

Linking CME with Quality Improvement



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One of the biggest challenges for physicians is to understand their educational needs, step out of their “comfort zone” and confront areas of practice deficiency. It’s natural to fall back on familiar topics and subjects, and learn via lecture, journal reading or audio or video programs. It’s a fact that physicians (and others) who actively engage in educational activities and compare their performance against “best practice” learn better. To that end, physicians should choose CMEs that address areas for practice improvement, and when possible, leverage that CME for quality improvement.

One example of this approach is a project recently undertaken with a central New Jersey internal medicine practice. Its physicians wanted to improve the quality of care for diabetic patients while keeping up with their CME requirements. Our office of Continuing and Outreach Education received a grant to conduct a blinded chart review of quality of care indicators for diabetic patients. Using the certified format from the American Diabetes Association criteria and the National Committee for Quality Assurance, charts were reviewed for documentation of foot exams, measurement of hemoglobin A1C, dilated eye exams, etc. The physicians’ CME credits were targeted to their needs and, at the project’s end, they became ADA-certified diabetes providers.

Physicians interested in more information about this project, or other similar initiatives can contact my office at 732-235-6383.

The RWJ Health Network’s Clinical Integration Program – a Quality Commitment

The Robert Wood Johnson Health Network was founded in 1995 based on a commitment to quality health care that still provides direction for Network activities today. As part of an affiliation agreement, members support the Network’s Clinical Integration Program (CIP), the Network’s primary quality activity. The program is led by the Physician Coordinating Council (PCC) – who are physician leaders at member hospitals and the UMDNJ-RWJ Medical School, and hospital performance improvement specialists. The PCC monitors individual hospital and Network performance on 31 quality indicators using a common information system. This focus on achieving excellent patient outcomes gives the PCC direction for Network hospital clinical activities, educational programming and administrative decision-making.

The Physician Coordinating Council approves CIP study topics, sets performance benchmarks and reviews data reports for best practices as well as opportunities for improvement. The Network takes a “shine the spotlight” approach to performance improvement. It regularly presents trended quality outcome studies to the PCC, the Nurse Coordinating Council and the Network Board.

The PCC monitors compliance with mutually agreed upon benchmarks, and hospital members submit corrective action plans when targets are not met. PCC members disseminate CIP results within their organizations and the hospitals use that information to complement their own performance improvement initiatives

Initially, the Clinical Integration Program’s quality studies focused on *clinical outcomes* such as mortality, complications, procedure rates and length of stay. (Results are found on the PCC Pulse’s back page.) The program later expanded to include *evidence-based care processes* that have become the standard of care for patients with myocardial infarction, stroke, community acquired pneumonia, heart failure and risk of surgical infection –the subject for both state and national hospital report cards. Last year, the PCC added reports from Press Ganey’s *patient satisfaction survey*, a key service quality indicator. And in 2004, the CIP will include *patient safety* assessments, based on the National Quality Forum’s Safe Practices for Better Healthcare.

The PCC’s intellectual assets are always available to Network members and have included analysis of coding practices, symposiums on state-of-the-art medical practices and consultations on clinical and administrative issues. Network and Medical School programs are open to the staff at all Network member organizations.

PCC Pulse is published quarterly by the Robert Wood Johnson Health Network’s Physicians Coordinating Council.

Clinical Outcome Measures – How are we doing?

