Insightful practice and competency assessment: how do we comply with the “autoregulation”

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Practice Enhancement Division

Collège des médecins du Québec

...from quality assurance to quality improvement

Disclosure

- **My team and I, do not have** any affiliation

with a commercial organization

- Emergency medicine specialist (Sacré-Coeur Hospital)
- Université de Montréal, Université Laval

OBJECTIVES

- Understand the concept of autoregulation and the link with our medical practice
- Identify the tools used in the assessment process
- Evaluate the risk factors present in a medical practice
- Integrate QA/QI before and after an inspection visit and respond to the CPD mandatory regulation in Québec

Outline of the Presentation

- Context: Historical, legal, medicolegal, social
- The physicians' assessment programs
  - Risk-factor based, Process, Efficiency
- Remediation…helping
- QA and QI of your practice ?

Quality medicine at the service of the public

The Board of Directors

Executive Office
President and Chief Executive Officer
Secretary

Practice Enhancement Division

Inquiries Division

Medical Education Division

Administrative Services Division

Legal Services Division

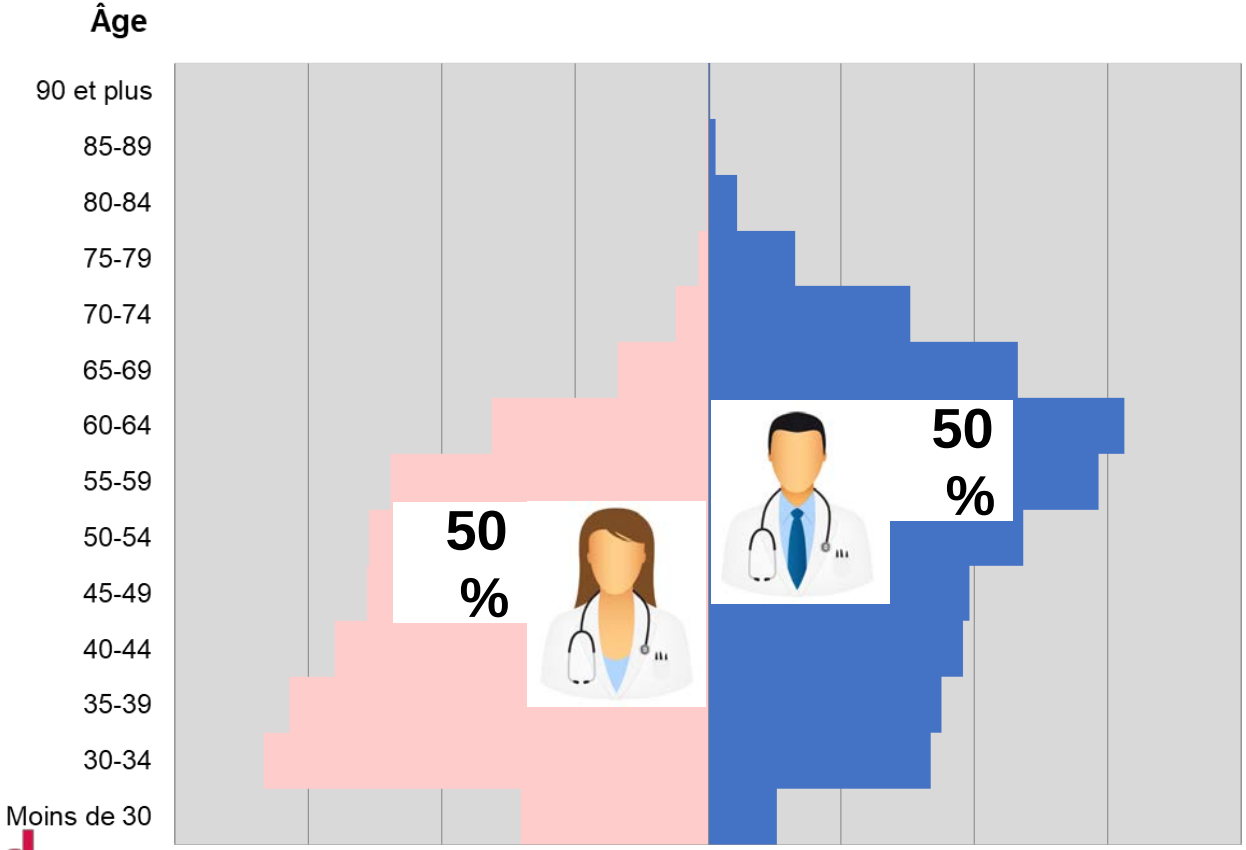
As a baseline…

- How would you evaluate the practice of the physician sitting next to you ?
- How (process/tool) would you evaluate your practice ?
- How would you like that the physician sitting next to you, evaluate your pratice ?

