



IQI Insights **Volume 2, Number 3, Summer 2010** ***Setting a Performance Goal***

A Note to the Reader:

IQI Insights is a series of brief informational pieces from the AAAHC Institute for Quality Improvement. Our focus is on enhancing quality and safety through educational activities. In this series, we hope to provide you with the opportunity to learn more about basic issues and concepts associated with quality improvement in ambulatory health care. These short documents are not meant to provide in depth or complete information; however, we hope that they will increase your comfort with these topics and perhaps, lead you to seek additional information. We welcome your feedback.

Sincerely,

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Introduction

This *IQI Insights* focuses on setting a performance goal for a quality improvement (QI) activity (please see AAAHC Standard 5.II.B. 2). As with all of the AAAHC Institute for Quality Improvement's *IQI Insights*, this one is limited in scope to addressing key issues.

What Purposes Do Performance Goals Serve?

Performance goals provide:

- 1) A performance “*target*” for your QI activity
- 2) Information that will let you know *whether the issue* you have chosen for your QI activity *is frequent or severe enough to warrant corrective action* or if you need to consider another issue.

Using certain processes for developing performance goals can also provide ideas about the *source(s)* of the issues you are examining, so that *more effective corrective action(s)* can be planned.

Why Do I Have to Set a Performance Goal So Early in the Quality Improvement Process?

In the QI process, once you identify a potential important problem or issue (AAAHC Standard 5.II.B.1), you are supposed to set a performance goal (5.II.B.2)—even before deciding how to measure (5.II.B.3), actually collect information (5.II.B.4), etc. This timing may seem too early in the process to know what a performance goal should be. On the other hand, if you wait until you have the initial data on your performance, will that influence the goal you set? Will this lead to setting a goal you *know* you can attain with minimal corrective action?

Given that you don't know what your performance is when you set a performance goal, what sort of processes are there to set the performance goal in a realistic and appropriate manner? Let's consider some alternatives to use to set performance goals:

- Guessing
- Significant sustained improvement from measurement results
- Clinical practice guidelines and benchmarking [1]

Guessing

Without *any* information other than common sense and experience, the first alternative some may consider for setting a performance goal is guessing. Let's use an example from the game or sport of darts to illustrate the problem with guessing; guessing may not only give you a “target” that is not near the “bull's eye” but isn't even on the same wall as the dartboard!!! Further, guessing doesn't provide you with much information about what could be causing a problem or how to correct the problem. Although this may seem to be the only alternative, that is not the case.

Significant Sustained Improvement from Measurement Results

A slightly better option (than guessing) for setting a performance goal is aiming for “significant sustained improvement.”

Via a monitoring project, internal benchmarking, or pilot study, you may have already collected data on your issue. Unless your performance is perfect (100% *influenza immunization* of all appropriate patients or administering *prophylactic antibiotics* within 60 minutes of incision for all appropriate patients)—and therefore you need to consider another issue for your QI activity—your goal will be 5%-10% improvement over current performance over a sustained (several month or longer) period of time. Yes, this is setting your performance goal from your measurement results, but it does not allow you to set a goal that you *know* you can attain with minimal corrective action. What are some of the problems with this method of setting a goal?

- If the issue isn't flu shots or antibiotic timing, we may not know what “perfect” is—for example, what is “perfect” for *patient wait time*?
- Where we do know what “perfect” is supposed to be, is it attainable in “real life?”
- Continuing to use the dartboard analogy from above, 5-10% improvement (or more) may still be pretty far from the bull's eye (at the edge of the dartboard or on the wall nearby).
- You may not have gathered much information about the cause(s) or solution(s) to your problem.

Since it is mentioned, let's look at how we could set a goal for *wait time*: Organization A has completed an internal benchmarking [1] study and practitioners have already reduced the wait time (the time the patient checks in to the time the patient is brought back to the exam room, prep, or operating room) from almost an hour for some practitioners to 45 minutes, on average, for each of its practitioners. That's much more than a 5% to 10% improvement! Patients haven't complained; but sometimes the waiting area can still become a "little" crowded. So, Organization A might assume that 45 minutes is the "gold standard" (or "bull's eye").

Clinical Practice Guidelines, Research Literature, and Involvement in Benchmarking Activities

When you read the "significant sustained improvement" examples of *flu shots* and *antibiotic timing* on the previous page, you may have asked "Who says what 'appropriate' is and sets the bar at 100%?" The flu shots and antibiotic timing *examples are from clinical practice guidelines*. National medical specialty societies and others develop guidelines from evidence and expert opinion, in order to provide recommendations for improving health care delivery. An important part of developing the guideline recommendations is defining the "appropriate" patient populations and once these are defined, some guidelines may suggest 100% compliance with recommendations is an appropriate (short term) performance goal.

When you see 100% compliance recommendations in guidelines, you must consider what *barriers* (and possible solutions) there are to 100% compliance. This information may be contained within guidelines themselves or research literature developed from the measurement of real world compliance with guidelines. Here are a couple of examples.

Compliance with antibiotic timing guidelines: if a prophylactic antibiotic is recommended (depending on the type of procedure being performed and the patient) in Centers for Disease Control and Prevention (CDC) guidelines [2], the recommendations also include very specific recommendations for timing the administration of most antibiotic prophylaxes within 60 minutes of first incisions.

