The Quest for Quality Hospitals & Health Networks Nov 2005
Hospitals & Health Networks

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BY, Wade, Richard

BODY:

In a roundtable discussion, several health care executives, quality experts and an industry vendor discussed the best practices of organizations that have won the Baldrige National Quality Award or the AHA/McKesson Quest for Quality Prize, as well as members of the Q4Q committee. The discussion also explored core quality and safety issues, such as the development of a culture of safety, management accountability and evidence-based practices. Trudy Johnson, R.N. of Presbyterian Hospital said a culture of safety really comes from the grass roots of the organization. Lee Domanico of El Camino Hospital said the relationship between doctors and nurses is an important part of organizational culture. Mary Beth Navarra, R.N. of McKesson Corp said in observing and working with a lot of hospitals, the ones that are the most successful support the workforces' quality efforts. Hamilton Christy Stephenson of Robert Wood Johnson University Hospital said another effective tool is to make sure everyone is connected to the organization's goals.

FULL TEXT:

The Institute of Medicine's "Crossing the Quality Chasm" challenged health care organizations to strive for excellence in six quality aims: safety, patient-centeredness, effectiveness, efficiency, timeliness and equity. Health Forum convened a group of health care executives, quality experts and an industry vendor July 28 in San Diego to examine progress in achieving these aims. The closed-door discussion focused on the best practices of organizations that have won the Baldrige National Quality Award or the AHA/McKesson Quest for Quality Prize, as well as members of the Q4Q committee. The discussion also explored core quality and safety issues, such as the development of a culture of safety, management accountability and evidence-based practices. Health Forum would like to thank all of the participants for their open and candid discussion, as well as McKesson Corp. for sponsoring this event.

MODERATOR (Richard Wade, American Hospital Association): There isn't a more overused phrase in our field today than "culture of safety." But everybody has a different take on what that means. What is your definition of a culture of safety inside an institution? How do you know when you have achieved a culture of safety?

TRUDY JOHNSON, R.N.

(New York-Presbyterian Hospital):

A culture of safety really comes from the grass roots of the organization. Everybody must understand his or her role. Studies support that. We have done a large-scale initiative on service excellence so employees really feel that each of them has an important contribution. We teach everyone that they are part of the safety culture.

The biggest challenge, and one I think we still want to improve on, is risk mitigation. We want to achieve culture change where it's not a matter of just learning from the events but preventing them. That's really where the culture has the greatest growth potential-in the risk mitigation area.

We are excited about our completion of order entry because a tremendous opportunity lies in how we use technology. It embeds safe practices into what our clinicians do every day. It's built into their processes and how they communicate with each other.

MARY COOPER, M.D.

(New York-Presbyterian Hospital):

In many ways, quality is poorly defined in health care. Trying to explain it to our trustees and to our physician staff and to our employees has been a real struggle.

If we were to go to the staff on the floor and ask, "What is quality?" we'd get many different responses. The Institute of Medicine's six quality aims have helped further the explanation. It defines the categories. Being able to show demonstrable results in those categories has allowed all of us to take great strides forward.

MODERATOR: Does that culture start at the top of the organization? Does it come up from the grassroots? Can it be generated from the middle?

JOHN HEER

(North Mississippi Medical Center):

True quality is going to start with the leadership. From there, it has to be taken throughout the entire organization. Employees have to be educated; they have to understand quality.

During my interview process at North Mississippi, the board complained to me that all they hear from administration is financial information. There was a balanced approach throughout the organization, but it wasn't being communicated to the board. When it finally was communicated, we really made huge strides and advancements.

The organization needs to define quality. It involves the commitment and engagement of all of the staff. It's not hard to get physicians engaged when you're talking about what they do every day. If you're communicating to them all the financial stuff and nothing about clinical quality, you're going to have a hard time getting the physicians involved. It also takes a commitment to patient satisfaction and making sure that everybody understands our focus.

Also, the accountability has to be there and has to be measured frequently. It has to be reported throughout the entire organization on a weekly, biweekly or monthly basis. The Malcolm Baldrige award criteria creates an alignment throughout the entire organization to that commitment.

KATHLEEN GOONAN, M.D.

(Massachusetts General Hospital Center for Performance Excellence):

In health care, we have assumed that doctors and nurses and health care workers are all very well trained and are knowledgeable. Building a culture of safety starts with defining how we train people to behave. It also requires developing really explicit deployment methodologies of those expectations. Health care is just learning how to do that. That's what generates culture.

