PERFORMANCE MANAGEMENT AND PROCESS IMPROVEMENT

Chapter 3

Mohamed Eldeeb
CPHQ,CPHRM,LSSBB,TQM,SCRUM Master ,TOT , Team STEPPS master training, TEMOS approved Consultant

Medical Record Review Process:

- Usually begins with the determination of what should be reviewed.
- The content to be reviewed will depend on the utilization of the information.
- In many cases, the data is screened by some predetermined criteria
  If the documentation meets the criteria, further review is not required.
- Reviewers usually include physicians, nurses, other relevant clinical professionals, health information management professionals (screening), and quality data abstractors.

not possible or feasible in many circumstances for all medical records to be reviewed due to time and other limitations.
Therefore, sampling is often utilized.

- **The purpose of theses process:**
  - The medical record is complete (reflect the patient's condition, The timeframe for completion usually never exceeds 30 days).
- **Sample size:** 5% or 30
- **Reviewers:** non healthcare providers by using detailed criteria, with summary reports of any opportunities for improvement.

Type of clinical review:

Prospective	Before treatment
Concurrent	During hospitalisation (open MRD)
Retrospective	After discharge (closed MRD)
Revalidated	Peer review

Multilevel review process

1st level:

Screening & data collection by professionals **in the point of care delivery**

2nd level:

Initial analysis & Confirmation of variation (**Peer review**)

3rd level:

In-depth analysis.

(**Focus peer review**)

4th level:

Improve or design

new process

5th level:

Monitoring and **evaluation**

Peer-review steps:

First Read

- General overview
- Is article within journal's scope?
- Identify main aims of the article and why it's innovative
- Identify fatal flaws
- Can REJECT if fatal flaws identified at this step

Second Read

- Critically examine the full manuscript
- In-depth read with comments/notes.
- Look at references, tables and figures
- Describe Major flaws or concerns.
- Use guidelines as appropriate (table 1).

Third Read

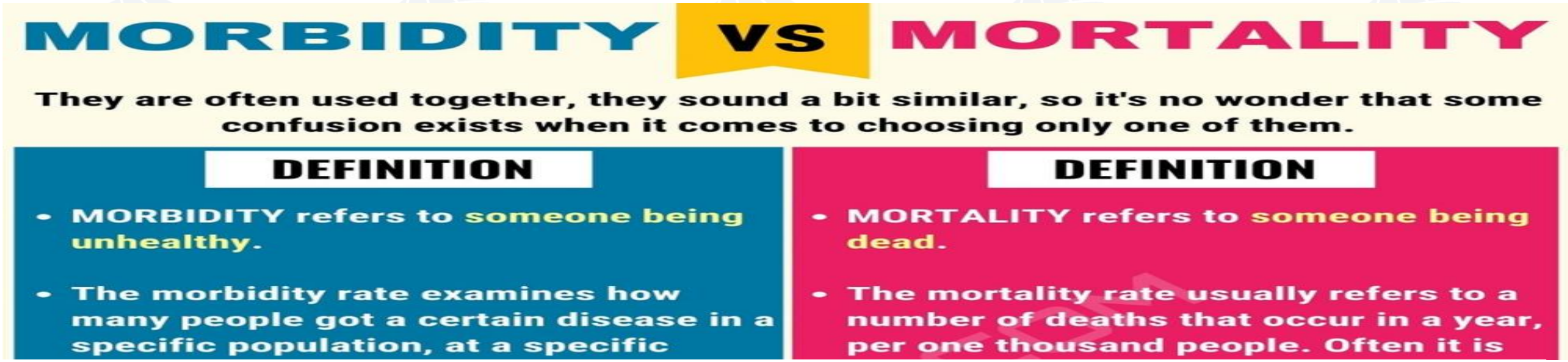
- Focus on the flow of the article and how cohesive the story is.
- Assess writing skills, language and presentation.
- Identify additional flaws that may have been missed on 1st and 2nd reads.

