The Case for Quality Improvement

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Abstract

Healthcare systems around the world are facing increasing public and government scrutiny, financial pressures and challenges from growing complexity. There is a need to accelerate the pace of change, and improve the quality of care while reducing cost. These changes must centre on improving care and increasing accountability for quality in the system. But how do we achieve this goal?

Canadian healthcare today relies heavily on quality assurance mechanisms as the primary way to drive high quality care. This approach is based upon extrinsic motivators such as sanctions, targets and pay-for-performance to improve care. An alternative approach would rely more on intrinsic motivators, including individual personal values and emotional connections to the work that create energy for change. We need both, but currently there is an overreliance on extrinsic motivators, which can have the unintended consequence of dampening intrinsic motivation – one of the key levers for change and transformation.

There are several frameworks that outline the key components required to achieve quality (Baker, 2008; NHS Change Model, 2013; Health Foundation, 2015). All have common components with roots in Deming's Theory of Profound Knowledge or Juran's Quality Trilogy. However, what hasn't been clearly outlined is an understanding of how we might best optimize each of these levers to maximize the benefits of each.

Juran's Quality Trilogy is often displayed by using the three equal components of quality planning, quality control and quality improvement (Figure 1). This representation often implies an equal balance across all three areas as the basis for driving high quality within a system. However, I would argue that an equal balance between these three components will not achieve the change needed in the system.

FIGURE 1.
Juran's Quality Trilogy

The Health Foundation in the UK recently published a paper that outlined the types of organizations that are required to drive quality, delineating three broad types of approach. These include: "prod mechanisms" (e.g., those developing legislation, targets, pay for performance, accreditation and performance management; "proactive support" (e.g., those offering commitment based approaches to change built upon intrinsic motivations); and "people-focused support" (e.g., those providing education, training, professional regulation and clinical standards) (Health Foundation 2015). Unfortunately, in a system under pressure there is often a tendency to rely upon the "prod mechanisms" - their concrete actions offering reassurance that progress is being made. However, evidence has shown that prod mechanisms deliver approximately only a 10% impact overall, despite being the most common and dominating force for driving change within our systems (Health Foundation 2015).

The implementation of the surgical safety checklist offers a good example of the limits of this approach. Mandating use and monitoring adherence of the checklist, while well-intentioned, provided only a measure of checklist utilization rather than necessary improvements in teamwork and communication required to reduce surgical morbidity and mortality (Muniak et al. 2014). The benefits of focusing on the people-support side of change are clear. In fact, positive shifts in culture are linked to improved clinical outcomes and patient satisfaction (Flin 2005; Janss 2012; Sacks 2015; Yule 2006;). These shifts also have tangible benefits for healthcare providers, teams and organizations by reducing work-related conflict and stress, fostering team communication to lessen harassment and bullying, and improving job satisfaction and perceptions of working conditions (Pettker 2011; Wolf 2013). All of these factors combine to improve the quality of care.

In British Columbia, the Ministry of Health created Clinical Care Management (CCM) in 2008 as a strategy to implement evidence-informed guidelines to reduce unnecessary variation in patient care across the healthcare system. CCM was ultimately intended to support rapid quality improvement; however, the focus on establishing metrics that had the perception of quality assurance drove a desire for measurement that ultimately slowed down practice change. Clinicians and administrators were engrossed on achieving perfection in measurement, due to accountability, rather than focusing their energy on improvement.

Recognizing this, the BC Patient Safety & Quality Council undertook a voluntary, commitment-based campaign to focus on clinical practice to achieve improvements in the identification and treatment for sepsis (one of the CCM areas of focus). Launched in October 2013, and ending 150 days later in March, the *150 Lives in 150 Days* campaign took a completely different approach with a focus on the values-based connection of saving lives for healthcare providers. During the 150 days of the campaign, an e-learning module provided education to over 800 interdisciplinary care providers in the province, and through a mobile app reached over 2600 clinicians with pertinent sepsis literature. Thirty-two hospitals participated in the campaign across the province. It was an incredible success in terms of clinical engagement and resulted in the use of over 750 life-saving protocols for patients with severe sepsis and septic shock. Additionally, the BC Sepsis Network – a voluntary group of clinicians engaged in improving care for sepsis – grew by 52%.