JOHN WADE

(Saint Luke's Health System):

It does start with leadership. When Rich Hastings took over as our president and CEO 12 years ago, he said we must demonstrate the quality of our services to the community. We must use evi-

dence-based medicine. When we started on the journey to quality, there wasn't any such thing as Baldrige in health care. He has worked to make sure the employees and physicians are working to create a culture of quality.

We now have the ability to measure, and it drives the whole process within Saint Luke's. Our outcomes data are available electronically, and the employee can go in and look and see where are we on various components. They can see their goals and how they are doing because their goals are aligned with those measures. It takes a whole organization to develop quality, but it starts at the top.

LEE DOMANICO

(El Camino Hospital):

The relationship between doctors and nurses is an important part of organizational culture. At our organization, it's one of mutual respect, and it's palpable. The doctors have greater respect for the nurses there than any place I've worked before.

That's the start of what I feel is extremely important for safety, which is teamwork. We measure teamwork. We ask our patients about their perception of our teamwork. We ask doctors what they think of teamwork. And we ask our employees how they rate teamwork because the handoffs from one team member to another are where many errors can occur. It starts with the nurse-physician relationship. Without that, you're handicapped in terms of promoting quality.

MODERATOR: In some cases that requires breaking down ingrown, calcified hierarchies that may have been in an institution forever. How do you get at that?

DOMANICO: We have a physician counselor on each nursing floor or unit. They are there to resolve behavioral issues that develop between physicians and nurses and take corrective action.

It shows that we're serious about the relationship in terms of treating the other team members with respect. It's one of the things we do to promote the teamwork between doctors and nurses.

RONALD SWiNFARD, M.D.

(Lehigh Valley Hospital and Health Network):

Another way to achieve cultural change is to empower nurses and physicians so they will speak up for quality. It creates a level playing field. If everyone feels emancipated to speak freely, it will create a partnership.

CHRISTY STEPHENSON

(Robert Wood Johnson University Hospital Hamilton):

It was a real cultural change and transformation of work processes that made a difference within our organization. We have the respect. But respect goes beyond the doctors and the nurses. It has to include all professionals so it becomes part of the climate. Everyone is aligned toward the same goal and objective as it relates to quality.

It's not easy for us to structure. The Baldrige structure helped accelerate the rate of change. I've heard people at Baptist Health Care talk about it. The Baldrige structure gave us a framework that's evidence-based.

PETER PLANTES, M.D,

(VHA Inc.):

Leadership is paramount. The cultural transformations we see in hospitals that are led by the CEO have gone further faster. They're at the cutting edge because the leadership is there. When

it's part of the executive agenda, it will he part of the staff's agenda. It then becomes ingrained within the organization. It's hard to establish unless the leaders are on point for the whole process.

AL STUBBLEFIELD

(Baptist Health Care):

When we started our cultural transformation in 1995, we focused on service excellence. We realized that you don't deliver great service unless you imbue your workforce with it. That creates a culture of service. We want to create an environment where everybody knows every day they're going to be focused on service excellence. That's where we're going as an organization.

panelists

It starts with the top management. And it has to be non-negotiable. We accept no excuses. If our employees want to be a part of it, let's make it happen. If not, they can leave. We've had phenomenal results focusing on service excellence and employee morale, realizing we've got to totally engage the workforce.

During this time, however, we did not place the same focus on our clinical product. We started the Baldrige process for the wrong reasons; we wanted to win an award. We soon realized that wasn't going to happen unless we got a broader focus. We found that having a culture where we knew how to communicate and engage the entire workforce allowed us to focus on clinical quality and safety.

The feedback we received from the Baldrige process was invaluable. Our workforce climbed on board early because delivering great service fed their primary motivation to go into health care anyway. Having the Baldrige platform took an already special culture and allowed us to view it on a broader basis. It took us to another level in the quality and patient safety arena.

COOPER: There has been a seismic shift at the clinical level in understanding variability in care over the past eight to 10 years. Physicians, for example, used to be very resistant to the idea of doing things the same way every time. Now they see that consistency improves outcomes. If we can teach other organizations around the country how to move clinicians to that concept, it will have the biggest impact on care.

HEER: The same goes for the administration. The senior leadership has to be committed, and it's not easy. It gets boring at times because we focus on the same stuff all of the time. We have to constantly focus on the critical success factors we've identified. Distractions will come up, but we have to be very careful to make sure that we incorporate those things into what we have been doing all along.

WADE: While Baldrige and Six Sigma may provide a good framework, quality can be improved without them. It requires that organizations measure and report, measure and report. If you measure and report it, then you can act on it. If you're not measuring and reporting it, how the heck do you know?

MARY BETH NAVARRA, R.N.