Summarize

- Summarize your review into major and minor concerns.
- Read your final review.
- Rephrase offensive or rude comments.
- Complete questionnaire.
- Make recommendation on publication.
- Submit Review

Organization Measurements/Monitors

- Organization Review Processes
- Clinical Process Review
- operative & Procedure Review
- Medication Management
- Blood & Blood Component
- Mortality Review
- specific Department Reviews



Autopsy requests and results, organ donation requests, Do Not Resuscitate (DNR) status and other such topics are usually covered in the mortality review. There is often a group of medical staff department-specific data summaries (trended over time) that should include at least:

- Total deaths, all departments and each department/service
- Overall mortality rate and mortality index with comparison data
- Number of deaths by specialty/section, major diagnostic category, Diagnostic Related Groups (DRG), or as specified in CMS mortality data summaries

In general, the clinical processes reviews fall into the following review categories :

- Indications/appropr iateness
- Preparation/dispensing
- Administration/performance
- Monitoring effects
- Patient education

Seven Essential Intervention Categories for Patient Transition to Another Facility	
1	Medication management
2	Transition planning
3	Patient and family engagement and education
4	Information transfer
5	Follow-up care
6	Healthcare provider engagement
7	Shared accountability across providers and organizations

Physician Monitoring:

Medical staff departments generally meet quarterly to review summary reports of quality management activities.

- **The overall effectiveness of physician/LIP participation in organization wide quality management/performance improvement activities, leader involvement, and participation on teams should be evaluated along with the department specific and Medical Executive committee activities**
- **This evaluation can be integrated into an annual organization wide reappraisal of the quality management/performance improvement strategy and approach.**

Nursing Monitoring:

- The nurse executive and other nursing leaders participate in and/or support all of the listed activities that impact the safety and quality of care provided to patients.

We should have national Database of Nursing Quality Indicators (NDNQI) to promote and facilitate the standardization of information on hospital nursing quality and patient outcomes.

Hospitals can compare their outcomes with others across the country.

Table 24: National Database of Nursing Quality Indicators (NDNQI)

National Database of Nursing Quality Indicators (NDNQI)
Nursing hours per patient day (NHPPD): RNs, LPNs/LVNs, unlicensed assistive personnel (UAP), and mental health technicians (for psychiatric units), with direct patient care responsibilities more than 50% of their shift, employed and under contract/agency
Patient days (for patient falls and nursing hours per patient day (NHPPD)
Patient falls (adult and rehab populations), plus data regarding injury level, prior risk assessment, restraint in use, prior falls
Pain assessment, intervention, reassessment cycle (adult/neonatal/pediatric populations): quarterly one-day prevalence study (first two pain cycles of 24-hour study period), including age, pain scale, type of pain, intervention
Peripheral IV (PIV) Infiltration (neonatal/pediatric populations): monthly one-day prevalence study, including # PIVs, age, gender, height, weight, PIV site, solution, extent of injury (Standards of Practice scale)
Pressure ulcer prevalence (adult and rehab populations): quarterly direct examination of all patients on designated day, including risk assessment prior to survey; age; gender; pressure ulcer prevention protocol; # ulcers; # hospital/ facility-acquired; # at each stage, e.g., Total # patients w/NPUAP-AHRQ Stage I, II, III, or IV ulcers / # patients in prevalence study
Physical restraints
Healthcare-associated infections: catheter-associated UTI; central line-associated blood stream infection; ventilator-associated pneumonia:

RN education/certification: highest nursing degree, plus specialty certifications for all full time, part time, and as needed employees with direct patient care responsibilities at 50% or greater time
RN satisfaction survey
Lactation consultant hours – Percent total lactation consultant hours supplied by RN; Percent of total lactation consultant hours supplied by agency staff of licenses categories; Total lactation consultant FTE per 1,000 live births
Unassisted falls
Patient volume (for ED, perioperative services, and ambulatory)
Device days (for CAUTI, CLASBI, and VAP)
Nurse turnover
Physical/sexual assault (for psychiatric areas)
Care coordination (for inpatients and ambulatory)
Births data (for hospital)
Nursing care minutes (for perioperative services)
Readmissions (for hospital, from Medicare's Hospital Compare website)

Patient Satisfaction Review:

- **Consumers now evaluate quality based on such criteria as:**

1. Access to practitioners.
2. Geographical access.
3. Service.
4. Relationship/connectedness/affinity.
5. Cost.

- As customers, the patients/members offer organizations vital information for validating quality of care and services, or for prioritizing needs for improvement in delivery processes.

- Feedback is based on perceptive quality and it may take the form of complaints, positive or negative perceptions of care, or even innovative ideas for improvement.

