HEALTH LAW

Using Evidence-based Care Paths

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Oscar Wilde was quoted as saying, "Life imitates art far more than art imitates life." This was never more apparent to me than a few Mondays ago when I was paraded in front of a number of primary care doctors who questioned the use of "care paths" in urgent care medicine.

The leader of the mob was a gentleman who was the patriarch of a local family practice clinic. The meeting opened this way: "I don't like you, I don't like what you are doing, and I don't like the fact you are here!"

Now, once would have been tolerable; even twice would have been OK. But, he said that exact same sentence to me three times over the course of a 45-minute diatribe. I wanted to say, "It sounds like you have a case of the Mondays!" But it was a serious meeting so I responded, "Wow, you just met me; it usually takes people at least 15 minutes to realize they don't like me."

For a brief moment, I felt like the antithesis of Sally Field as she gave her 1985 Academy Award acceptance speech ("I haven't had an orthodox career...and I can't deny the fact that you like me, right now, you like me!").

As it turns out, however, it was not only me he didn't like; it was also the use of "care paths" in an urgent care setting. His invectives were directed at me in my role as chief executive officer of NextCare—a capacity in which I've instituted care paths at our clinics. His unwavering belief, however, is that *only* the doctor knows what to do for the patient; hence, to his way of thinking, the use of care paths and order sets have no place in healthcare. I know what you are thinking, "Toto, I've a feeling we're not in Kansas anymore...;" we are in 2010.

The mob's contention was that care paths increase the cost of care unnecessarily by "prescribing" a course of treatment which can be initiated before the provider who ultimately gives care actually sees the patient.

On the other side of the coin is the rationale for care paths having been implemented in emergency departments and other institutions across the country. By recommending tests and diagnostics based on the presenting complaints, care paths increase the likelihood that the patient will be evaluated to a degree appropriate for those complaints, thereby increasing efficiency and, more importantly, protecting the patient.

This is especially relevant in the ED and the urgent care center; since we don't have the luxury of a longitudinal relationship with the patient, we cannot simply try different diagnostic and therapeutic approaches based upon the patient's response. We have "one bite of the apple" to get it right.

For example, a 45-year-old male who presents with chest pain would, based on care path, receive an EKG and troponin; a 26-year-old female with lower abdominal pain would get a urinalysis and pregnancy test. Clearly, not rocket science.

Although CMS does not specifically opine upon the use of standing orders in an urgent care setting, in the hospital context, CMS has expressed support for use of such orders.

In a Survey and Certification Group letter dated October 24, 2008, CMS writes:

> "CMS strongly supports the use of evidence-based protocols to enhance the quality of care provided to hospital patients. Many hospitals employ such protocols developed by physicians and... staff that are designed to standardize and optimize patient care in accordance with current clinical guidelines or standards of practice."

About a week after the meeting I described, the following (redacted) article appeared in the local paper where this group's office-based practice was located. (The provider mentioned in the story was *not* part of the practice with whom I met.)

> "An XXXX County doctor has been reprimanded by the XXXX Board of Medicine for failing to properly diagnose and treat a patient with heart problems. The medical board said that Dr. XXX 'failed to appreciate' that her patient's symptoms were 'risk factors for an acute cardiac event.' Immediately after the man left...he was in a single-car auto accident and died. The medical board disciplined XXX at a hearing. The board ordered her to take 12 hours of continuing education classes in emergency and urgent care....

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"According to board documents, the 52-year-old man, identified in the board's order as 'Patient A,' came to XXX after having heartburn for three weeks. He described his pain as 'pressure-like,' according to XXX's office note. The man had a history of high blood pressure, used tobacco and alcohol and did not take his medicine regularly. His blood pressure in her office was 200/100. According to the board's findings, XXX failed to take and record a complete medical history of the man, did not repeat the blood-pressure test and did not do an electrocardiogram or perform lab tests to rule out heart problems as the cause of his distress.

"XXX told the medical board that she counseled the man about his diet. She prescribed a blood-pressure medicine and one for gastro-esophageal reflux. She also told the man to return for a follow-up visit in two weeks.

"'Immediately after leaving Dr. XXX's office, Patient A was involved in a fatal single-car motor vehicle accident,' according to the board's order. The man's death certificate listed blunt head trauma as the cause of his death. The death certificate also said that his heart condition was a 'significant condition' contributing to his death. No postmortem exam was done.

XXX graduated from the University School of Medicine, according to her profile on the Board of Medicine' Web site....She also was an instructor at the XXXX School in 2006-07. She obtained her medical license in 2006."

Sound like any one of hundreds of patients who walk into urgent care centers across the country on any given day?

If this patient had gone to a practice which followed evidence-based care paths would he be alive today? Maybe. At the very least, however, he probably would have had the benefit of a complete evaluation.

Clearly, the doctor involved in the aforementioned medical misadventure is well trained and well meaning. This unfortunate incident simply reinforces the fact that good doctors, like everyone else, can make mistakes. What makes it so much worse for providers is that when we make mistakes, the outcomes can be catastrophic. Lives can be lost and careers ruined.

Practicing medicine, like being a professional pilot, is a challenging and unforgiving career choice inasmuch as the tolerance for errors, human or mechanical, is very narrow. We can learn something from our aviation brethren, where the use of automated check lists and standard protocols has been commonplace since the days of Wiley Post.

To finally get to that point, we have to leave our egos on the tarmac and accept the fact that even medical care providers are fallible. ■

"Your clinic's approach depends on assessing your unique position in the market."

change, or is it forward-thinking and willing to do things innovatively and with a splash? Or is it somewhere in between? How deeply held and changeable is this cultural bias?

At the end of the day, your sales and marketing approach has got to be in line with your organizational culture and on the lookout for signs that this culture is open to change.

#5: Personnel Characteristics

Typical question: "What sales and marketing responsibilities can I add to the job descriptions for various personnel in our clinic?"

Answer: It depends. Assume you are a basketball coach and your team is comprised primarily of small, quick players. Your strategy would be to run, press, and play the game at a frenetic pace. However, if your team is comprised of slow, tall timber, you would in turn slow the game down and work to get the ball inside.

The same principle is true in sales and marketing: play to the strengths of your personnel by designing marketing tactics that fit the collective personality of your team.

#6: Your Clinic Vision

Typical question: "You suggest addressing both short-term goals and long-term positioning in our marketing plan. What percentage of the plan should address long-term goals?"

Answer: It depends. You need to go back to square one and reflect on why your clinic made a commitment to occupational health in the first place.

For example, is your commitment to occupational health's raison d'etre to serve as a basic occupational health clinic or does ownership view occupational health as a foundation for a more highly integrated and continually evolving series of services? Finding the proper place on this basic service/integrated service continuum allows your clinic do place the proper short-term/long-term division in your marketing plan.

The common thread of this column is that your clinic's approach to sales and marketing *depends* on assessing your unique position in the market. Think of every variable as a continuum upon which your clinic may be at one end or the other or somewhere in the middle. When it comes to sales and marketing, one size does not fit all. ■