

Quality-of-Care Standards in Glaucoma

Changes in methods of assessment should allow physicians to improve the care they provide.

BY PAUL P. LEE, MD, JD

As the demand from payors, patients, and licensure authorities for greater accountability in health care grows, professional societies and eye care providers are initiating and implementing new efforts to measure and improve glaucoma care. Traditional approaches based on legal theories of medical malpractice (“breach” of the so-called standard of care) and physician-credentialing standards governed by The Joint Commission have been complemented by

- professional standards embodied in practice guidelines
- efforts of the American Board of Medical Specialties and state licensure boards to ensure maintenance of competency
- payors who profile performance from claims and, increasingly, clinical data
- health systems’ and professional organizations’ use of registries and data warehouses to more rapidly help practitioners improve the eye care they provide

Considering this explosion of interest, it may be helpful to assess how these approaches could apply to the care of patients diagnosed with glaucoma.

THE STANDARD OF CARE

Tort law (malpractice) holds, in general, that the standard of care is the practice of the relevant community taking care of similar patients. The standard is established in each case by the input of established experts in the field (ie, those with experience in glaucoma care similar to that of the practitioner in question). Individuals who present themselves as specialists in the field are judged against a national standard, whereas generalists in the provision of eye care are held to the local standard relevant in their jurisdiction (ranging from citywide to nationally). Thus, what is required to obtain a diagno-

sis, provide treatment, or observe a patient (or failure therein) is based on what at least a respectable minority of similarly positioned practitioners does.

The growing prominence of practice guidelines has made these otherwise implicit standards more explicit. The American Academy of Ophthalmology’s (AAO’s) Preferred Practice Patterns (PPPs) explicitly disclaim that they are guidelines, but over time, the PPPs and their associated Summary Benchmarks have helped guide care within the ophthalmic community. This article will not repeat their content; the AAO’s PPPs are available from both the Academy (www.aao.org) and the National Clearinghouse for practice guidelines (<http://one.aao.org/guidelines-browse>; <http://1.usa.gov/1htgTgZ>). Demonstrating that a physician followed the relevant practice guideline is deemed a matter of law in some states—and as a practical matter in almost all jurisdictions—dispositive that the relevant standard of care was met. Failure to follow a practice guideline is not in itself proof of negligence, but it necessitates an explanation of relevant community practice standards and why the guideline was not used in a particular case.

ASSESSMENT OF CARE

The content of guidelines has also become important to many expanded traditional and new approaches to improving the care of patients with glaucoma. Physicians who practice in facilities accredited by The Joint Commission are now monitored by a new approach to credentialing that involves regular, ongoing scrutiny of their performance (ongoing professional practice evaluation [OPPE]). In addition, a focused professional practice evaluation looks deeper for initial credentialing, when new privileges are requested, and when issues arise from the OPPE or other review processes.

OPPEs and focused professional practice evaluations are based on both process measures (ie, those exemplified by practice guidelines) and outcomes metrics (ie, the results of care). In the field of glaucoma, examples of process measures include documentation of the performance of gonioscopy, optic nerve evaluations, or the use of visual field assessments. Outcomes used include rates of infection, a return to the OR within 30 days of surgery, and the achievement of the target IOP (or an explanation of why it was not achieved) after the initiation of therapy.

The approach of using both process and outcomes is complementary to efforts of the American Board of Medical Specialties and some state medical licensure boards to ensure maintenance of competency. These organizations also seek to measure other key attributes such as knowledge, systems-based practice, and professionalism as well as clinical performance. Reviewing the content of the American Board of Ophthalmology's new Practice Improvement Modules (<http://bit.ly/K2mv34>) provides insight into a minimum data set of key elements central to the care of patients with glaucoma (as well as other conditions).

DATA WAREHOUSES

The data elements embodied in the Practice Improvement Modules are major elements of the AAO's Intelligent Research in Sight (IRIS) Registry. The goal is to create a clinical, ambulatory data registry and potential data warehouse that will enable individual ophthalmologists to determine how they care for patients relative to their colleagues and to improve their own performance over time. Data from the IRIS Registry will inform physicians how patients are actually being cared for today, without the need for laborious and time-consuming chart abstractions by trained reviewers. Eventually, IRIS data will enable a real-time determination of how a community is caring for patients, how that care compares to practice guidelines, how different patterns of care may produce different outcomes, and how changes in these patterns can improve the care of patients almost immediately. With the application of "big data" techniques, not only should the quality of the care that patients with glaucoma receive be much more readily assessed, but it should also be improved much more quickly than it is today, benefiting both patients and medical colleagues. ■

Paul P. Lee, MD, JD, is the F. Bruce Fralick professor, chair of ophthalmology and visual sciences, and director of the W. K. Kellogg Eye Center at the University of Michigan in Ann Arbor. Dr. Lee may be reached at (734) 764-6468; pleemd@med.umich.edu.

