North Coast Physician

In This Issue:

The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication. hdncms@sbcglobal.net

Cover Photo
"KAYAKING IN THE BAY"
Kate McCaffrey, D.O.

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In My Opinion

QUALITY IMPROVEMENT (QI): or Is It?*

Emily Dalton, M.D.

Who says the quality of medicine needs improvement? According to some, we have the best health care in the world. What could we possibly do better? Do you suppose that during the 11 years of medical training I received, the focus was on giving substandard care? And besides, how do the health care wonks know that what they suggest will improve upon what we are already doing? Did anyone think to ask those of us providing primary care if we want to do this, or have time to participate in these protracted projects? No! However, let's give the policy makers the benefit of the doubt, and suppose that primary care does need quality improvement. Common sense would dictate that no one does anything perfectly and that we all can find ways to improve.

The world of QI is not a pretty picture. First off, it seems as though everyone and their grandmother has some QI program that physicians are expected to implement. These programs are all different, and they all require significant amounts of data collection which we know is tedious and can be fraught with error. As a pediatrician in primary care, there are 3 organizations that expect me to do a QI program and none of them give any consideration to the fact that I am getting pushed and shoved in all different QI directions at the same time by multiple organizations. I don't think physicians should have to do more than one QI program at any given time. For goodness sakes, we are trying to see our patients!

Secondly, the data measured in these programs is pretty basic. We are looking at things like vaccination rates, nutrition counseling, BMI measurements, and so forth. These are the types of things best handled by public health personnel. It is a waste of my training to force me, a physician, to do data entry on basic health information. I am trained to diagnose your child's meningitis, or lay out a treatment plan for your child's attention deficit disorder. A lay counselor with nominal training can advise patients to exercise more or to eat more vegetables. Why target physicians? I spent over a decade studying medicine so that I can properly diagnose and treat the spectrum of pediatric diseases. Exercise and nutrition counseling would be better done with a physiologist or a nutritionist. BMI tracking would be better done by an epidemiologist. Let physicians do what we were trained to do.

There are numerous organizations that want primary care physicians to take on QI projects. First, the American Board of Pediatrics has such a requirement, and if you don't participate, you will lose your board certification. (Ironically, maintaining physician staff that are board certified is also a QI measure) What participation in a QI program has to do with whether or not I am a competent physician eludes me, but then, no one asked my opinion. Thankfully the American Academy of Pediatrics has a decent but lengthy web-based program that teaches the components involved in doing a QI program, and walks you through a variety of projects. So far I have spent about 6 hours on this activity, but there is no end in sight yet.

Second, Partnership runs a massive QI program which is linked to a large "bonus" which is typically up to 25% of your total income from them. Each year they pick a number of Healthcare Effectiveness Data and Information Set (HEDIS) measures upon which to reward doctors (or not). Believe me, you don't want to be in the "or not" category, or you won't be able to afford to see your Partnership patients anymore.

Third, the California Healthcare Performance Information System, or "HPI" collects data for Anthem Blue Cross, Blue Shield, and United Healthcare. I recently received a mailing from HPI rating me on three metrics: "Appropriate Treatment for Children with Upper Respiratory Infection (J06.9)", "Well-child visits in the third, fourth, fifth and sixth years of Life", and "Adolescent Well-Care Visits". On the first measure they had too few patients to score reliably (WTF??--like a pediatrician doesn't see a shitload of URI's?). I looked up the criteria on which my performance is judged and was surprised to see that if I diagnose "Upper Respiratory Infection" and that child takes an antibiotic anytime in the next month, I will be dinged. Just because the kid has a cold one day, does not mean he won't get pneumonia 3 days later. Am I supposed to forbid my patients from getting sicker until a full month passes? What if he comes back 5 days later with a urinary tract infection? In that case I will be "punished" by prescribing him a needed antibiotic. Wow, the quality here is just terrific. I guess I will stay away from that diagnosis in the

"QI", Continued on Pg. 16

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"QI", Continued From Pg. 4

hopes of keeping my statistics unmeasurable. For the patients with a cough and stuffy nose who are insured by Blue Cross, Blue Shield or UnitedHealthCare, I can use J00 (acute nasopharyngitis) or J22 (acute lower respiratory tract infection) instead of J06.9 (acute upper respiratory infection). Maybe this will help me look better on my metrics. Wow, Isn't medicine just getting better and better?