A bit of epidemiology

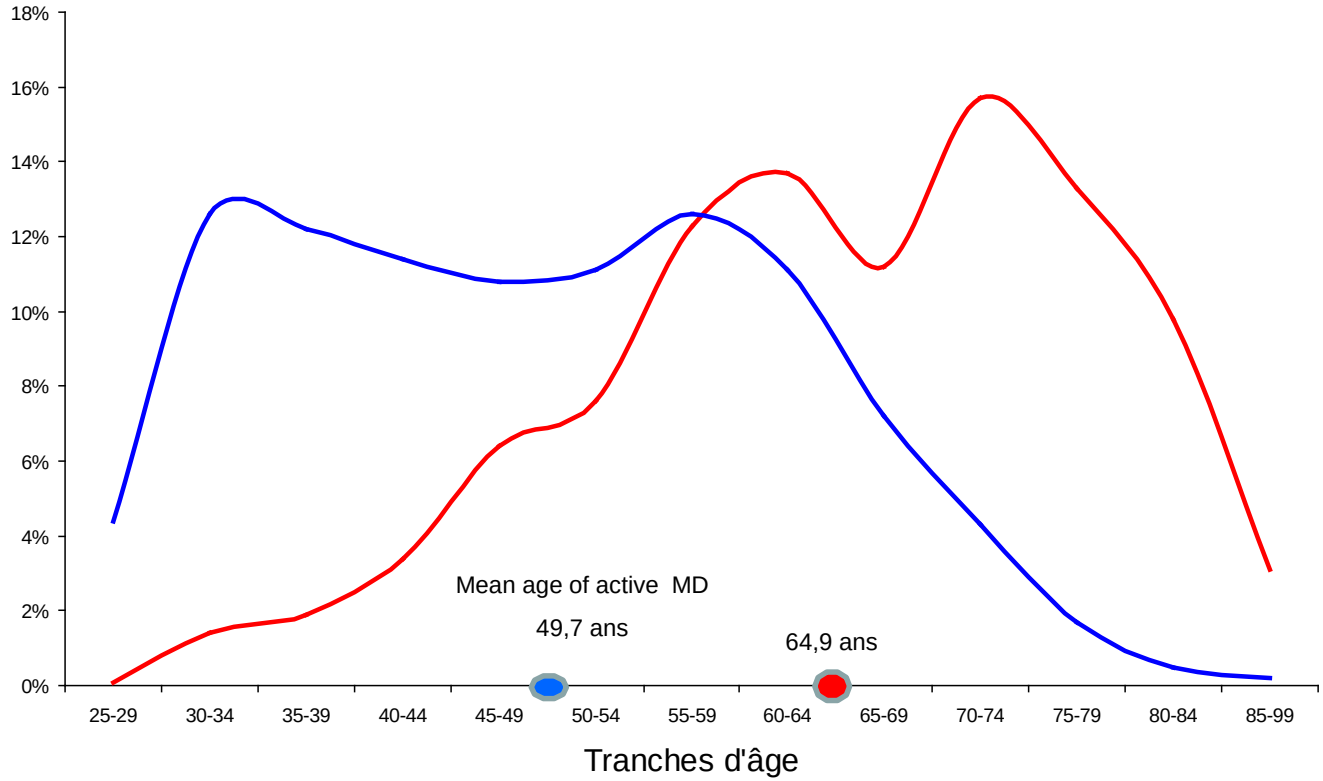
Age distribution of active physicians

2018-2019

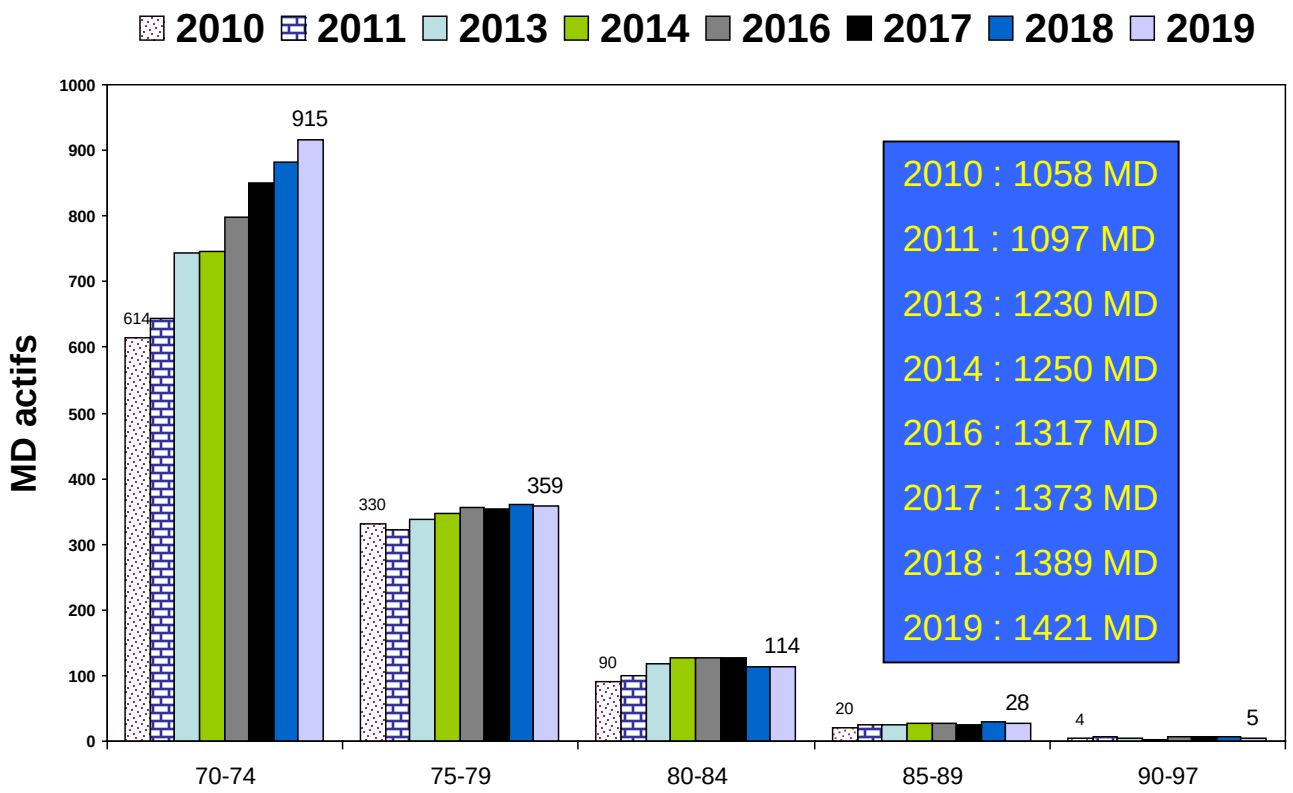


% and age distribution

active 2018 vs « red line …later »



Active physicians ≥ 70 yo
Jan 2019



Context

- Only College with licensing and regulatory activities
- Reporting to the Ministry of Justice
- Mission: quality medicine so as to protect the public

<u>Self-regulation: a peer-managed profession</u>

Professional Code

- A framework law adopted in 1973
  - Office des professions du Québec
- Code of Ethics of physicians determines the duties and obligations to be discharged by every member of the Collège des médecins du Québec (CMQ) (art. 87)
- A professional inspection committee (PIC) is established within each order by the Board of Directors (art. 109)
- Self-Regulated Profession
  - Public representatives

Background

1973

Québec
© Éditeur officiel du Québec

chapter C-26

PROFESSIONAL CODE

- screening
- needs assessment
- remediation
- evaluation

1990

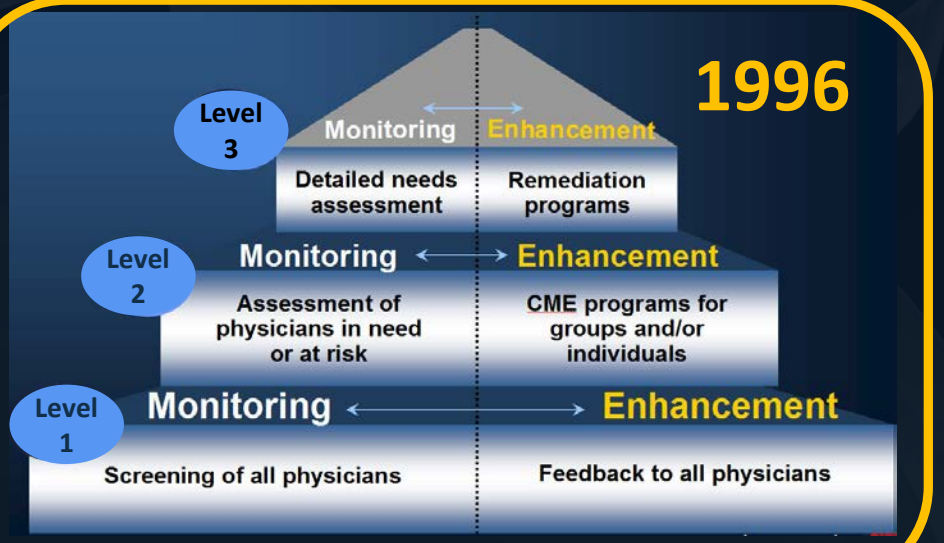
Université de Montréal | Faculté de médecine

Université de Sherbrooke

McGill | Faculty of Medicine | Faculté de médecine

Université Laval | Faculté de médecine

1996



- 1996: A study* on a random sample of 100 family physicians reveals that 95% had an adequate quality of practice

- 1997: the Practice Enhancement Division develops inspection programs based on indicators of quality of care
  - 40 programs have been developed over the years (15 still active, 4 major)

*Goulet et al. (2002), "Performance assessment: Family physicians in Montreal meet the mark!", Can.Fam.Physician, vol 48, pp 1337-1344

- 2008 College of Physicians and Surgeons of Ontario (CPSO) annual report
  - > 89 % of physicians selected randomly have a satisfactory practice

Everything is « context », right ?

What we, and the public, have been… and are reading

Groundbreaking 1989 essay Avedis Donabedian

- Foundation document for all studies of health care quality
- Health outcome: end results of medical care measures by health status (outcome) and patient satisfaction

Institute of Medicine (IOM)

- Medical quality: the degree to which health services for individuals and populations increased the likehood of desired health outcomes and are consistent with current professionnal knowledge
- Purpose of oversight: ensure that proper structures in health care delivery and processes ensuring good quality and measure patient outcomes in ways that enhance improvement efforts

Safety Culture…since the Err is human

« In the news: medication errors in 50% of surgeries »

- Massachusetts General Hospital, over 7 months from 2013-2014
- Drug labelling errors/ incorrect dosing/ Drug documentation mistakes/ Failing to properly respond to changes in a patient's vital signs

How dangerous is health care?

- Less than one death per 100 000 encounters
  - Nuclear power
  - European railroads
  - Scheduled airlines
- One death in less than 100 000 but more than 1000 encounters
  - Driving
  - Chemical manufacturing
- More than one death per 1000 encounters
  - Bungee jumping
  - Mountain climbing
  - Health care


News Alert
BREAKING NEWS
May 3, 2016
Medical Error is Third Leading Cause of Death in US
Medscape Medical News
Read Now ›
Medscape

Davis et al. JAMA 2006

- « Strong evidence suggests that none of us are good at knowing what we don’t know. »

Baron, Braddock NEJM 2016

- « We believe that protecting the integrity of a peer-defined, discipline specific credential is not the role of the government, health care delivery systems, or payers …it belongs to those of us who practice the discipline, maintaining highly specialized knowledge and demonstrating that we have done so. »

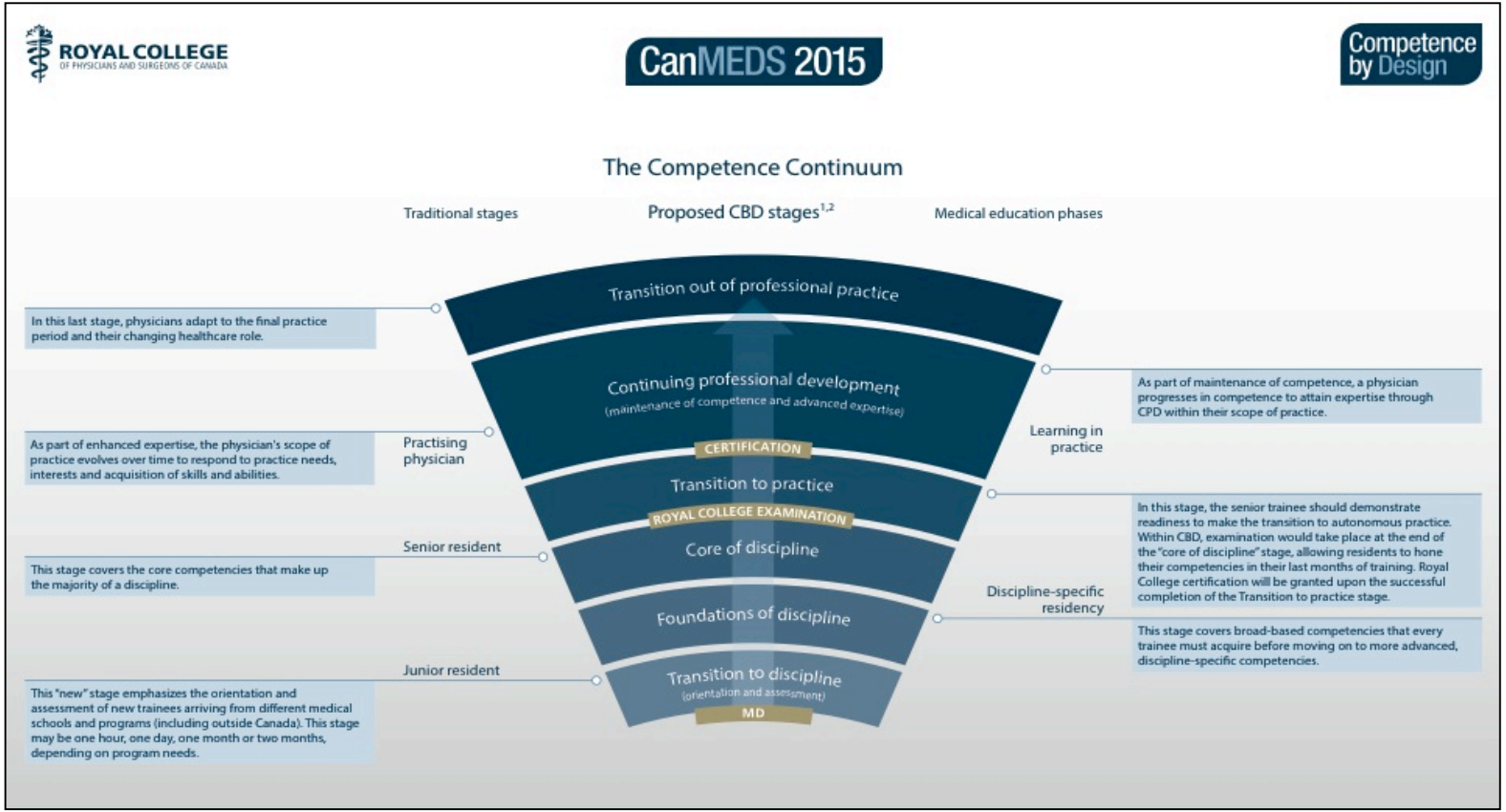
NEJM 2017 Barnett et al. Opioid-prescribing patterns of emergency physicians and risk of long-term use

