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INSIDE

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Evidence-Based Practice Should Be Goal for Everyone

Evidence-based practice is a proven approach for hospitals as well as individual physicians and nurses, but it is not always easy to implement beyond a project-by-project approach.

Generally, evidence-based practice is described as the integration of clinical expertise and opinion acquired through one's training and experience; evidence gathered from scientific literature and from data about the patient; and the patient or caregiver perspectives regarding values, priorities, and expectations.

Evidence-based practice can improve quality of care, lower costs, and prompt better patient outcomes. However, inadequate knowledge and skills, along with a lack of leadership support, can hamper attempts to fully embrace evidence-based practice. Competing organizational priorities and limited funding also can prove challenging.

The deployment of evidence-based practice in healthcare minimizes unnecessary variation in practice, says **Kim Pardini-Kiely**, director in the clinical and operational excellence and innovation services practice with the consulting firm Protiviti in San Francisco. Evidence-based practices are based on published scientific evidence and are used in medicine, nursing, and other clinical services, she notes. Such practices guide clinical decision-making, which results in better patient outcomes.

"Evidence-based practice can take many shapes, from standard order sets to clinical protocols for treatment of disease and medical conditions. For example, a standard order set for a surgical procedure can direct the most appropriate use of preventive medications, such as antibiotics," Pardini-Kiely says. "An example of a clinical protocol is for the administration of blood and blood products, which would set when to administer blood products by setting indications for transfusions."

Evidence-based practice is best implemented by consensus and developed by bedside clinicians using the evidence-based research, she says. A broad representative group should be convened and guided by the use of common improvement methods such as

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lean healthcare or design thinking. Evidence-based practice should be approved and supported by oversight bodies such as the medical executive committee or nursing practice councils.

"The biggest challenge is breaking down long-held beliefs about how best to manage patient care and getting the team to embrace newer, more compelling evidence. Overcoming these challenges is best managed by developing a deep understanding of current beliefs and practices, and then working together to design an approach that focuses on better outcomes," Pardini-Kiely says. "Changing practices is hard because it often includes a change in beliefs and behaviors. Giving clinicians an opportunity to understand why the change is necessary and to be a part of designing new practices is essential to achiev[ing] success."

The most common mistake made with implementing evidence-based practice is taking a top-down approach, Pardini-Kiely says. Just publishing evidence-based practice in an organization and telling clinicians to use them is ineffective, she cautions. Leaders from medical staff, nursing staff, and administration need to engage not only clinicians but also the distribution of the evidence-based practice, she says, paying particular attention to the workflow that supports the ease of use of guidelines.

Hospital Revises Processes

Rady Children's Hospital-San Diego used evidence-based practice to develop a process that aligned organizational culture, underlying infrastructure, and staff training. Other institutions can use the same method to develop practices and documents based on the best evidence to support patient outcomes, says **Suzan R. Miller-Hoover**, DNP, RN, CCNS, a nurse scientist and owner of SRMH Consulting in Pine, AZ. She worked with Rady on the evidence-based practice project.

Working with other hospitals, the evidence-based practice team at Rady identified challenges related to infrastructure, including fragmented resources, inconsistent guidance, and lack of organization. They determined clinical units operated under their own standards of care, and that policies and procedures often varied among units.

The team developed a standard of nursing care for all patients and standardized documentation. They also consolidated standing orders and standardized procedures. The group eliminated duplications and inconsistencies, reducing variations in care for staff who floated among different units. *(More information on Rady's experience is available online at: https://bit.ly/2YuvHqD.)*

Miller-Hoover is a clinical nurse specialist who focused much of her education on evidence-based practice. She describes evidence-based practice as taking research data and putting it to work in a hospital in combination with a nurse's experience and the particulars of the patient population. Combining those elements into the most effective way to provide patient care is at the heart of evidence-based practice, she explains.

"It's important that everything we do in nursing and physician care has been researched, but that often is not enough for getting the most impact from that research," Miller-Hoover says. "You have to bring that research into your organization, find all the right players, and develop a

way to incorporate that research with what your people know and what you know about your patient population."

Clinicians May Resist

Some of the common challenges with implementing evidence-based practice involve clinicians who are not sure what this approach entails, beyond what they know generally as good medical and nursing skills, Miller-Hoover says. It is important to educate them on evidence-based practice and gain their trust when trying to fully implement evidence-based practice.