On the second and third measures I scored 73% and 62% respectively. How is it is fair to penalize the doctor if his patients don't want to do their well visits? We can't force them to come in if they don't want to, and nor should we.

Who are the National Committee for Quality Assurance (NCQA) and why do they create HEDIS measures? The NCQA is a private, 36 year old 501(c)(3) non-for-profit organization dedicated to improving the quality of medical care. They make an annual list of metrics that they believe reflects the overall quality of medical care (although some assert that the list includes mainly features that are easy to code and count). It's a big problem is that the NCQA is not coordinating with the World Health Organization (WHO), who sets the ICD-10 codes. Exercise counseling is an example of an important HEDIS measure with no ICD-10 code. As a result, accurate reporting of this metric requires tedious alternate data entry methods. This means a lot of DATA ENTRY for some unlucky person on your staff, which is both boring and expensive.

The acronym HEDIS stands for "Healthcare Effectiveness Data and Information Set" and it is a tool used by more than 90% of america's health plans to measure and compare the performance of aspects of health care and service. It was developed so that the health care given by various organizations can be compared on an "apples-to-apples" basis. The dozens of different 2017 HEDIS measures are laid out in the following categories.

1. Effectiveness of Care includes metrics such as adult BMI assessment, counseling about exercise and nutrition, child and adolescent vaccination rates, breast cancer screening, chlamydia screening, appropriate testing for children with pharyngitis, use of spirometry in the diagnosis of COPD, medication management of asthma, hypertension control, comprehensive diabetes care, antidepressant medication management, avoidance of antibiotics in acute bronchitis, and smoking cessation counseling among other things. There are a total of 52 metrics we are supposed to keep track of.

2. Access/Availability of Care looks at access to preventive/ambulatory health services, access to primary care, access to dental care, addiction treatment and pregnancy care. As a primary care provider, I feel this metric is particularly unfair. We have no control over over the number of health care providers in a given area. This stuff is insulting--what do they think I do all day? Sit on my couch watching Star Trek reruns while methodically denying appointments to a long list of needy patients? Come on! We are all seeing as many patients as we possibly can, and we still can't keep up with the demand. And despite our hard work we get dinged because patients in our area having poor access to care and long wait times. Call answer timeliness is also on the list. We take telephone advice call as a service and a courtesy to our patients. We don't get paid for it. To be graded and penalized for a service that we do for free really rubs me the wrong way.

3. Experience of Care translates into... you guessed, it, surveys!, one of our most favorite activities. This category also includes "Children with Chronic Conditions" and "Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics". I don't know about the rest of you, but I am having a terrible time getting patients in for therapy appointments. When all the therapists in the area are full, there is no way we are going to score well on the psychosocial care metric. (So I get penalized because there are not enough therapists in this area? Really??)

4. Utilization and Risk Adjusted Utilization is mostly about preventing unnecessary Emergency Room visits and hospitalizations, and having good attendance rates at standard preventive care appointments. Sorry, but I have very little control over when my patients go to the emergency room. There is no urgent care in the area that accepts Partnership, so I am not sure what those patients are supposed to do.

5. Relative Resource Use seems to be about measuring how often people with chronic diseases end up hospitalized. I don't know how one could improve those numbers unless you "cherry pick" only healthy patients into your practice. I don't think that would improve anyone's quality of care.

6. Health Plan Descriptive Information looks at features of health plans, and Measures Collected Using Electronic Clinical Data Systems looks at the use of the PHQ-9 to monitor depression, and depression response rates.

In summary, foisting an obligation to perform complicated, tedious quality improvement programs onto already overburdened primary care providers is unfair and ineffective. Primary care providers should be encouraged to focus on and rewarded for seeing patients and providing thoughtful medical consultations. Data tracking on basic public health issues would be better done by wellness programs staffed by non physician medical personnel.

*Warning: in order to understand this article you will need to know or learn the following acronyms: QI; HEDIS; NCQA; PHQ-9-:HPI; WHO; BMI; URI; WTF §

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