- « Wide variation in rate of opioid perscribing existed among physicians practicing within the same emergency department, and rates of long-term opioid use where increased among patients who had not previously received opioids and received treatment from high-intensity opioid prescribers. »

BMJ, march 2017 Concurrent prescribing of opioids and benzodiazepines

- Retrospective analysis Stanford University: more than two fold increased risk for ED visit or inpatient admission for overdose
- During the past 15 years, opioid prescriptions increased nearly 3-fold and one third of fatal opiod overdoses involve also benzodiazepines
- In 2001, 9% of opioid users also used a benzo… while in 2013, 17% (relative increase of 80%)

Competence by Design (CBD)



http://www.royalcollege.ca/common/documents/canmeds/framework/competence_continuum_diagram_e.pdf

Let's go back to the original question…

- How should we evaluate a medical practice…and how?
- Who should evaluate the practice ?
- Medical records: what aspects? How many?
- Current knowledge? (exam? Revalidation ? Recertification?)
- Simulation of a frequent clinical condition ?

Inspection process…and urban legends ?

- An inspector, disconnected from the reality of the practice, « makes the call… » ?
- Random inspection process, and I may be the « lucky one » ?
- The goal of the inspection is to absolutely find problems
- I heard that the success rate of remediation activities is near 0%, so they can radiate physicians or push them to retirement

Professional inspection

What do we need to measure?

Miller's pyramid of competence

Miller G.E. The assessment of clinical skills/performance. Academic Medicine 1990; 65(9): s63-s67

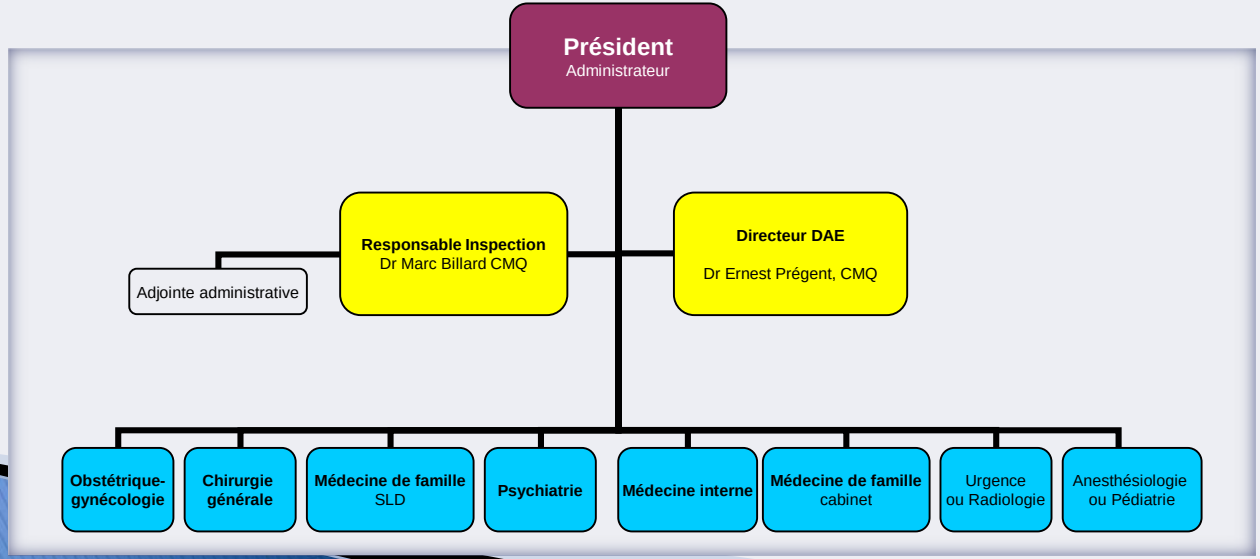
Personalized or “one size fits all”?

Physicians in practice differ in terms of:

- specialty
- demographics (gender, age)
- scope of practice (types of patients, medical problems, techniques and procedures)
- practice setting (e.g. hospital, private office)
- clinical environment (solo or group practice)
- attitudes, skills, knowledge, personality

Bylaws of the Professional Inspection Committee

- The Board of Directors appoints an elected physician from the Board + 9 **physicians** registered on the Roll for at least 10 years+ a member named by the Office. (art. 1)
- CMQ members do not participate during discussion/decision period



Evaluations

type de visites / année	VIP individuelles Niveau 3	Programme (70/2) + 60* + secteurs CH** Niveau 2	VIP d'établissements avec CMS*** Niveau 1	VIP individuelles annulées	Total
2009	146		1362	54	1562
2010	151		2363	45	2559
2011	146		2669	44	2859
2012	154	465	1632 ***	45	2296
2013	198	703	1510 ***	79	2490
2014	190	295	1806 ***	89	2380
2015	210	953*	1288 ***	93	2544
2016	207	1028* **	4937	113	6285
2017	220	921* **	5633	112	6886
2018	210	1257* **	3861	103	5431

MDs evaluated since 5 years

	Mds visited	% active MDs
level 1	15 719	75%
level 2	4454	21%
level 3	1037	5%

In sequence…

- Tools
- Programs and results
- Risk factors identified
- Quality indicators

THE PROFESSIONAL INSPECTION VISIT

COLLÈGE DES MÉDECINS
DU QUÉBEC

Tools that can be used

- Review records and other documents
- Conduct a structured oral interview
- A guided interview or direct observation
- Obtain a physician practice profile
- Competency assessment questionnaires
- Psychometric tests

Pre-visit

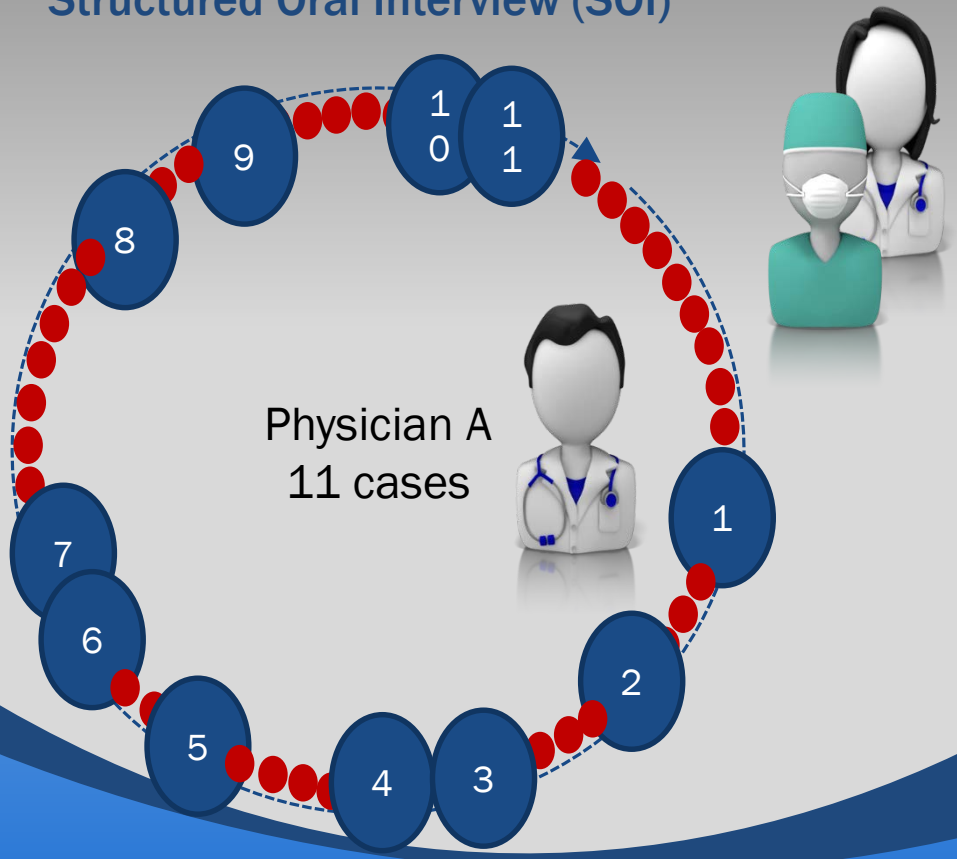
- Professional inspection questionnaire, call
- RAMQ profile: level of activity, samples of specific conditions
- A « peer » needed?
- Visit or …

During the visit…

- Review of questionnaire, office, EMR
- Medical records review: legibility, documentation, complaints, histories, functional inquiries, physical exam (+ and – pertinent findings) diagnoses, investigations, results recorded, particulars of any referral
- EMR: use and tools, content, confidentiality
- Equipment, registry

OSCE vs SOI

Structured Oral Interview (SOI)



Sample case in family medicine

To be read to the candidate:

Evaluators

Mr. Hargrove, 75 years old, has come to see you without an appointment. He is a new patient. He tells you that for the last two days he has a heaviness in the left lumbar region, as well as an undefined discomfort in the abdomen.

Q 1 YOU BEGIN WITH SOME QUESTIONS. WHAT ARE YOU LOOKING FOR?