In the case of Rady Children's Hospital, that effort was aided by the fact the hospital was participating in a nine-month program involving a consortium of medical facilities in the San Diego area. Participants focused on learning how to read research and ascertain its value, and how to apply the findings to their own organizations.

A hospital seeking to fully and effectively embrace evidence-based practice needs a champion who is enthusiastic about the initiative, Miller-Hoover says. This person does not necessarily have to be a top executive, but this champion needs to be able to work with senior administration and clinicians.

The Rady team also worked closely with the quality director to be sure the evidence-based practice team was complying with all applicable quality directives and compliance requirements.

"The most important lesson I took away from the experience was that administration absolutely has to be on board because evidence-based practice is not inexpensive," Miller-Hoover says. "For example, the group of clinical nurse specialists and I had to meet weekly for a year just to hash out the policies and procedures and standardize things. Without the administration's approval, our directors probably never would have had been able to let the nurses out of the units they worked on."

As the team moved forward with changing standards of care and creating uniform practices, Miller-Hoover says it was essential the administration knew what they were doing and were supportive.

"Everyone should make an effort to implement evidence-based practice. Study the research, find out the why behind it, then look at your nurses' experience to see if it is something that will fit," Miller-Hoover says. "That's what evidence-based practice is all about, taking what is known to work and generalizing it down to your population. Not all patients are the same. You may have to tweak it to your nurses' experience and your patient preferences."

Evidence-based practice is one way healthcare organizations and individual clinicians can manage the wealth of information on which they are expected to stay current and apply to their patient care, says **Robert Dean**, DO, MBA, a cardiac anesthesiologist and senior vice president in performance management with Vizient, in Holland, MI.

"Particularly now with COVID-19, there is so much evidence coming out, and it's changing all the time. What we knew three months ago doesn't seem relevant in some ways," Dean says. "We're always looking for the best way to do something from a clinical standpoint. It can be hard to know what to do with data. [The data] seem legitimate, but might not be a complete match with what you know of your own patients and what your own experience tells you."

Evidence-based practice addresses the fluidity of medicine and the changing outlooks on what physicians, nurses, and other clinicians originally learned, Dean says.

"Many of us are trained to do certain things in our resident or our postgraduate training. While it is current at the time, many clinicians stick to that training even when they are years out into practice," Dean says. "That makes using evidence-based practice challenging sometimes. I've had partners who say, 'This is the way I've trained, and this is the way I'm doing it.' It's really incumbent on other clinicians to help pull together the current information on a regular basis in order to say,

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'Yes, we trained this way to treat perioperative hypertension. Now, the evidence shows that there is a better way to reduce patient mortality and morbidity, improve compliance, and have better long-term results.'"

To make any impact on reluctant clinicians, the people pulling together that data and urging new pathways need to be fellow clinicians, Dean says. These are not just clinician leaders, but also physicians and nurses who are respected in the organization for how they stay updated on current best practices.

"That's a key there, having not just an outside voice that says this is the best evidence but using people within your organization who have that day-to-day credibility," Dean says.

Hospitals should make the data available for review and also make time in clinicians' schedules for them to discuss the research and how it might be applied to a care pathway, Dean offers.

When working with the Transformation of Clinical Practice Initiative with the Centers for Medicare & Medicaid Services (CMS), which helped clinicians move from a fee-for-service environment to a value-based environment, Dean and his colleagues monitored four criteria: hemoglobin, hypertension control, smoking cessation counseling, and depression screening.

After collecting data for a year, Dean's team saw no real improvement in the numbers, even though they were emphasizing how to use evidence-based care with those practices. Dean and colleagues asked the practice organization leaders why the effort was not successful.

"They said it was because we really don't have performance improvement capabilities in our practice organizations. We haven't made time during the week or the month to regularly review our data, look at what the evidence is and how we are complying with that," Dean explains. "There is a structure and process component to implementing evidence-based care that isn't always there. If people don't make time for it, it really never is fully or successfully implemented."

More Important Than Ever

Evidence-based practice applies across the board to all clinical specialties and settings, Dean says. It has become more important recently because so many people have avoided routine care for chronic disease or new disease onset because of the COVID-19 pandemic, he observes. It will be more important than ever to use evidence-based practice to optimize the care of these patients who may have lost progress in their disease management or who have become more seriously ill before receiving treatment.

