McLaughlin and Kaluzny's

Continuous Quality Improvement in Health Care

FIFTH EDITION

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To my home team—Paul, Harrison, Tore, and Elijah.

–JJ

To my family for their loving support always and especially to our newest addition, Mason, who represents the future, which is what this book is all about!

–WS

Contents

Acknowledgments

As we developed the fifth edition of *Continuous Quality Improvement in Health Care*, we were inspired once again by Drs. McLaughlin and Kaluzny. While we are very appreciative of their contribution of the Preface, their contribution has been so much greater through the years, as mentors and as colleagues.

We were also inspired by the thought provoking Foreword written by Dr. Paul Batalden where he outlined the model of CQI in improving quality, safety, and value and the model of coproduction in improving the "value of the health care service contribution to better health."

We have benefited greatly from the feedback of students who have provided insight and understanding of the importance of making this book a practical teaching tool that addresses the continuing challenges of improving quality and safety of health care in the future. We are most appreciative to our friends and colleagues around the globe who authored chapters. The coordination and integration of the contributing authors was a tremendous undertaking and we were privileged to work with excellent colleagues, who are truly expert practitioners of continuous quality improvement in health care.

The production of the book required a team effort at all levels and in multiple locations. We would first like to acknowledge the assistance and guidance of the editorial team at Jones & Bartlett Learning. In Chapel Hill, special appreciation goes to Dean Barbara Rimer, of the UNC Gillings School of Global Public Health, whose leadership inspires a learning environment that stimulates innovations and the motivation to pursue them. Deep appreciation is also given to the faculty and staff in the Public Health Leadership Program at the University of North Carolina and the Center for Healthcare Studies and Surgical Outcomes and Quality Improvement Center (SOQIC) at Northwestern University with whom we shared ideas that led to a better product. We especially thank Dr. Rohit Ramaswamy, who not only authored two chapters but also shared his wisdom about the current and future trends in CQI globally. Finally, we appreciate the feedback and guidance that we received from the readers of the *Fourth Edition*, which among other things led us to reduce the number of chapters in this edition, but also gave us the incentive to go into greater depth on some of the new topics, such as implementation science. While several chapters of the *Fourth Edition* have been eliminated, we would like to acknowledge several of the authors of those chapters here, as the concepts (listed below) were integrated into this edition's remaining chapters. They include:

- Vaughn Upshaw and David Steffen—the importance of the learning organization concepts in CQI
- Anna Schenck, Jill McArdle, and Robert Weiser—the use of Medicare data in CQI and the real-world example of the Clemson Nursing Home Case Study
- Curt McLaughlin and David Kibbe—the importance of health information technology and understanding the strengths and weaknesses of various data sources used in CQI

Once again, as with CQI itself, the production of this book truly required teamwork and we appreciate and acknowledge the vital role of all of our fellow team members, not the least of which includes our families.

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Preface

The first edition of *Continuous Quality Improvement in Health Care* was published in 1994. Continuous quality improvement in health care was in its infancy. Paul Batalden had kindly educated us, and others, on his philosophy and groundbreaking efforts at Hospital Corporation of America. The Joint Commission had recently launched the *Agenda for Change*. Within the larger health care community there was interest as well as skepticism as to whether manufacturing techniques that were popular and successful were applicable to health care. The obvious need was to explain the basics and provide documentation to illustrate its applicability to health care organizations. The *First Edition* provided the basics along with a series of cases to illustrate its relevance to health care. A key chapter was "Does TQM/CQI Really Work in Health Care?"

By the *Second Edition* in 1999, the issues of quality in health care had come of age with the publication of the IOM report *Crossing the Quality Chasm*. Many issues of implementation had become evident and a new key chapter was "CQI, Transformation and the 'Learning' Organization." At the same time the importance of such efforts was recognized by the health care version of the National Malcolm Baldrige Quality Award, whose standards were included in the text.

The *Third Edition* in 2006 emphasized measurement, especially outcomes measurement, as the use of CQI concepts expanded. It also paid attention to information technology that had the power to enhance implementation and to disseminate results more widely. At the same time the barriers to widespread adoption of the knowledge produced were evident. The new cases on Intermountain Health Care and the American Board of Pediatrics efforts at organizational and professional learning were featured illustrations.

The *Fourth Edition* in 2013 was under the capable leadership of Bill Solliceto and Julie Johnson. Its publication aligned with the passage of the Affordable Care Act expanding the insurance coverage to 50 million people and the role of the CMS to assess different delivery models of care. It was a time of great expectations with emphasis on measurement and the movement of these efforts into a number of professional, governmental and international spheres. The CQI approach to quality and quality improvement had now achieved global prominence and led to the development of the companion volume, McLaughlin, Johnson, & Sollecito, *Implementing Continuous Quality Improvement in Health Care: A Global Casebook*.

As the *Fifth Edition* goes to press, basic elements of the ACA have been dismantled and, while quality improvement is a well-accepted management tool, issues of institutionalization, measurement, implementation and adaptation to environments remain challenging. One is tempted to conclude that not much has changed; major segments of the population are at risk of losing insurance coverage, interest in empirical evaluation of alternative care models and quality improvement efforts has slowed, and some evaluation studies on cost savings of quality improvement have not met expectations.

