QUALITY REVIEW: PART I

Get with the Guidelines: The Importance of Quality Improvement from a Resident's Perspective

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In a rapidly changing health care system, primary care physicians have to become leaders and stay ahead of change. We are expected to see the same number of patients in less time and with less reimbursement, making quality measures harder to achieve. With new models of care developing rapidly, it is up to us to improve our service and keep up with the times. In this respect, quality improvement projects benefit our practice.

Our patients are complex. Although we do not always have time to address all problems in one patient visit, we cannot compromise patient care due to the pressures of time. It is important to use guidelines and screening and diagnostic tools in the appropriate setting. Still, guidelines change rapidly, and we have to adjust our practice accordingly to provide excellent patient care and improve satisfaction.

Quality problems include underuse, overuse, and misuse of services. Reviewing charts and using statistical analysis to interpret our data will help improve our practices. It is important then to keep developing projects in our practices to improve patient care. The question then is: How do we develop these projects? The first requirement is to follow our passion—choose projects that you enjoy. Since I have a special interest in pulmonary disease, my project involved the most common pulmonary diseases in the primary care setting: chronic obstructive pulmonary disease (COPD) and asthma. Research the latest guidelines, and review your charts to evaluate your performance in that specific area. Each of us has a unique approach to addressing clinical problems; once you find your solution, implement it—and don't forget to evaluate the improvement.

My project included a review of all the patients seen during the last six months of 2011 by the residents at the Mercy Care Internal Medicine Clinic of St. Joseph's Hospital & Medical Center. During my review, I found 106 patients with a diagnosis of COPD/asthma and 32 with symptoms compatible with that diagnosis (e.g. dyspnea, cough, and wheezing). I was, however, surprised to find that of the 138 patients seen during the selected time period, only 11 had pulmonary function tests (PFT). Our clinic has a spirometer on site, which means that residents have not been ordering this test. Perhaps residents are not aware that the guidelines state that any smoker with cough and dyspnea should be tested for COPD and that anybody with a diagnosis of COPD/asthma requires PFT. There is no consensus on the frequency of testing lung function; the American Thoracic Society recommends yearly testing, and the American College of Physician just recommends diagnostic PFT. The solution? I have proposed an addition to our electronic health record software; if the diagnosis of COPD/ asthma or history of smoking is added to the chart, the software will ask the user if PFT are needed.

As a resident, I think it is of vital importance to learn about quality improvement projects in the practice of medicine. We are improving daily and challenging ourselves to be better physicians; why shouldn't we strive to improve our practices as well? It is also easier now, in the era of electronic health records, to review our charts and make improvements through the software. Consider that every one of your patients will be thankful to receive better care, which should always be our goal.

References

1. ATS/ERS Task Force Standardization of Lung Function Testing. General considerations for lung function testing, 2005.
2. Qaseem A. Diagnosis and management of stable chronic obstructive pulmonary disease: a clinical practice guideline update from the American College of Physicians, American College of Chest Physicians, American Thoracic Society, and European Respiratory Society. Ann Intern Med 2011; 155:179-91.