of Clinical Quality and Health Management for BlueCross BlueShield of South Carolina presented compelling data regarding clinical performance and the need to improve. She suggested payers play an important role in measurement, improvement and incentives. Improving quality and reform of the payment model will result in a more value-based healthcare delivery system.

Katherine Grichnik, MD, MS, Director, Center for Educational Excellence, DCRI, Duke Patient Safety Center, focused on Change Management for Performance Improvement. She started with a real example of an egregious patient safety issue at Duke Medical Center. She indicated that traditional response to these types of errors was, “be more careful, take safety modules, be more alert.” Dr. Grichnik posed a more effective method, based on the book, Switch, by Chip Heath and Dan Heath and The Happiness Hypothesis, by Jonathan Haidt. Some surprising conclusions: what looks like resistance is often a lack of
Using CME/CPD to Improve Performance was presented by David Davis, MD, Sr. Director, Continuing Education and Performance Improvement, Association of American Medical Colleges. He began with definitions of CME/CPD, practice gaps, diffusion and implementation science. Dr Davis shared that methods which work best include “interactive lecturing, sequenced sessions and accurate needs assessment. Those that aren’t as effective include one-off lectures. Group sized doesn’t seem to be a variable in effectiveness. Pathman’s model of learner stages, Awareness, Agreement, Adoption, and Adherence were presented as important considerations in developing CPD activities. Dr. Davis recommended a toolkit for disseminating new clinical information and guidelines including formal education, informal learning, reminders, audit and feedback, policy and patient education.

Strategic Management for PI: Why CME and QI Need to Work Together was presented by Morris Blachman, PhD, Assistant Dean, Assistant Dean, Continuous Professional Development & Strategic Affairs, University of South Carolina School of Medicine. His message was to make change intentional, directional and strategic. The value proposition for integrating QI and CME should be clear and based on the desire to improve patient care. Dr Blachman shared the strategy at his own organization including a QI/CME shared staff position, regular communications and integrated staff meetings. There are several joint ventures include PI CME and Patient Centered Medical Home. The case to administration leadership included financial and quality challenges; a desire for life-long learning; productive and satisfied clinicians and staff; and satisfied patients. A new service has been created that includes an educational home made up of specific competencies, a database profile of practice and organizational needs, and guided self-reflection.

An Update on ABMS Maintenance of Certification was provided by Richard Hawkins, MD, Sr. Vice President, Professional and Scientific Affairs, American Board of Medical Specialties. An overview of the ABMS, member boards and history of MOC was followed by a review of current revisions based on stakeholder feedback of original MOC including: QI is not frequent enough; MOC is not dealing with cost or appropriateness; the patient experience of care not routine; and the need to be more transparent.

Cary Sennett, MD, PhD presented an Overview of Accountable Care Organizations. He defined ACOs as:
- “Provider-based organizations that take responsibility for meeting the health care needs of a defined population with the goal of simultaneously improving health, improving patient experience and reducing per capita costs”

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• Entities capable of accepting accountability for clinical/quality and financial outcomes
• Enabling better coordination and integration of care across providers/sites of care
• A legal construct, intended to permit hospitals and physicians to collaborate in ways that do not violate Stark and anti-kickback laws

He emphasized that ACOs:
• Are not gatekeepers
• Do not require changes to benefit structures
• Do not require exclusive patient enrollment

There are a wide range of ACO models including integrated delivery systems, multispecialty physician groups, physician-hospital organizations, independent practice associations, and regional collaboratives. Current pilots include Medicare PGP, Brookings-Dartmouth, Premier and Medicare MHCQ. Coming soon are Medicare Shared Savings Plan and Pioneer pilots. ACO shared savings will only occur if savings and quality thresholds are met. Challenges continue regarding financial models and selection of quality measures. Bottom line message: organizations will be required to collect more clinical performance data and use data to improve care and reduce cost.

Quality Improvement as Research was presented by Ed Dellert, Ed Dellert, RN, MBA, Senior Vice President, Clinical Education, Informatics & Research, American College of Chest Physicians. He led with Paul Batalden’s definition of quality Improvement and health care:
“Combined and unceasing efforts of everyone – health care professionals, patients, and their families, researchers, payers, planners and educators – to make the changes that will lead to...
  a. better patient outcomes (health);
  b. better system performance (care);
  c. better professional development (learning).

