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Measuring Clinical Performance

From QA to QI

In my last column, I outlined the three primary modes of organizational learning and highlighted the opportunity to measure clinical performance during peer review. Clinical performance measures can be used to promote self-correcting behavior through timely performance feedback. They can also serve to identify performance trends among groups of clinicians. Extracting such measures greatly increases the efficiency and value of peer review. Let's see how.

When peer reviewing a chart, physicians invariably look at the admission history and orders, the operative report (if applicable), major test reports, consultant reports and the discharge summary. In the more complicated cases, they'll also look at progress notes, nurses' notes, etc. In the prevailing QA mode of peer review, the learning from all this effort is reduced to a standard of care judgment: a single data point. This is a great waste.

Alternatively, a simple form can be developed to capture ratings on multiple elements of clinical performance. Figure 1 shows the structure of one such form. With this QI approach, more than 10 times the information can be captured with minimal additional effort. Moreover, even though these are subjective measures, they are much more reliable than the standard of care judgment (which is itself subjective).

The secret ingredient is the rating scale. Reliability is all about differentiation. It is not the same as agreement. If, for example, as is commonly done, we rate almost all physicians as having met the standard of care, the agreement is nearly perfect, but the reliability of the evaluation is close to zero because we haven't differentiated shades of grey between outstanding and miserable. Up to a point, the more intervals on the scale, the greater its reliability. Most standard of care judgments are made on scales with three levels. For clinical performance measures, some authorities suggest an asymmetrical scale with seven to nine categories, having more categories describing the range of above average performance.

Regardless, the standard of care judgment is the wrong question. As we saw in *QA vs. QI: The Battle Royale* (*CHPSO Patient Safety News*, September 2011), the QI model succeeds because it is focused on finding any and all learning opportunities. Chart documentation reflects the clinical data gathering and decision-making processes. It is vitally important for communication among all care givers. It is no longer just "notes to myself." Thus, case review is well-positioned to look at many factors considered important to good patient care for which borderline performance may contribute to problems downstream. The QI approach to measuring clinical performance enables balanced feedback and avoids making threatening judgments about competence from a single case. Such subjective measures nicely complement objective measures like CMS Core Measures, NSQUIP, resource use, etc. that are commonly included in OPPE profiles.

Quantification of clinical performance during peer review also helps to mitigate potential biases. More on that next time.

Coming next: Minimizing Peer Review Bias

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Figure 1: Sample Review Form for Measuring Clinical Performance

	Very Poor	Poor	Medium	Good	Excellent
Assessment by physicians of patient's *prior* risk factors and *prior and chronic* disease	☐	☐	☐	☐	☐
Assessment by physicians and nurses of *functional* status and *psychosocial* situation	☐	☐	☐	☐	☐
Initial data gathering by physicians about *acute problems* present at admission (including information from history, physical, labs and procedures).	☐	☐	☐	☐	☐
Physicians' integration of admission information and development of appropriate *diagnoses*.	☐	☐	☐	☐	☐
Physicians' initial *treatment* plan and initial orders.	☐	☐	☐	☐	☐

Source: Rubin, HR, et al. *Guidelines for Structured Implicit Review of Diverse Medical and Surgical Conditions.* RAND; 1989 N-3066-HCFA.

Responding to Serious Adverse Events

The Institute for Healthcare Improvement recently released an important document: "Respectful Management of Serious Clinical Adverse Events" (2nd ed). This is the second in a series of articles discussing crisis management.

The four hallmarks of a strong crisis response are immediacy, transparency, apology and accountability. Internal and external communications around serious clinical events are essential.

Internal and External Communications

The questions that arise include: What can we say? How can we say it? To whom? Essential messages can, when appropriate, include the following:

- The hospital has apologized and regrets that the incident happened (see figure 2 on page 3 for language to use in such communication).
- We have disclosed to the patient and family everything we know. Keeping them informed and supported is a priority.
- The board of trustees and leadership are actively engaged in understanding why our systems failed this patient and family and what steps are needed to prevent a similar occurrence in the future.
- We are working with appropriate authorities.
- We are an excellent organization and staff, but not perfect. We come to work every day to provide the best care we can and continuously seek ways to improve it.
- We will use this tragedy to make this organization a better and safer place for our patients, family, staff and community.

Organizations should be prepared to detail what went wrong and why, including addressing policies designed to minimize harm. A tried-and-true rule in public relations is, "Whoever informs the first story informs the overall story." Early information is often incorrect. Misinformation fills a vacuum and is very hard to correct later. Credibility is essential and the organization should never speculate. Public relations (PR) professionals advise that, in telling the story, you should define your essential messages as clearly and concisely as possible, centralize and narrow the flow of information and determine who will speak on behalf of the institution. All spokespersons must be briefed and prepared. All staff should be reminded to direct outside inquiries to the PR department, which should review communications to all core audiences.

When serious clinical adverse events occur, communication priorities should include the following: those most directly affected; employees, as sometimes they can be victims, too; those indirectly affected — families, relatives, neighbors, friends; customers, suppliers, government, regulators, third parties; and the news media and other channels of external communications. Those with experience in these matters advise talking to patients, staff, trustees, regulators, supporters (donors, community leaders, and local officials) and interested parties (insurers, etc.) Core constituencies should never learn anything from the news media; they should receive the information directly. Email, Twitter and other social media have changed everything — most obviously, the speed and content of communications — and the integration of social media into other crisis efforts is being found helpful. Many people want and need to believe in you; make that possible. Use all available tools to provide regular updates, including personal calls, email, fax, websites, letters, Q&As and social media.

