HIDDEN OBSTACLES TO IMPROVING QUALITY IN HEALTHCARE.

BY: BILLIE ANNE SCHOPPMAN AND DON JARRELL

It's difficult to plan a risk manager's job on a day to day basis because it is natural in that role to be reactive instead of proactive. Of course this is to be expected in an emergency department, if it's an urgent situation with a physician, or an issue arises in a medical surgical unit, one must react. This can make it difficult to see the big picture and assess quality from a critical thinking point of view.

It's important to look at the entire process to be proactive and prevent quality problems before they happen. By looking at the big picture, one can develop a forward looking process to not only improve specific issues but to truly create a culture of performance improvement in an organization.

Ideally, Clinical Risk Managers should be surrounded by input from the patient, from the family, outside vendors, accreditation agencies, doctors, executives, and department managers. There is a lot of information and competing interests from the CEO and CFO who are focused on reimbursement levels and reducing the costs of litigation to Risk Managers who are tasked with event tracking and reporting in addition to managing the day to day operations of busy facilities.

However, communicating can be difficult for providers for a number of reasons; some more obvious and others often hidden from view.

In this Executive Report, I'll be uncovering the most common, hidden factors that your team might be missing in the ongoing mission to improve the quality of care for patients.

More often than not, in most organizations, initiatives are generally focused on more visible factors including:

- Reducing events in general
- Consistent and accurate data entry
- Improving and streamlining reporting
- Equipment
- Core Standards
- Training of staff
- Medication errors
- Falls
- Surgical events
- And many more

Of course all of these are important. However, there are many factors that are often overlooked; invisible factors that can have significant impact on patient quality measures, reimbursements and outcomes.

More importantly it is these hidden factors that produce better outcomes for patients.

Here are five hidden factors to consider to improve the quality of patient care.

1. Culture and Leadership
2. Mistaking Information for Insight
3. Having a common and comprehensive definition of "quality"
4. Not having the right technology
5. Hiring practices

Culture and Leadership

An often overlooked factor is the culture among team members. For example, do people feel empowered to speak up? Too often an environment is created where there is a perception that pointing out weaknesses might have negative repercussions, so people keep quiet. Another example is motivating the entire team to look beyond the data and reporting to focus on the outcomes. We call this developing a culture of care.

Hospital leaders must demonstrate their commitment to patient experience in terms of having a clear mission, vision and values for the organization that can be, and are, put to work. These need to be very specific and driven through to every member of the team.

> *"There is so much under the service in busy clinical settings. Unless we look at the entire eco-system in a holistic way, it's almost impossible to achieve real performance improvement. "*
>
> *~ Billie Anne Schoppman*

Leaders must listen to staff and patients. When patients feel their voice is heard and acted upon, they feel more engaged in their care, more empowered and more satisfied. This can have a direct impact on overall morale and motivation of the team to keep the focus not only on high quality clinical care, but a positive patient experience.

Front line staff also need to understand why they have to change practices. It's not enough to decree a change from the top down. Everyone on the team should be asking "why?" "Why are we doing it that way?" Too often the answer is "Because that's the standard." This does not encourage people to go above and beyond the standard. Another common answer is "Because that's the way we've always done it."

By encouraging people to ask "why?" we can help teams think in broader terms and think outside the box. By empowering people to speak up, all levels of staff are more engaged and feel they are part of the solution.

Cultural change in any organization depends on strong leadership from the top. By effectively communicating specific strategies throughout the organization, hospital leaders can rally everyone around a common goal and, importantly, provide more effective support to specific initiatives.

It's also important to recognize staff who report safety issues or have good ideas for improvement. This can go a long way to creating real performance improvement by giving staff credit for their ideas and engaging them in your hospital's safety culture. Make sure the information is shared widely throughout the organization so everyone is encouraged to deliver the best care possible. Think effective collaboration, visibility and transparency.

Creating a culture of care is an ongoing process that must be nurtured and made a priority. This can lead to significant performance improvement both in terms of quality scores and patient satisfaction.

Mistaking Information for Insight

One challenge providers face is the sheer amount of information required to adequately track, identify and correct quality issues. With a myriad of agencies and regulating bodies, each with their own reporting requirements, it can be overwhelming for even the best teams to manage.

Too often the focus is on entering data and producing reports instead of improving the outcomes of their patients. Whether it be environmental, operational, or clinical, that's the real goal, and that's where the focus should be.

Information is a means to an end. That end is only achieved through analysis of the data which leads to insight. It is this insight that makes it possible to achieve true breakthroughs in quality. Part of this equation are the tools. Are they difficult or cumbersome to extract usable insight? Are there many different systems that need human intervention to bring together the right data to identify problems? Is the data accurate and current?

All of these factors directly impact whether or not the information can be translated to action. The more human interaction and process work is required, the more the possibility of errors. This leads to "bad" data and ultimately to poor decision making and lower quality measures.

Not having a universal and specific definition of "quality"

There are many different definitions of "quality". The Institute of Medicine (IOM) defines healthcare quality as "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."Frequently, people focus on obtaining more professional knowledge without ensuring best use of that which they already have.

Too often the definition of quality in any given organization can vary greatly from one individual to another. There is also debate within the industry as to what the overarching definition of quality should be.

And this definition is always changing. Patient safety was defined by the IOM as simply "the prevention of harm to patients" with the emphasis placed on the system of care delivery that:

1. Prevents errors;
2. Learns from the errors that do occur; and
3. Is built on a culture of safety that involves health care professionals, organizations, and patients.

Patient safety practices have been defined as "those that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions."

To a person with cancer, "quality cancer care" may mean a chance to be cured of their disease and to be treated with respect and compassion. To a hospital administrator, it may mean that staff follows the highest standards of professionalism. They are up to date on the latest information, provide treatment that is based on guidelines accepted by peers, and there is ample communication between members of the cancer team with different specialties.