(McKesson Corp.):

In observing and working with a lot of hospitals, the ones that are the most successful support the workforces' quality efforts. Staff-level individuals are empowered when they see something wrong to actually stop and change it.

On a visit to El Camino, I met a physical therapist who said she is required to spend 30 minutes of patient therapy with each patient per visit. At her previous organization, if a patient came down and spent 20 minutes in the bathroom, the patient received 10 minutes of therapy. At El Camino,

that patient would still receive 30 minutes of therapy, regardless of whether it throws off the schedule or reimbursement. The message that the staff hears loudly and clearly from their senior leaders is that it's important.

DOMANICO: We talked about the importance of training and education. It used to be what we did almost exclusively to improve quality. But what we were overlooking was the human condition. In order to take safety and quality to the next level, we must also provide the tools and systems to eliminate the possibility of error. The next level beyond the training, education and reinforcement is providing our employees with tools, systems that prevent mistakes. Providing them with that type of technology and systems is then self-reinforcement of the organization's commitment to quality, making their jobs safer and easier, and eliminating errors.

STUBBLEFIELD: In the early part of my career, if we were in the 50th to 60th percentile, we were happy. We decided to reach higher than that and ended up creating a vision to be the best health care system in America. What did that do for us? All of a sudden it raised the target for everybody.

We have a program called Bright Ideas. We ask our employees to help us come up with ideas to improve what we do. Our employees are required to have several Bright Ideas implemented each year, which will be over 10,000 implemented Bright Ideas this year. That's 10,000 times that an employee has stopped and thought about how they can improve what they are doing.

COOPER: That's a great program because the front lines need to see that we respond to their concerns and ideas and make sure they have the tools to do their jobs properly and safely. It reinforces the concept that the organization is committed to quality.

MODERATOR: Everyone around this table knows there is no environment more vulnerable and more volatile than the front lines of health care in the hospital. How do you sustain the kind of culture that you all work for over time, with all the things that can disrupt that?

GOONAN: Sustainability is a new word injected into the Baldrige criteria in the past year. The way we think of leaders in health care is shifting and needs to shift. In health care, we have to move away from the concept of the internal hero. Servant leadership is one way to accomplish this. An individual is not responsible for the greatness of an organization. We have to realize that everyone contributes. A sustainable culture can lose a few individuals and it will continue to be excellent. It's not dependent on any one person, no matter how great, no matter how wonderful their role and the contributions they make. An organization has to ensure that everyone can be replaced.

That's a different model for health care, because we have been dependent on the great individual for a long time. What that triggered for me is the realization that hospitals need to generate leadership from within. Internal leadership will drive the change, not external consultants. An organization is great because it builds into the fabric that anybody could lead.

PLANTES: Sustainability will depend on whether the culture has actually changed. Sustainability is going to be in measurement, particularly the measurement of the impact of clinical excellence and clinical quality as it relates to the financial performance of the organization. We're seeing this in intensive care units. As care improves, the costs go down dramatically. And as the length of stay decreases, you can handle more patients and increase revenue.

STEPHENSON: Communication is a big part of success. While it's important to measure, we need to communicate so the message can be understood and show how we're doing compared to the best in the country.

JOHNSON: I agree. We're at the point now where there is truly a passion for quality throughout the organization. Our core business is providing excellent patient care. That requires reducing

variability. To do that, we have to use tools such as Six Sigma to help our staff see how they can improve patient care in a consistent way. The critical piece here is to integrate all of the pieces. It's the tool you use, be it Six Sigma or something else. It's what you do with the information. The way that we will be able to sustain our success will be to continuously provide that information to people.

On another note, to really accelerate change, we're going to need technology to give our clinicians that information in real time. We have been doing that in a number of areas and have been able to change patient care outcomes. A hospital may have people committed to that excellent care, but it won't be sustainable unless it has a tightly integrated program and good tools to work with. It requires feedback mechanisms to both the clinicians and administrators.

SWINFARD: One of our purposes here is to help other members of the AHA emulate the successful practices of our organizations. What we have done is really boring. The consistency does get a little monotonous, as mentioned earlier. It's a culture you create that's self-sustaining and not dependent on an individual. Consistency will help sustain culture.

Our CEO attends every new employee orientation for more than two hours. We hold new employee orientations every two weeks, and he goes to reinforce his message about quality and culture. It provides a consistent message to everyone who works at Lehigh.

MODERATOR: How do you get the parts of the organization that are farther and farther away from the patient care experience to feel passionate about their work? Don't they have to feel that same passion, that same drive?