Expected responses:

Tick (✓) when mentioned by candidate

A. Previous cardiac or vascular problems _____ A

B. Time and mode of onset of pain _____ B

C. Precise site of the pain _____ C

D. Permanent or intermittent pain _____ D

E. Pain intensity _____ E

F. Aggravating or triggering factors _____ F

G. Trauma _____ G

H. Urinary tract symptoms _____ H

I. G-I symptoms (nausea, vomiting or stool changes) _____ I

J. Fever or chills _____ J

Candidate

Mr. Hargrove, 75 years old, has come to see you without an appointment. He is a new patient. He tells you that for the last two days he has a heaviness in the left lumbar region, as well as an undefined discomfort in the abdomen.

Q 1 YOU BEGIN WITH SOME QUESTIONS. WHAT ARE YOU LOOKING FOR?

Scoring of the SOI

Q 2 DESCRIBE WHAT YOU ARE LOOKING FOR IN THE PHYSICAL EXAMINATION.

Expected responses:

Tick (✓) when mentioned by candidate

A. Vital signs _____ A

B. Cardiac auscultation _____ B

C. Abdominal examination _____ C

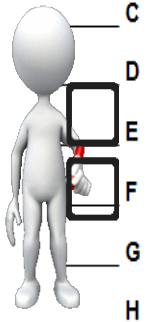
D. Abdominal aortic palpation

E. Peripheral pulses

F. Low back examination

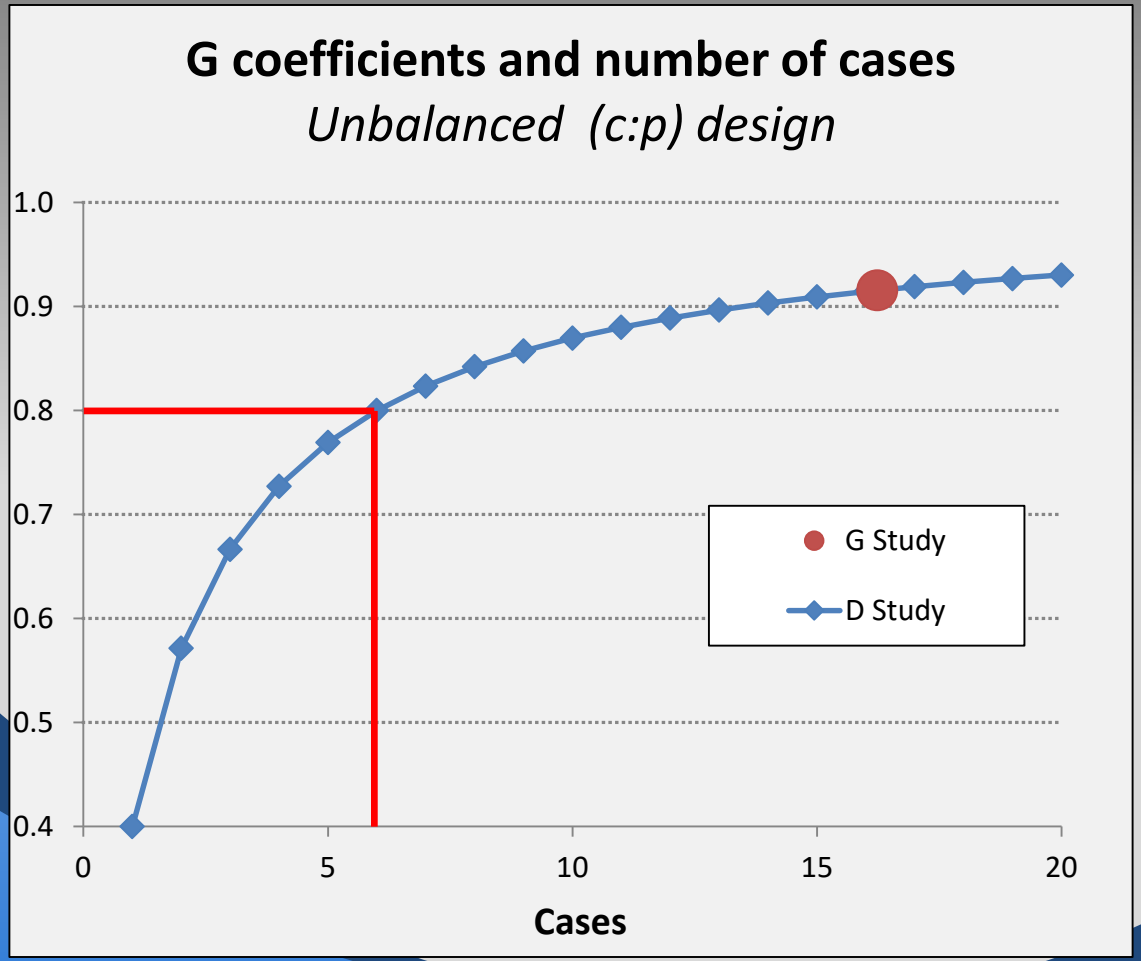
G. Renal punch _____ G

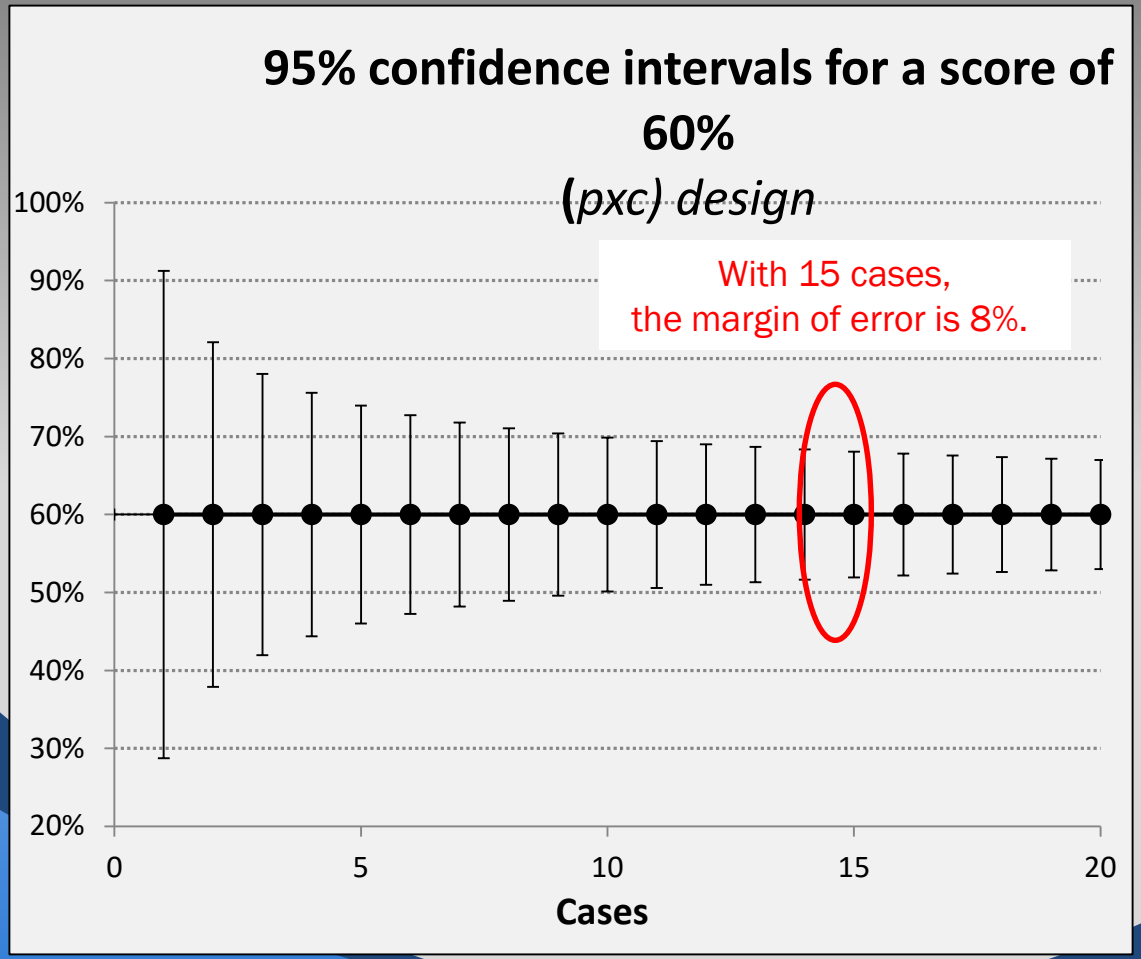
H. Abdominal murmur _____ H



Score for a case = percentage of expected answers mentioned by the candidate across all questions

Global score given by the two evaluators not considered in the scoring of the SOI