- Think rationally about your organization's ability to comply with this guideline. For example—what happens to antibiotic timing when the a case runs long and the next patient has already received the recommended antibiotic prophylaxis because you don't want to "push" the antibiotic too fast but you want to have the patient ready when the surgeon is ready?
- A search (5/10/2010) of the research literature, using the US National Library of Medicine Medline (via <http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed>), and the search terms "antibiotic timing compliance," yields a wealth of information about issues associated with compliance and what a realistic goal (benchmark) may be. Now, you should look in the search results for research that appears to most closely resemble your setting and that can give you ideas that may help you improve [next page: references 3 -4].

Compliance with immunization guidelines: the CDC also has recommendations for annual influenza immunization for adults with certain risk (medical, occupational, lifestyle, etc) factors or who are over 50 years of age. [5]

- Consider what sort of issues may interfere with your organization's compliance with this guideline. For example: what if you have a very transient patient population (example: student health services) or issues of "medical record scattering" (example: immunization information from the Indian Health Services [IHS] RPMS system versus state registries, prior to 2005 [6])?
- A search (5/10/2010) of the research literature, using the US National Library of Medicine Medline (via <http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed>), and the search terms "influenza immunization compliance," provides several ideas about issues associated with annual vaccination compliance (such as the importance of having a regular provider [7]) and what a realistic goal (benchmark) may be. Now, you should look in the search results for those items that most closely resemble your setting (for example, replace "compliance" with "Native American" in your search terms for IHS populations or add "adolescent" to your search terms for information more relevant to student health services) and ones that can give you ideas that may help you improve [7].

Let's go back to our "wait time" example, where there aren't any clinical practice guidelines to indicate what an appropriate wait time goal is and peer-reviewed research literature offers little to nothing in the way of relevant benchmark information. Here is where external benchmarking [1] can provide guidance.

When we left Organization A (on the top of page 3), 45 minutes met and exceeded their patient wait time performance goal. However, Organization A has now become involved in an *external* benchmarking study and sees that some peer organizations (Organizations C, G, N, with similar provider bases and similar patient loads and services, etc.) have average wait times of 20 to 25 minutes. Organization A would not know whether a shorter average wait time than 45 minutes, or how much shorter a wait time goal, is realistic without the information received from Organizations C, G, and N. Organizations C, G, and N's average wait times of 20 to 25 minutes, suggest that 20 to 25 minutes is a more realistic/appropriate goal for Organization A to try to accomplish than 45 minutes. Further, if information is gathered from Organizations C, G, and N regarding the processes they use to move patients from check in to the exam, prep, or procedure room, Organization A can try these to help shorten their own patients' wait times.

Summary

Appropriately framed performance goals are important to QI activities because they give organizations targets (information on what they are striving for in their QI activity) that can be used to judge if an organization has a problem and how big the problem is. Also, the process of setting these goals may provide information about potential reasons for the problem and ways to correct the problem.

Although guessing and setting significant sustained improvement goals are options when setting goals, they are not optimal. By doing the "legwork" to find out whether there are relevant clinical practice guidelines or research that can provide information on actual performance from organizations like yours (benchmarks), you are more likely to develop not only more realistic/appropriate goals, but also find information about possible barriers to optimal performance and ideas for corrective action. When a search for relevant guidelines and research literature leaves you empty-handed, by becoming involved in a benchmark study you can obtain information on realistic goals and processes that have been used successfully to reach performance goals.

Additional References and End Notes—please note: references to web sites or products are not endorsements.

NOTE: The National Guideline Clearinghouse (www.guidelines.org) is a source of extensive guideline information available via the internet.

[1] See the Spring 2009 *IQI Insights* on benchmarking and the Fall 2009 *IQI Insights* on clinical practice guidelines. From the *Accreditation Handbook for Ambulatory Health Care* benchmarking is "a systematic comparison of products, services or work processes of similar organizations, departments or practitioners to identify best practices known to date for the purpose of continuous quality improvement. Internal benchmarking compares performance within an organization, such as by physician or department, or over time."

[2] Mangram AJ, Horan TC, Pearson ML, Silver LC, Jarvis WR. Guideline for Prevention of Surgical Site Infection, 1999. Centers for Disease Control and Prevention (CDC) Hospital Infection Control Practices Advisory Committee. *Am J Infect Control*. 1999. 27:97-132.

[3] Braxton CC, Gerstenberger PA, Cox GG. Improving antibiotic stewardship: order set implementation to improve prophylactic antimicrobial prescribing in the outpatient surgical setting. *J Ambul Care Manage*. 2010. 33:131-140.

[4] Wax DB, Beilin Y, Levin M, Chadha N, Krol M, Reich DL. The effect of an interactive visual reminder in an anesthesia information management system on timeliness of prophylactic antibiotic administration. *Anesth Analg*. 2007. 104:1462-1466.

[5] Advisory Committee on Immunization Practices. Recommended adult immunization schedule: United States, 2010. *Ann Intern Med*. 2010. 152:36-39.

[6] http://www.ihs.gov/epi/index.cfm?module=epi_vaccine_projects

[7] Hueston WJ. Does having a personal physician improve quality of care in diabetes? *J Am Board Fam Med*. 2010. 23:82-87.