**ABO IMPROVEMENT IN MEDICAL PRACTICE ACTIVITY**

**(NON-CLINICAL)**

**Topic**

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| **Title of Project**: | Improving Follow-Up Documentation for Patients Seen Urgently/Emergently on Weekend Call |

**Project Description**

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| Describe the quality gap or issued addressed by this activity. (Included in your response to this question should be a description of the resources that informed your decision to pursue this topic, a description of what the literature says about the issue you identified, and the rationale for choosing to address this clinical project | Detect the percent of patients seen for emergent/urgent ophthalmic conditions seen on call in Spokane who do not have follow up documented in the EHR and to intervene to lower this number by 50 percent in an effort to prevent ophthalmic morbidity due to noncompliance with follow up. |
| **Background Information**: The month you pulled the baseline IRIS performance report and any additional information that me be pertinent: | My job is to evaluate and treat patients with urgent/emergent ophthalmic conditions while on call over most weekends for the Spokane Eye Clinic. The impetus for this PIM is the observation that about 30 percent of patients have no discernable follow up documented in our EHR. I decided to perform this project to see if I could lower the percent of patients with undocumented follow especially in an effort to catch patients needing follow up but who have not followed through to schedule it. |
| **Project Setting**: (Please select from options below):* Group Practice
* Healthcare Network
* Hospital
* Multi-Specialty Group
* Solo Practice
* Surgical Center
* Other
 | Group Practice |
| **Study population**: (describe the type of patient for whom the care process will be improved, e.g., all patients in your practice, patients with diabetes, patients presenting for emergency care: | Community and regional patients presenting for urgent and emergent ophthalmic problems over the weekend. |
| **Quality Indicators / Performance Measures**:It is important to carefully define outcome or performance measures that will be quantified at baseline (before the care process is changed) and at re-measurement (after you have implemented the proposed improvement) to quantify the impact of your care process change. There are two basic types of performance measures - process of care measures and outcomes of care measures. . Process of care measures (e.g. timely treatment of diabetic retinopathy) can influence outcome measure (e.g. decreased risk of severe vision loss); . Outcome measures can be linked to processes of care that can be improved. Generally, performance measures are expressed as rates, often as percentage rates. For example, if the intent of a project is to improve the quality of glaucoma care in your practice, you may choose to improve your rate of establishing a goal IOP in patients with newly diagnosed glaucoma, measured over a 3-month period. . The numerator of this process measure would be the number of newly diagnosed patients during this time who have a goal IOP recorded in the medical record.. The denominator would be the total number of patients diagnosed during that same time period. Continuous variables (e.g. the refracted spherical equivalent after cataract surgery) can often be simplified and transformed then into percentage rates by setting a quality threshold (within 0.5 diopters in the intended spherical equivalent) which, if attained, would qualify the patient to be in the numerator (e.g. number of patients within 0.5 diopters / total number of patients). It can be advantageous but not mandatory to have more than one quality measure in order to gauge the impact of your process change. In the example above, an additional outcome measure might be the percentage of patients in whom the goal IOP is attained within the first 6 months after diagnosis. If possible, measure quality indicators for at least 30 individual patients or data points during the baseline and again during the follow up period.  | **Measure Type:** Outcome**Measure Name:** Percent of patients with documented follow up**Numerator Statement:** Numerator statement (Number of patients who have documentation of follow up in EHR within recommended follow up period)**Denominator Statement:** Denominator statement (30 consecutive weekend patients presenting urgently/emergently for evaluation and treatment)**Measure Type:** Outcome**Measure Name**: Percent of patients with actual follow up**Numerator Statement:** Numerator statement (Number of patients who have actually had or scheduled follow up) Denominator Statement: **Denominator Statement**: (30 consecutive weekend patients presenting urgently/emergently for evaluation and treatment) |
| We realize that this may not be feasible or appropriate for all projects. Please indicate at least one measure below; either a process or outcome measure: **Example Measure**:. Measure Type: Process Measure. Measure Name: Patient pain level during intravitreal injection. Numerator Statement: Number of patients in who pain levels decreased by 2 points on a 1-10 scale. Denominator Statement: 30 consecutive patients undergoing intravitreal injection. |  |
| **Project Interventions**:Quality improvement requires that you analyze your care delivery processes and identify changes, which if implemented, will improve care and outcomes. Generally, educational interventions are thought to be weak and demonstrate little impact. The introduction of tools, strategies or systematic approaches to care delivery is more powerful. A tool is a thing, for example a preoperative checklist, or written standardized process or protocol. Strategies include changes in procedures or policies like the introduction of a surgical time out before surgery is initiated. Systematic approaches to care delivery involve a comprehensive analysis of care process and the introduction of a combination of tools and strategies designed as a complete process. Please describe the changes to your care processes you intend to introduce: | Systematic approach: Weekend patients presenting urgently/emergently for ophthalmic care are seen at the clinic by myself and an ophthalmic technician. The patient is assessed, and treatment is instituted with an appropriate follow up suggested to the patient. This follow up is either scheduled at the time of evaluation, tasked to a scheduler or verbally recommended to the patient for them to schedule at the appropriate interval with the clinic or appropriate eye provider of their choice in their community. Normally no further efforts are made to document follow up.For this project the intervention will involve myself noting the patient and suggested appropriate follow up interval and contacting the patient within the follow up period to see if they have scheduled follow up or plan on scheduling follow up. This will be documented in the EHR. For those planning to schedule follow up I will contact them a second time just after their suggested follow up interval lapses to inquire whether or not they have received follow up or not. This will be documented in the EHR. |
| **Project Team**:(include roles for yourself and all members of your team):List the individuals who will be involved in your quality improvement project (i.e., solo project, partners in practice, office staff, OR personnel, anesthesiologists) and the roles they will contribute. | Myself and Ophthalmic Technician |
|  Will any other ophthalmologists be requesting MOC credit for participation in this SD-PIM? | NO |

