

No Outcomes, No Incomes—Using Clinical Practice Guidelines

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In this article...

Take a look at how to implement, get buy-in and overcome barriers for clinical practice guidelines.

Today’s limited health care dollars have forced payers like CMS, Aetna, Blue Cross, and Cigna, as well as others, to avoid paying for certain preventable conditions. The current transition from pay-for-reporting to pay-for-performance has caused hospitals to look for innovative ways to demonstrate results.

Indeed, the situation has become even more critical with CMS adopting the National Quality Forum’s “never pay for never events.” The first 11 of these events for which CMS stopped paying were associated with nearly \$22 billion in hospital charges in fiscal year 2007 alone. (Fig.1)

In an effort to prevent financial bleeding, many hospitals have opted for clinical practice guidelines (CPGs) and checklists as strategies.

CPGs are systematically developed, science-based tools to assist physicians and other caregivers regarding specific treatment options for particular clinical conditions. They represent decision-making strategies, which are derived from verifiable evidence, published in peer-review journals. CPGs are an attempt to distill a large body of medical knowledge into convenient, readily useable formats.

In 1999 the National Guideline Clearinghouse sponsored by the Agency of Healthcare Research and Quality listed

Figure 1. Non-reimbursable never events Oct, 2008.
(Centers for Medicare & Medicaid Services).

Hospital-acquired condition	Cases	Average charge per hospital stay	Total Medicare cost
Stage III & IV Pressure Ulcers	257,412	\$43,180	\$11.1 billion
Falls resulting in serious injury/fractures	193,566	\$33,894	\$6.6 billion
Vascular catheter-associated blood borne infections	29,536	\$103,027	\$3 billion
Foley catheter-associated urinary tract infections	12,185	\$44,043	\$536.7 million
Surgical site infection/Mediastinitis after CABG	69	\$299,237	\$20.6 million
Air embolism	57	\$71,636	\$4 million
Blood incompatibility	24	\$50,455	\$1.2 million
Surgical site infection following total knee replacement	539	\$63,135	\$34 million
Deep vein thrombosis/pulmonary embolism	140,010	\$50,937	\$7.1 billion
Diabetic coma	1,131	\$45,989	\$52 million
Diabetic ketoacidosis	11,469	\$42,974	\$492.9 million

650 CPGs. Today, the same site lists more than 2170 active guidelines. Most CPGs take the form of simple algorithms with step-by-step decision trees and checklists. The formats usually include a sequence of steps of care, decisions to be considered, and actions to be undertaken in the management of clinical conditions.

Use of consensus-driven guidelines and checklists is becoming ubiquitous in the health care delivery system. Depending on the stakeholders, there are numerous applications of CPG and checklists that are utilized by sundry stakeholders (Table 1).

Presently, users range from hospitals, payers, physicians, patients, government, as well as accreditation bodies. Specifically, stakeholders include managed care organizations (MCOs), public policy makers, boards of trustees, researchers, consumers and consumer groups, and practitioners. No matter the user, these strategies are used to identify, evaluate, compare, and measure in terms of outcomes and cost containment.

Arguably, the ultimate use of clinical guidelines and checklists is to articulate clear goals of patient care, decrease rework (by reducing special cause variation), and increase the bottom line.

Take the case of MCOs; they currently utilize guidelines for determining the value of health care services and have successfully tied financial decisions to use by way of pay-for-performance. In fact, by also using such phrases as “no P for no P,” and “no outcomes, no incomes,” payers have tied reimbursement to compliance with guidelines.