- **Patient satisfaction survey** is one of the **key factors** in quality management and performance improvement that **provides perceptive quality information and helps measure outcomes of care and service.**

Patient/member feedback mechanisms include:

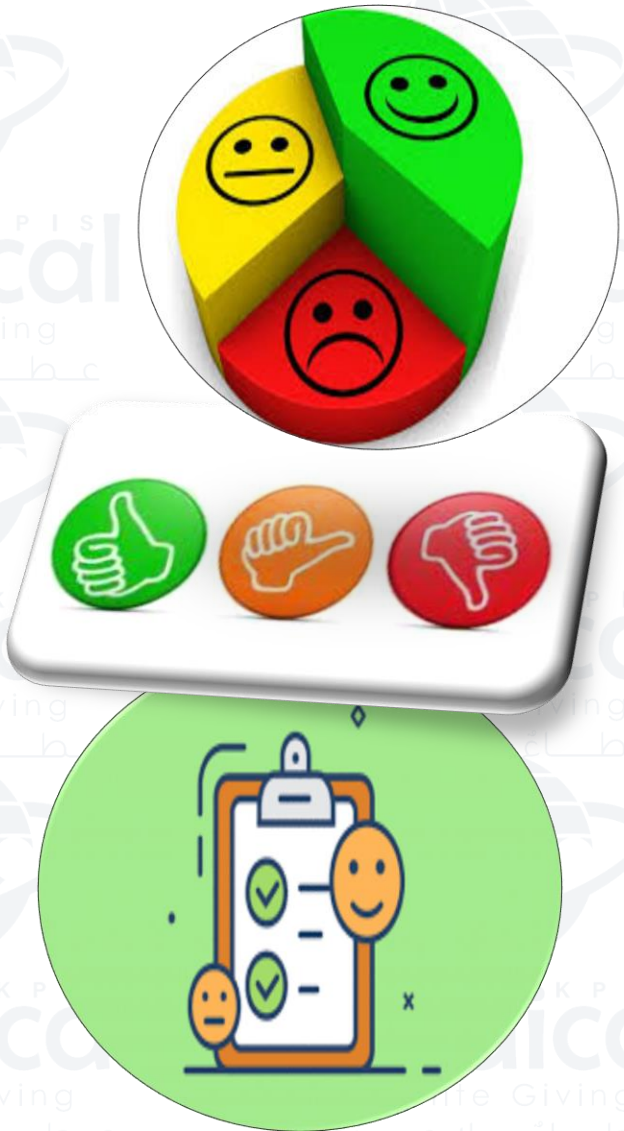
1) surveys/questionnaires (written and internet)
2) Telephone and face-to-face interviews
3) focus groups
4) internet email communications (questions, comments, etc.)
5) the complaint and grievance processes

Patient/Member Satisfaction Surveys:

- Patient /member satisfaction surveys are designed to measure performance and to diagnose sources of dissatisfaction.

➢ The survey (questionnaires) should be developed with consideration given to:

1. the length, language/reading level, layout, and size of type.
2. The survey should be offered to all patients all the time or on a periodic basis for example every 6 months for 30 days.
3. The survey could also be used with a representative sample of all patients all the time or all patients within certain categories, such as those on a specific unit, or having a particular treatment.
4. Use scale from (1 to 5) to assure that degrees of satisfaction or dissatisfaction.



- The facility must be cautious about distributing the survey to be filled out prior to discharge of the patient, as the patients may feel less open while they are within the confines of the organization.

- **Patient experience:**

  Focus on what they are thought and coordination of their health need.

