

“QI Hour”: Early Lessons Learned from Developing a QI Practice

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It is impossible to ‘teach’ the principles that we loosely clump together as ‘quality improvement (QI)’ or ‘systems-based practice.’ The only way to get trainees to adopt specific improvement strategies is to model them ourselves.

This insight hit me last year after a challenging attempt to implement another “QI curriculum” in our outpatient resident practice. After 10 years, I concluded that no matter what materials I designed, no matter what software we used, no matter what model we chose (e.g. PDSA, A3, six sigma), getting large numbers of residents to conduct meaningful QI in the outpatient setting was forever going to be like pulling teeth. I concluded that unless my colleagues and I were walking the walk on a daily basis, it was going to be very challenging to ever see the change we were hoping for in the practice of trainees.

With this in mind, I embarked upon crafting a personal “QI practice.” Modeled on “yoga practice”—a set of exercises yoga practitioners go through on a regular basis—I set aside one hour of uninterrupted time each week during which I would perform a series of structured activities directed at improving the quality of the care I deliver. My “QI hour” would include data collection, self-education, changes in practice, and logging my experiences. This report represents themes that have arisen in the first 12 weeks of this practice.

What I Did

In the first week, I outlined my weekly “QI hour” schedule. I brainstormed and identified 10 elements of care delivery that I believed deserved my undivided attention for an hour a week. My list included screening items, chronic disease metrics, and other areas such as end-of-life care planning.

I first chose to tackle pneumococcal vaccination (PV) because of my

knowledge deficits around these vaccines, the opportunity for improvement (i.e. my PV rates were abysmal), and incentives (financial) to our practices from local insurers for improved PV rates. In weeks one and two, I educated myself about PV and who should get it. I investigated our practice’s standard operations around vaccine delivery, who was assigned to monitor overdue vaccinations, and why those protocols were not being followed.

Next, I solicited the list of “my” patients “overdue” for PV. I methodically reviewed the list, correcting documentation errors that mistakenly categorized patients as eligible for PV—including deceased patients—or erroneously identified them as overdue (e.g. immunizations documented in my notes yet “invisible” to the data query).

I then drafted and sent a letter to targeted patients explaining their eligibility for PV. I signed an order for the appropriate vaccine so patients could make an appointment and receive PV without my further involvement.

In week six, I solicited another list and surprisingly found a new group of patients on my “overdue” list. I repeated the exercise above with this new list.

I then began piloting a series of exercises during each patient care session, tweaking my practice daily to find activities I could live with that would improve my PV rates.

What I Learned

I thought I would work on PV for two weeks (maximum) and then move on to other items on my list. Much to my surprise, meaningful PV improve-

ment has consumed my entire dedicated “QI hour” for the first 12 weeks.

First and foremost, I improved my knowledge of current vaccination recommendations for PPV23 and PCV13. I created a PV indication “cheat sheet” for easy reference. I answered my remaining questions about PV indications for patients with diabetes and malignancies by contacting the Immunization Action Coalition and the Centers for Disease Control (CDC).

I learned that our medical assistants (MA) were supposed to initiate a PV order for eligible patients when they arrived for visits, and I came to understand why they were not doing so. I re-learned how (and where) to appropriately document a patient’s refusal of vaccination, as well as how to document when PV was previously completed. I learned what my division defined as “PV eligible” patients and was surprised to learn that I was responsible for the immunization of patients who had seen me only once, as long as three years ago.

I learned that electronic health record (EHR) errors explained a sizable portion of my variance. My list of “eligible” patients included about 30 people who did not belong there—including deceased patients, patients I had never seen, patients who had changed primary care providers, and “fake” patients crafted for training but inexplicably assigned to me as their primary care physician.

I came to realize that the legwork on each project—the self-education, gathering of information from

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multiple sources (including experts, office stakeholders, and patients), requesting data, and contacting patients—takes much longer than I thought it would. It cannot be a solo physician job, and an important part of this effort is going to be crafting manageable workflows for others in the practice.

The most important lesson I have learned is this: There is immeasurable value in designating time for review and reflection on the processes of care delivery, and the impact of this work is directly proportional to the time dedicated to it. If a physician begins a project believing that real change can be achieved by doing this between patients, at night, or at the beginning or end of the day, he/she should not be surprised to find minimal progress even months after starting. So I am sticking with QI hour and will be excited to see whether the test of time supports my impression.

What I Still Need to Learn

Most of my knowledge gaps relate to our EHR and how my institution expects us to use it. For example, I have been unable to determine how to request changes to order sets that might make vaccine ordering easier. I still cannot generate my own list of patients overdue for PV and export it to a spreadsheet.

I have several outstanding questions about how my “performance”

is calculated: Do I get credit for documenting a patient declining a vaccine? Does vaccination during an inpatient admission “count”? Will PCV13 vaccination satisfy the insurers who are incentivizing PV? I am hoping to find answers to these questions soon.

What Was Lost

Invariably, devoting one hour to a new task means giving something else up. What “fell off the list” as I added an hour a week of “care of my care delivery system”? Most obvious was advocacy. In the past two months, I have made little time for my advocacy committee work and regrettably have skipped some meetings and missed some deadlines. Some elements of the July resident clinic transition—one of my prime responsibilities—fell off my radar. There were interns who arrived without EHR access and nights with no phone coverage for resident patients. Notably, I found no clear causative link between “QI hour” and these two gaps; it’s simply an observation.

It was also pointed out to me that what started as a personal exercise has consumed a fair bit of office resources. My requests for data generation, my conversations with the MAs during their work day, and the changes in practice workflow I was requesting pulled staff from their day-to-day roles. I have had to be cognizant of that impact.

Going Forward

I plan to meet with the MAs to modify our PV protocol to suit their needs and keep patients moving quickly. I also will help them draft a script they can use when asking patients about PV. I will develop resident education materials regarding PV and will ensure that the residents in my practice know that PV is a practice priority. I will reinforce it with e-mails, posters, and podcasts.

I will investigate the possibility of sharing PV incentive payments with our staff. I strongly believe that if we expect our MAs to be our foot soldiers in vaccination efforts, we need to identify ways to share financial incentives.

Most importantly, with this project I will demonstrate to trainees and colleagues that it is possible to effect change in care delivery by dedicating scheduled time to structured QI activities. In this era of CLER visits and milestone reporting, I hope my “QI practice” can serve as a nidus for trainee, practice, and institutional change for how clinicians spend some non-face-to-face time. I believe that only when trainees see faculty role models “walking the walk” will they begin to incorporate these skills into practice. My belief is that then they will be far more willing partners in influencing the care delivery systems in which they will spend their careers.

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