**Project Outcomes/Results**

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| **Project Summary** | In the following sections, please prepare a brief summary of the project highlighting the data collected, effectiveness of your measurement approach, interventions, and the overall impact of the project. |
| **Baseline Data**:Quantify each of the quality indicators / performance measures described above for the baseline period (before interventions for improvement were introduced). Report the numerator, denominator and the calculated percentage rate for each measure. | Pre-Intervention: Outcome Measure #1: Percent of patients with documented follow upNumerator Statement: Number of patients who have documentation of follow up in EHR within recommended follow up period. n=19 Denominator Statement: 30 consecutive weekend patients presenting urgently/emergently for evaluation and treatment. n=30 Percentage Rate for Outcome Measure #1 pre-intervention: 63.33% |
|  | Outcome Measure #2: Percent of patients with actual follow up or scheduled follow up Numerator Statement: Number of patients who have actually had or scheduled follow up. n=20Denominator Statement: 30 consecutive weekend patients presenting urgently/emergently for evaluation and treatment. n=30 Percentage Rate for Outcome Measure #2: 66.6% |
| **Follow-up Data**:Quantify each of the quality indicators / performance measures described above for the re-measurement period (the period following implementation of the interventions for improvement). | Post-InterventionOutcome Measure #1: Percent of patients with documented follow upNumerator Statement: Number of patients who have documentation of follow up in EHR within recommended follow up period. n=30 Denominator Statement: 30 consecutive weekend patients presenting urgently/emergently for evaluation and treatment. n=30 Percentage Rate for Outcome Measure #1 post-intervention: 100%Outcome Measure #2: Percent of patients with actual follow up or scheduled follow up Numerator Statement: Number of patients who have actually had or scheduled follow up. n=20Denominator Statement: 30 consecutive weekend patients presenting urgently/emergently for evaluation and treatment. n=30 Percentage Rate for Outcome Measure #2: 66.6% |

**Project Impact**

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| Compare the baseline data to the re-measurement / follow-up data and quantify the impact of the process of care changes (your project interventions). The project hopefully resulted in improvement; however, some projects may result in a diminution in quality. If a lack of improvement or reduction in quality occurred, suggest other strategies that might be more effective. | In regard to Outcome Measure #1 pre-intervention about 66% of patients evaluated on the weekend urgently/emergently had documentation of the status of their follow up in our EHR. Intervening by contacting those patients noncompliant with follow up improved this number to 100%. I feel that calling these patients for follow up is important as it provides a second point of contact with those who may need an extra push to set up follow up either because they do not realize the seriousness of their condition or the importance of rechecking their condition. It also more clearly places the responsibility for follow up non-compliance on the patient and provides a hedge against later medical legal claims. Unfortunately, some of the most at risk patients such as a patient with mental illness were not able to be contacted due to their providing contact information that is not valid.In regard to Outcome Measure #2 calling the non-compliant patients in regard to their plans for follow up only improved the percent of actual follow up 10%. While this is good, I would have predicted that it would have improved the actual follow up to closer to 100%. Of the 5 patients with no actual follow up, 40% (2) were recovered, 40% were unable to be contacted and 20% (1) were still deciding whether and when to follow up due to insurance conflicts. If the 2 patients who were recovered are removed, then 90% of post intervention patients who needed follow up actually received follow up. |

**Project Reflection**

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| Did you feel the project was worthwhile, effective? | YES |
| How might you have performed the project differently? | Due to time constraints I would need to have clinic personnel assist in calling those patients who are in need of documentation of follow up and actual follow up. It also might make sense to focus more on higher risk diseases (diseases with a higher propensity for ophthalmic and systemic morbidity) and patient populations (lower socioeconomic status or mental illness). |
| Please offer suggestions for other ophthalmologists undertaking a similar project. | Identify diseases that place patients at high risk of further morbidity without appropriate follow up Identify patients that are at high risk of non-compliance with follow up and verify that their contact information is valid. |