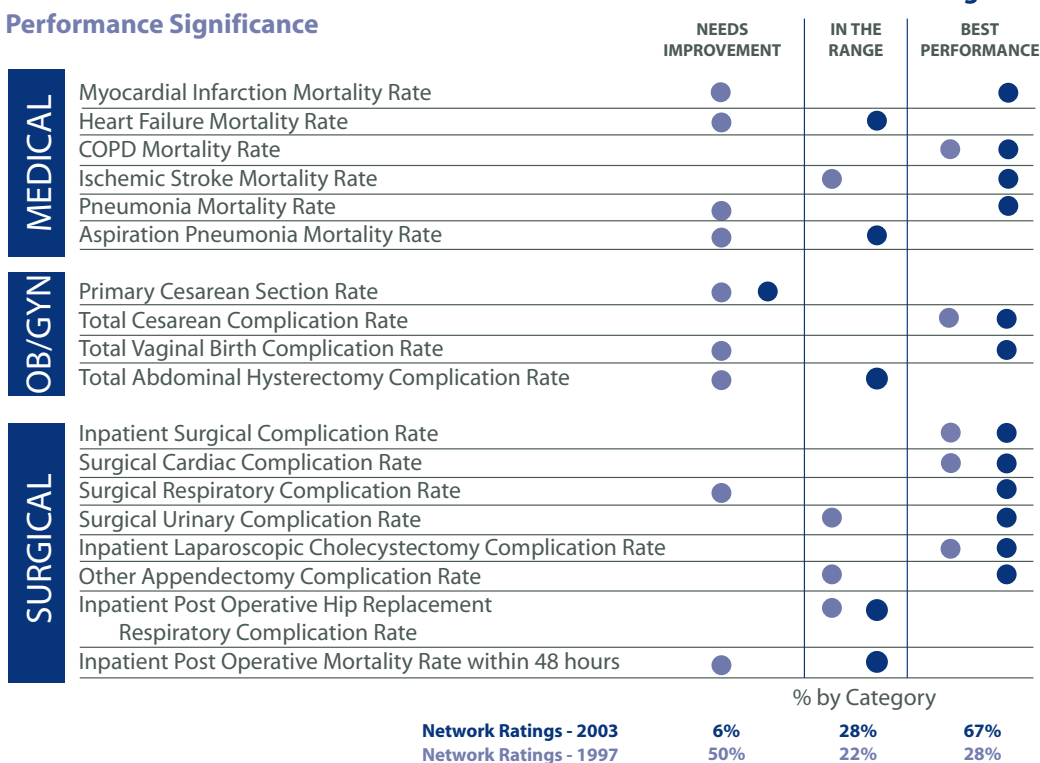
Clinical outcome studies are just one of the Network's Clinical Integration Program's (CIP) quality components. Early on, Physician Coordinating Council (PCC) members knew that data must be valid, reliable and severity-adjusted data to gain physician acceptance and be actionable. After reviewing software systems, the PCC recommended, with Network Board endorsement, the installation of QuadraMed's Performance Measurement system at all member hospitals.

The PCC reviews 31 outcome studies targeting patients in high volume DRGs and procedure codes. Individual hospital and Network aggregate rates are captured and compared against severity-adjusted expected rates and N.J. state rates. Eighteen studies are modeled, or severity-adjusted, using a methodology that derives expected outcomes based on each patient's acuity levels. Trended data from 1997 to the present demonstrate the CIP's positive impact:

- 94% of all 31 study topics had improved outcomes
- 89% of the 18 modeled study topics had rates better than the severity-adjusted expected rate in 2003 an impressive result.

ROBERT WOOD JOHNSON HEALTH NETWORK Performance Significance

1997 and 2003 Ratings



As the chart above shows, studies are grouped into Medical, Surgical and OB/GYN categories. Hospital performance is rated as either unfavorable (needs improvement), as expected (in the range) or favorable (best performance). The thresholds for the rating groups are the upper and lower confidence levels at the 95th percentile confidence level. Grid results confirm the high quality of care provided at Network hospitals: In 2003, sixty-seven percent of indicators have statistically significantly better than expected rates and it's the PCC's goal to move all indicator rates to the far right column. The PCC is evaluating hospital performance, coding practices and indicator definitions for primary cesarean section rates, which are consistently lower (better than) the N.J. state rate for the periods studied. Other CIP quality components will be presented in upcoming PCC Pulse issues.

The Robert Wood Johnson Health Network operates a quality physician billing service at competitive rates. Call Peg Douglas for more information – 732-418-8055

RWJ Health Network Health Plan – MEWA Update

All new programs and new rates are effective July 1, 2004

Plan A – Open access POS plan – average rate increase is less than 7%.

Plan B – New HMO plan option - rates are approximately 8.5% less than Plan A.

Plan C – New high deductible plan option - rates are approximately 31.5% less than Plan A. Special participation guidelines apply. New Dental plan offered as a Rider to the Medical/Rx Plan through Delta Dental of New Jersey. Extremely competitive rates and comprehensive coverage. 100% coverage for preventive services and orthodontia for children.

The Physician Coordinating Council is comprised of the medical leadership of the Robert Wood Johnson Health Network members which include:

- Bayshore Community Health Services, Inc.
- CentraState Healthcare System
- Children's Specialized Hospital
- Raritan Bay Medical Center (Perth Amboy and Old Bridge)
- Robert Wood Johnson University Hospital (New Brunswick, Hamilton, and Rahway)
- UMDNJ-Robert Wood Johnson Medical School (New Brunswick)
- Eric B. Chandler Health Center
- Henry J. Austin Health Center
- Plainfield Health Center
- VNA Community Health Center
- Presbyterian Homes & Services, Inc.

It is the only healthcare network in New Jersey to include a medical school among its partners.

Please direct questions about any information contained in PCC Pulse to your chief medical officer or the Network's Clinical Integration Analyst, lois.dornan@rwjuh.edu.