

The Performance Improvement Imperative

GNYHA
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Quality Healthcare

- **Quality of Care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.**
 - **Institute of Medicine, 1994**

Institute of Medicine Reports

■ To Err is Human (1999)

- Errors due to overuse, underuse, misuse
- Cause 44,000-98,000 hospital deaths per year
- Systems, not individual people are to blame

■ Crossing the Quality Chasm (2001)

- “A call to action to improve the American health care delivery system as a whole, in all its quality dimensions, for all Americans...”
- “Yet physician groups, hospitals...operate as silos, often providing care without the benefit of complete information about the patient’s condition, medical history...or medications...For those without insurance, care is often unobtainable except in emergencies...”

IOM, 2001

Ten Rules

Current

- Visits
- Professional variability
- Professional control
- Medical record
- Training and experience
- Do no harm
- Secrecy
- React to needs
- Cost reduction
- Professional roles

New

- Continuous relationships
- Variable patient choices
- Patient control
- Shared information
- Evidence
- Safe systems
- Transparency
- Anticipate needs
- Decrease waste
- Cooperation among clinicians

Who's this?



Quality Improvement Methods

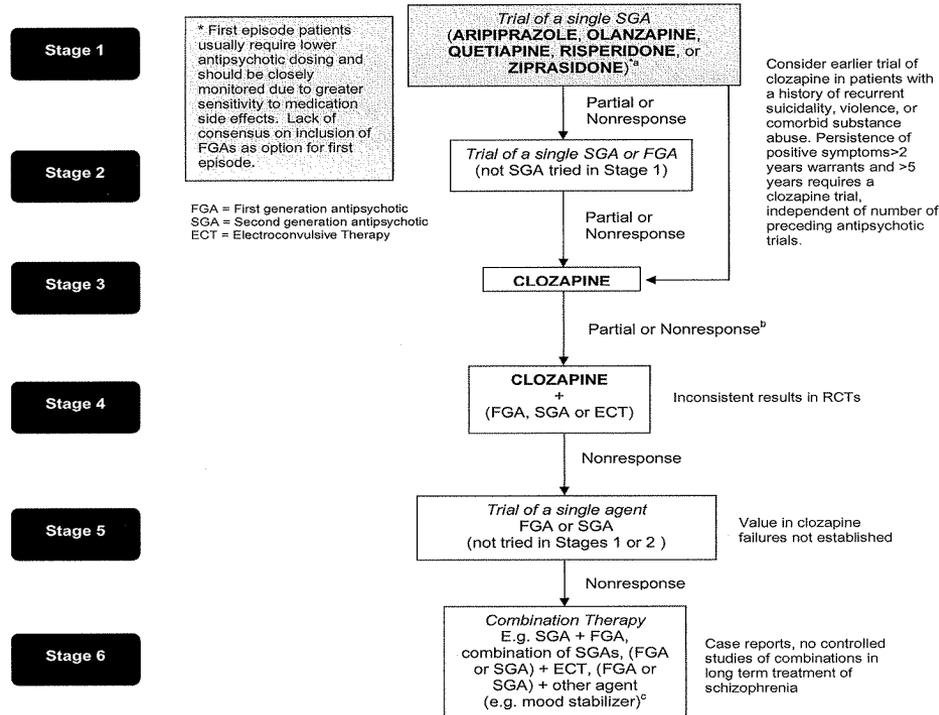
- **Continuous quality improvement concepts borrowed from industry:**
 - **Improvement teams**
 - **Process description (work flow chart)**
 - **Data collection**
 - **Data analysis**
 - **Collaboration**
 - **Change concepts**
 - **Process re-design**
 - **Rapid, reiterative, small-scale PDCA (Plan Do Check Act) cycles**
 - **Interdisciplinary measurement**

Texas Medication Algorithm Project (TMAP): Schizophrenia

Algorithm for the Treatment of Schizophrenia

Choice of antipsychotic (AP) should be guided by considering the clinical characteristics of the patient and the efficacy and side effect profiles of the medication

Any stage(s) can be skipped depending on clinical picture or history of antipsychotic failure and returning to an earlier stage may be justified by history of past response