DOMANICO: We spend a lot of time trying to connect the dots. Our distinctive quality is nursing care. But we describe nursing care in broad terms. It's not just what the nurses do. It involves all of the people who support the nurse on the floor. And we continually reinforce that. It doesn't matter whether it's the transporter, the housekeeper or another ancillary service. All of that contributes to what we are known for, which is outstanding nursing care.

COOPER: We have a couple of programs that bring groups from finance, IT or some other support services to the bedside so they can see what happens on a day-to-day basis. We believe that anybody who goes into health care does so because they want to make patients feel better. That extends to our services that are not directly taking care of patients. If someone is an administrator for the radiation oncology department, we believe that they're there because they want that patient experience to be better. In one program, we have people follow the patient's steps through the hospital. They come in the front doors of the hospital and shadow a patient through the course of the day to see how it impacts their job.

On all of our Six Sigma teams, we have representatives from finance, IT and others who are not directly taking care of patients. We have trained over 1,500 people in the past two years in Six Sigma methodology. About 200 employees went through a formal eightmonth training process. Many of these came from non-patient direct-care areas so they could understand how to fix processes right at the bedside.

We also have performance improvement teams that include clinicians and support services at the table. Individuals who are not directly taking care of patients sometimes have ideas that the people on the front line may not be thinking about because they're so intimately involved in the process.

STUBBLEFIELD: All the organizations that are represented here have taken communication to employees to a whole new level. We look to share our positive experiences. When employees hear good things about our organization from patients or someone in the community, we encourage

them to send a brief e-mail to other employees, whether it's 500 employees or 3,000, so everyone receives positive reinforcement.

STEPHENSON: Another effective tool is to make sure everyone is connected to the organization's goals. We call it E3-Engage Every Employee. Every employee within the organization carries a card that's attached to their name badge that says how their personal goals are connected to their department's goal. The department goals are then connected to the top five goals of the organization.

Every employee has a clear vision of how their work connects to the organization's goals. Every quarter we talk about how we're doing and post that information, along with monthly updates.

DOMANICO: I have an example about connecting the dots. I was walking out of the hospital one evening and passed an employee who recently won the Employee of the Month award. He was down on his hands and knees scrubbing the baseboard, and I greeted him as I walked by. He told me what he was doing, and he pointed to the other side of the hallway that he hadn't done yet. Without any prompting, he told me how important his job was because if people think a hospital is dirty, they might think the nursing care is poor. This guy really gets it. If the other 2,000 employees understand as well as this guy, I've done my job. We're not quite there yet. This is a remarkable example of one individual really understanding his role in the organization.

MODERATOR: Has all of this changed how your human resources department hires new staff people?

JOHNSON: That's an area in which we've done a tremendous amount of work. We've trained our front-line managers to interview potential employees so the organization's principles of behavior are incorporated in their interviews. As a result, they look for employees who embrace our values. It's built into management evaluations as well. One of the main initiatives for the hospital has been the premise that to be a high-quality organization, we have to have consistency in the people. This is a way to ensure that.

NAVARRA: I participated recently in a chief nursing officer strategic summit. One of the topics was evidencebased nursing practices. One of the best practices I heard discussed was enabling the staff-level nurses to participate in the recruiting and interviewing process. Several of the hospitals have put a staff nurse on the interview committee, and they are able to have feedback on whether the person they are interviewing fits as part of the team. One of the hospitals was initially surprised when a staff nurse said they should pass on a potential candidate. The nurse said it was more important to find someone to help the team than to hire someone to fill empty shifts.

STUBBLEFIELD: That's a step in the right direction. Beginning seven or eight years ago, we do not hire individuals for any job in our organization unless the peers that will he working alongside you have interviewed you.

Peer interviewing slows down the process, and there have been multiple times when the manager is ready to hire someone when the staff says, "No." The outcome is that you tend to get people that fit better.

When a new employee shows up, their peers have already met them. They have a vested interest in their success now.

WADE: It's a better fit both ways. The employee joining the organization knows what he or she are getting into. Sometimes he or she may opt out. We do this at our organization and we've seen the turnover rate drop.

SWINFARD: We have a 5-by-7 sheet that lists personal attributes on anyhody that's coming through the door tor an interview. It can be filled out by anybody who comes in contact with the interviewee. If they were treated rudely or didn't have eye contact, they can fill out the card.

In one example, we had a physician interviewing for a position who was well-received by the department. However, our driver who transports potential job candidates to the airport in Philadelphia or New York City returned and said to the department chair, "I don't know if I ought to say something to you or not, but I've never been treated more rudely by someone than this physician treated me." The physician wasn't hired, even though she'd done well in all the other aspects of her interviews.