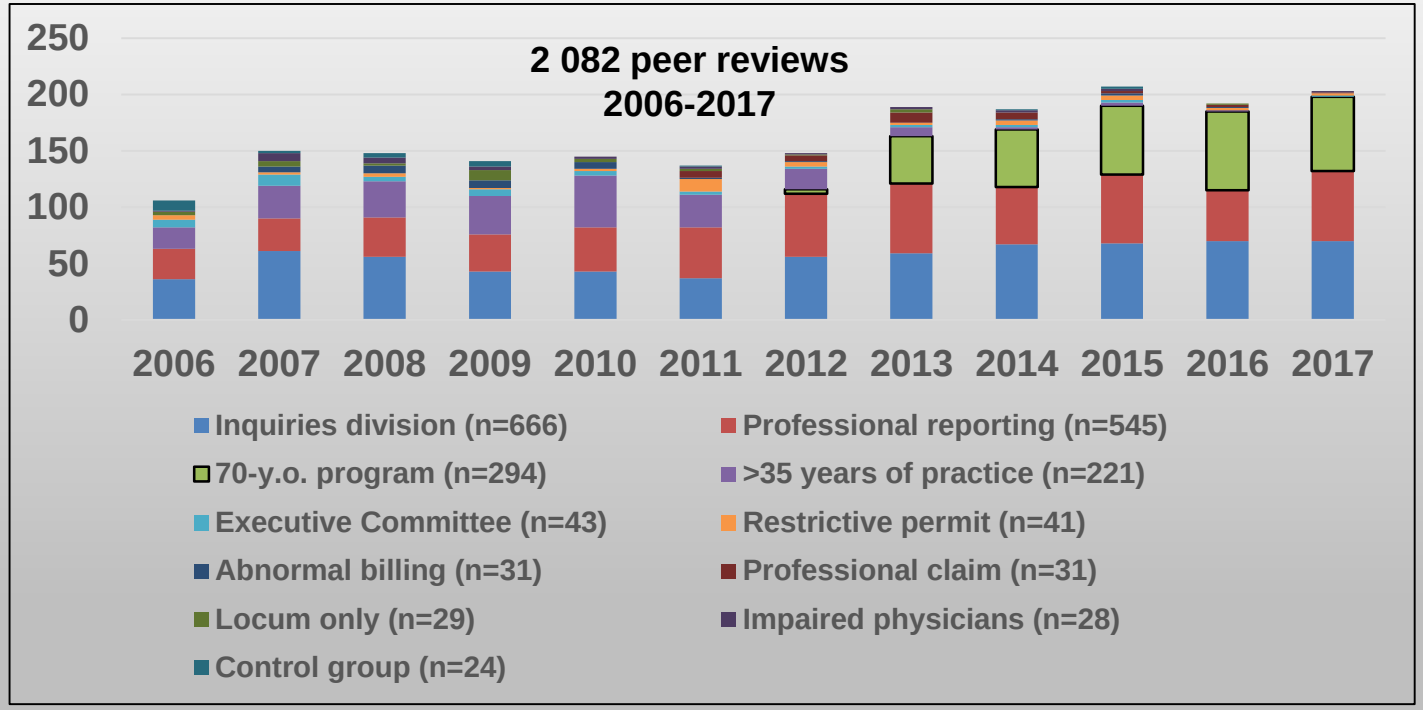

G coefficients and number of cases
Unbalanced (c:p) design
1.0
0.9
0.8
0.7
0.6
0.5
0.4
0
5
10
15
20
Cases
G Study
D Study


95% confidence intervals for a score of 60%
(pxc) design
With 15 cases,
the margin of error is 8%.
100%
90%
80%
70%
60%
50%
40%
30%
20%
0
5
10
15
20
Cases

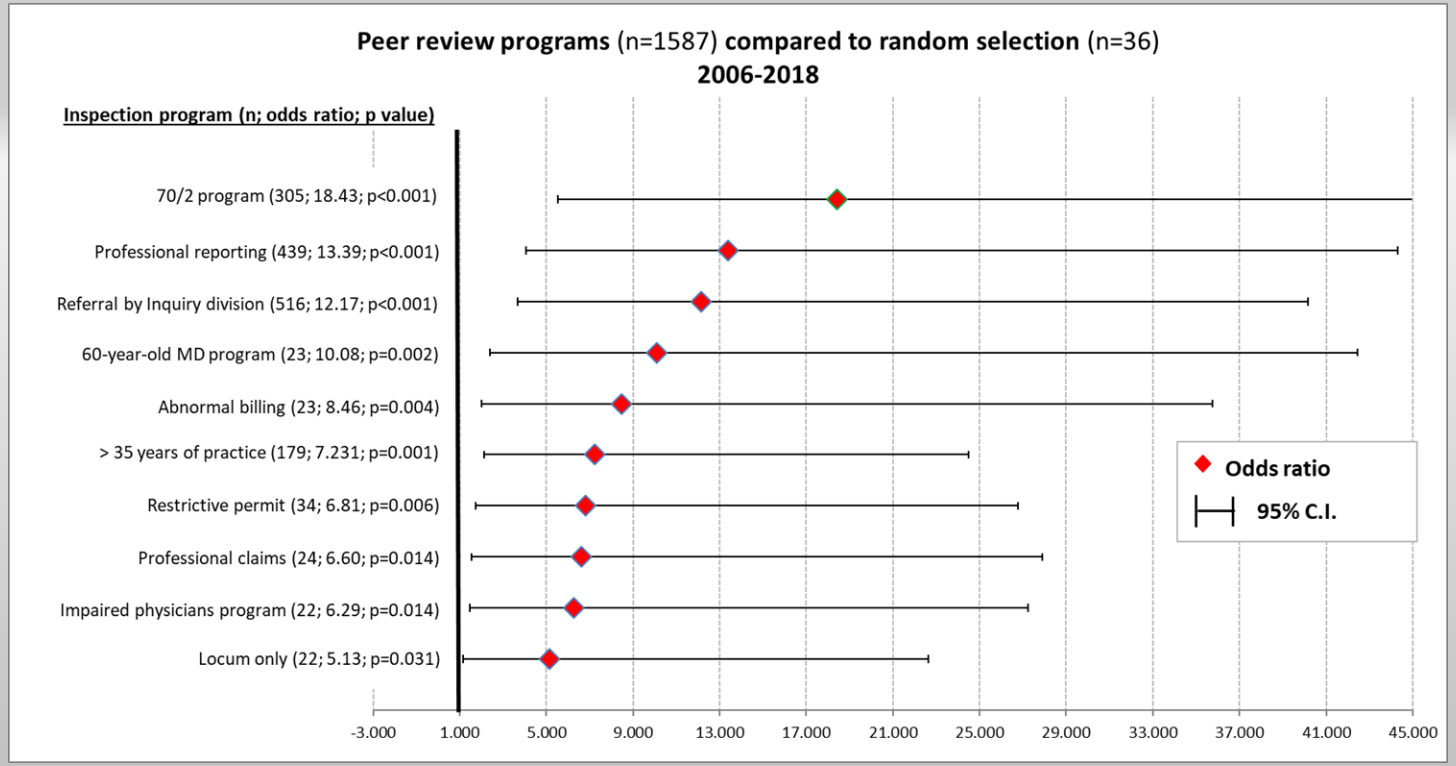
Programs

Peer review programs

- Since 1997, the PIC has been using screening programs to target physicians for inspection

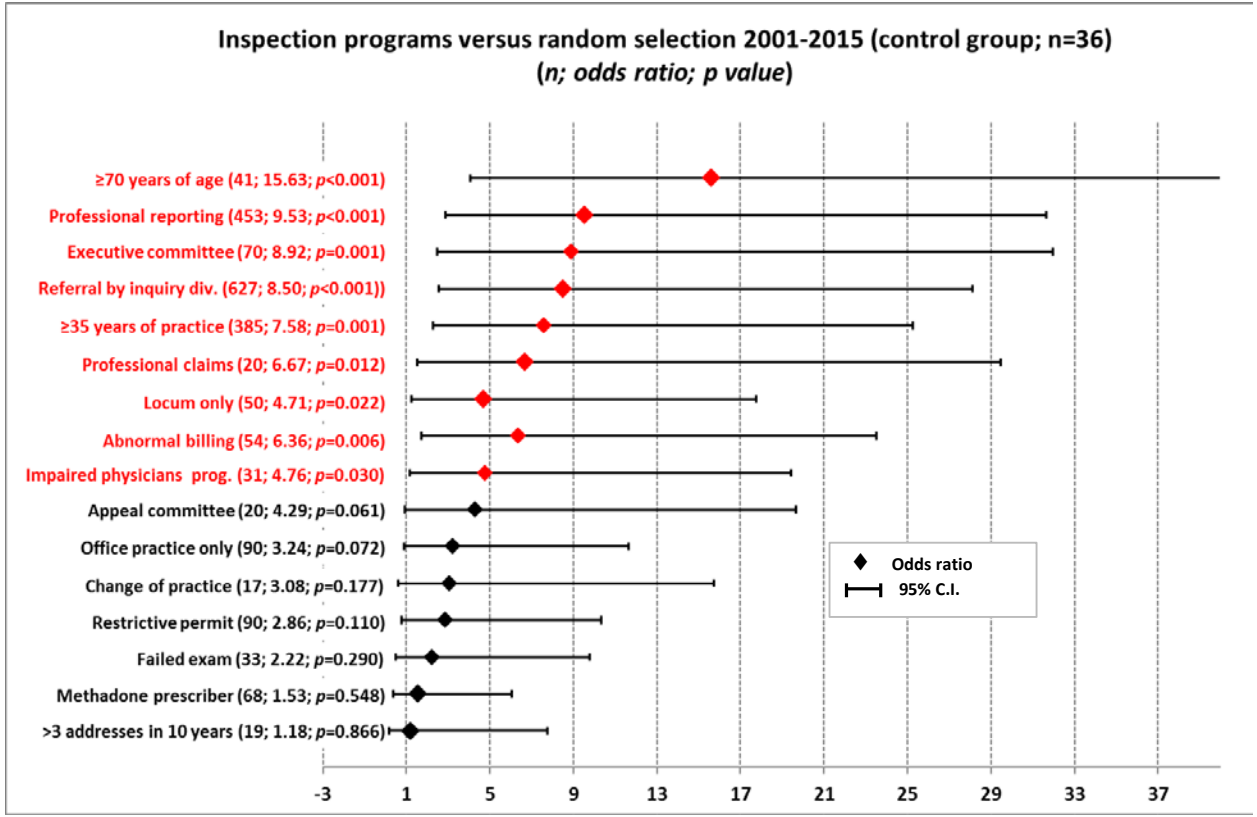


Relative efficiency of programs*



*Initial visits only (control visits excluded)