"I think evidence-based care has never been more important than it is right now," Dean says. "Those organizations that have value-based payments, in an ACO [accountable care organization] or in a shared saving program where their payment is based on how well they manage these patients, really require the use of evidence-based practice. I think we're going to see a shift in the next few years of more organizations moving toward that value-based payment. To do well there, they are going to have to adopt evidence-based practice."

In addition to its adoption throughout an organization, individual physicians, nurses, and other clinicians can pursue evidence-based practice, Dean notes. Clinicians tend to be lifelong learners, and many must stay abreast of current research to meet state licensing requirements.

"There are performance measurements. Most organizations, through their quality departments, are using process measurement to look at things like how often you use ACE inhibitors for heart failure," he says. "Everyone is being measured these days, by payers and organizations you're affiliated with, and CMS — even consumer ratings, in a way that didn't exist 10 years ago. It is important for physicians and others stay up to date because others are monitoring and measuring their performance. Evidence-based practice is the best way to provide excellent care."

Care Practices Not Uniform

Healthcare interventions based on evidence are the gold standard for high-quality patient care, according to **Charles Tuchinda**, MD, MBA, president of Zynx Health, a company based in Los Angeles that assists healthcare organizations with evidence-based quality improvement.

"The unfortunate truth is that we haven't quite gotten to a state of practice where people routinely deliver all the correct evidence-based interventions to every patient," Tuchinda says. "We see variations in clinical practice from what we define as best. The goal for anyone in quality improvement should be to increase the use of those evidence-based interventions, and that will lead to more effective care, with a lower risk of complications."

Evidence-based practice is about more than just keeping up with the latest research, Tuchinda notes. Medical studies are reported at such a rate that the typical clinician cannot keep up with all the latest findings in their own fields, much less research from

other fields that still may be applicable to care decisions, he says.

Some research also requires a public health or epidemiological background that most clinicians do not have, he notes. For those reasons, a formal evidence-based practice approach is necessary. The hospital or other healthcare organization provides insight into the latest research, and then assists clinicians with understanding how it applies to them and their patients.

All areas of healthcare are adopting evidence-based practice, Tuchinda notes.

"It is the standard of care now. Evidence-based practice is the norm. Frankly, if you have variations from it, you are creating liabilities for yourself and the institution," he says. "When you think about how you actually put it into practice and drive those quality measures, you have to think about what are the key interventions that you have to do to make sure the patient gets on the right track. The body of information out there is overwhelming, but you have to find the key nuggets, the things that, even if you forget everything else, are going to drive your mortality, your morbidity, the lengths of stay."

Play on Competitiveness

Even that is not enough if physicians are reluctant to follow the information provided. Tuchinda notes that physicians tend to be competitive and will respond well when presented with a comparison of their performance against their peers.

"Physicians hate it when you tell them they are performing poorly or they are in the bottom 25%. That was a big motivator for me to receive a report like that. I was highly motivated to find out what I could do differently," he says. "Once you give people the knowledge and tools, you still have to drive them to make the change. There was a time when people thought that if you just put it in the process, then things will get better. But we've seen that variances still occur. That speaks to the fact that there is a human part of this."

The transition to value-based care has spurred evidence-based practice by incentivizing healthcare organizations to produce the best data on patient care, notes **Dana Bensinger**, MSN, RN-BC, an informatics nurse specialist and client solutions executive with Computer Task Group in Buffalo, NY. With outcomes dramatically affecting the bottom line, hospitals and clinicians have become more open to hearing what others are doing and which practices have been most successful, he says.

"The key elements in evidence-based practice is the evidence itself, the clinician's judgment, and the patient population. Being able to understand what others are doing and what applies to your patient and your practice is key," Bensinger says. "In the past, people were more comfortable saying they knew best and saw no reason to change. Value-based care has pushed them to be more open about what others are doing and what they might adopt."

Bensinger says the COVID-19 experience may prompt healthcare organizations to make evidence-based practice more agile. The rapidly evolving, and often conflicting, research on the coronavirus prompted some concerns that evidence-based practice could not adapt as rapidly as needed, he says.