Over the past 25 years we have learned a lot about quality improvement, its implementation

and the challenges and opportunities of quality and quality improvement as a core function in health care. What has changed is the context within which health care is provided that must be accommodated within future quality improvement processes. Many of these contextual changes were un imaginable 25 years ago; the sequencing of the genome and its implication for genomic medicine, the commercialization of health care, the consolidation of heath care organizations on a massive scale, and the introduction of new forms of provider organizations, (e.g., ACOs, Walmart, and Humana), the deprofessionalization of health care providers, the basic demographics of the population, and the types of care that will be needed in the years ahead.

With these changes have come new issues involving quality improvement:

- Will the addition of ever more quality and "value" measures turn attention away from an overall culture of improvement? Will people focus in on what is measured? That is already one reason why health care is great at increasing revenue, but not at reducing waste.
- Can we overcome the gaps between professional points of view? Or will we continue to have an attending specialist see the story boards in the his unit as "something the nurses are doing?"
- Will the institutionalization and professionalization of quality in ever large and more complex institutions be relegated to the quality officer/office rather than a fundamental responsibility of all personnel?
- Will health care management recognize that their departments and institutions are part of a larger system of care? A system of care characterized by handoffs that transcend organizational boundaries involving an array of organizations and providers with different professional and organizational cultures yet critical to providing an integrated seamless care continuum from prevention to end of life.

These are not abstract academic issues. These are real issues, involving real people, of which we are all at risk. We know what it is like to observe specialists exhibit mutual hostility at the bedside because one didn't comprehend why the other demanded a prompt weekend consult, or wonder how a case manager can expect an emotionally exhausted family, following an extended and traumatic hospital stay, to select from a list of long term care facilities without any guidance or insight about the facilities. These experiences change your perspective on quality, quality improvement and the role of management in implementing organizational structures and mechanisms to assure interdisciplinary collaboration and training hospital personnel to effectively manage the transition points in the care continuum.

As we enter an era of an aging population and precision medicine supported by genomics and big data, the quality of care at the front end will rapidly improve leaving the greater challenges and the greater payoffs to society in chronic and end-of-life care. What Deming, a pioneer in quality improvement, stated 50 years ago remains relevant today—that the problems are with the system and the system belongs to management. Our methods of quality improvement must encompass these larger, increasingly relevant systems.

Curtis P. McLaughlin, DBA
Arnold D. Kaluzny, PhD
Chapel Hill, North Carolina

Foreword

…questions
that have no right
to go away (Whyte, 2007).

This book invites two questions that may "have no right to go away" in our journey toward better health:

1. If we make improving quality, safety, and value an "enterprise-wide effort," what do we need to know and do?
2. If we make improving the "value of the health care service contribution to better health" our focus, what do we need to know and do?

Enterprise-Wide Effort?

In response to this question, our attention has been directed at the ways and structures through which leaders lead organizations and the way(s) organizations and their people respond. In the last few decades, in addition to work "inside," we have been encouraged to look outside of the health care services sector to organization-wide efforts in automotive, computer, aerospace, and elsewhere, where great gains in quality, safety, and value have been made. We have learned a great deal about our own work: health care service as a system, process; system leadership; measurement of outcome; unwanted variation; system failure and unreliability; organization-wide contributions to better health; making improvement part of everyone's job; accountability for better performance and many other themes.

The *First Edition* of this book was published as we were deeply into these pursuits and learning (McLaughlin & Kaluzny, 1994). Several chapters in this edition of that book honor this question and help identify what might be known and done currently. Their content helps frame important contributions to leader development, selection, and performance assessment. In the short-term, following these chapters can offer today's leaders and organizations real substance in the performance of "leader and organization-wide work" for the improvement of health care service.

Value of Health Care Service Contribution to Better Health?

This question invites focus on the words "service," "value," and "contribution." It suggests that we recognize that we are mainly in the business of making services, that we are invited to attend to the economic value of our efforts and that we acknowledge that our services are best thought of as a contribution to health.

Service

Victor Fuchs in his early review of the emerging service economy noted that making a service was different from making a product (Fuchs, 1968). Services always required the active participation, insight from two parties: the professional and the beneficiary. Vincent and Elinor Ostrom were the first to call that

