NCC_BSL_SteveJencks_03142016

Hi, I am Steve Jencks. I have been in quality improvement for years and years and years. And I wanted to talk to you now about a bite size piece of information or wisdom that has become very important as the quality improvement enterprise has evolved.

Let's call this the fable of perfection. Once upon a time, about 20 years ago, not long after the pros began to turn into QIOs, people began to look at timeliness of care in emergency rooms. And any of us who's been in emergency room can understand why they were worried about timeliness. They began to look in particular at how much time passed from the arrival of the patient in the emergency department to the initiation of care. And specifically for pneumonia, time from arrival in the emergency department to the beginning of antibiotics.

What they found was that about 15% of pneumonia patients were waiting more than eight hours for antibiotics, and nobody really thought they could defend this as good practice. So here we were with a problem. And what happened? Well, the first thing that happened was that this was publicized and the results were widely promulgated, QIOs went and spoke to many, many hospitals. Then in a couple of years a follow-up study was published. The percentage of patients who were waiting more than eight hours decreased, but it decreased from 15% to 13%. A lot of people had believed that if institutions only knew these problems, they would fix them and the people who thought that they felt very sad about the slow progress.

So the next thing that happened, many things happened, was that Premier came to CMS and said our hospitals will improve care a lot if we can provide some rewards. So Premier agreed with CMS as to how this was to happen, and they provided the rewards and the timeliness of antibiotics in pneumonia became very much better. Indeed it became so much better that the rewards could be lost by having one patient who waited more than eight hours, a single missed deadline was enough to keep the hospital from getting a reward. So now performance in most the successful hospitals in Premier was pretty nearly perfect by this measure. And this is where the learning begins.

Because we began to hear stories that were not quite so reassuring. The first story that began to be heard was of patients who looked as if they might have pneumonia but didn't. But it turned out they got antibiotics too, just to make sure the deadline was not missed. And at the same time other stories began to emerge about hospitals that were putting nurses full time on monitoring the care to make sure that none of the things on which they might get reward would be missed. Now the problem of course was that that didn't necessarily mean that everything else was done perfectly. But this process did produce results and it was expensive and it was inefficient. But it was worth the reward.

And the third thing that happened was that a bunch of professionals who were very serious about improving care began to be seriously concerned that this was not what they had had in mind, that an obsessive focus on one measure just was wrong. And so what happened next was that people began to [inaudible].

Now the moral of this fable is a little complicated. Parts are simple. The first of these parts is that it is worth asking how perfect you want to be. And when you ask that question you need to have two things in mind. One is familiar, that is the cost of having people running around, checking charts, checking numbers and contributing not much to the actual improvement of care because care is, by this time very good anyway.

But the second part of this moral is more important [inaudible] so, and that is that most measures are imperfect. They have false positives and false negatives. And if you create a system where the whole aim is to avoid having false negatives, that is the whole aim is to avoid not treating somebody who should be treated, then what you are going to do is treat people who don't need to be treated. Maintaining that balance is a real challenge of process of care measures and pursuing perfection can really have a third effect, which is that it's not very good for morale if you are pursuing more perfection than the clinicians think make sense. They began saying we are just counting beans, we are not improving care.

And so we need to sort of take the fourth moral from this, which is in some ways the hardest one to get people to be reasonable about, and that is that it's not a sufficient reason for doing something that's not very smart, to be able to say that CMS told you to do it, that the joint commission told you to do it or somebody else told you to do it. You need ultimately to come back to exercising good clinical judgment.

Now given that, what do we do, because you are not going to say either that it's all right constantly not get the care to the patient or not do what you intended to do. First of all you have to keep in mind that the move toward measuring outcomes, which is very strong, has more logic to it, than just counting the number of things that are important. That is we're not just moving toward counting survival or kidney failure or injuries, rather than counting the number of people who get their medications on time, in order to have something that's more meaningful to patients. We are also doing it because it permits us to get passed a lot of judgment calls that it's very hard to get paid right if you are doing process of care measures.

Possess of care measures have been built into the DNA of the care. But for a lot of folks, and that would include CMS, are subject to joint commission are beginning to realize that they are only a part of the story. What we are being pressed to is to go to the things that matter because they get out of rules that are too rigid for science [inaudible].

So now let's just try to sum this up, to get your teeth and jaws around this bite sized [inaudible], and talk about the idea that process of care measures were especially useful when we were starting to do clinical quality improvement, where we really needed to have things that had a solid science foundation under them and on which we were very confident that we could achieve improvement. Where the quality movement has evolved, has evolved a lot. We are taking on far more challenging issues like patient evaluations and their care, readmissions and a lot of outcomes, for example surgery and medical care as well. That shift is something you need to be aware of because when your DNA tells you that you are not doing what you learned to do when you were in medical school or nursing school, the message is right but it may be a good thing rather than a bad thing and I wish you luck in making it work. Thank you.