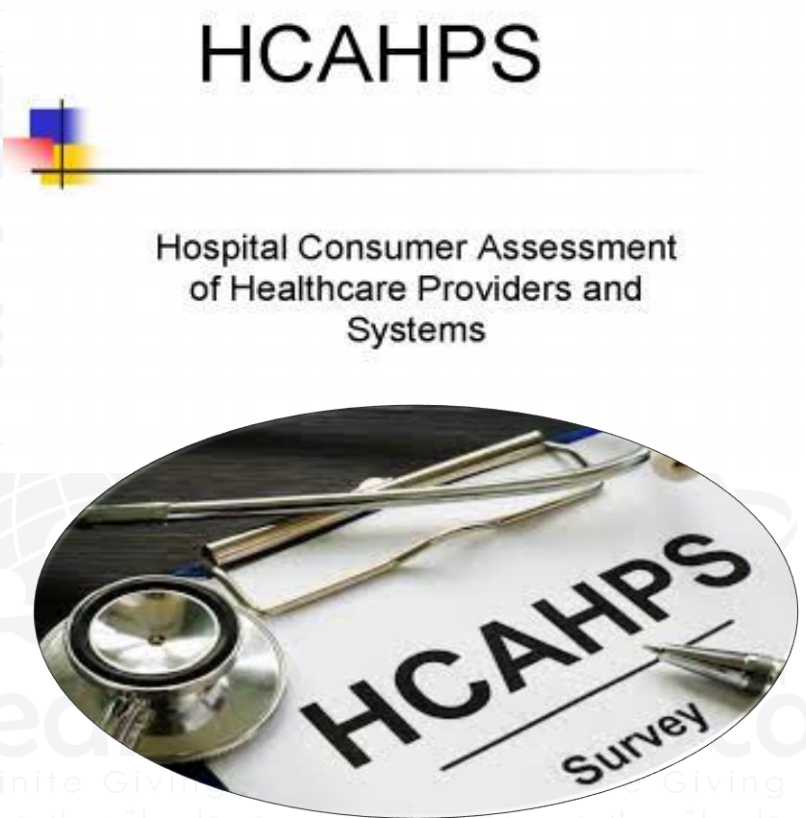
- **Patient satisfaction:**

  Focus on how satisfied the patients are with their care

HCAHPS survey:

- Survey **instrument** and data collection methodology for measuring **patients' perceptions** of their hospital experience.
- Importance of HCAHPS survey:
  1. **VOICE of patient** (view patient perception).
  2. Results are **publicly reported** (to see the impact of these result on our **reputation**)
  3. Keep hospital **financially strong.**

Patient will be surveyed 48hr till 6 weeks after discharge



HCAHPS survey:

HCAHPS Domain	Question
Nurse Communication	Nurses listen carefully to you
	Nurses treat you with courtesy and respect
Care Transition Domain	Hospital Staff took preferences into account
Doctor Communication	Doctors listen carefully to you
Pain Management	Staff do everything to help with pain
	Pain well controlled
Hospital Environment	Room and bathroom kept clean

Patient Interviews:

- Used more and more to assess patient adherence to treatment plans and satisfaction with care , to follow up on discharge plans, and to determine health outcomes.
- Patient interviews can be by telephone or in person (e.g. at time of follow-up office visit, home care visit, or planned return to Emergency Services).

- Follow-up interviews are being used by teams implementing clinical paths to evaluate the care process, specifically asking patients and families for suggestions to improve both the care and the process of care delivery.
- As with surveys, a face-to-face interview while the patient is still receiving treatment or prior to discharge may bias the patient to be less open about the answers.

Focus Group:

- **Focus Groups are small groups of persons (6-10) with like conditions or experiences who are selected by a sampling technique to interface with interviewers and each other, offering input about a predetermined topic or reactions to an idea.**

➢ ***Guidelines :***

1. **No right or wrong answers.**
2. only **differing points of view** We're tape recording,
3. **one person speaking at a time**
4. **We're on a first name basis**
5. You **don't need to agree with others**, but **you must listen respectfully** as others share their views
6. **Rules for cellular phones and pagers** if applicable.(For example: we ask that your turn off your phones or pagers. If you cannot and if you must respond to a call, please do so as quietly as possible and re join us as quickly as you can.)
7. My role as moderator will be to guide the discussion Talk to each other Opening question

➢ The recommended pattern for ***introducing the group discussion includes***:

(1) Welcome
(2) Overview of the topic
(3) Ground rules and
(4) First question

Patient Complaints & Grievances:

- The patient has a right to register a complaint or file a grievance concerning the healthcare organization or the quality of care and a right to timely review and resolution.
- The patient also has a right to multiple levels of appeal of denials of treatment, level of care, benefits, or coverage, and a right to timely review and resolution.
- Both hospitals and managed care plans must respond to grievances in a timely manner and must maintain a written record for each grievance

Complaint: is defined as a minor *verbal request* that can be resolved quickly. Examples of a complaint include complaints about ((the room temperature, housekeeping issues, food and beverage preferences, or changing the bed.))

- The patient must be informed as to how to file a grievance if the patient so desires.
- If the complaint is *a written complaint*, it automatically becomes a *grievance*.
- If the complaint is postponed for later resolution, referred to another staff member for later resolution, requires investigation and/or requires further actions for resolution, it becomes a grievance.
- A complaint is resolved when the patient is satisfied with the actions taken.