"I think we're going to see more agility, an effort to get evidence-based guidelines out faster than we have before," Bensinger says. ■

SOURCES

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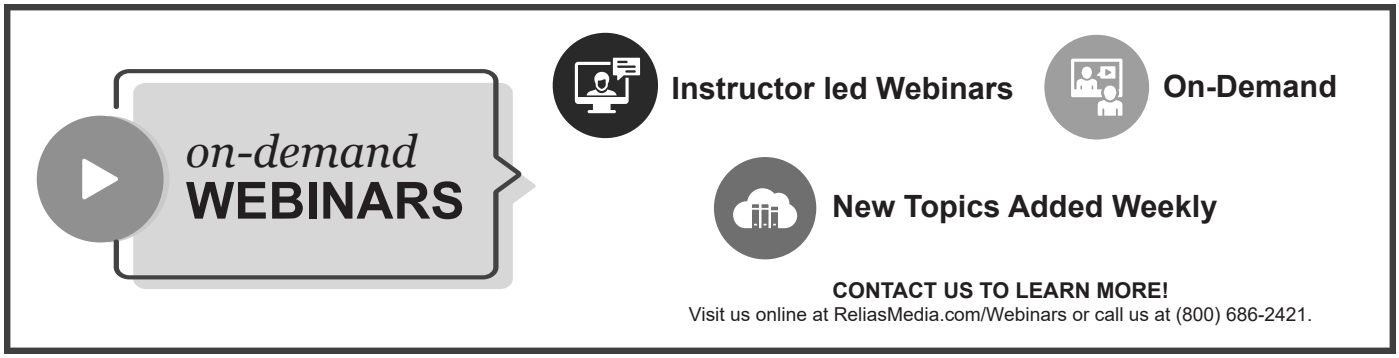

After Identifying Best Practices, Implement Them Effectively

It is not enough to identify and accept evidence-based practice regarding any particular form of patient care. The evidence must be put into practice in a way that is effective, notes **Charles Tuchinda**, MD, MBA, president of Zynx Health, a company based in Los Angeles that assists healthcare organizations with evidence-based quality improvement.

"Once you know what you should be doing, you have to make it easily accessible to physicians. That often means putting it into a physician's workflow. That usually means building it into the electronic health record so that you can bring [best practices] as close to the bedside or patient encounter as possible," he explains. "You're trying to make it easy for the clinician to do the right thing, easier than doing the wrong thing or doing nothing at all. Order sets, care plans, and alerts can all be tools for delivering evidence-based care."

The goal should be for a patient to experience evidence-based practice throughout the entire care journey, Tuchinda says, from admission to discharge. But it is important to present the evidence-based care suggestion at the right time in the process. An emergency physician will ignore, and possibly be frustrated by, a reminder about the medications a cardiac patient should receive on discharge.

"You want to make sure vital interventions show up at the right time. The challenge after you know what to do is finding the right spot in the workflow, and making sure your organization is doing it consistently," Tuchinda adds. ■

Hospitals Cut Common Infection Cases by Half with Scalable Process for System Goals

Typically, healthcare mergers have not led to consistent improvements in quality and outcomes. Research suggests mergers may cause a quality decline. When hospitals in Massachusetts were facing a merger, leaders sought to address the quality issue head-on and achieved substantial improvements in some categories, including a reduction in *Clostridioides difficile* cases.

When leaders from the Lahey Clinic and Beth Israel Deaconess in Cambridge, MA, announced their intentions to merge in 2017, multiple facilities took the opportunity to set quality goals that would improve outcomes and value. Years later, the newly formed Lahey Health System has made significant improvements, including a significant reduction in *C. difficile* cases.

When merger talks began, participants held learning sessions and roundtable discussions to confirm the system's commitment to providing high-quality, high-value care, says **Barbara A. Savage**, director of performance measurement at Beth Israel Lahey Health. Quality goals were set with input from local leaders and a chief quality officer, says **Richard Iseke**, MD, chief quality officer at Beth Israel Lahey Health.

The initial quality improvement meetings led to a set of consensus-driven goals with appropriate threshold, target, and outcome criteria for incentive-based programs. The goals they set were reducing readmission rates, reducing *C. difficile* infections, and improving the patient experience.

Lahey assembled a forum for chief medical officers and chief nursing officers. That was expanded to include the quality and risk leaders from each facility or organization, along with patient experience leaders, physician-hospital organization leadership, human resources and employee health, and the chief medical informatics officer. The chief quality officer and system performance measurement director worked together to develop a reporting calendar that would be used to set data submission dates. Data were reviewed in the forum before submission to the system and entity boards. Any deviations from the goal pathways were discussed in the forum, and the affected entity presented plans for addressing the problem.

