The Role of Program Personnel in Driving Quality Processes and Outcomes

By Susan Heck

In evaluating success in any disease-specific program, three focal points should be evaluated, 1) the people who deliver care, 2) processes and technology that support this delivery of care, and 3) the achievement of metrics that ensure quality of care. Thus, it is essential to clearly define the roles and contributions of the program leaders and personnel, the important processes that must be developed and adhered to, and the technology that can provide the necessary support for both the people and the processes. In this article, we will compare and contrast the essential areas of focus across both the cardiac and stroke/neurosciences service lines.

The Role of the Service Line Administrator: Cardiac Services

For most cardiovascular (CV) service line administrators, the responsibility for quality and safety resides at the top of their priority list. Surely, competing in the local or regional marketplace, growing program services, and/or attracting top physician talent will prove difficult if the program's foundation is not based on a solid-quality framework that produces excellent results. Given their full and varied scope of responsibilities, the CV service line administrator cannot be embedded in the minutia of operational items, such as data collection and analysis, but rather, an over-arching understanding of the all of the elements of quality that span the service line is required, along with basic knowledge of how the program performs.

Corazon advocates that the CV service line administrator be paired with key physician leaders for programs such as cardiac surgery, congestive heart failure, cath lab, and so on, to ensure that quality metrics are identified, captured, and analyzed in a meaningful way. This information can then be used to for internal benchmarking and also benchmarking with national best-practice standards.

The Role of the Service Line Administrator: Stroke/Neuroscience Services

The stroke/neuroscience ("neuro") service line administrator must likewise be laser-focused on the processes and systems of care that drive quality across many care areas for a diverse neuro patient population with varying levels of acuity. Connecting these care areas around patient-centric and time-responsive communications takes vigilance. Therefore, surveillance and interactions by the service line administrator at the points of care, concurrent with patients' acute care experiences, can lead to optimal outcomes.

Indeed, there are many care processes known to drive best-practice outcomes, and often these processes serve as key quality metrics to be identified, measured, and used — some even before patient discharge (rather than retrospectively to change future care delivery). Metrics where care can still be improved while the patient remains in the acute stay episode should undoubtedly be the priority focus of point-of-care surveillance. Key examples include intense statin therapy being prescribed, patient education, and antithrombotic therapy at discharge. The opportunity is actually two-fold: improving patient care, while also capturing the real-time window of staff and physician comprehension — a standard goal for the service line administrator role.

Generic Elements to the Service Line Administrator Role

The service line administrator, regardless of clinical specialty, must be focused on quality, but there is also the added responsibility of formulating and driving outcomes in three additional areas:

1. Financial and growth outcomes;
2. Satisfaction and perception of care outcomes; and
3. Quality of life or functional outcomes.

Corazon recommends that each of the above areas contain internal metrics that include a baseline, benchmark, goal, data source, and performance trends. At least one performance improvement (PI) or new development initiative should be underway within each of the three additional outcome areas (beyond the first area of clinical outcomes).

For instance, a metric example and PI initiative in the area of financial and growth outcomes is to examine the breakout of stroke volume by DRG Level (DRGs 064, 065, and 066) separately vs in aggregate as a means to assess the effectiveness of documentation, and capture of complications and co-morbidities. Taking a deeper look into quality of life (or functional) outcomes is another metric example. New development initiatives may include the Modified Rankin Score, a selected depression screen, or the Epworth Sleepiness Scale to screen for sleep apnea.

Next is leadership. Corazon experience has proven that the design and oversight of the service line is most successful through a dyad leadership model with a program medical director and administrator. These two

leaders can then facilitate a multidisciplinary committee leading the service line. The essence of this committee's success lies in the work before and after the actual committee meeting, wherein the leaders work with champions (as assigned initiative leader) for each initiative or topic to make progress in their work, and communicate their achievements or challenges in succinct committee documents.

Additionally, successful leaders coach the champion on presenting information with a focus on driving committee interaction, achieving consensus, and ultimate decision-making around the initiatives. This may be harder than the dyad leaders doing the work themselves, but imperative to the ultimate success of the team. This approach, however, takes time and a commitment to team development for the eventual success of the full service line overall.

Lastly, an increasingly important function for both service line leaders is post-acute care patient navigation. Typical items include post-discharge phone calls, which can expand to patient surveys, tracing adherence with the post-acute plan of care, and navigating next steps in the unfolding care plan. With avoidance of readmissions being a strategic priority, this newer and maturing aspect of the service line administrator's role is an exciting and important professional development opportunity.