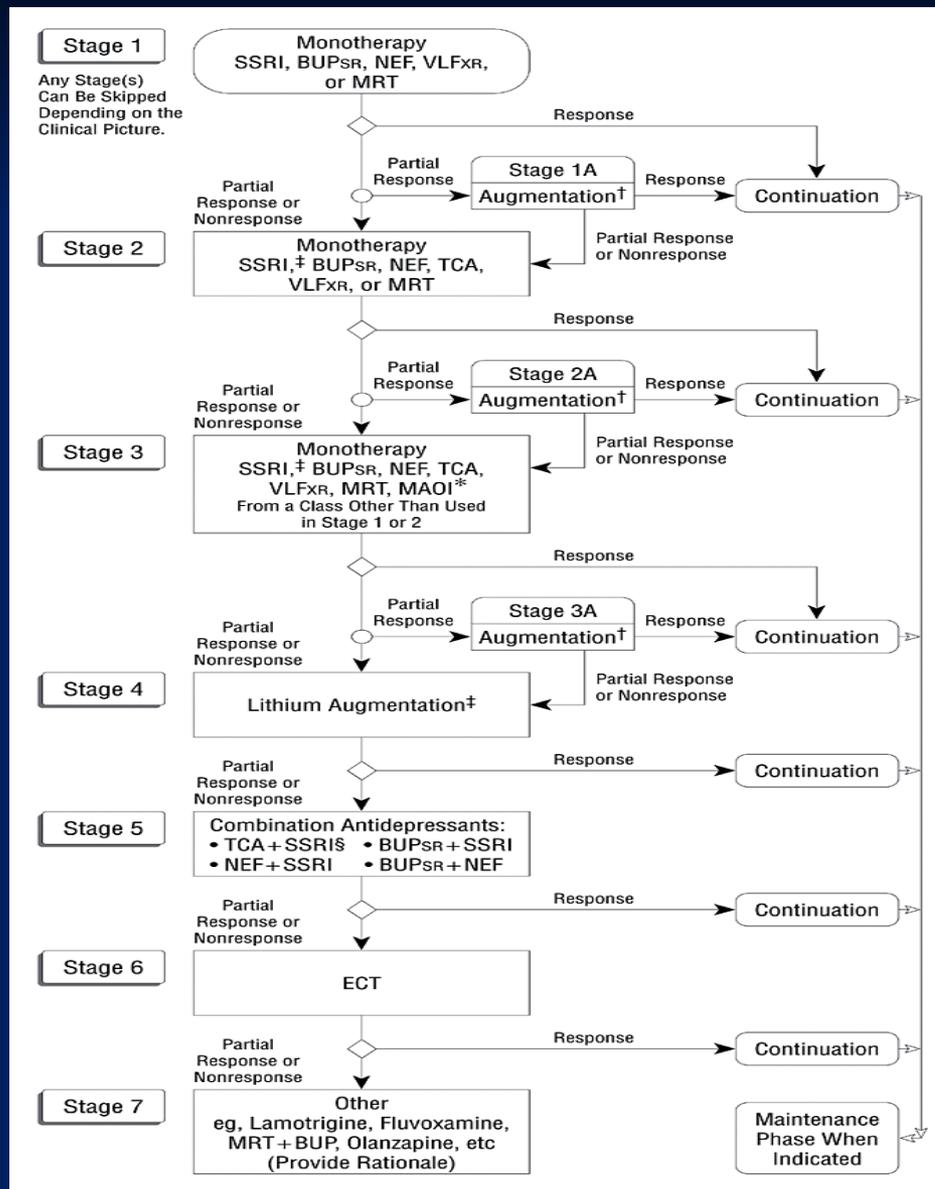


^a If patient is inadequately adherent at any stage, the clinician should assess and consider a long-acting antipsychotic preparation, such as risperidone microspheres, haloperidol decanoate or fluphenazine decanoate.

^b A treatment refractory evaluation should be performed to reexamine diagnosis, substance abuse, medication adherence, and psychosocial stressors. Cognitive Behavioral Therapy (CBT) or Psychosocial augmentation should be considered.

