Why is understanding clinical performance important?

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AHHA Monday 24th Sept 2012
It depends on how you define healthcare

• A Healthcare entity’s **core business** is clinical quality. This is how we will be judged in future

• Clinical Quality happens at the level of the clinician – patient interaction

• If we’re serious about improving health care, we have to understand and be able to influence what happens within that interaction
And how you think about performance in the new healthcare....

20\textsuperscript{th} Century
- Provider centred
- Clinicians as technicians
- Clinicians actively disengaged
- Price driven
- Knowledge disconnect
- Slow to innovate
- Reactive, episodic care – illness based
- Paper based
- Outcomes ignored
- Cost increases
- Safety static or worsening

21st Century
- Patient centred, team based,
- Clinicians truly engaged
- Driven by value to consumer
- Knowledge management
- Rapid innovation
- Health oriented
- Data in electronic form
- Outcomes measured
- Cost declines
- Safety improves
Understanding Clinician performance when...

- Shift to patient from provider
- From soloist to orchestra
- Continual improvement
- Systems focus
- Increasing accountability for quality – system and individual
And also on your thoughts about what performance is….

- Technical quality?
  - What we think is important

- Functional quality / Service quality?
  - What consumers think is important

- Political quality?
  - What somebody else thinks is important
Understanding clinician performance

“Professional competence”....

The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.”

Epstein R and Hundert E  JAMA 2002
It also depends on your perspective…
Chain of Effect for Healthcare

Health Care Environment

Organisational context

Clinical Microsystems

Patient and Community

Health Care Policy
  Government
  Societal
  Constraints and regulation

Organisation level management
  Translate policy into action

Clinical Service delivery
  Translating management into clinical outcomes

Recipients of care

Blunt instruments
  Policy
  Regulation
  Finance

Management instruments
  Personnel
  Organisational processes
  Finance

Clinical Practice
  Clinical rules
  Service design and structure
  Patient involvement

Interpreters of care
  Does care meet needs?

This is where healthcare happens
Government

- Wants to improve healthcare delivery and health outcomes
- And reduce the unit cost of care
- And maximise community trust

- But has very blunt instruments and measures
Doctors criticise own death of boy from drug-taking

Doctor not harmful

Kate Hagan
August 11, 2011

Members of an Australian medical group have condemned the death of a boy who was being prescribed a drug that may have caused his death.

A MELBOURNE doctor has been allowed to continue prescribing the drug.

The Victorian CMO has ordered a review of the case.

Doctors were not consulted before the drug was prescribed.

The clinic was Services for Children and Family Health, a debt collection agency for the Department of Human Services.

The boy was an 11-year-old boy who died of an overdose of the drug.

The doctor was not consulted before the drug was prescribed.

The Australian College of Pharmacy has expressed concern about the drug.

The drug has been prescribed to children and adolescents.

The Australian Medical Association has called for the drug to be removed from the market.

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Fact Sheet: New reporting obligations

From 1 July 2010 new reporting obligations will apply to all registered health practitioners.

Mandatory reporting obligation

Section 140 of the National Law requires that a registered health practitioner must notify the Board if, in the course of practising their profession, they form a reasonable belief that another registered health practitioner has behaved in a way that constitutes 'notifiable conduct'.

Notifiable conduct is defined as when a practitioner has:

1. practised the profession while intoxicated by alcohol or drugs, or
2. engaged in sexual misconduct in connection with their profession, or
3. placed the public at risk of substantial harm in their practice because they have an impairment, or
4. placed the public at risk of harm during their practice because of a significant departure from professional standards.

After 1 July 2010, registered health practitioners will be required to report to their National Board any registered student who, because of impairment, places the public at substantial risk of harm during their clinical training.

A number of exemptions from these mandatory notification obligations are set out in section 140 of the National Law. Each Board has also consulted on draft Guidelines to help practitioners understand their obligations under the National Law. The final Guidelines will be published on the website when they have been finalised. Practitioners should be aware of their mandatory reporting responsibilities.

Any registered practitioner who fails to report notifiable conduct on the part of a student may be found in breach of their obligations under the National Law.
Managing Medical Practitioner Performance Concerns
A Handbook for Managers
Organisations

- Want to maximise efficiency – use of available resources for greatest good
- Improve the health of users
- Meet external quality obligations
- Maximise their reputation amongst community and providers
- But are asked to use big picture tools to understand performance
Is this clinical performance?