Most payers also use this strategy to identify areas of improvement in care management programs with the aim to persuade physicians to adopt practices that would lead to better outcomes. For health plans, there is yet another reason to encourage use of clinical practice guidelines—guidelines are intricately linked to cost

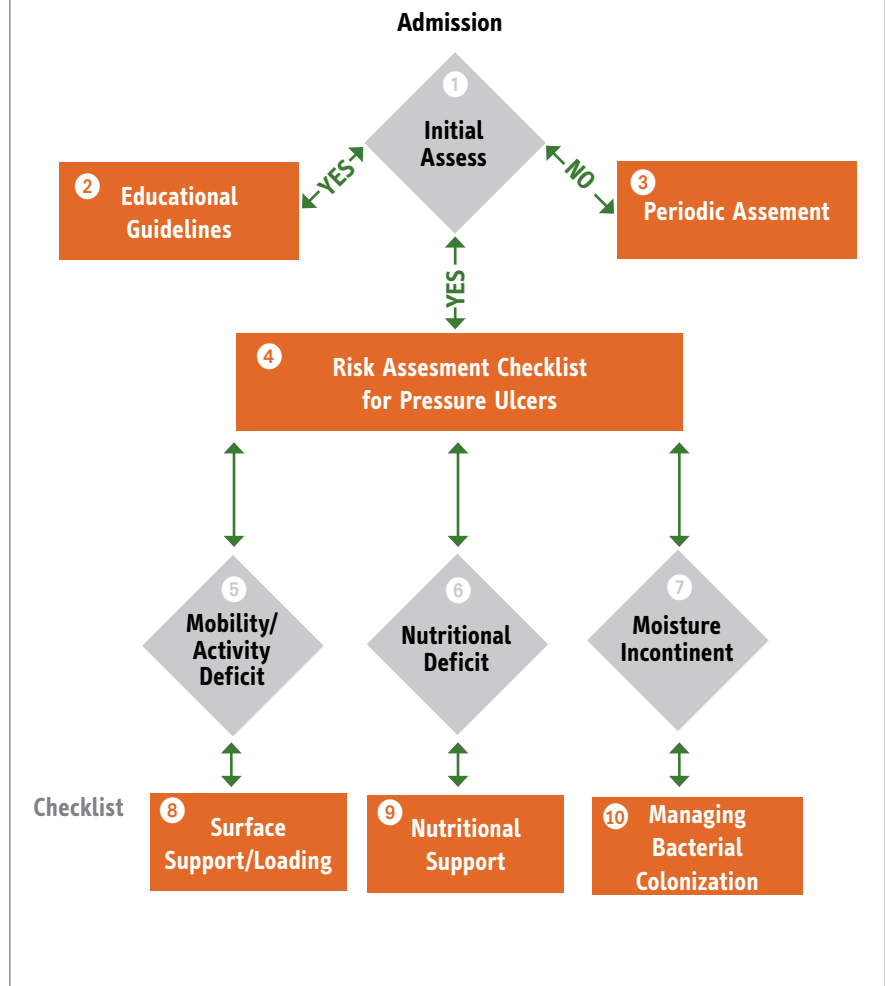
Table 1. Uses of CPGs and checklists.

Stakeholders	Uses
Payers/MCOs	Determining the value of services, cost-containment, credentialing of physicians
Hospitals	Monitor data internally, benchmark externally
Policymakers	Allocation of resources, identify trends
Accreditation agencies	Review data usage
Patients	Education about care processes, understanding of personal responsibility
Caregivers	Validate performance, peer review, report card

Figure 2

Prediction, Prevention, and Treatment of Pressure Ulcers.

(Adapted from the Agency for Healthcare Research and Quality).



A significant barrier to implementation of CPGs is the perceived loss of prestige to physicians.

containment and better profitability.

Not only have payers been looking at CPGs and checklists keenly; others are also clamoring up. Patients use clinical practice guidelines to gain understanding about the process of caregiving and what is expected of them at the individual level. Hospital boards of trustees are also now getting onboard; there is increasing plan to use CPGs and checklists as part of a strategy to evaluate performance internally, and benchmark against other organizations.

Furthermore, in an effort to advertise involvement with quality initiatives, governing boards are eager to share outcomes data with policy makers and accreditation agencies. Policy makers often use these data to guide resource allocation, as well as identify and track trends. These are reported to accreditation agencies that review the data to monitor effectiveness of care.

For caregivers, CPGs and checklists can provide a means to implement standardized methods of treatment. Adherence to these strategies could help with prediction and prevention of non-reimbursable conditions. Pressure ulcers are the most common and costliest for hospitals, and a strategy of checklists and guidelines would be the best way to weather the storm (Fig.2).

