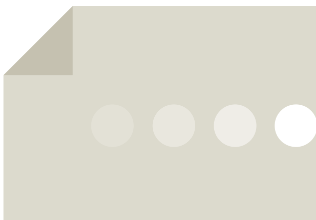

PI SOLVING THE EQUATION

RICK KENNISON, PeerPoint Medical Education Institute, LLC,
discusses the evolving role of performance improvement (PI) in healthcare delivery

In healthcare over the last 10 years, major quality and performance improvement initiatives have been implemented with the goal of improving healthcare delivery. Many of these programs have come down from the state and federal levels, while others are more like grassroots campaigns, trying to affect change at the local or departmental level. While some of them have been successful, most have not, due to a variety of factors, many of which were not anticipated during the creation process.

Although there have been failures, few can deny the empiricism behind the intent. By reducing the amount of variation in a process or system, we can improve the current state of medicine. This concept is not new. Many well-respected organizations, such as the Institute for Healthcare Improvement have been around for years showing us the importance of improving healthcare by improving process and the stakeholders within these systems. Other organizations have followed this lead. Many of them, such as the National Committee on Quality Assurance, we are familiar with because of the interaction with the federal government. These groups have helped forge a place in healthcare quality that has led to significant advances in improving patient outcomes, quality of life, and reducing waste associated with healthcare dollars.

When we examine the reasons why some programs have failed in their goal of improving outcomes and the standard of care, we usually don't need to look much further than the implementation process. Private payers, federal and state governments, the medical societies that are responsible for validating board certification status and healthcare systems have unilaterally implemented performance improvement initiatives to healthcare providers from a "top-down" approach — with a vast majority of these initiatives failing in the goals they were set up to meet. The perception from healthcare providers is that these programs were confusing, an administrative burden, futile, not relevant for their practice, and countless other reasons, which may have been the undoing of these initiatives.

THE PERCEPTION OF HEALTHCARE PROVIDERS

Few healthcare providers and administrators feel that quality and performance improvement programs are of no benefit. A recent survey conducted by the PeerPoint Medical Education Institute determined that over 85 percent of respondents believe that if done correctly, these programs may have a significant impact on improving healthcare delivery. However, when asked what steps could be taken to improve these programs, there was no uniform response. As mentioned earlier, administrative burden was one of the largest determinants of success by participants, but participant vestment was nearly as important. What is the big picture? How will this program work to improve the standard of care? How will this program benefit my practice? These are questions that illustrate the uncertainty in the role of teams and individual participants, which need to be addressed early on in order to be successful.

As the foundation for quality improvement (QI) became more stable, attention was directed from the overall process of a system to the system's individual role players. This became known as performance improvement (PI). Today, PI focuses primarily to get these same players to a standardized level. In healthcare, this translates to actions such as getting providers to deliver care to the accepted standard for a particular condition. However, this is only one example, PI can be used to improve processes, understanding, and coordinated care efforts implicated in improving the level of healthcare delivery. It can also be used to correct deficiencies and overcome internal barriers.

Many QI campaigns have begun focusing more on the individual stakeholders rather than on systems. Of course, in any organization, there are going to be barriers that reduce efficiency. However, by addressing variations in people, the theory is they may face these barriers "head on" while improving their own skill sets. Fortunately, the mindset of healthcare providers is such that they want to perform well. Perhaps, there is an inherent driver for them to succeed, which in turn may equate to improved care that they deliver.

However, quality and performance programs must provide value to healthcare providers. They must have an intrinsic understanding of the project, its goals and reasonable expectations. Without these, there is greater likelihood they will not get the most out of the program, which may be interpreted as overall failure.

One area that is coming to the forefront is the role of provider-based education in PI. Through education, professional practice gaps can be brought to the surface. Healthcare providers will be provided with a forum that explains why it is so

important to provide consistent, high-quality care, as well as the effects of not making the best or timely decisions. Recent research indicates that by educating providers in greater detail, they become more vested in the program and the quality and commitment of their involvement increases.

The landscape of healthcare provider involvement is evolving. The determination of how PI can be implemented into healthcare education has typically not been uniform. Insurance companies have implemented quality improvement programs for their physician members that generally consist of minimal education as to why it is important, and then undergo a review of claims data to determine if physicians are listening. Many medical societies have implemented improvement programs in an attempt to see if their membership is providing patients with the standard of care for particular conditions. This is the correct strategy for using PI in healthcare, but their initiatives generally fall short because reporting processes are often antiquated and time consuming, causing members who implement these programs to fall short of their goals. Some medical schools and healthcare systems have created PI programs that have combined the benefits noted within the QI processes of insurance companies and medical societies to create a hybrid model. However, many of them have encountered similar problems in terms of reporting, resource commitment by the participants and providing value.