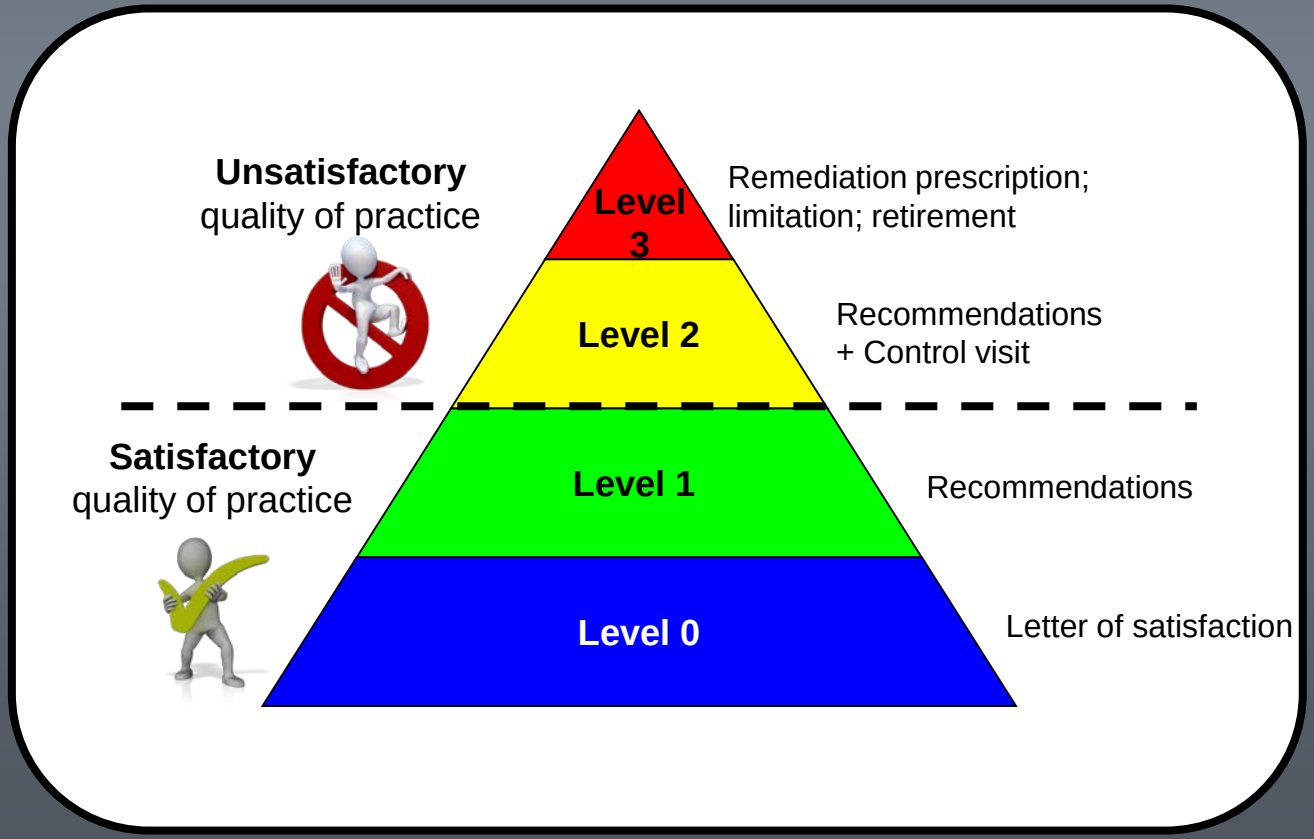
Efficiency of inspection programs



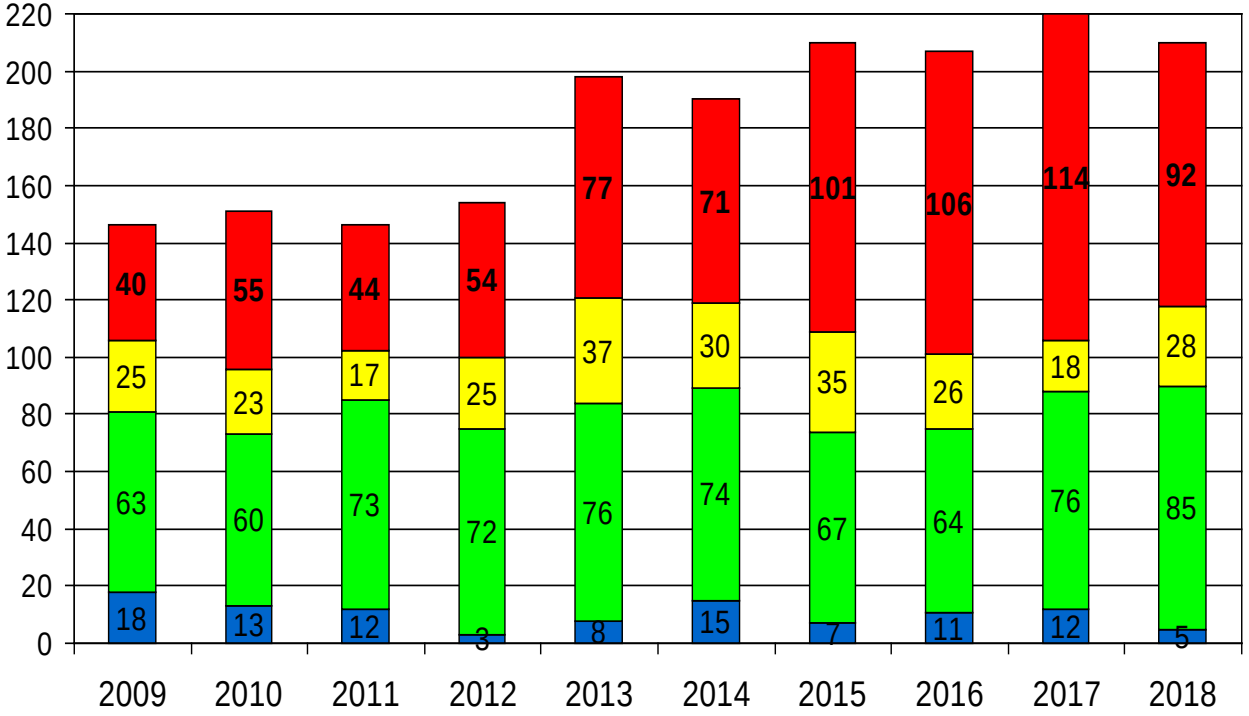
Programs PIC
2009-2018

60 Y.O.	23	SYNDIC (inquiries)	585
EXERCICE EN CABINET	3	SIGNALEMENT(reporting)	519
MÉTHADONE	6	D>35-70/2	357
PERMIS RESTRICTIF	34	SUIVI MD EN DIFFICULTES	15
GROUPE TÉMOIN	9	CHANGEMENT DE CHAMP	8
ÉCHEC AUX EXAMENS	2	COMITÉ DE RÉVISION	15
MD DÉPANNEUR	19	CMS + ESTHÉTIQUE	13
RÉCLAMATIONS	31	DPC	5
MD MIGRATEUR	FERMÉ	COMITÉ EXÉCUTIF	24
MD EXPERT	4	DIPLÔME 35+	142
PROFILS ATYPIQUES	19	VISITES ANNULÉES	777