The Data Collection/Coordination Role in Cardiac Services

In many mature cardiovascular programs, personnel within the base department (e.g., cath lab, cardiac surgery, heart failure clinic, etc.) have assumed responsibility for the necessary data collection. This is often accomplished by designating a portion of someone's role to this effort or by delineating a unique role and job description with a focus on data. Unfortunately, there is not a "one-size-fits-all" answer to the best approach. Our team recommends that regardless of the approach, the responsibility cannot be relegated to getting the data collection and submission done only when there is time. This task must be a priority, considered part of the daily work. For instance, in the cath lab, data needs often fall to the bottom of the to-do list, which results in leaders missing opportunities to correct clinical fall-outs in real time.

Cardiac services enjoy the advantage of a 20+year history of cardiovascular information system (CVIS) development. In fact, the focus on data and benchmarks in cardiac services has been the foundation for similar developments of data collection/information systems for other clinical services. For example, early efforts to interface physiologic monitors in the cath lab to feed CVIS systems were important for cath lab efficiency and the ability to build standardized reports to document intra-procedural activity. Clearly, there is an opportunity to leverage these efforts as interventional services are expanded and developed for the stroke/neuroscience population.

The Data Collection/Coordination Role in Stroke/Neuroscience Services

As a component of each metric on the neuro dashboard, a data source should be identified. Selecting metrics includes an individual evaluation of the benefit versus burden of obtaining reliable data for the identified metric. For example, metrics spanning all four aspects of a stroke program's outcomes should be chosen so a balanced dashboard representing the "big picture" is formulated. The role of the service line administrator is to receive this data from many sources, compile it in a dashboard, and review the information as a means to distill key trends – both good and bad.

That said, many hospitals also voluntarily collect and submit patient-level data to The American Heart Association (AHA) Get with the Guidelines (GWTG) Stroke Registry Databases operated by Quintiles. Corazon also offers the software application Cerebros as an option to manage the stroke patient population and collect and analyze stroke patient data in real time. The Cerebros application has actually been designed to feed the GWTG registry through an automated .csv upload file. Both systems provide robust report-writer supports that obtain the majority of clinical and process metrics in many data cuts.

Typically, this data abstraction, and all of the data input, does not require a program administrator to perform the work, but in some smaller facilities, the administrator must "wear many hats" and assume this responsibility. With the enormity of this singular aspect of patient-level data, many programs find their resources exhausted and fail to take the steps to include metrics in other areas. Thus, they never have the full capability to examine or understand the whole program, which can fail to bring improvement opportunities to light.

The Challenges of Database Participation

In today's highly competitive healthcare environment, the development and integration of information technology (IT) to support clinical process of care and quality outcome measurement brings great results, though this effort remains one of the largest challenges. Hospitals across the country are scrambling to meet the escalating demand for discrete clinical information, while also struggling to dedicate the resources necessary to do so accurately and adequately.

Participation in national or statewide databases continues to be a vehicle to benchmark organizational performance against peer or national samples. Sometimes database participation is voluntary, and other times it is mandated by states or the Centers for Medicare and Medicaid Services (CMS). For instance, participation in the American College of Cardiology National Cardiovascular Data Registry (ACC-NCDR) Implantable Cardioverter Defibrillator (ICD) Registry is required by CMS for hospitals to receive payment for these costly implants. This can be contrasted with participation in the ACC-NCDR Cath and PCI [percutaneous coronary intervention] registries, which can be voluntary or required for state accreditation processes (such as in Pennsylvania). For primary stroke programs to be certified in many states, the achievement of certification

standards requires participation in databases such as Get with the Guidelines or the Coverdell Registry.

Embedded within the current registry requirements is the need for credible data to support ongoing quality improvement processes. Also important in this process is the enforcement of a standard approach to documentation, so that important metrics can be captured consistently and in the same format to assure that documentation mirrors a consistent care process. Technology's foundational role in the development of a continuous quality improvement (CQI) model cannot be overstated.

However, it is not all about technology. Best-practice organizations are working to find the appropriate balance between their investment in IT technology and the human resources that are necessary for collecting data and assuring its integrity. This balance implies a conscious effort to understand the true cost of technology advancements and the investment in the people and processes already in place.

Personnel Pitfalls and Solutions for the Service Line Administrator

Increasing numbers of hospital and health systems have service lines at the core of their organizational structure, with strategic plans crafted, and outcomes aligned, to budgets and performance goals. These are the savviest organizations that build a foundation for ongoing success. But, even with a solid structure in place, the service line (regardless of specialty) can be challenged to perform effectively when key positions are vacant.