According to the CPG for pressure ulcers:

1. An initial evaluation is done to spot for abrasions or decubitus, especially over bony prominences.
2. A robust educational program for the prevention of pressure ulcers should target all levels of health care providers, patients, and family. If no ulcers are detected upon

screening, the patient should be periodically reassessed for changes in activity and mobility status as per a written plan. The frequency of reassessment would depend on patient status.

3. Caregivers should use either the Norton Scale or the Braden Scale to evaluate for individual risk factors. Risk factors include mobility/activity impairment, moisture/incontinence, impaired nutrition, and altered sensory perception.
4. Bed-bound patients or those whose ability to reposition is impaired should be considered at risk for pressure ulcers.
5. Nutritionally compromised patients should be investigated for factors that compromise dietary intake.
6. If there is moisture or incontinence, the skin should be cleansed and dried at the time of soiling. For 7, 8, and 9 there are references to specific checklists (Fig. 3).

Benefits and drawbacks of CPGs

When viewed as tools rather than rules, utilization of CPGs and checklists can be invaluable when it comes to tackling day to day clinical problems (Table 2). They can serve as priceless monitoring tools for clinically significant variations in diagnosis and treatment.

Used for peer review, they would allow physicians to quickly identify sub-optimal care treatments, as well as validate exemplary clinical performance. Nursing units could be evaluated for checklist compliance to

ensure that all the pertinent steps are being followed.

Department heads and other physician executives could assess adherence to the evidence-based criteria, and track outcomes as part of ongoing professional practice evaluation.

CPGs and checklists can assist clinical decision making by being a ready resource for treatment options. By providing clarity, they can offer unambiguous treatment direction.

Common examples where they have been shown to make a difference are with CMS core measures like surgical infections, pneumonia treatment, and DVT prophylaxis. By establishing standards of appropriate pathways of care, CPGs and checklists also lend themselves to proper education and training techniques. When used as a performance improvement tool, they can help to target special cause process variations that are responsible for suboptimal outcomes. By doing so, they can also help to improve the effectiveness of treatment.

On the other hand, even though CPGs and checklists can be beneficial, they can have certain disadvantages associated with their utilization (Table 2). Regarding implementation, most physicians are inherently skeptical to “cookbook recipes,” so there is a reluctance to embrace them.

This hesitancy has led to unacceptable turf wars within hospitals that have been detrimental to patient care. This has mainly been the case when the guidelines have been unilaterally put together by non-clinical personnel without physician engagement.

Furthermore, when guidelines are not evidence-based, they can stifle more innovative ways of achieving excellent outcomes. This is especially true when certain new techniques have successfully worked and practitioners are afraid of trying them because of set guidelines.

Another drawback stems from too many guidelines and checklists, and too many inconsistent guidelines,

Figure 3. Treatment Checklists for Pressure Ulcers..

Mechanical Loading, Surface Support	Nutritional Support, Skin Care	Managing Bacterial Colonization, Infections
Reposition at least every 2 hours	Dietary consult to investigate inadequate dietary intake of protein or calories	Prompt treatment of urinary/fecal incontinence
Foam wedges to support bony prominences	Supplementation for nutritional deficits	Skin cleansing with mild cleansing agent that minimizes irritation and dryness
Elevate the heels	Apply moisturizers to dry skin	Avoid hot water, excess force/friction to skin
Lifting devices during transfers/ position changes	Minimize exposure to cold	Moisture control with absorbent pads

which are issued by competing quality groups. This can make it difficult for caregivers to be compliant. To make the process easier to follow, competing guidelines and checklists should never be conflicting, but complementary.

Gaining buy-in for CPGs

Enlisting caregiver/physician involvement with the creation of CPGs and checklists can be made a lot easier by incorporating certain key elements into the formulation phase. (Table 3)

First and foremost, it should be recognized that physicians are safety champions who are always seeking opportunities to improve care, treatment and services. Proper organization of the process means offering physicians the opportunity to buy-in at an early stage.

More cooperation could be enlisted by mentioning that CPGs and checklists are not necessarily only about expediting care, but also a means of delivering clinically appropriate care. A possible barrier at this point would be physicians complaining that there is no need for change – “if it ain’t broke, don’t fix it.”