- If after the patient is discharged from the hospital, the patient or representative calls (verbal communication) regarding the patient care received, and it would have been treated as a complaint if it had been voiced as an inpatient, it should be treated as a complaint not a grievance. However, if it is in writing, or if the person voicing the complaint requests it be treated as a grievance, it must be treated as a grievance.

Appeal:

An application to higher court

Complaint or dispute concerning organization determinations

The determinations by the organization to approve or not allow certain treatments procedures or medications prescribed in their plan to be utilized are addressed through appeal procedures rather than grievance procedures

Organization determinations:

Decision we make about your medical benefits and the amount that we will pay for medical service, include payment , provision of care and out of plan service

Appeal Process

If there is a "denial" of authorization or payment for level of care (e.g., hospitalization) or treatment, the organization making the denial must permit appeal of the decision and must describe that process in writing.

➢ Appeal and grievance:

An appeal is a request that you make to Medicare or your Medicare Advantage or stand-alone **Part D plan** to reconsider its decision to **deny coverage of an item**, service, or medication. If your **Medicare Advantage plan refuses coverage**, it must send you a written notice that explains the reason for the denial and your appeal rights.

A grievance is an official complaint filed with your Medicare Advantage or Part D plan **if you are dissatisfied with the behavior or actions of your plan or its representatives.**

Ex: if your plan **refuses to pay for a lab** test that you received, then you should file ***an appeal***. The appeal will ask your Medicare Advantage plan to reconsider its decision to deny coverage of the test. If your plan is covering the lab test but ***you were dissatisfied with the plan's actions*** during the process (for example, a plan representative was unhelpful when you asked how to file an appeal), you ***can file a grievance***

Complaint	Appeal	Grievance
An oral expression of dissatisfaction(minor and can be resolved quickly. A person “register” a complaint ,generally about the process of care **Resolved once pt is satidfied**	A request to change a previous decision made by the organization. (**denial to pay**)	Formal expression of dissatisfaction about quality of care or financial issue. (**Usually written/may be oral**)

The analysis process:

- The trick is to know what to do with the data. We need a systematic way to aggregate, display, and analyze the data, even once it is "organized," to turn it into good information for decision making.
- First the data has to be submitted in a timely manner and delivered in the format that ensures it will be ready to use.
- Without these steps, we will have no opportunities to improve and/or no evidence of improvement.
- The analysis process operates most effectively *when* it is collaborative, with involvement of those most familiar with the process.

The analysis process answers one or more of the following questions:

1. What is our current level of performance?
2. Patient/family needs and expectations met?
3. Outcomes of care processes as expected?
4. What is the stability of our current processes?
5. Is there need for more intensive analysis?
6. Are there areas that could be improved?
7. Was a strategy to stabilize or improve performance effective?
8. Were design specifications of new processes met?
9. Are we consistent with our priorities for process improvement?

The questions are asked in advance of the data collection.

➢ The importance of analysis:

The data that is essential to answer the questions is clearly identified and defined as the first step in the monitoring process.

compare the aggregate level of actual performance for each indicator with the designated triggers /signals/benchmarks.

- Self compare.
- Comparison with others.
- Comparison with standard/guideline/regulation.

Self-comparison:

- Data *monitoring over time* is used by most of the healthcare organizations.
- The internal patterns and/or *trends over time* are utilized to identify the organization's improvement processes through the use of the upper and/or lower control limits or design specification levels, pre-established criteria or performance expectations, and single sentinel event or total number of occurrences.

Comparison with others:

- Assists the organizations in identifying how their data relates to the performance of similar processes and outcomes in other organizations (reference-based).

Comparison with standards/guidelines/regulations:

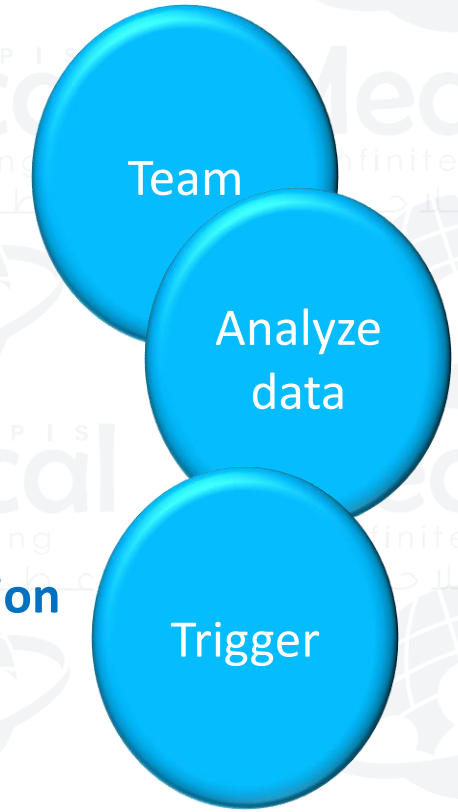
- Assists the organization with regulatory and accreditation compliance in designing new or redesigning old processes.
- Comparison with best practices and benchmarks can be either internal or external to the organization.
- The information on benchmarking assists the organization with identifying improvement opportunities and measuring the effectiveness of the improvements made.

Initial Analysis:

❖ For each process being monitored, the organization must first collect data to determine if the process is meeting the expected outcomes.

➢ **FIRST STEP:**

Identify the team, committee, department/service, or individual qualified and responsible for the aggregation, initial analysis or interpretation of the data and for in-depth/more intensive measurement and analysis if necessary.



➢ **SECOND STEP**:

The organization should secondly *specify time* tables for the data aggregation must be established. The data should be *analyzed at regular, adequate intervals* specified by the department/service/team/setting.
This should be determined based on the *volume* of patients, services, or procedures and consider the degree of impact on direct patient care, including risk of sentinel event.

THIRD STEP:

The analysis should be performed at the designated time intervals.

The analysis should include a review for *accuracy*, *validity*, and *reliability* of data.

- The organization should look for undesirable variation in data compared to baseline, previous measurement periods, or other appropriate comparisons and then determine if immediate action, continued measurement, or intensive analysis is necessary.

- *Lastly*, the organization should identify any individual cases or sentinel events requiring in-depth analysis and identify any obvious problems, patient risks, or opportunities to improve.

❑ Triggers for intensive analysis should be identified, including, but not limited to:

- ❖ Sentinel events
- ❖ Levels of performance or patterns/trends at significant and undesirable variance from the expected, based on appropriate statistical analysis
- ❖ Performance at significant and undesirable variance from other similar organizations Performance at significant and undesirable variance from recognized standards

Depending on the setting :

- Hazardous conditions (circumstances significantly increasing the likelihood of a serious Adverse outcome)
- Significant medication errors
- Major single or pattern discrepancies between preoperative and postoperative diagnoses , Including pathologic review
- Confirmed transfusion reactions
- Significant adverse drug reactions Significant adverse anesthesia-related events

Intensive Analysis:

- ❖ **Additional investigation or special study is initiated when undesirable variation in performance has occurred or is occurring presently.**
- ➢ **Intensive analysis is *performed by* those individuals who are *most familiar with*, and can best assess all facts of, the particular process or aspect of care or service .**
- ➢ **When prioritizing for intensive analysis the organization must include consideration of real or potential effect on patient care and service, available organization resources, and the organization's mission and priorities.**
- ➢ **These individuals must be able to evaluate appropriately aggregated and displayed data/information (totals, percentages, summaries, graphs), specific patterns and trends tracked over time .**
- ➢ **Intensive analysis seeks to identify and/or clarify opportunities to improve care and service processes, significant deficiencies/problems in care and service processes, the scope and severity of those problems and possible causes of problems/root causes of variations.**

Analysis Process Steps

1. Data is collected for prioritized performance measures and is ongoing and with targeted studies.
2. Ongoing systematic aggregation and initial analysis of data occurs with the frequency of aggregation and analysis predetermined/appropriate to measure(s).
3. Utilization of statistical tools and techniques are appropriate to the data collected.
4. The comparisons, internal and external, should be utilized to identify excessive or undesirable variability, unacceptable levels of process and outcome performance, and best practices.

((External sources for comparisons can be found in literature, evidence-based practice guidelines, performance measures, reference databases, standards.))

5. Intensive analysis occurs when indicated, if performance varies significantly and undesirably from the expected, other similar organizations, recognized standards, if sentinel event occurs, and/or if specific clinical events are triggered.
6. Determine if there is a need for change determined and possible changes identified.
7. the change is selected, plans are made for pilot/implementation across the organization, and/or new performance expectations or measures are elected.

Run charts display summary and comparison data over time

Control charts display variation and trends over time.