Over three years, the effort produced significant improvement in reaching goals set by the health system and also in metrics related to performance on commercial value-based contracts, Iseke reports.

New Merger Revives Goals

Then, in 2019, Lahey Health System merged with seven other hospitals to create Beth Israel Lahey

Health. Again, hospitals sought to improve service rather than succumbing to a possible downgrade in quality. Participants used the Lahey Health System framework to establish goals with broad consensus of leadership, Iseke says.

The board of trustees developed four goals based on the recommendation of the 10 hospital boards and their quality leaders: reducing *C. difficile* cases, reducing hospitalwide readmissions, improving Hospital Consumer Assessment of Healthcare Providers and Systems responsiveness scores, and creating an ambulatory measure focused on diabetes care.

Even deciding on the goals so soon after the merger was an accomplishment, says **Yvonne Cheung**, MD, MPH, chief quality officer and chair of the department of quality and safety at Mount Auburn Hospital in Cambridge, MA, part of Beth Israel Lahey Health.

"These are all institutions that, the day before the merger, were competing. The day after, they were sharing data and collaborating on best practices," she says. "One of the best things we did was to have everyone meet in person and build relationships face to face. Then, it became easier to share data, show what we did well, [and] what we wished we were doing better."

The health system focused on *C. difficile* because rates were high at the facilities, Iseke says. These infections affect patients significantly and put a heavy burden on staff.

Cheung notes *C. difficile* is a preventable hospital-acquired complication, making it a compelling choice for the health system's quality improvement goals.

To reduce *C. difficile* cases, the health system focused on total cases to facilitate communicating goals and progress throughout the system, Iseke explains. Individual hospitals established goals that would improve value-based scores.

There were 389 *C. difficile* cases in the health system in the 12 months ending March 31, 2019. Quality leaders endorsed the initiative in April 2019, after which the chief medical and quality officers began sharing best practices for standardized testing protocols and antibiotic stewardship programs.

The improvements had been established in most of the hospitals by September. From there, the quality team monitored monthly scorecards. For the 12 months ending March 2020, *C. difficile* cases were down nearly 50% from the prior year.

"When we expanded to the bigger hospital system, the quality working group was able to expand and spread the model that had been successful before. [We] have been, collectively, able to move the needle, with a lot of great knowledge and information-sharing," Cheung says. "We went from competitors to collaborators."

Savage notes the *C. difficile* strategy and other interventions all were evidence-based. "It was all about how to apply the evidence from randomized trials so that it will actually work to achieve the better health outcomes that we're trying to achieve in the real world," she says.

Board Wanted Faster Results

Iseke notes the effort in the first merger resulted from a challenge the health system board issued. During the second merger, administrators wanted to see even faster improvements.

"We essentially set up the classic structure-process-outcome model. We set up a structure to bring people together from all the organizations on a regular basis, to review the needs of the patients, the community, our staff, the board, our clinical leaders," Iseke says. "We came up with a matrix of goals that were common to all of our organization so that we could select what we should focus on."

With the assistance of an outside consulting firm, the team used various quality maps to score goals based on how many of those aims a goal would hit.

"There was a fair amount of negotiation, but we used evidence-based medicine to show what we thought could be achieved. We also used trend lines to show what could be achieved in a certain period," Iseke says.

"We used Vizient data, CMS [Centers for Medicare & Medicaid] data, BlueCross data. We also brought in our ACOs [accountable care organizations] and primary care contracting groups so that everyone was on the same train going in the same direction," Iseke continues. "We set up a series of measurements and reviews and in-depth reviews with institutions that were lagging."

One of the hospitals joining the Lahey Health System had been performing better with *C. difficile* than the other facilities. Thus, a quality leader from that hospital showed the other facilities how to include some of the best practices that worked well. Soon, the other hospitals were showing better metrics.

"The system created a learning network and a friendly competition to adopt what was working and to drop what wasn't," Iseke says. "When we came into the Beth Israel Lahey Health system, we had multiple institutions and multiple EMRs [electronic medical records]. We ...

showed that you could take the same model and scale it to three times the number of institutions."