## Financial performance

<table>
<thead>
<tr>
<th>Key performance indicator</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating result</td>
<td></td>
</tr>
<tr>
<td>Annual operating result ($m)</td>
<td>-4.5</td>
</tr>
<tr>
<td>Cash management</td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>&lt; 60 days</td>
</tr>
<tr>
<td>Debtors</td>
<td>&lt; 60 days</td>
</tr>
</tbody>
</table>

## Access performance

<table>
<thead>
<tr>
<th>Key performance indicator</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care (1)</td>
<td></td>
</tr>
<tr>
<td>Percentage of operating time on hospital bypass</td>
<td>3</td>
</tr>
<tr>
<td>Percentage of emergency patients transferred to an inpatient bed within 8 hours</td>
<td>80</td>
</tr>
<tr>
<td>Percentage of non-admitted emergency patients with a length of stay less than 4 hours</td>
<td>80</td>
</tr>
<tr>
<td>Number of patients with a length of stay in the emergency department greater than 24 hours</td>
<td>0</td>
</tr>
<tr>
<td>Percentage of Triage Category 1 emergency patients seen immediately</td>
<td>100</td>
</tr>
<tr>
<td>Percentage of Triage Category 2 emergency patients seen within 10 minutes</td>
<td>80</td>
</tr>
<tr>
<td>Percentage of Triage Category 3 emergency patients seen within 30 minutes</td>
<td>75</td>
</tr>
<tr>
<td>Elective surgery (1)</td>
<td></td>
</tr>
<tr>
<td>Percentage of Urgency Category 1 elective patients admitted within 30 days</td>
<td>100</td>
</tr>
<tr>
<td>Percentage of Urgency Category 2 elective surgery patients waiting less than 90 days</td>
<td>80</td>
</tr>
<tr>
<td>Percentage of Urgency Category 3 elective surgery patients waiting less than 365 days</td>
<td>90</td>
</tr>
<tr>
<td>Number of patients on the elective surgery waiting list (2)</td>
<td>1,645</td>
</tr>
<tr>
<td>Number of Hospital Initiated Postponements (HiPs) per 100 scheduled admissions</td>
<td>8</td>
</tr>
</tbody>
</table>

(1) Established benchmark targets for patient access to public health services. It is expected that health services show demonstrable improvement towards achievement of benchmark targets.

(2) The target shown is the number of patients on the elective surgery waiting list as at 30 June 2012.

## Service performance

### Key performance indicator

<table>
<thead>
<tr>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>96 to 102</td>
</tr>
<tr>
<td>1,439</td>
</tr>
<tr>
<td>1,499</td>
</tr>
<tr>
<td>1,550</td>
</tr>
<tr>
<td>1,652</td>
</tr>
</tbody>
</table>

### Critical care

| ICU minimum operating capacity | 8 |

### Quality and safety

- Health service accreditation
  - Full compliance
- Residential aged care accreditation
  - Full compliance
- Cleaning standards
  - Full compliance
- Infection Surveillance Clinical indicators
  - No outliers
- Hand Hygiene Program compliance rate
  - 65
- SAB rate per occupied bed days (2) $< 2 /10,000$
- Victorian Patient Satisfaction Monitor (OCQ) (4)
  - 73
- Consumer Participation Indicator (2)
  - 75

### Maternity

| Percentage of women with prearranged postnatal home care | 100 |

### Mental Health

| 28 day readmission rate | 14 |
| Post-discharge follow up rate (2) | 75 |
| Seclusion rate per occupied bed days (3) $< 20 /10,000$ |
Organisations also need to be engaged with their clinicians.

Enhancing Engagement in Medical Leadership

Medical Engagement Scale

Research has shown that medical engagement is one of the key factors to influence organisational performance. Are you interested in learning how engaged doctors are in your organisation, and ways this may be improved?

"NHS management includes both those who have clinical backgrounds and those who do not. Regardless of whether they have a clinical or non-clinical background, managers and frontline clinicians must forge a strong partnership, sharing successes or setbacks. In all cases, managers must be involved in the core business of clinical practice, helping, supporting and challenging clinicians to deliver the best possible care for patients."

High Quality Care for All: Next Stage Review Final Report, Department of Health 2008

Why is medical engagement important?

Medical engagement is seen as crucial in ensuring that health service changes are properly planned and effectively implemented. This has been highlighted in the recent High Quality Care for All: NHS Next Stage Review Final Report. Organisations where clinicians are engaged in strategic planning and decision-making perform better than those where clinicians are alienated from strategic processes of the organisation.

Why was the scale developed?

The Enhancing Engagement in Medical Leadership project is a UK-wide initiative being led jointly by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement. It aims to encourage doctors to become more actively involved in the planning, delivery and transformation of services and to help the NHS create a culture where doctors are much more engaged with the organisation in which they work.