Batalden PB. What is “quality improvement” and how can it transform healthcare? Qual Safe Health Care 2007; 16: 2-3.

<table>
<thead>
<tr>
<th>Feature</th>
<th>QI</th>
<th>Research</th>
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<tr>
<td>Purpose</td>
<td>Improve a local care process and outcome</td>
<td>Create generalizable knowledge</td>
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<tr>
<td>Question/Audience</td>
<td>Clinicians/leaders local clinical setting</td>
<td>Researchers/Funders/Science/Medical public</td>
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<tr>
<td>Measure &amp; Sample Size</td>
<td>Few, simple, small</td>
<td>Many, complex Large to very large</td>
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<tr>
<td>Analysis &amp; Confounders</td>
<td>Awareness Keep it simple</td>
<td>Measure or control Statistics</td>
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<tr>
<td>Resources &amp; Timeline</td>
<td>Few, short, so can be used quickly</td>
<td>Many, long Who cares?</td>
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Solberg et al. Jt Comm J QI 1997;23:135
Dellert discussed the value of healthcare, defined as value=quality/price. He discussed the variable methods in QI methods, from simple, pencil and paper to complex computer programming and electronic data collection.

Research has made a difference in health of the public. NIH reports that for approximately $44/person, life expectancy has increased, HIV transmission from mother to child has been eliminated, and deaths due to heart disease and stroke have greatly decreased. Additionally, AHRQ reports examples such as:

- Redesign of primary care office practice (nurse educator/case manager plus enhance physician leadership) reduced symptom days (asthma).
- Provider education and DM approached significance (diabetes)
- QI strategies in general but no specific strategy emerged (hypertension identification & control)
- Some evidence that some interventions are effective (minority health improvement)
- CME – in some circumstances, may affect process and outcomes, but specifics are needed

He summarized with:

- QI is closely related (and should be integral) to clinical practice.
- QI is considered good clinical care combined with systematic, experiential learning. This is PI-CME!
- QI methods are largely systems issues, where researching these interdependencies and relationships within systems is at the heart of QI.
- QI activities will often use the science of organizational change to design strategies for changing behavior in the local setting (i.e. adherence to new practice guideline recommendations or patient safety protocols.) What are best practices in healthcare organizational change? Can it be replicated?

The final session of the conference was a wrap up Let’s Build a Value-Added PI Initiative, presented by Jack Kues, PhD, Assistant Senior Vice President for Continuous Professional Development, University of Cincinnati Academic Health Center. He started with the definition of “value”:

Val•ue  noun  \ˈval-ə(ˌ)yü\  
A fair return or equivalent in goods, services, or money for something exchanged
The monetary worth of something : market price
Relative worth, utility, or importance <a good value at the price><the value of base stealing in baseball><had nothing of value to say>

Stakeholders at the “value table” include physicians (and other healthcare providers, healthcare Institutions (eg., hospitals, healthcare systems), payers, employers, patients, organized medicine (Healthcare), CPD/QI/PI providers.

Using a logic model, Dr Kues described a framework for value added PI:
INPUT: data, funds, knowledge, etc
OUTPUT: the result of the input-- CME activities, PI initiatives, system changes; or data, new knowledge.
OUTCOME: changes in practice, performance, knowledge, systems.
IMPACT: Size and scope of change to the larger healthcare enterprise--health outcomes for individual patients or populations; Or systemic changes to how care is delivered or reimbursed.

**Best Practices**
Six Best Practices from the Field were presented showing how performance improvement initiatives are being developed and delivered. They included:
- Debra Gist — Translating Psoriasis Treatment Guidelines into Clinical Practice
- Ted Bruno -- PROTECT (Suporting AppROPriate ImmunizaTions Across the AgE SpeCTrum)
- Ron Gibbs -- Obstetrical 3rd and 4th Degree Lacerations (OTFL) (PDF)
- Janet Leiker -- AAFP Healthy Communities Collaborative (HCC) TM
- Chittur A. Sivaram -- Cardiology Quality Rounds
- Suzanne Ziemnik -- CheckPath: An ASCP Performance Improvement Activity

The NIQIE 2011 Conference was an interactive, discussion-based conference with sharing of new information, practical application to the field, and recommendations for development and dissemination of continuous performance improvement in healthcare delivery.