We also have an online questionnaire that we require potential employees to fill out. It helps direct questioning during the interview process. I just had an experience with hiring a department chair who took an advanced questionnaire, which was 350 questions, that directed me to bring him back for a third interview. It was very puzzling to him that he had to come back, but there were some real red flags in that process that needed to be addressed. We also have a video that we show potential hires on how to be a servant to the public. Afterward we ask them what they think. If they don't feel they can comply with our philosophy, we ask them to drop out of the process.

MODERATOR: We've discussed hospital leadership. I want to talk a bit more about hospital boards and physicians. How do you engage physicians and the board?

PLANTES: If you are building an organization of quality, you have to have a solid foundation. That foundation consists of the relationship between leadership with the physicians, the board of trustees and the workforce. If that relationship is not built into the foundation, it doesn't matter what you build above it. It will not sustain itself.

It's important to involve the trustees. You have to invest in the trustees so they understand the issues. They'll relate it to experiences they have in other industries, and that's extremely valuable.

SWINFARD: There's a bigger challenge in educating board members because they don't have health care backgrounds. It takes extra effort. During our orientation I try to do that, to explain the quality and patientsafety issues that we have. And we had a full-day retreat a year ago in which we talked about quality and patient safety. Once they understand that, tiiey become very proactive.

HEER: It's important to go back to the basic foundation. Having good mission and values statements that were developed in conjunction with the board is extremely important. That gives us the tools we need to go back and say, "Why are we here? Our mission doesn't say, 'Make a lot of money.' Our mission here is to provide great care."

We have a Quality Standard Committee, a group that is half board members and half physicians, that meets on a monthly basis. They go through all of the safety and quality information. The board members on this committee keep the rest of the board up to date.

It's important to keep things simple. If you go into a board meeting and you report on 450 indicators, their eyes are going to roll back in their heads. We've developed a scorecard process to report 41 indicators. The board receives a scorecard every month that shows how we are doing in quality. That's a little dangerous because you're not doing a deep dive into all of the quality-of-care issues.

COOPER: We have several subcommittees that help break down quality issues. One committee looks at clinical quality, another service quality, and one looks at environmental safety. These groups delve into the details. They meet for at least four hours each month.

Just as consumers have become more sophisticated about health care, so have our board members. Our board drives many of our quality efforts. Six Sigma, for example, is a board-driven initiative.

STEPHENSON: Our board is certainly much more engaged at this point and more sophisticated than in the past. The board completes an annual evaluation process, where they discuss how they can improve things. We hear year after year from the board that they'd like more education. We've restructured our board meetings completely, and that has helped. Each meeting, we provide indepth education on a particular topic that is selected by the board in conjunction with the executive management team.

I underestimated my relationship with the board prior to taking this position. I feel I need to package the information I share with them so they know my business. The communication is valuable. It has been a nice process of creating die business case for quality. I've learned that from the board.

DOMANICO: I have found that community board members come to the board with an expectation of quality and service. One of my board members said to me, "You know, Lee, it's not enough just to be good. We also have to do good." That's the perspective that most board members bring from the community.

MODERATOR: When the board members leave the boardroom and interact with clinicians and physicians, are there any special issues that you have to pay attention to?

DOMANICO: You've got to worry about what they're saying.

HEER: It helps you to be accountable for what you're doing. If you aren't doing what you say you are, the doctors are going to tell the board members.

STUBBLEFIELD: My experience is that the board members tend to show great deference to the physicians. They look to them as the experts and are learning from them. The physicians like being put in this role. It's a nice fit.

HEER: Most board members are going to be focused on service and quality because they're leaders in their community. They recognize that what makes a hospital is the physicians. The physicians bring the patients to us.

The board has a very high regard for physicians, and putting them in the same room together once a month has been beneficial. It's not an adversarial type of relationship.

JOHNSON: In order to develop a working dialogue, we have to get the different groups together. Our medical staff president gives a report every month to the board. They're used to the dialogue. If there were to be a serious event, they would he included in that discussion with our chair of the board. The relationship makes the physicians think differently. The physicians value their time with the board. They really like the opportunity to share what they're doing. And they like the opportunity to get in front of the board to say how they think we need to improve.

PLANTES: Having hoard members and physicians work together helps build the momentum toward quality. It will be necessary to move those objective measures of quality forward. That's especially true when it comes to investing in technology and information systems.

WADE: As the CIO, I often sit in meetings between board members and physicians. I'm there to support the physicians. They are the ones who really make the organization work.

Our role is to make sure the trustees know the physicians' needs and how certain technologies will improve their work.

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-Trudy Johnson, R.N.

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