In addition to the heightened engagement, evidence showed a drop in severe-sepsis mortality corresponding with the campaign (McKeown et al. 2016).

There is increasing evidence that a commitment-based approach to change is more effective than one based solely upon compliance (Bevan and Fairman 2014). Evidence also shows that social connection and discussion is one of the most powerful approaches to change (Milton 2014). Quality improvement as a strategy for achieving high quality care provides a significant opportunity for engagement, embracing complexity that exists within our system and facilitating emergent versus planned program development required today (Terry 2017). Hefietz (2009) notes that one of the most common failures in leadership is treating adaptive (cultural) issues as if they are technical ones. We need a system in which we support a system which values an investment in both the people side of change in addition to the technical components.

Investments in programs that build the capability to lead improvement such as the BC Patient Safety & Quality Council's Quality Academy, the IDEAS program in Ontario and the Executive Training in Research Application (EXTRA) program led by the Canadian Foundation for Healthcare Improvement are fundamental to achieving this high-quality care. These initiatives offer training in quality improvement methods and tools that help translate the intrinsic motivations of healthcare clinicians and managers into improved care for their patients.

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The cases presented in this edition provided examples of the potential impact we can achieve in system improvement and transformation through a dedicated focus and investment in developing the capability and creating the capacity to lead change through quality improvement. As well, they demonstrate the results that can be achieved in embracing

the complexity of the healthcare system, in valuing and addressing both the adaptive and technical components in improving quality. Vuong et al. (2017) demonstrate the potential of successful medication reconciliation to reduce costs and improve patient safety through their approach of tapping into the intrinsic motivators for change and creating a platform for the broad engagement through patient story, required in the redesign on this process. As well, additional cases presented in this edition: reducing length of stay in hip fracture patients by the Greater Toronto Area Rehabilitation Network (Levy et al. 2017); improving discharge summaries in St. Thomas Elgin General Hospital (Sheridan et al. 2017); and preventing 'error-based transfers' through improving advanced directives at William Osler Health System (Oliver and Chidwick 2017) provide excellent examples of utilizing the model for improvement as a means to engage those providing and receiving care to redesign and improve the quality of services provided.

The challenge ahead for those of us charged with leading improvements in care, in systems that are publically funded that have political expectations and pressures with a need to use existing resources effectively, is how we can achieve optimal balance between compliance and commitment so that accountability can be realized, but not at the expense of rapid improvement. Our system has valued evidence-based clinical best practice recognizing the importance in providing high quality care, moving ahead we need to place the same value on evidence-based change management that places the optimal emphasis on the levers of change including quality assurance and quality improvement to achieve our ultimate aim of high quality care for all. HQ

References

Allcock, C., F. Dormon, R. Taunt and J. Dixon. 2015. *Constructive Comfort: Accelerating Change in the NHS*. London, UK: Health Foundation.

Baker, G.R., A. MacIntosh-Murry, C. Porcellato, L. Dionne, K. Stelmacovich and K. Born. 2008. *High Performing Health Systems: Delivering Quality by Design*. Toronto, ON: Longwoods Publishing Corporation.

Bevan, H. and S. Fairman. 2014. *The New Era of Thinking and Practice in Change and Transformation: A Call to Action for Leaders of Health and Care*. London, UK: NHS Improving Quality. Retrieved April 24, 2017. <http://www.jarche.com/wp-content/uploads/2014/07/NHS-White-Paper-Extract-2014.pdf>.

Flin, R. and S. Yule. 2005. "Advance in Patient Safety: Non-Technical Skills in Surgery." *Surgeons' News* 4(3): 83–85.

Heifetz, R., A. Grashaw and M. Linsky. 2009. *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World*. Boston, MA: Harvard Business Press.

Janss, R., S. Rispens, M. Segers and K. Jehn. 2012. "What Is Happening under the Surface? Power, Conflict and the Performance of Medical Teams." *Medical Education* 46: 838–49.