Levels of intervention following an inspection visit

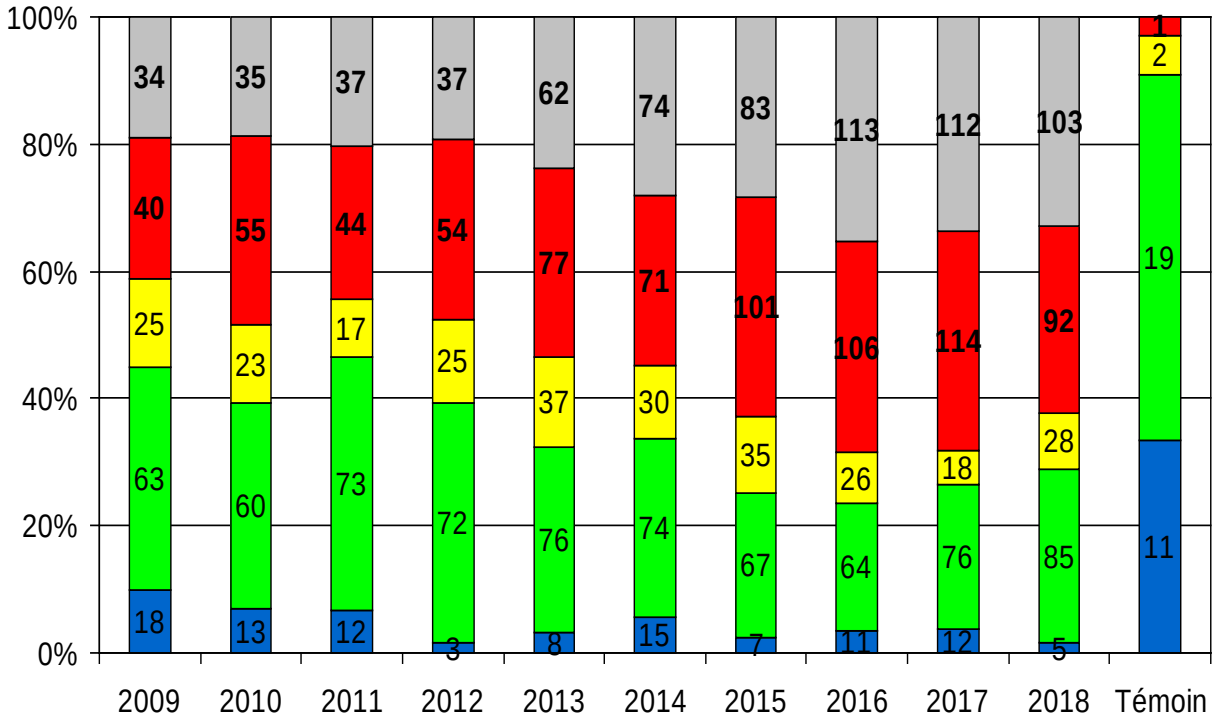


Individual visits/year



Individual visits/year

including canceled visits for retirement, limitation or death



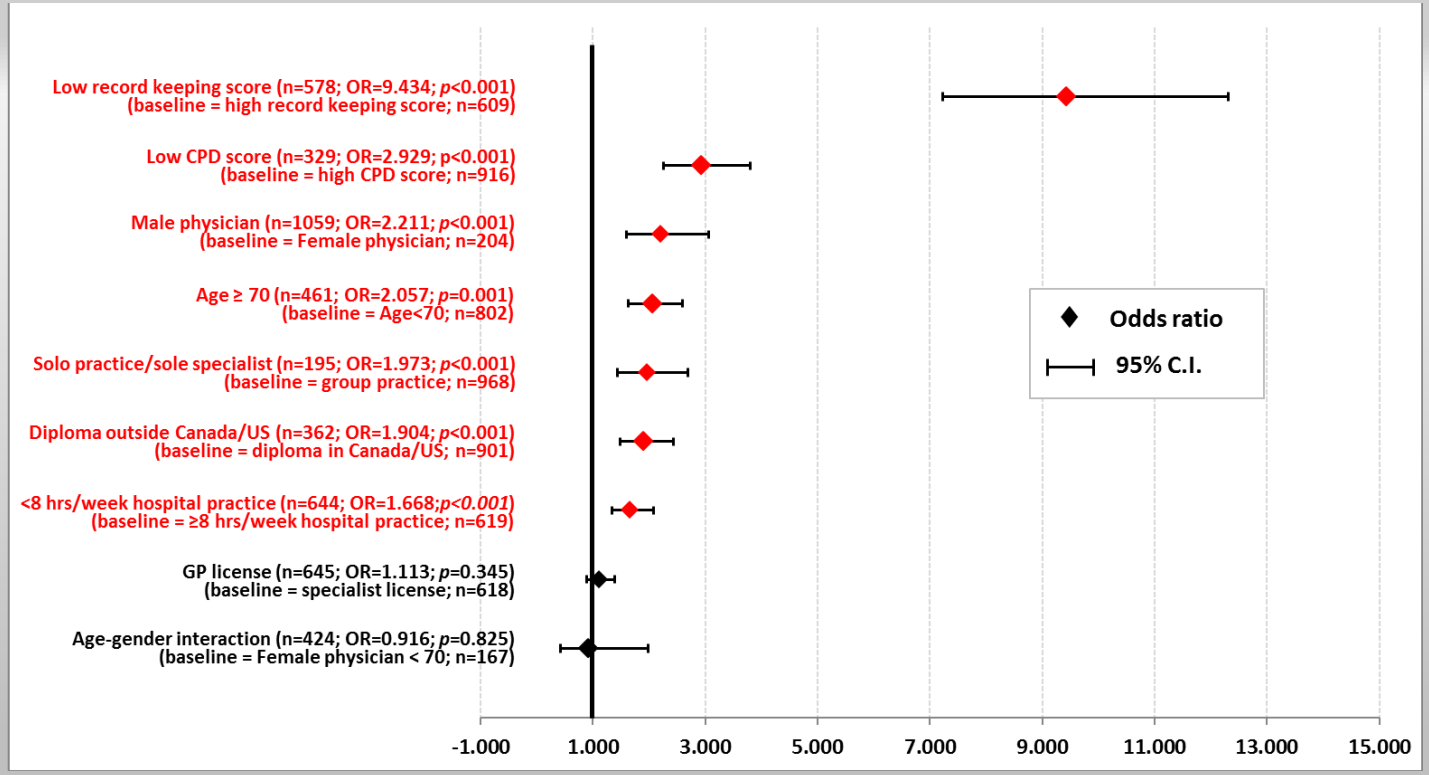
MAJ 2019

Identifying risk factors for physician performance

- Retrospective analysis of inspection visits* made since 2006
- Potential risk factors considered in the analysis:
  - **Demographic factors:** gender, age (<70 or ≥70)
  - **Medical training factors:** training specialty (family physician or specialist), country of medical degree (Canada/USA or outside Canada/USA)
  - **Practice factors:** type of practice (solo or group), weekly hours of hospital practice (<8 or ≥8), quality of medical record keeping, quality of continuing professional development

*Control visits of the same physician were excluded to reduce correlation.

Univariate logistic regression



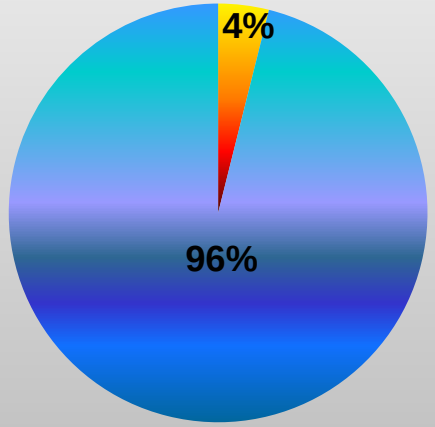
Multivariate logistic regression model (2006-2015)

RISK FACTOR	Odds ratio (95% C.I.)	p-value	Relative risk*
Low record keeping score	8.41 (6.27-11.27)	< 0.0001	3.41
Diploma outside Canada and USA	2.13 (1.53-2.97)	< 0.0001	1.46
Low CPD score	2.10 (1.51-2.92)	< 0.0001	1.47
Solo practice	1.59 (1.06-2.38)	0.03	1.27
Male gender	1.57 (1.03-2.40)	0.04	1.35
Age ≥ 70	1.44 (1.05-1.98)	0.02	1.24
Constant	0.10	< 0.0001	

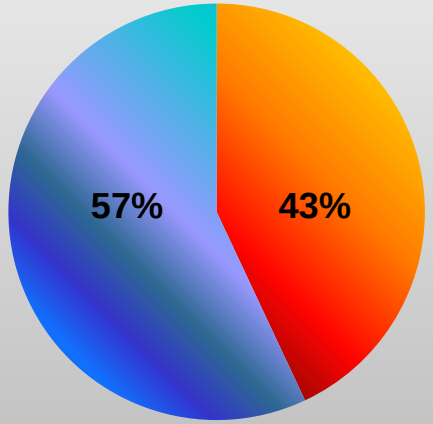
*For each risk factor, the odds ratio was converted into a relative risk using the formula : $RR = \frac{OR}{(1 - P_0) + (P_0 \times OR)}$, where P_0 is the incidence of non-satisfactory visits in the unexposed group (the group without the risk factor).

Level of decision following peer review versus number of risk factors

Physicians with none of the model's risk factors (n=128)



Physicians with **at least one** of the model's risk factors (n=1 892)



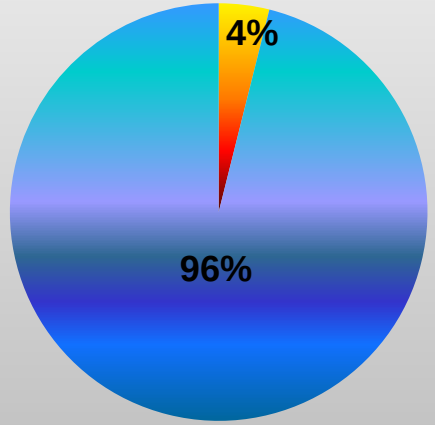
Level of decision following peer review

Satisfactory (0-1)

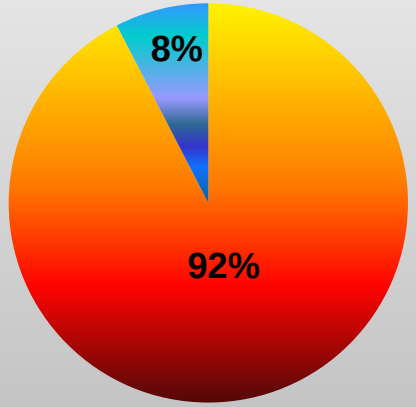
Not satisfactory (2-3)

Level of decision following peer review versus number of risk factors

Physicians with none of the model's risk factors (n=128)