Healthcare providers must seek out and participate in educational programs in order to maintain their board certification and in many states, their licenses. Entities that can ensure a non-promotional, fair and unbiased theme for those that participate in a program must accredit this education. Accredited provider education in the form of continuing medical education has been around for decades and is considered the hallmark method of informing providers on advances, trends and products that impact their practice of medicine. The inclusion of PI components into accredited education is an exciting new way to allow physicians and other providers an opportunity to acquire the necessary education, while being able to improve not only the way they practice, but also the outcomes they deliver.

CAN EDUCATION-BASED ORGANIZATIONS PRODUCE THESE PROGRAMS?

Having the knowledge on how to create and implement educational initiatives is one thing; having the business model to accommodate it is another. Many people that have careers in quality or performance improvement will be the first to agree that moving to this model is not an easy feat. Many companies, including our own, needed to take multiple steps to ensure that we were in a position to create and support improvement initiatives.

Fortunately, many accredited providers have at least a baseline understanding of PI and how it is translatable to the delivery of healthcare. This knowledge is usually coupled with the tenants of PI, especially the Plan-Do-Study-Act model. The PDSA model is another systematic process similar to the familiar scientific method and is accepted QI theory. Basically, it involves goal development, obtaining a baseline assessment of a process, implementing a change, and then reassessing that change.

This type of product offering is not rocket science; it simply follows PI to the letter. It starts with education that discusses what the issues and problems practitioners are facing today. It then presents logical and comprehensive tools that give the practice an opportunity to develop an unbiased perspective on their functionality in comparison to their peers in similar situations. Next, the participants work to obtain a functional baseline assessment of their site that becomes the foundation for the QI initiatives specifically designed to address these gaps. Throughout the improvement process, participants should be given the level of attention they need to apply the QI processes into their practices, and in return, submit data that gauges the impact of the initiative on their practice.

DOES THIS WORK?

PI initiatives in medical education work. We recently completed two, four-week PI studies on pain management in 477 dialysis patients, where a PI tool was implemented to gauge the level of pain in these patients and gave the provider resources to appropriately treat that pain, a clinically and statistically significant ($p\text{-value}<0.001$) benefit was noted. The conclusion of these studies is that patients had less pain when providers were properly trained on how to manage that pain. These types of educational interventions work when adequately supported, and based on these data, improve healthcare delivery.

WHAT'S THE PROVIDER FEEDBACK?

Healthcare providers are interested in participating in programs that have a goal of improving the delivery of care to the public. Based upon participant comments and feedback, providers appreciate the new approach towards education. Many facilities across the U.S. are interested in participating in novel PI programs that are free, less labor intensive and private in terms of reporting mechanisms.

One initial concern was uptake of these types of initiatives by healthcare providers. Although PI CME is primarily targeted towards therapeutic areas that may not be of particular interest to all healthcare providers, the transference of the program is of interest to most. In order for PI education to be most effective, providers need to be able to take the things they have learned regarding PDSA and other concepts and apply them to areas within their practice that would benefit the most. The goal of transference within PI can be very difficult — sometimes perceived as a square peg in a round hole — however, by teaching routine PI concepts, theories and strategies this can be achieved with minimal effort.

As the state of healthcare continues to reform, PI will continue to play a larger role in the delivery of care. Healthcare providers will find themselves in positions to embrace PI and make it an integral part of their business, or they will die by it. The Internet has created educated healthcare consumers, rather than simply smarter patients. These consumers are no different than those that consult consumer reports on which appliance to buy. They expect quality care and they expect their healthcare providers to give it to them or they will simply spend their healthcare dollars elsewhere. Now is the perfect time for all parties — companies and individuals alike — to assist healthcare in meeting all its needs; to step up and help this massive industry regain the stature it once had. FH

RICK KENNISON As president and general manager of the PeerPoint Medical Education Institute LLC, Dr. Rick Kennison, DPM, MBA, CCMEP, has transformed the company from a traditional CME provider to one that focuses on using education to improve the performance of healthcare providers and the quality of healthcare they deliver. Dr. Kennison began his medical career as a state-licensed physician with a focus in lower limb reconstruction. He moved on to further his education by obtaining and MBA and entered the pharmaceutical world where he eventually became a medical services director for Schering-Plough.