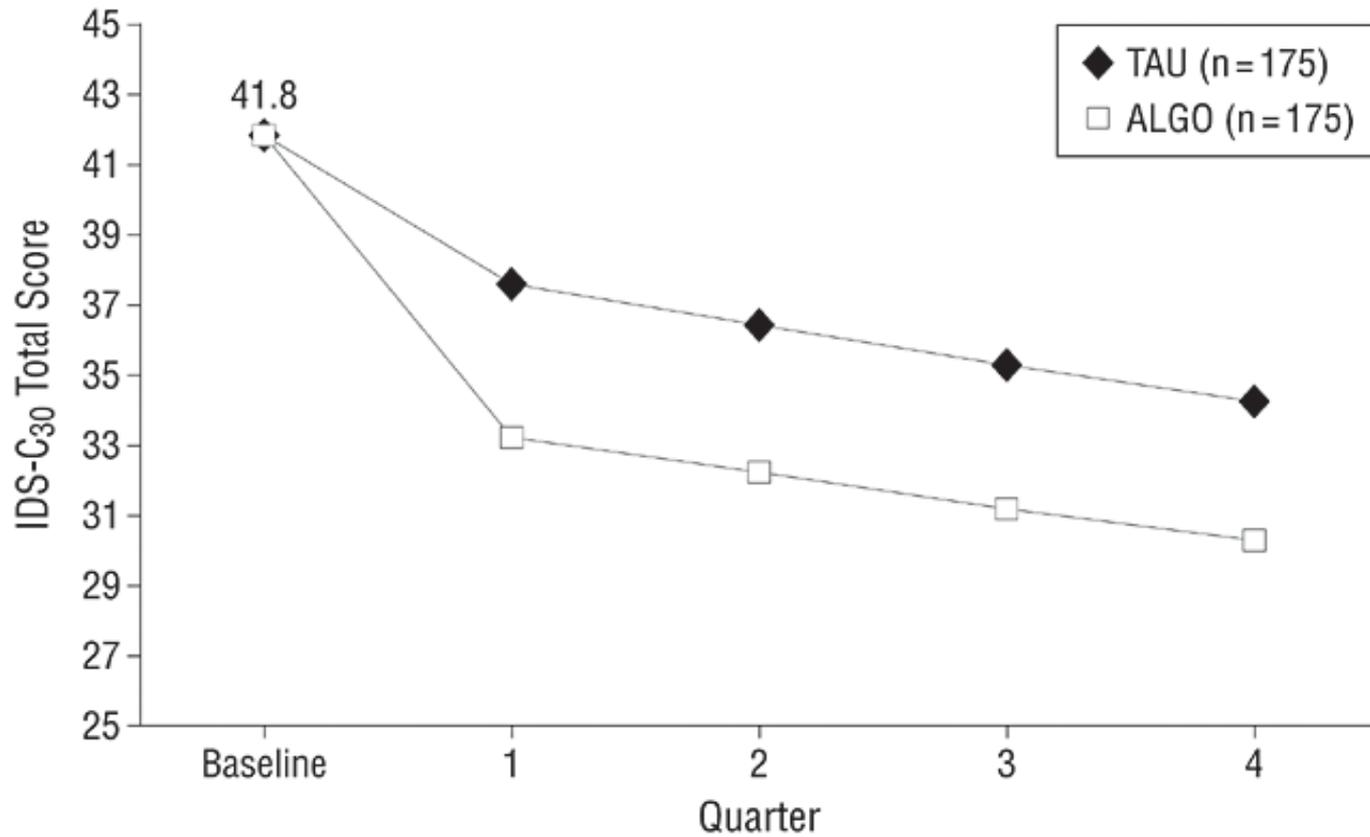
^c Whenever a second medication is added to an antipsychotic (other than clozapine) for the purpose of improving psychotic symptoms, the patient is considered to be in Stage 6.

Texas Medication Algorithm Project (TMAP): Depression



TMAP: Depression Outcomes

(Trivedi et al, *Arch Gen Psych*, 2004)



Evidence-based Guidelines

- Removing unnecessary variation in processes
- Providing care consistent with current professional knowledge

Consensus Statement on Monitoring of Physical Health For Patients with Schizophrenia

(Marder et al., Amer J Psychiatry, 2004)

- **Weight: BMI (Body Mass Index) every visit for 6 months after medication change.**
- **DM: Glucose or HbA1C at baseline and 4 months, then yearly, unless gaining weight (then every 4 months).**
- **Lipids: Baseline and every two years unless LDL > 130 mg%, then every 6 months.**
- **EKG: Prior to ziprasidone in patients with known heart disease, syncope history, family history of sudden death, or congenital long QT by history.**
- **Prolactin: Screening (women: menses, libido, galactorrhea; men: libido, erectile dysfunction) baseline and yearly; and every visit after offending drug started or changed, until stable.**

Consensus Statement on Monitoring of Physical Health For Patients with Schizophrenia

(Marder et al., Amer J Psychiatry, 2004) Cont'd

- **EPS (Electrophysiology Studies):** Check for Parkinsonism and TD before initiation of antipsychotic. Weekly monitoring after initiation or change in dose for 2 weeks. AIMS every 6 months on FGA; yearly on SGA, except in the elderly (every 3 months and every 6 months).
- **Cataracts:** Yearly screening history; yearly optho referral in patients over 40; every 2 years in younger patients
- **Smoking, drug abuse, alcohol screening and treatments.**

How do we know whether we are doing these things?

- FQHC (Federal Qualified Health Centers) Learning Collaborative for Diabetes, Hypertension, Depression:

REGISTRY

- Patients
- Processes
- Outcomes

How can we provide consistent, evidence-based care?

Stages of change!

- Move from pre-contemplation
- Contemplate (as a team and teams)
- Decide
- Act
- Measure
- Act again
- If we relapse, we have to try again