Service line leaders and data collection roles often pose recruitment challenges, as it takes time to develop the necessary skills and talents if internal staff members are promoted to these roles. Vacancy, often due to high turnover in these key positions, is an all-too-frequent interruption in service line development. Therefore, it is important to know the pitfalls that often initiate turnover in these roles, along with their solutions so as to avoid vacancies.
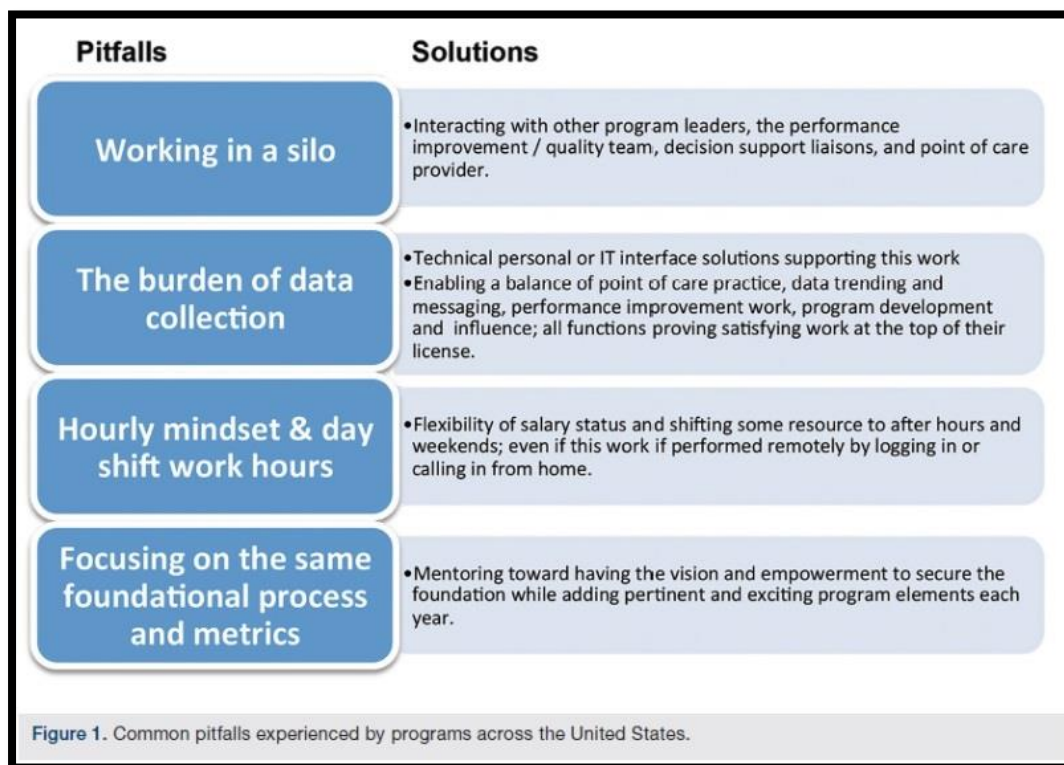

Pitfalls	Solutions
Working in a silo	• Interacting with other program leaders, the performance improvement / quality team, decision support liaisons, and point of care provider.
The burden of data collection	• Technical personal or IT interface solutions supporting this work • Enabling a balance of point of care practice, data trending and messaging, performance improvement work, program development and influence; all functions proving satisfying work at the top of their license.
Hourly mindset & day shift work hours	• Flexibility of salary status and shifting some resource to after hours and weekends; even if this work if performed remotely by logging in or calling in from home.
Focusing on the same foundational process and metrics	• Mentoring toward having the vision and empowerment to secure the foundation while adding pertinent and exciting program elements each year.

Figure 1. Common pitfalls experienced by programs across the United States.

Figure 1 identifies some of the most common pitfalls in our experience with programs nationally, along with an accompanying solution that Corazon would recommend to a client struggling with recruitment or retention of talent for these key service line roles.

Recommendations

Organizations are continuously challenged to do more with less. The Corazon team often finds that different departments spend a significant amount of time and resources collecting what is essentially the same data. Often, the stroke coordinator collects the same data that the quality department collects. Likewise, the cath lab data

coordinator may be collecting many of the data points that are collected by the Society for Thoracic Surgery (STS) data coordinator. A programmatic approach should be taken in order to collect each piece of data in a coordinated, organized fashion, later sharing and distributing the information. Therefore, our oft-repeated motto: collect the data once, and use it many times.

Administrative and physician leadership must work to assure data integrity, and then commit to using the data in a robust review and reporting process. As our team conducts assessments at programs across the county, it is not unusual to find evidence of quality issues in older reports — quarter after quarter. Information must

immediately be analyzed and acted upon in order to vigilantly improve quality outcomes. A rigorous quality oversight process must have its foundation in the data, but also must be viewed and scrutinized though a focused dyad (administrative and physician) lens to identify opportunities for improvement and action.

Successful service lines are always working to develop people, processes, and technology to support the delivery of quality, cost-effective care. How does your program measure up? The answer to this question could indeed make the difference between clinical, operational, and financial success or failure, in 2016 and beyond.

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