Whole Health System Affected

The team believed *C. difficile* affected the most people across the health system, Iseke says. All parts of the health system could contribute to improving *C. difficile* rates by optimal use of handwashing, antibiotics, and testing criteria, as opposed to some goals like readmissions and patient experience that some entities in the system could not affect so directly.

"We thought if we ever could bring the group together to use evidence-based medicine, it should be on *C. difficile*," Iseke says. "We also had organizations in the earlier health system that had remarkably low rates. When we began to compare what they were doing, it turned out to be less around handwashing and more around being very detailed about strict criteria for locating, testing, and follow-up. *C. difficile* showed us that if you go after goals in a very rigorous, dramatic way, you can make dramatic improvements. Then, those practices can be applied to other quality goals."

For example, a chief medical officer or chief quality officer may not be able to discuss *C. difficile* rates and testing, perhaps deferring the question to the infection control department.

That should be a red flag, Iseke says. "A chief quality officer and medical officer have got to know those details. If you don't have those two working as partners, you will end up with some gaps in your process. That often leads to the results you don't want," he explains. "*C. difficile* taught us some of those lessons, and we've now applied some of that knowledge to readmissions. For that goal, we found out that the quality officers and chief medical officers were trying to do too much themselves, not assigning people to carry out some of the team tasks and holding them accountable." ■

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Transparency, Organization Improve Relations with Board, Top Execs

Quality improvement professionals know their efforts will be more successful when they gain the support of the hospital board of directors and top executive leaders. However, it can be difficult to obtain this backing. Organizing data and intentions properly, as well as transparency regarding current operations, are key.

The C-suite is critical to achieving quality and patient safety objectives at any hospital, according to **Richard Becker**, MD, senior managing director with ToneyKorf Partners, a management and advisory firm in New York City specializing in the healthcare industry.

Becker says leadership engagement tracks directly with accomplishing outstanding results. Hospital boards and top executives should help make the hospital or health system a high reliability organization (HRO), in which the organization achieves and continuously maintains excellence in quality and safety across all services.

Becker explains HRO performance is built around these three major areas:

- Leadership committed to the goal of zero harm;
- A culture of safety throughout the organization that allows and encourages all staff to report anything that would negatively affect the organization, its patients, and staff;
- An empowered workforce that employs specific tools to address improvement opportunities they find to drive significant and lasting change.

"Every member of the C-suite must be tirelessly and continuously engaged in developing this approach and culture," Becker says. "Without leadership that both communicates and demonstrates these principles and behaviors, the hospital will never achieve the level of excellence it seeks."

Quality improvement professionals should build on the desire of board members and top executives to be associated with a top-quality organization, Becker says.

"Every board wants to be proud of its hospital. Such pride can only be as great as the quality of its services," he says. "A good quality leader makes

sure that leadership is informed and communicates with them the existing state and the desired goals of quality at the hospital. Once the board understands the organization's current performance and the pathway to improve, getting buy-in and support for specific initiatives is relatively simple — as long as the board reviews the plan and sees the C-suite's leadership commitment to and accountability for accomplishing the objectives."

Follow Same Principles on Projects

For any new quality improvement projects, the principle is the same, Becker says. An effective quality leader should engage the board about the issue, help them understand the pathway to improvement, and clearly identify realistic timelines and resource requirements. This allows the board to see a fully informed view of the request for support, he says.

"Ultimately, the board must understand that achieving excellence in quality is the cornerstone of the organization," Becker stresses. "Great quality builds value and attracts patients, physicians, nurses, and staff, which all supports the hospital remaining in good financial health to sustain its mission."

Working closely with top leadership will assist hospital quality and patient safety professionals with the complex task of developing organizational quality and patient safety objectives, Becker says. That support will improve the ability to design and implement tactics to achieve those targets, and then continuously monitoring and communicating the results.

"The ultimate performance of a hospital ... depends on not only the approach to quality but also the results and outcomes," Becker says. "Gaining support and buy-in for quality goals from all stakeholders is, therefore, critical to the organization's long-term sustainability."

It is important for every person in the organization to understand their roles in supporting and contributing to the overall quality and patient safety in the hospital, Becker says. Quality comes down to team performance, and it is the individuals on the team who determine the effectiveness of every quality project and program.