As part of the project, the NHS Institute commissioned the development of a reliable and valid measure of medical engagement that would be quick and relatively inexpensive to use.

What does the scale measure?

The Medical Engagement Scale (MES) is designed to assess medical engagement in management and leadership in NHS organisations. The MES differentiates between the individual's personal desire to be engaged and the organisation's encouragement of involvement. It also includes a framework of organisational strategies to enhance medical engagement and performance. The scale is particularly useful in respect to strategic planning and service delivery.

Who developed the MES?

The tool has been developed by an external and independent company Alpha Research Ltd who will conduct all data analysis, prepare summary reports for each trust and maintain the comparative database.

How was it tested?

The MES was piloted in four trusts and was shown to have both face and construct validity. Three trusts undertook the MES in late 2008, with the resulting data being used to establish a normative database. A range of trusts (total and
Tools to drive engagement?

1.11.1 A valid and reliable performance review process is in place for the clinical workforce

1.11.2 The clinical workforce participates in regular performance reviews that support individual development and improvement
Consumers

- Own the system
- Want to receive quality care that meets their needs
- Expect competence
- Demand performance
- Want a sustainable system but don’t know what that looks like
- Can’t judge technical quality
- Accountability?
About Patient Opinion

Patient Opinion was founded in the UK in 2005 and since then has grown to be the UK’s leading independent non-profit feedback platform for health services. Patient Opinion Australia (POA) was established in 2012 and, similar to its UK counterpart, is registered as an independent not-for-profit charitable institution. Patient Opinion is about honest and meaningful conversations between patients and health services. We believe that your story can help make health services better.

How it works:

1. **Share your story** of using a health service
2. We send your story to staff so that they can learn from it
3. You might get a **response**
4. Your story might help staff to **change services**

**Share your story and help make our health service better!**

Patient Opinion regularly features in the national and local press, or you can find out what we are up to by visiting our [blog](#) or following us on [Twitter](#) or [Facebook](#).
Satisfaction or quality?

Situational factors

Service Quality

Product or “technical” Quality

Price

Customer Satisfaction

Personal Factors

Reliability
Responsiveness
Assurance
Empathy
Tangibles
Clinicians

- Deliver healthcare
- And want to deliver it well
  - Nobody wants to be a bad clinician
- Whilst being “professional’
  - Adhering to professional standards and cultural norms
Physician Clinical Performance Assessment

“the quantitative assessment of physician performance based on the rates at which their patients experience certain outcomes of care and/or the rates at which physicians adhere to evidence based process of care during their actual practice”

Able to ‘prove’ performance on the basis of technical quality?

adjusted colonoscopy completion rate 2007. data presented in batches of 10 as % completion rate
Attributes of performance measures of technical quality

- Evidence based
- Agreed standards for satisfactory performance
- Standardised specifications
- Adequate sample size – reliability
- Adjustment for confounding factors
- Feasible to collect and present data
- Attributable to the individual
Mortality for paediatric cardiac surgery, 1991-Mar 95 for open operations for children aged under 1 year using SCTS data with 95% and 99.8% control limits based on the national average.
The professions

- Increasingly describing a new professionalism.
- Based in various performance domains including technical quality, but also in behaviours, attitudes, approaches (non technical attributes)

- “demonstrable professionalism”
Informed reflection / informed performance
Supporting great performance
“Partnering for performance”

• Guiding principles
  • The vast majority of doctors are doing an outstanding job
  • Supports the relationship between organisations and clinicians
  • Embeds organisational support for individual performance
  • Peer based approach
  • A range of performance domains
  • Technical and functional quality
  • Support 'Demonstrable professionalism'
Chain of Effect for Healthcare

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Blunt instruments
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Interpreters of care
- Does care meet needs?

Manager
- Communicator
- Collaborator
- Advocate
- Professional

Technical Expert

Patient and Community

Clinical Microsystems

Organisational context

Health Care Environment
If we’re serious about improving health care, we have to understand what happens within this interaction. This is clinician performance.

This is why clinicians get out of bed!

We can’t manage it, we can only influence it.
All healthcare systems are perfectly designed to achieve the results they get.

It’s no surprise that we have a limited understanding of clinical practice.
Why understand clinical performance?

- **It is core business**
  - We’re dreaming if we think we can influence clinicians without understanding what they do
  - Central to genuine improvement
  - It requires will and good systems

- **Important for patients & consumers**
  - It’s their healthcare system

- **Important for clinicians**
  - Innate Professionalism
  - Reinforce excellence
  - Drive their engagement