Levy, C., S. O'campo-Chan, L. Huestis and D. Renzetti. 2017. "Early Rehabilitation for Patients with Hip Fractures: Spreading Change Across the System." *Healthcare Quarterly* 20(1): 29–33. doi:10.12927/hcq.2017.25088.

McKeown, S., C. Krause, M. Shergill, A. Siu A and D. Sweet. 2016. "Gamification as a Strategy to Engage and Motivate Clinicians to Improve Care." *Healthcare Management Forum* 29(2): 67–73.

Milton, N. 2014. *Why Knowledge Transfer through Discussion is 14 Times more Effective than Writing*. (Blog post.) Retrieved April 12, 2017. <http://www.nickmilton.com/2014/10/why-knowledge-transfer-through.html>.

Molloy, A., G. Martin, T. Gardner and S. Leatherman. 2016. *A Clear Road Ahead: Creating a Coherent Quality Strategy for the English NHS*. London, UK: Health Foundation.

Muniak, M., D.D. Cochrane, M. van Dijk, A. Hamilton, S. Schwarz, J.P. O'Connor et al. 2014. "What Would I Want for my Surgery?" *Healthcare Quarterly* 17(4): 7–9.

NHS Improving Quality. 2013. *An Introduction to the NHS Change Model*. Retrieved April 24. 2017. <http://theedge.nhsiq.nhs.uk/wp-content/uploads/2015/10/nhs_change_model_july2013.pdf>.

Oliver, J. and P. Chidwick. 2017. "The PoET (Prevention of Error-based Transfers) Project." *Healthcare Quarterly* 20(1): 40–44. doi: 10.12927/hcq.2017.25089.

Pettker, C.M., S.F. Thung, C.A. Raab, K.P. Donohue, J.A. Copel, C.J. Lockwood et al. 2011. "A Comprehensive Obstetrics Patient Safety Program Improves Safety Climate and Culture." *American Journal of Obstetrics & Gynecology* 204(216): e1–e6.

Sacks, G., E. Shannon, A. Dawes et. al. 2015. "Teamwork, Communication and Safety Climate: A Systematic Review of Interventions to Improve Surgical Culture." *BMJ Quality Safety* 24: 458–67.

Sheridan, E., C. Thompson, T. Pinheiro, N. Robinson, K. Davies and N. Whitmore. 2017. "Optimizing Transitions of Care – Hospital to Community." *Healthcare Quarterly* 20(1): Pg #s and DOI to be added

Terry, S. 2017. *Planning for Execution vs Emergence*. (Blog post.) Retrieved April 12, 2017. <https://simonterry.com/2017/04/04/planning-for-execution-vs-emergence/>

Vuong, V., D. O'Donnell, H. Navare, D. Merrill, M.L. Racki, S. Burton et al. 2017. "BOOMR: Better Coordinated Cross-Sectoral Medication Reconciliation for Residential Care." *Healthcare Quarterly* 20(1): Pg #s and DOI to be added

Wolf, F.A., L.W. Way and L. Stewart. 2013. "The Efficacy of Medical Team Training: Improved Team Performance and Decreased Operating Room Delays: A Detailed Analysis of 4863 Cases." *Annals of Surgery* 252: 477–85.

Yule, S., R. Flin, S. Patterson-Brown and N. Maran. 2006. "Non-Technical Skills for Surgeons in the Operating Room: A Review of the Literature." *Surgery* 139: 140–49.

About the Author

Christina Krause is executive director of the BC Patient Safety & Quality Council based in Vancouver. The BC Patient Safety & Quality Council was created in 2008 by the provincial government to enhance patient safety, reduce errors, promote transparency, and identify best practices to improve patient care.

Call for abstracts

Quality Improvement Initiatives

The editors of *Healthcare Quarterly* are pleased to announce a new quarterly series profiling quality improvement initiatives that have demonstrated improvement in the delivery of health services.

Sharing accounts of locally successful quality improvement initiatives across the country could have a profound impact on the overall Canadian healthcare system. We are seeking submission of abstracts from healthcare facilities and organizations across Canada that propose manuscripts describing local efforts that resulted in improved service delivery and patient care. We are specifically interested in quality improvement projects, improvement science and similar initiatives that engage staff and improve how services are delivered and the outcomes for patients, clients and communities.

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