"Buy-in begins with stakeholder participation in developing quality objectives. Hospital quality managers should work with unit-based teams and clinical medical services that include all stakeholders from relevant disciplines to identify gaps in the process and performance of various quality, safety, and efficiency metrics," Becker says. "These goals are prioritized with the strategies and tactics to achieve them. While not always obvious, it is important to include clinical and nonclinical support departments that are integral to implementation, analysis, and even funding of various quality initiatives."

Once these alignments are "baked-in," accomplishing the goals becomes a mantra and part of the organization's top priorities, Becker adds.

Include Frontline Employees

Essential to gaining buy-in is a process that solicits information and solutions from the front-line providers and staff rather than one that dictates or mandates the best answer to an ongoing issue. Often, the care delivery team will have the right answers and, if asked and empowered, will own the solution and execute it to achieve the desired outcome, Becker observes.

It is important to identify quality champions in every clinical service area of the hospital.

"Quality departments are generally small and nimble in most hospitals, which does not allow the quality manager to monitor and advance every project, every day when, in fact, this level of attention is required to achieve the targeted results," Becker says. "A frontline project champion or leader who can motivate and monitor colleagues to

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execute on specific initiatives will ensure success and create a grassroots pride throughout the hospital as performance and reputation improve."

All this should be part of a board-approved, comprehensive, organizational quality and patient safety plan that clearly defines and identifies objectives, timelines, resources, responsibilities, and methodology of performance improvement.

"This plan, which should be shared with stakeholders, becomes the living document that serves as both the framework and roadmap for accomplishing and maintaining excellence in quality and safety," Becker says.

Transparency Vital to Success

Transparency and communication about current performance are important to establish a baseline and focus relevant groups around the existing vs. the desired results, Becker says. Monitor, report, and communicate widely the ongoing performance. Without this, it becomes too easy for stakeholders to lose their focus and sense of urgency. "Data-driven processes help healthcare organizations make the right decisions. When decisions are not supported by data, organizations are less likely to move in directions that help achieve their goals," Becker explains. "Develop structures that clearly identify a common purpose, lay out goals and expectations, establish effective communication, provide coaching and feedback, and set up consequences for both positive and negative outcomes. Lack of a clear accountability structure often results in failure to effectively execute a plan and achieve the intended goal." Becker says it also is important to prioritize. Identify the most significant challenges and focus resources around them to ensure successful outcomes.

"While every organization wants a five-star performance in every measurable area of quality, most organizations do not have the resources to tackle every objective at once," he notes. "It is much better to focus on a finite number of areas with positive results than to overwhelm the organization with aggressive goals and timelines that are unrealistic and may also lack adequate resources."

It is critical to gain the support of the C-suite at the level of sponsorship, says **Leslie Solomon**, PhD, director of healthcare at human capital advisory firm FMG Leading in San Diego. Many healthcare leaders do not understand what the role of sponsor is and need to be given guidance on how to sponsor without micromanaging.

"Clarifying the role of sponsorship as a co-planning and review role, while leaving the deployment and problem-solving to the improvement teams, will be critical," she says. "It is also helpful for sponsors to understand how to review the improvement project using skillful inquiry to determine whether the process is robust without inserting bias."

When approaching board members and senior executives, Solomon advises beginning with a vision of the desired state rather than the "problem." Engage people with what is possible, and that will open their thinking and neural pathways to new thinking rather than beginning with the problem, which will tend to evoke negative emotions and less creativity. Follow leading indicators and metrics for process health so everyone knows which processes are performing and which are failing, Solomon says. Keep leaders and the board updated with dashboards of process performance.

Also, be willing to use nonlinear approaches to problem-solving, such as cognitive interviews and double-loop modeling. Police use cognitive interviews to help witnesses effectively recall details about a crime, using multiple retrieval techniques that acknowledge how memories are made up of a network of associations. Double-loop modeling involves teaching people to think more deeply about their own assumptions and beliefs.

These methods are more conducive to learning from improvements and are more suited to the complexity of healthcare systems, Solomon says. When presenting to board members and top executives, quality leaders should avoid framing process improvement as a fix of failure. That approach does not support a culture of learning.

"Many organizations lack the trust and safety required to report accurately on issues. All quality improvement needs to rest on a Just Culture framework," she says. "This will provide the safety for employees to report accurately and will also help leaders separate environmental and work design issues from personnel issues."