What is important is that everyone on the team has a consistent definition of what quality means. Being specific in this regard is the only way to implement a holistic quality and performance improvement effort. One approach is to avoid using the word "quality". Instead ask the team "What did you see today? Is there anything that we could do better?" Let them know that you really want their input and their involvement.

Above all, determine what the definition of quality is for your organization beyond the standards and make sure that everyone understands this definition in specific terms. With the big picture of quality clear, it still needs to be broken down to workable-sized pieces for practical application to work that can be measured and managed.

The Wrong Technology

Technology is a central part of Quality Management yet it is highly misunderstood and variable in terms of sophistication. Too often providers have disparate systems ranging from spreadsheets to software systems that track events and produce required reports, but don't provide analysis of data. This makes extracting actionable insight difficult if not impossible. And, the repeated attempts at better technology are often simply reactive, superficial "tweaks' instead of changing the fundamental approach to the design of the applied technology. That means real progress, innovation and efficiency are all but impossible.

Another missing link with regard to technology is that it's not enough to manage events and quality. An effective system should include Performance Improvement as a core function. The systems collect information, but don't clearly point to action. After the data is collected, the analysis done, and the reports generated, if no action is clear, what is the point of the exercise? It's crucial to do deep dive analysis, identify the things that need to be done, then do it. But to do that, you must have a system that connects everything together where everyone can be involved.

In other cases, the technology that is employed is difficult for the staff to use. This causes gaps in data and in some cases failures to identify trends. There is no "one size fits all" solution for quality management. Every organization has different needs at the surface, but the fundamentals in applying technology to quality-safety improvement are the same and - in most case - fundamental innovation is needed . For example a single location hospital will have very different requirements than a system with multiple facilities, but good principles can be scaled.

We only need to look at the history of EHRs. Organizations have expended enormous energy, money, time and stress implementing and re-implementing EHR systems that don't fit their needs. Too often we hear "We don't have time for anything else. For the next year, we're going to focus on this one thing, and it still isn't fixed."

A mismatch in technology, training and culture dramatically increases risk and can be dangerous for outcomes and patients. It can negatively impact the culture of the organization.

Hiring practices

One of the most commonly overlooked factors in improving patient quality is known as the "Peter Principle". Developed by Laurence J. Peter, the idea is that people in a hierarchy tend to rise to their "level of incompetence". In other words, an employee is promoted based on their success in previous jobs until they reach a level at which they are no longer competent, as skills in one job do not necessarily translate to another.

Too often a high performing RN is promoted to Enterprise Risk Manager without the background, training or skill-set required to be effective. Risk Management is a specific discipline. As Jim Collins famously said, "You need to get the right people on the bus." Nowhere is this more important than in healthcare.

Here are some ways you can avoid the "Peter Principle" in your organization.
- Put the right people with the right skills in the right job.
- Ensure all leaders have better focus on the future than the past
- Have clear qualifications for each position.
- Provide the appropriate training and development for each new level of responsibility.
- Test for specific skill-sets and leadership ability (there are many assessments available for this)
- Set up a mentoring program for future leaders

This in no way should be interpreted to imply that RN's are not generally qualified to oversee risk management. In fact, with the appropriate training and mentoring, RN's are in an excellent position to become risk managers. But these decision must be made, not on effort, but on qualifications.

Today's Quality Management landscape is very complex. For those working in the healthcare enterprise, the current complexity of clinical decision-making challenges human cognitive capacity to manage information. Moreover, administrative complexities, from complicated workflows to fragmented financing, add inefficiency and waste at the system level and prevent health care from centering its efforts on the patients it serves.

This means that patients and clinicians have more information to consider and more decisions to make than ever before. Even accomplishing a seemingly straightforward activity such as filling a medication order is marked by unexpected intricacies. The results of this administrative complexity and inefficiency are delayed medications, potential errors, waste, and higher costs. Inefficient workflows also restrict the amount of time nurses can spend directly caring for patients.

Conclusion

Obviously there is much more to improving patient care than can be covered in this brief report. Ultimately, organizations must look at the challenge holistically. For example, it's not enough to upgrade or change software systems, you must assess your team's level of sophistication with regard to using software and choose systems with easy to use interfaces to improve consistent use and adoption of the system.

Of all the hidden issues, developing a culture of quality throughout the clinical operation is of utmost importance and it is hard to do. If done successfully (and the job is never-ending) the right culture can, in itself, be a powerful tool in the end goal of improving patient outcomes.

Reporting has become a central issue for risk managers and clinical staff. It's crucial to not only satisfy mandatory filings, but to have the ability to quickly and efficiently produce meaningful analysis and insight for the C-suite. This is easy to overlook when selecting software which can lead to unilateral and inefficient manual process.

Before the digital age, nurses were utilizing paper forms to document important patient information. A significant factor in the nursing profession is the transition to electronic documentation and systems. These systems

can help in assembling information about the patient's needs, improve the patient's information accuracy, and enhance the quality of patient care. But the system needs to do more than store and retrieve entered data. It is processing - moving, rearranging, consolidating, calculating and analyzing - of data, designed using a combination of expert disciplines, that delivers the real value to users that technology can provide. A well designed information system can facilitate and provide an easier and faster information flow that is needed for efficient documentation processing. More importantly the right system can drive clinical performance and achieve the end goal: providing the best patient care with the least risk as efficiently as possible.

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About Prista:

Prista's flagship product, ActionCue Clinical Intelligence, has transformed the way hospitals manage risk, quality and performance improvement by making information immediate and easy-to-use and understand. While a number of software solutions address some of these functions separately, none deliver information in a single, collaborative environment that provides the actionable insights and reporting found in ActionCue CI.