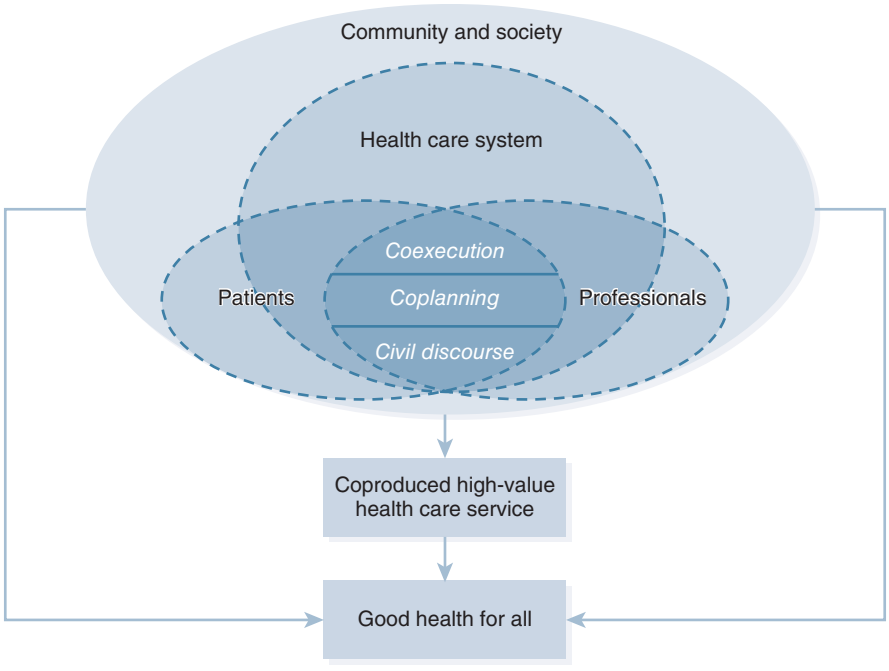

FIGURE 1 Conceptual Model of Health Care Services Coproduction

Reproduced from Batalden M. et al. *BMJ Qual Saf* 2016;25:509–517.

phenomenon "coproduction."[4] Building on the work of Lusch and Vargo (2014), Osborne, Radnor, and Nasi suggested that a "product-dominant logic" had overtaken a clearer view of the logic involved in making a service.[6] Building on these ideas of "service" and how "making a service" might be different from "making a product," Batalden and colleagues offered a description of the coproduction of health care service and a model for understanding and use, as illustrated in **FIGURE 1** (Batalden, Batalden, Margolis, et al., 2016).

The model invited attention to the interactions of patients and professionals. It suggested that a variety of interactions might be possible, ranging from "civil discourse" to "co-execution." It recognized that these interactions occurred partly within an openly bounded health care system and in the context of social and community systems. This variety of interaction depended in part on the knowledge, skill, habits and willingness to be vulnerable as the parties engaged in the relationships and actions that characterized a health care service.

These insights formed the basis of a clearer idea of the interdependent work of two groups of people, some of whom might be named "patients" and some named as "professionals"—though in reality they each brought different expertise to their shared interactions.

If we really mean that health care services are "coproduced," new tools that enable visualization and design that reflect the contribution of patients and professionals will be helpful. The measurement of process and result will need to reflect both the implementation and effect of the professional's science-informed practice (Greenhalgh, 2018) and

the methods of addressing and the degree of attainment of the patient's goal.

But not all health professional work seems to fit this service logic. Sometimes the health care work seems to better fit "making a product." Helping professionals know when to use which logic—service-making or product-making—will open new approaches to design, as well as professional education, development.

Value

Øystein Fjeldstad has suggested that multiple system architectures might be useful to create value in modern service-making. He includes the development of standardized responses to commonly occurring needs in linked processes (value chains), customized responses to particular needs (value shop), and flexible responses to emergent needs (value network) (Stabel & Fjeldstad, 1998; Fjeldstad, Snow, Miles, Lettl, 2012). Using this typology one can begin to imagine the opportunity to link them in ways that match need and system form. Much more development of these multiple ways of creating value seems likely.

Contribution

This word invites us to remember that a person's health is not easy to "outsource" to a professional. At best, the health professional's coproduced service makes a contribution to further another person's health. Recognizing that the shared work is a contribution to health, invites inquiry into patient need, patient assets, patient supports, patient knowledge & skill, patient's lived reality as part of the understanding for service coproduction design. A similar inventory of knowledge, skill, habits, capability and interest of professionals seems in order. Even the professional-patient relationship itself could be explored for its capability in contributing to the process of coproducing a service. Assessments of the role that other complementary resources & services, such as social services must become even more clear and reliable as we use and integrate them with health care services for "improved outcomes" (Bradley & Taylor, 2015).

With this edition, the editors point to the future of the second question and have opened this space for readers (Chapter 14).

In Summary

Both questions seem to have "patiently waited for us" in the poet's words (Whyte, 2007). They both invite strategic thinking and aligned professional action. Both recognize that "knowing" alone is not sufficient. Books like this can invite knowing and doing, but it is the reader who makes things happen. Enjoy the authors and editors' words in this book but enjoy their intent in the work of an informed, acting reader even more. Let me close with Mary Oliver's words (Oliver, 2005):

What I Have Learned So Far

> Meditation is old and honorable, so why should I not sit, every morning of my life, on the hillside, looking into the shining world? Because, properly attended to, delight, as well as havoc, is suggestion. Can one be passionate about the just, the ideal, the sublime, and the holy, and yet commit to no labor in its cause? I don't think so.
>
> All summations have a beginning, all effect has a story, all kindness begins with the sown seed. Thought buds toward radiance. The gospel of light is the crossroads of—indolence, or action.
>
> Be ignited, or be gone.

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