Even with all this in mind, it still can be intimidating to go before the hospital board seeking support for quality improvement initiatives. When that time comes, Solomon advises keeping some key points in mind.

"Begin with the desired state, explain why it's important, clarify the desired impact in risk management, and cost savings. Delineate both

hard costs, like investment dollars and savings, and soft costs, like work climate and safety," Solomon says. "Clarify what you are looking for from them, such as their role as sponsors and how you will keep them engaged in progress. Provide best practice examples at the outset so they have a basis of comparison and a vision of success." ■

SOURCES

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- **Leslie Solomon**, PhD, Director, Healthcare, FMG Leading, San Diego. Phone: (714) 628-2900. Email: lsolomon@fmgleading.com.

In Quality Improvement, Emphasize Consistency, Error Metrics

Quality improvement efforts often fall short by not following through with measurement after implementing new guidelines or care processes, according to **Raul Coimbra**, MD, PhD, FACS, surgeon-in-chief at Riverside University Health System Medical Center in Moreno Valley, CA.

After seeing many quality improvement efforts throughout his career, Coimbra argues that a key measure should be how often clinicians actually do what they say they do.

Coimbra notes that often, hospitals implement new procedures or processes, and then intend to measure compliance. However, the measurement often falls short and may rely on only a clinician's report.

Coimbra cautions that the result can be that quality leaders may see a rosy picture of compliance. In reality, what really may be happening with patients could be quite different.

"I believe quality improvement in medicine today should be based on consistency, because consistency decreases costs and improves quality," Coimbra says. "It is consistency that will make us better and better, but we have to keep an eye on it every day to make sure we are doing the best we can for our patients."

There may be some hospitals that rely too much on the morbidity and mortality (M&M) conference to assess performance and identify deviations, Coimbra suggests.

"The M&M conference is a very antiquated method of doing quality improvement. You go into this room, and the chairman of the department is like a god sitting in the front row. You present your information, and then you are criticized. They throw tomatoes at you. Hopefully, at the end, there will be some lessons learned," Coimbra says. "That does not take quality improvement to the next level where you identify a problem, develop actions to correct the problem, and measure our performance six months from now."

Coimbra also believes quality leaders should push for more measurement of what the physician does rather than just conditions associated with the patient. Coimbra suggests that physicians need to know what they are doing that affects those more commonly measured metrics.

"For me, it's less important to know how many times my trauma patients develop a pneumonia in the ICU [intensive care unit] than it is to identify how often I go to the operating room and there is delay in making a decision, or how many times there is a delay in obtaining a subspecialty consult," Coimbra shares. "I need to know how many times there is an error in reading a CT scan and we make the wrong clinical decisions, all of the things that are related to ourselves and how we deliver care." ■

SOURCE

- **Raul Coimbra**, MD, PhD, FACS, Surgeon-in-Chief, Riverside University Health System Medical Center, Moreno Valley, CA. Phone: (951) 486-4000.

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes;
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general;
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

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CE QUESTIONS

1. **What is the biggest challenge to implementing evidence-based practices?**

   a. Breaking down long-held beliefs about how best to manage patient care and convincing the team to embrace newer, more compelling evidence.
   b. Convincing senior management to allow new ways of providing patient care.
   c. Explaining clinical data to employees who may not have sufficient educational background to understand the material.
   d. Convincing clinicians that changing their processes will not result in metrics that will affect them negatively.

2. **Why is evidence-based practice more important now than ever?**

   a. Medical malpractice insurers are emphasizing it to reduce liability costs.
   b. The Centers for Medicare & Medicaid Services considers it a primary metric for quality.
   c. Accreditors are tying more requirements to evidence-based medicine.
   d. Value-based care relies on evidence-based practices to ensure the best outcomes and payment.

3. **What is one way to gain more support from a hospital or health system board?**

   a. Build on their fears of litigation.
   b. Build on their desires to be proud and part of an excellent organization.
   c. Remind them of their fiduciary responsibility to the organization.
   d. Discuss individual cases to personalize the quality improvement goal.

4. **What is one reason Beth Israel Lahey Health focused on *Clostridioides difficile* as a quality improvement goal?**

   a. Rates were high at many of the hospitals.
   b. It was the problem that resulted in the highest cost to the health system.
   c. The health system had not addressed the topic previously.
   d. The system's board of directors insisted it be one of the first topics addressed after the merger.