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Implementation of a clinical performance and outcome assessment program: lessons learned

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Objective:
To study physicians' compliance and attitudes with a clinical performance and outcome assessment program, specifically analyzing the affect of clinical setting, managerial intervention and work load.

Methods:
As part of the organizational strategy in Sheba medical center, a performance and outcome assessment model has been developed in order to handle medical and organizational control and improvement processes while supporting managerial decision making. The model is based upon the business concept of the "Balanced Score Card" that was adopted and refined to fit the medical arena and includes four perspectives: clinical, economic, service and crew resource management (CRM).

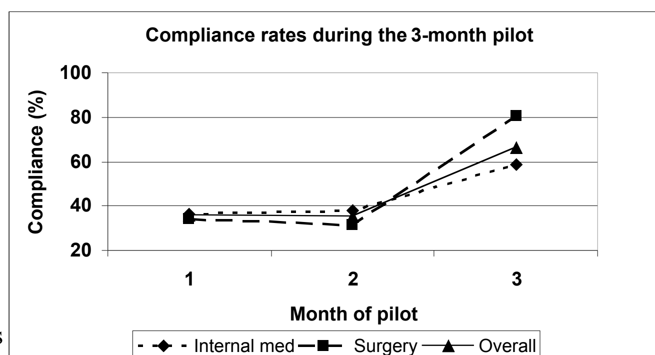
Data is automatically collected by a personal "check list sweep" from the computerized information systems. However, clinical performance data includes electronic questionnaires filled in by physicians for patients treated, on several time frames during the hospitalization.

We have launched the program as a pre-defined 3-month pilot study at two departments: internal medicine, and urological surgery. A briefing was done to all participating physicians before launch, and during the second month of the pilot feedback meetings representing compliance were held with department heads. We tested compliance of physicians with completing the computerized questionnaires. Work load for physicians was measured based on number of admissions to the department per physician and on department patient load.

A survey was handed out to all participating physicians. The anonymous questionnaire dealt with attitudes and knowledge toward the assessment program and the overall strategy. The physicians were asked to assign a score – 1 (lowest) to 5 (highest) - to indicate their agreement with each statement.

Results:
Overall, 33 physicians participated in the pilot, treating 1428 patients. During the 3-month pilot we have seen an overall increase in compliance rates from 35.6% to 66.3%, with compliance in surgery departments being significantly higher than in internal medicine (P=0.002). Following presentation of compliance rates during the second month, measures were undertaken by both department heads, with greater involvement by the head of surgery department. Indeed, the significant increase in compliance was observed from the second to the third month (figure). Work load, as represented by total patient loads in the departments, was significantly higher in internal medicine department vs. surgery (P=0.03). Compliance rates were found to be inversely related to work load (P=0.0012 on pearson correlation). On analysis of survey results we have found a positive correlation between compliance rates and the familiarity of the physician with the overall strategy and his understanding of the rationale.

Conclusions:
Successful implementation of a clinical assessment program requires a tailored intervention prior to program initiation, taking into account the clinical setting and work load, importance of managerial influence, and requires that staff be well familiarized with program objectives. Our conclusion allow us to better implement our assessment program within all departments of "Sheba Medical Center", and reinforces the importance of custom-made vs. generic quality assessment programs.



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