Another factor to consider, physicians have been trained to be keen students of the scientific method. Bearing that in mind, engaging physicians in the formulation of CPGs and checklists does require strict adherence to scientific data.

Table 2. Advantages/Disadvantages of CPGs.

Advantages	Drawbacks
Promote sound clinical decision making	Viewed as “cookbook” medicine
Resource for treatment options	Turf wars
Training tool	May stifle innovation
Performance improvement tool	Too many of them, too many inconsistencies

Table 3. Engagement and Barriers to Creating CPGs.

Goals	Barriers
Enlist physicians as members of the team at the inception of the project	“It ain’t broke, don’t fix it” reluctance to participate
Use of scientific validation methods	It has worked well all these years
Demonstrate how the disease process can extend beyond the physician’s own area of expertise	Physicians fail to see the implications of diseases outside their own areas
Use of physician committee meetings to advance discussion	Time management issues

Ahead of time, physicians ought to be shown hard evidence as rational for wanting to create practice guidelines and checklists. The process should not merely rely on so-called expert opinions, but upon evidence-based outcomes. Liberal use of scientific validation for the proposed tools would dispute any arguments about how well the current treatments have worked over the years.

Furthermore, in order to enlist the participation of physicians, it is imperative to point out the systemic nature of the disease process that is being tackled. Clinical applicability of the proposed guideline should be explained; there should be a systematic review of the disease process from the time the patient presents at the door to when the patient is discharged.

Table 4. Engagement and Barriers to Using CPGs.

Goals	Barriers
Implementing guidelines/checklists	Loss of prestige
Use of appropriate feedback process	Inadequate communication with case managers etc.
Reduced risk of legal liability	More documentation to show care not followed
Availability of resources to ensure success	Lack of skill and resources necessary for guidelines
Demonstrate successful outcomes lead to profitability	Fear of fiscal erosion

Finally, issues relating to physician time management should be actively addressed. As a result of budget cuts, understaffing, and increased patient loads, physicians are cramped for time. To solicit physician participation requires any discussion be scheduled at regular committee meetings.

Using CPGs

Once the CPGs/checklists have been created, physician cooperation for implementation must be secured in order to have any chance for success. Like getting buy-in with the formulation process, gaining physician agreement to implement could also be challenging. This is because the implementation and utilizing process is also fraught with barriers. (Table 4)

A prominent argument used by some physicians is that CPGs/checklists are nothing more than stringent recipes without room for variation. Another reason, some physicians view them as leading to the erosion of physician autonomy.

While there is some merit to these arguments (CPGs/checklists do seek to limit special cause variations), this is not the entire truth. The strategies themselves are actually evidence-based, and if diligently implemented do result in better outcomes.

Use of appropriate feedback mechanisms is also important for successful

implementation by physicians. It has been shown that CPGs/checklists are best practiced if they are understandable and could be reinforced.

This may involve widespread dissemination of information in the form of video instructions, user-friendly reading material, and other training publications. These may take the shape of didactics sessions, as well as continuing physician education programs.

Another significant barrier to implementation is the perceived loss of prestige to physicians. Most physicians have always worn the “captain of the ship” hat, and communicating on an equal basis with non-physician case managers could be difficult.

Physicians also need to be convinced that implementation of CPGs/checklists would not lead to increased risk of malpractice claims, and that following the tools themselves would be enough evidence to thwart legal attempts. In fact, it must be stated that by streamlining the care process, adherences to the guidelines do help reduce the risk of legal liability.

Finally, physicians who oppose use of guidelines may do so by citing fiduciary reasons. These range from allegations that the guidelines discourage them from doing procedures in the office, to loss of revenues from patients shifting to hospitals. For successful implementation, physicians would have to be persuaded that better outcomes

from guidelines lead to better patient satisfaction which leads to more, not less profits.

If there is an important take home message for implementation of guidelines it should be that the physicians using them should have a say so from the onset. The process must be transparent, evidence-based, and presented with clarity. More importantly, the guidelines should be easy to document, and be easy to extract information for developmental and performance improvement efforts.



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Resources

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