Pareto charts prioritize where to start work, and the type and cause of variation should be assessed.

DISSEMINATION OF PERFORMANCE IMPROVEMENT INFORMATION

- After the analysis has occurred, the results need to be reported throughout the organization and to external users.
- Without communication, the actions taken will not be utilized and incorporated into the processes where the changes are needed.
- Any one must be provided enough information for decision-making, to meet their responsibilities for maintaining and improving the quality of patient care.

- Everyone in the organization has a right and a responsibility to know and respond to the results of QM/PI activities, to which, they have committed.
- The governing body generally receives quarterly and annual summary reports. To reach the entire organization, summary reports of successful QM/PI activities may be reported at management meetings and then disseminated by managers and supervisors through staff meetings.
- Leaders may present QI/PI summary reports (e.g., balanced scorecard and strategic initiativ.es) at periodic and annual organization wide staff meetings.

Outcomes of the Analysis Process:

- Analysis may result in opportunities to improve systems, knowledge, and individual behavior.

Documentation of all monitoring and analysis activities must be completed and maintained for a period of time, as designated by the organization, accreditation standards, and/or state/federal laws.

Reporting to the Governing Board:

- A summary report of quality management activities must be provided to the governing body on a periodic basis as defined in the Quality Improvement Plan.
- Most organizations report to the Governing board quarterly with goal/benchmark and previous year comparisons, and then provide an annual summary report.
- Typical annual reports to the governing board include:
  - All process and system failures
  - The number and type of sentinel events
  - All actions taken to improve safety, proactively and in response to actual occurrences.

Table 30: Suggested Communication Methods for Reports

Items to be reported	Details
Aggregate and trend reports (monthly, quarterly, semi-annual, and annual)	- Feedback on relevant performance measures/indicators to teams, committees, departments, staff and leaders to: -- Maintain commitment -- Identify patterns/trends -- Encourage action -- Track unresolved issues for intensive analysis -- Track resolved issues to sustain improvement - Needed data to track performance daily, weekly, monthly, quarterly, annually, or on demand - Comparisons year-to-date, year to year, against reference databases and benchmarks

Quality improvement project reports (team activities)	- Initial project statement/charter - Project process/progress reports - Project summary reports and "storyboards"
Minutes addressing performance improvement	- Findings - Conclusions - Recommendations - Actions - Follow-up
Department/Unit Level	Email is not an effective way to communicate important information to others Many emails are never read and are simply deleted More effective means to communicate with department/unit staff include: Bulletin boards, White Boards, Posters Staff meetings Presentations Department/Unit Committees

Table 31: Performance Measure (Quality Indicator) Data and Information Reported to the Governing Board

- All key performance improvement activities, including (see also Performance Improvement Processes, this Chapter):

  -- Status of strategic quality initiatives;

  -- Status of quality planning and quality improvement projects for key processes;

  -- Significant patient care and safety issues identified, actions taken, and results, including sentinel/adverse events, root cause analyses, actions, and outcomes;

  -- Summary performance measure and trend data (prioritized by the governing body), as applicable to the organization, including, but not limited to:

  --- Balanced scorecard or dashboard data, including Enterprise RM, as applicable, including links to patient safety and quality of care
  --- Clinical outcome data for key functions or services
  --- National Patient Safety Goals compliance
  --- Adverse occurrence data/trends (actual and potential) and key rates, e.g., medication errors, mortalities, and as prioritized
  --- Risk management prevention and intervention activity summaries
  --- Pertinent cost data for key services
  --- Healthcare-associated infection rates and infection control activities
  --- Utilization trends: Admissions, patient days, encounters, etc., as applicable; average length of stay (ALOS); unplanned admissions/ readmissions; discharges against medical advice

--- Utilization trends: Admissions, patient days, encounters, etc., as applicable; average length of stay (ALOS); unplanned admissions/ readmissions; discharges against medical advice (AMA)/left without being seen (LWOBS)

--- Satisfaction survey trends: patient, staff (professional and organization)

--- Complaint trends: patient, professional staff, organization staff

--- Staff turnover/absenteeism and staffing effectiveness data

--- Patient wait times

--- Liability claims and other financial data, e.g., total claims and average cost per claim, cost per case, cost avoidance, cost of quality (COQ), and cost of poor quality (COPQ), denials of payment

-- External reviews/studies/reports

-- Performance appraisals

- Evaluation of contract services
- Summaries of media stories


Thank You!