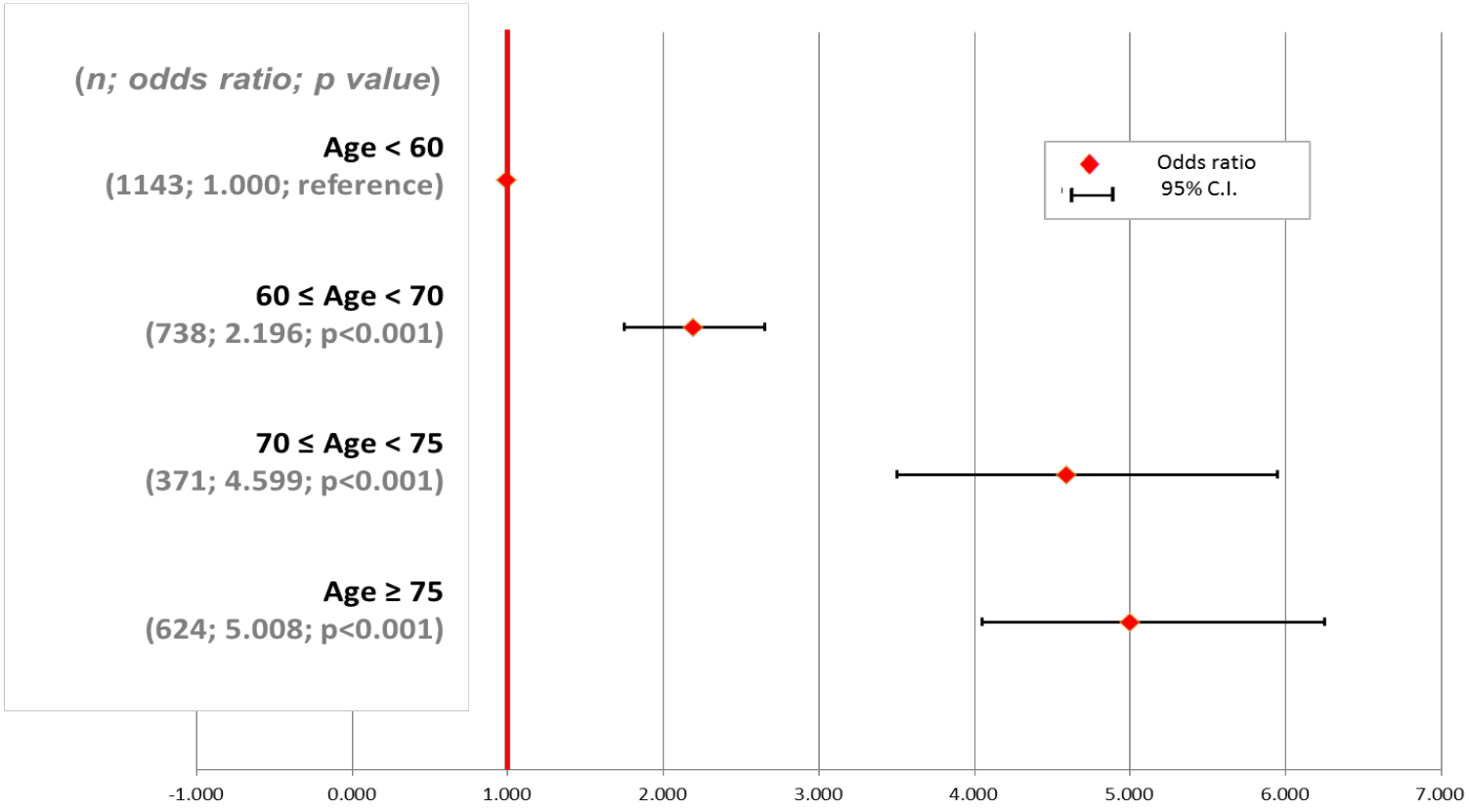
Physicians with **all** of the model's risk factors (n=66)



Level of decision following peer review

- Satisfactory (0-1)
- Not satisfactory (2-3)

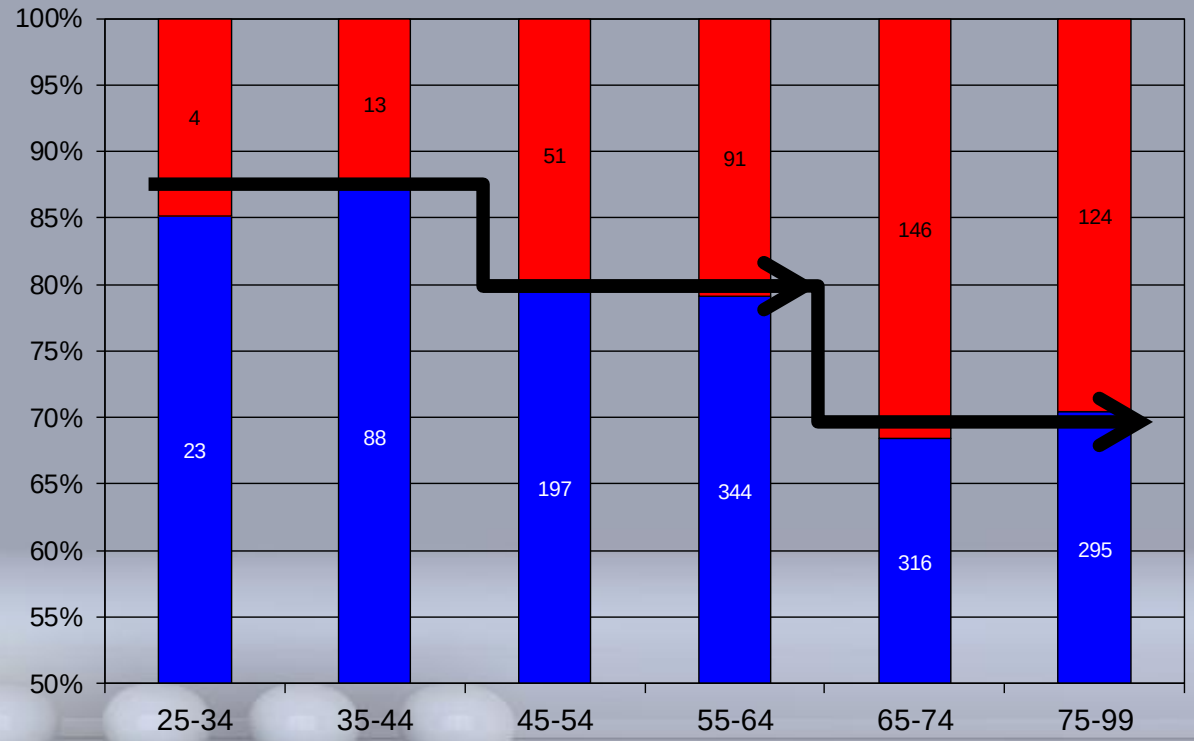
Effect of Age on Results of Peer Review
2001 to 2014



Peer reviews cancelled were included in the calculations as non satisfactory.

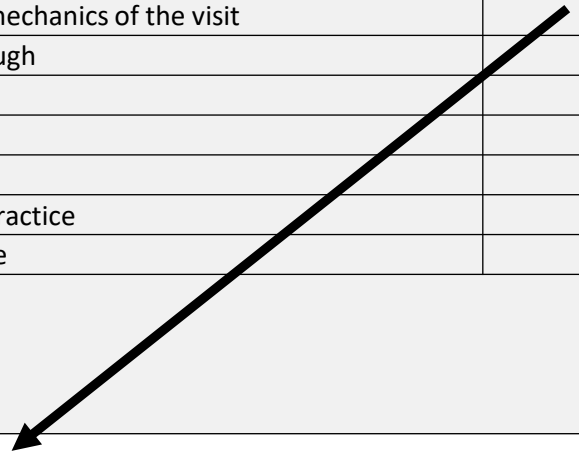
Results CPD per decade

visits from 2007



Confidential ans optional evaluation of the professional inspection visit

Énoncé de la question	COTE (1-4)
1- The letter annoncing the visit was clear enough on the mechanics of the visit	
2- The delay between the letter and the visit was long enough	
3- The questionnaire was easy to fill in	
4- The inspector was objective	
5- I could make my point in different aspects	
6- The mechanics of the visit has reflected accurately my practice	
7- The visit has allowed me to enhance my medical practice	
Comments :	



COTE (1-4)
1 – Totally at variance
2 – Partially at variance
3 – Partially in agreement
4 – Totally in agreement

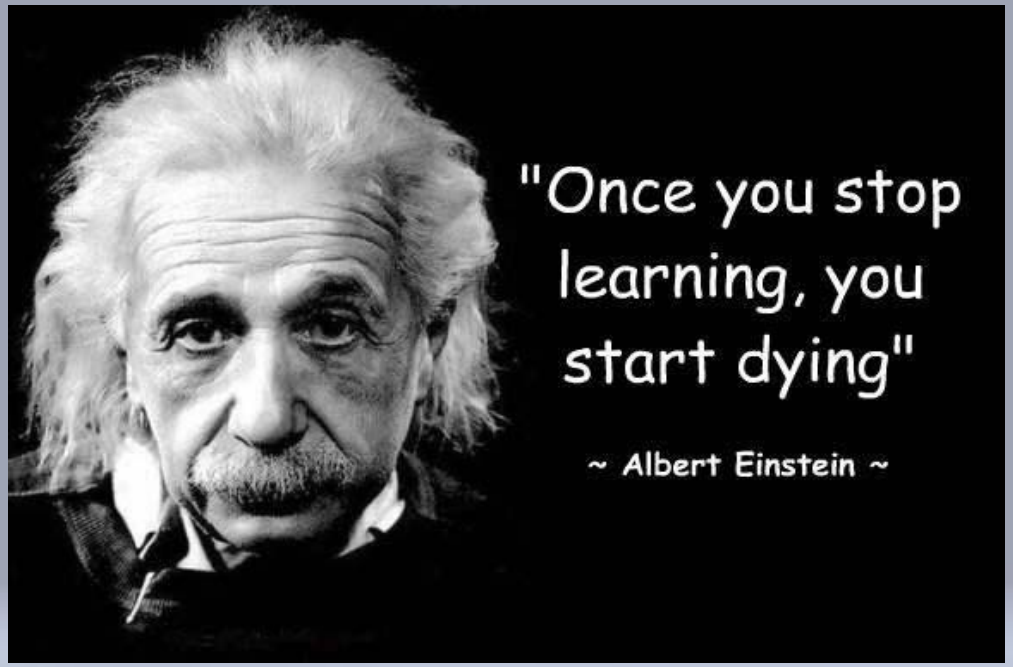
Revalidation is discussed around us …

What I would like to share…

In order to ensure the lifelong quality of their medical practice, physicians should:

- Maintain or improve their medical record keeping skills
- Participate in CPD activities that correspond to their needs
- Engage in group practice
- Be attentive to signs of cognitive, sensory-motor and physical decline associated with aging and adapt their practice accordingly, or retire before health issues affect their ability to provide safe and effective care to their patients.

Questions, comments…


"Once you stop learning, you start dying"
~ Albert Einstein ~