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Point of View

Prevention of Relapsing Mediocrity: How to Maintain Performance Improvement in Hospitals

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Anyone experienced in performance measurement and improvement has felt the frustration of maintaining high performance levels. Complex systems that we frequently rely on in hospitals are subject to breakdown through distracting forces such as changing priorities, staff turnover without adequate training, shortcutting due to excessive workload, etc. These systems that are codified as policies, procedures and processes seem subject to unforgiving degradation. This predictable deterioration can be referred to as “relapsing mediocrity”. *How can one maintain high levels of performance?*

IMPLEMENTATION ISSUES

It is a basic tenet that processes and procedures should be simple and unambiguous in design. Complexity begets errors through the possibilities of poor handoffs, misapplication, etc. Secondly, complex processes are high maintenance systems that require more resources to keep them functioning at the top level. Managers often do not recognize, or overlook, this second reality. Resources for the ongoing orientation of new employees, refresher training for existing staff, performance measurement of sufficient frequency to be meaningful, periodic feedback reports at both the group and individual level, and, if necessary,

revision and retraining must be anticipated in order to avoid relapse (deterioration of performance). A myriad of once-touted creative initiatives that have fallen to mediocre levels because of lost leadership or shifted resource priority can be cited. While organizations can, with fanfare, implement data-based “best practices,” it can be difficult to sustain those initiatives.¹

The evidence is that reimbursement concerns have long had a higher priority than the quality of care, including patient safety. Concern for the accuracy of financial data in the hospital information system has exceeded the concern for accurate clinical data at the individual provider level. The funds to purchase software and consulting for fiscal services have exceeded those available for risk management and quality management. Quality managers’ failure to maintain many of the past improvements in performance has not helped to forward the argument for resources. Staffing levels of the typical medical staff office and quality management and risk management programs are usually very small compared to the expectations demanded by even the basic requirements of the Joint Commission. The reason seems related to the focus on *short term* “return-on-investment” priority in resource allocation. Organizations may be

reluctant to implement or sustain improved care practices unless they can project a financial benefit.² Clinical outcomes have only recently become a consideration in this decision-making process. There are and will be increasing financial consequences of quality problems that will work to shift this balance.³

HOLDING THE LEVEL OF PERFORMANCE

What can be done now?

Most important is the establishment of genuine organizational support. If there is not commitment and advocacy within senior management that includes willingness to create the proper organizational structure, develop and enforce the necessary policies and procedures and provide adequate resources, it will not be possible to sustain and improve the level of performance within the organization. “Proper organizational structure” is an organizational chart that groups the departments that are key to execution of the collection, performance monitoring, training for performance improvement, performance measurement, quality, risk management/patient safety, physician credentialing and profiling and all related reporting into one administrative division. The “necessary” policies and procedures must be writ-

ten to ensure coordinated, uninterrupted flow of information and data that enables accurate monitoring, measurement and reporting, and unambiguous delineation of accountability for performance of each function. "Adequate resources," at a minimum, means sufficient software and programming to relieve the staff of the mountains of paperwork involved in aggregating data from dissimilar and non-communicating databases to produce non-standardized, individualized reports to countless committees, managers and other publics. It also means providing funds for a dedicated position with Staff responsibility for oversight of the key aspects of performance measurement and improvement within the organization. This position should be viewed as similar to an internal auditor but with an expert level of familiarity with the tools of quality improvement and quality management. The authority to hold any group or individual at any level within the organization accountable for compliance with the established Performance Improvement Plan should be granted. Accountability and reporting should be to a top manager and/or the top Quality oversight body.

The next most important activity is the provision of feedback, formatted to be useful to the target audience. This usually requires multiple revisions to reach a report that conveys the intended information to a large majority of the users. This is the reason for the data collection and analysis and performance measurement. Without the feedback of results, the collection and analysis activities are wasted.

OTHER CONSIDERATIONS

As one confronts new issues requiring improvement, the process designed is likely to include new work for someone. It may be a simple item for documentation. *But, how long will it really take? How inconvenient is it within the existing workflow of the provider? Is it truly "simple" to do or is it going to place additional stress on individuals who already struggle to meet all the demands placed on their time? Will this "last straw" force a decision to trade one task for another or as a last resort, since documentation is audited, to supply false documentation?* Don't forget the relationship between workload and performance as one approaches capacity for added duties. It may require a work analysis prior to process implementation.

Prudent direct observation of how a process is actually being performed is often dropped from consideration since it can embarrass the observer and is perceived to demean the observed. None-the-less, this is an important function within the performance management program. Familiar examples are anonymous observation of hand-washing and use of a disclosing compound to measure housekeeping effectiveness. Some activities, such as pre-operative protocols to prevent wrong site surgery, are too important to leave any doubt as to whether there is 100% compliance. Documentation is not the same as witnessing it happen.

Don't forget the characteristics of memory that should influence planning for training and retraining. The simple rule is, the amount learned depends on the time spent learning.⁴ This, of course, is impacted by the quality of the teaching provided and how well accelerated learning techniques can be

applied. Also to be incorporated in the planning is the reality that there is a rapid loss of material that has been learned. The frequency of retraining is modified by the complexity of the process design, the critical rating of the process or procedure, and the frequency the task is performed.

CONCLUSION

No professional wishes to affiliate with an institution that is not committed to achieving and maintaining a high level of performance. Mediocre performance demeans the provider and inevitably results in patient harm and wasted resources. Prevention of relapse in performance levels requires planning, persistence and a reward structure that promotes performance advances. Inattention will result in frustration and rework that competes with new initiatives. The energy devoted to maintaining improvement levels should be valued as equally satisfying and beneficial to patients as efforts given to new improvement projects. It requires both to produce a high level of performance throughout the institution.

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