Internal communications are also critical. Health care staff often report that in the aftermath of adverse events, "Everyone is talking about it except the organization." All staff are devastated when these events happen, as staff and as members of the public. They want and need to understand what's going on. There is no question that patients and family members will be asking questions. The staff, including the patient's extended care team, need to be trained to answer them.

Key Points:

- Determine: What can we say? How can we say it? To whom?
- Define message concisely, centralize/narrow flow of information.
- Identify who will speak on behalf of the institution.
- Directly communicate with core constituencies (trustees, supporters, community leaders).

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Engaging the Media

One of the more complex issues to address with serious adverse events is how to effectively manage the media throughout the crisis. These efforts need to begin long before an event occurs and include at least four steps:

1. The organization should have an up-to-date, tested media plan as part of the overall crisis management plan with an identified media consultant where appropriate.

2. Executive leadership must keep their own internal communications staff informed; if leaders are worried about something, their PR staff should be aware of it concurrently.

3. Engagement by PR and the organization with the media should begin long before any high-profile event. Health care organizations should be cultivating the media, building relationships, establishing credibility, serving as a resource for information and stories and striving to meet media deadlines.

4. Organization spokespeople should be required to go through formal media training to support them in times of normal operations, as well as during crisis events.

Calls from the media should be expected at any time — don't let people minimize the possibility that the event will go public — and preparations should be made for these inquiries. PR should be notified immediately. Organizations must be honest and not stonewall; one reporter described "no comment" as a reporter's stimulant. As the crisis evolves, PR should provide updates to the media, telling as much as they can. For the long term, PR should stay engaged with the press and have a story of learning and improvement to tell.

These efforts will help break the destructive cycle outlined below:

- A serious clinical adverse event occurs.
- The organization is not transparent, internally or externally.
- People close to the incident (patients, family members, staff, etc.), frustrated with how the event is being handled, contact the media.
- The media contacts the organization, gets "no comment," or incorrect or superficial information.
- The media go looking everywhere for any information they can find.
- Information, often incorrect, is supplied by people who don't know the facts of the case.
- The patient, family, staff, organization and community are further traumatized by the strident, inaccurate media attention.
- The organization's response to the event becomes as big a story as the story of the actual event, if not bigger.

Key Points:

- Need a tested media plan long before a serious adverse event occurs.
- Require formal media training for organizational spokespersons.

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Figure 2: Communicating after a Serious Clinical Adverse Event: Words of Compassion, Concern, Empathy, and Remorse

Alarmed	Appalled	Ashamed	Concerned	Disappointed
Embarrassed	Empathized	Failed/Failure	Humiliated	Let you down
Mortified	Regret	Sad/Saddened	Shocked	Sorrowful
Sympathetic	Tragic	Unfortunate	Unhappy	Unintended
Unnecessary	Unsatisfactory			

Source: Lukaszewski JE. Establishing individual and corporate crisis communication standards: The principles and protocols. Public Relations Quarterly. 1997;42(3):7-15.

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Register Now for Annual Meeting

Accelerate patient safety initiatives at your hospital by joining your colleagues at CHPSO's Annual Meeting — Take a Stand for Patient Safety: Eliminate Preventable Harm — March 13, 2012, in Glendale. Nationally renowned experts will share patient stories, case studies and critical elements to achieving a culture of safety. The program is designed for hospital executives; quality, risk and patient safety leaders; and physician pharmacist and nurse leaders.

Registration fees will increase $100 after February 13. Until then, participants from CHPSO-member hospitals may register for $200. Non-members are $400.

Partners include the California Hospital Association, the Hospital Association of San Diego and Imperial Counties, the Hospital Association of Southern California and the Hospital Council of Northern California. Sponsors include the California HealthCare Foundation and Kaiser Permanente.

The brochure and registration form are available at www.chpso.org/images/201203bro.pdf . To register online go to www.cvent.com/d/8cq8p2/4W.

Calendar Notes

Due to the holidays, the January CHPSO members call, scheduled for Jan. 9, is cancelled. The February call will be held at its regularly scheduled time —the second Monday of the month at 10 AM (Feb. 13).

Later this month, we will hold a webinar on our multi-state handoff survey. Watch your email for schedule information.

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International Survey of Patients with Complex Care Needs

Health Affairs recently published results from a 2011 survey of patients with serious illnesses, serious injuries or chronic diseases in eleven countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States. The survey focused on access, care coordination and management, patient engagement, safety and the extent to which having a primary care practice with attributes of a patient-centered medical home influenced the patient's care experience. The authors note that "the countries share the challenge of how to meet the needs of patients with complex conditions in often fragmented care systems. Our study points to areas of shared concern and opportunities to improve primary care, care coordination, and communication." Following are some of the results (as percentage of respondents answering affirmatively).

Country	Experienced provider coordination gaps in past 2 years	Experienced gaps in hospital/surgery discharge planning	Has a medical home	Because of cost, did not get recommended test, treatment or follow up	Because of cost, did not fill a prescription or skipped doses of medication for chronic condition
AUS	36	55	51	19	13
CAN	40	50	49	7	13
FRA	53	73	52	9	9
GER	56	61	48	13	13
NETH	37	66	48	8	5
NZ	30	51	65	15	10
NOR	43	71	53	7	7
SWE	39	67	33	4	6
SWI	23	48	70	11	8
UK	20	26	74	4	2
US	42	29	56	31	31

Schoen C, Osborn R, Squires D, et al. New 2011 Survey Of Patients With Complex Care Needs In Eleven Countries Finds That Care Is Often Poorly Coordinated. Health Affairs (Project Hope). 2011;30(12):2437-2447.