Every healthcare organization wants to be high performing. The desire to provide high-quality care to every patient during every encounter is woven into our very DNA. And of course, in an ever-changing environment, our ability to do so consistently determines our likelihood of survival.

Before we can hold any meaningful conversation, we need to define our terms. What is quality? At Studer Group®, a Huron solution, we define quality as the cumulative impact of all that happens to a patient while in an organization’s care. This includes the care provided as well as the outcomes achieved. Patient perception of care results, safety metrics, and the presence of hospital-acquired conditions (HACs) and preventable readmissions are measures that help define quality of care.

Most leaders realize that consistent quality is a product of a consistent culture — a culture in which everyone in every department is focused on quality at all times and held accountable for achieving it. Without such a culture, quality initiatives will not succeed. Sure, you may get surges of improvement here and there, but a) they probably won’t happen throughout the organization, and b) they probably won’t be sustained over the long term...especially as new regulations are added that pull your focus in different directions.

To get all of these outcomes right, every time, requires getting the culture right. And any organization’s culture is inextricably tied to its leadership. Since leaders are responsible for direction, example, and execution, quality improvement begins at the top.

That said, leader dedication is rarely the issue. In my experience, most leaders are passionate and committed. It’s just that leaders are often focused on their own area and not aware of the organization’s overall goals. They feel they are working hard and doing the right things, but in reality they may not be doing the best things to consistently meet the needs of the organization as a whole.

In other words, implementation, not motivation, is where most organizations fall short. The right culture — one where everyone is well trained, laser-focused on quality, and held accountable for achieving it — doesn’t happen on its own. Leaders need a “map” to follow, one that aligns goals, behaviors, and processes. This framework, along with a focus that consistently acknowledges the overarching why behind the work they ask people to do, supports the culture and keeps it strong over time.

**Evidence-Based Medicine**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Treatment Plan</th>
<th>Prescription, Modalities</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALIGNED GOALS</strong></td>
<td><strong>ALIGNED BEHAVIOR</strong></td>
<td><strong>ALIGNED PROCESSES</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leader Development</th>
<th>Must Haves®</th>
<th>Performance Gap</th>
<th>Standardization</th>
<th>Accelerators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective Evaluation System</strong></td>
<td><strong>ALIGNED GOALS</strong></td>
<td><strong>ALIGNED BEHAVIOR</strong></td>
<td><strong>ALIGNED PROCESSES</strong></td>
<td></td>
</tr>
</tbody>
</table>
Studer Group’s Evidence-Based Leadership (EBL) framework provides that map. We find that EBL and culture go hand in hand. As an organization begins to implement this framework, the culture needed to create consistent, sustainable results naturally evolves, strengthens, and grows. It happens simultaneously and organically.

**Evidence-Based Leadership: The Foundation of a Culture of Quality**

What is EBL? It’s an approach to leadership modeled after the concept of evidence-based medicine. Evidence-based medicine (EBM) aims to apply the best-available evidence to clinical decision-making. It assesses evidence of the risks and benefits of tests and treatments — gained from external scientific research — in order to determine whether or not they are likely to do more good than harm. Individual clinical expertise factors into decisions as well, as do the patient’s values and expectations.

Similarly, EBL is based on hardwiring the behaviors that have been shown through evidence to have the greatest impact on patient outcomes. In this case, the evidence is based in part on Studer Group’s work with hospitals across the U.S. and in Canada, Australia, New Zealand, and beyond.

The EBL framework serves two purposes: It provides the structure for hardwiring behaviors, and it aligns the culture with the “accountability” mindset.

To achieve and sustain the quality outcomes it takes to thrive in the healthcare environment, every individual needs to execute properly, every time. They need to consistently perform the right behavior in the right way. The EBL framework drives consistency in any behavior — in experience of care as well as in processes of care, flow, and safety.

We all know it’s possible to “force” new behaviors on employees. But it’s only when people choose those behaviors of their own free will — because they know that it’s the right thing to do for the patient — that you’ll see lasting results. It’s then that people will choose to practice the behaviors when no one is looking, and it’s then that they’ll hold others accountable too.

As EBL is practiced — as the tools and tactics are taught, reinforced, and measured — we see the engagement and passion that empower them to do this begin to manifest.

When we see that people won’t tolerate others not doing a proven prescribed behavior, we know that a cultural shift has taken place. The mindset and the behavior are both hardwired. It’s an accountable culture that creates the “it’s not okay if the behavior doesn’t happen” mindset.

Of course, building this culture takes time — and as the EBL framework is followed with a very strong focus on the why, it happens organically.

**EBL in Action: How (and Why) It Works**

Here’s how many organizations do it: As they seek to improve quality, they may implement a new process. They may paste it onto their old way of doing things. For example, they might not address leadership issues that are holding departments back. Or they may neglect to explain the why behind the changes they’re asking people to make.

It’s great to set a goal for, say, reducing falls and ask people to practice a new tactic that’s proven to accomplish it. But if you don’t connect the dots on why it matters that people execute the new behavior, or train them how to do it, or put in place a system for validating it, the changes won’t happen — at least not for long.

Starting with the EBL framework changes that reality. Here are some of the reasons why:

- It ensures that everyone is aligned with the goals that drive the organization’s mission.
- It requires that the right leaders are paired with the right goals and are held accountable for meeting them.
- It ensures that everyone is well-trained in the processes and behaviors they’re being asked to implement.
- It ensures that the why is communicated over and over, at many levels and in many different forms — during team meetings, during rounding, at employee forums, in newsletters and emails.
- It ensures that everyone knows how success is measured, that behavior is validated, and that gaps in performance are addressed.

Let’s say an organization’s chief nursing officer (CNO) and the chief quality officer (CQO) want to address performance gaps regarding patient falls. The organization has implemented the eight behaviors of Hourly Rounding®.
In addition, it has put in place a falls prevention program that includes posting fall risk signage on the patient’s door and using colored non-slip booties and colored arm bands to identify and protect patients identified as at risk for falls.

The CNO and the CQO round on the unit’s staff and patients and find that staff members are not always practicing these behaviors. Furthermore, they discover that none of the patients know the purpose of their colored arm band.

The CNO and CQO must now go back and “close the loop.” They may hold a meeting in which they explain to staff that behaviors are not being practiced consistently. During this meeting they will reinforce the why behind the tactics. They may solidify their point by reminding staff members of the evidence that shows these tactics get results (evidence that was first shared when the tactics were introduced).

Usually, this validation process needs to be repeated only a couple times before the staff “gets it.” They aren’t being retrained. They’re simply being reminded and held accountable.

It works! When we help organizations go through this validation process, we find most people will practice the new behavior right away. A small percentage will need one coaching conversation in order for the new behavior to reach “hardwired” status. Of this small percentage, the majority will respond positively and begin practicing the desired behavior.

Once an organization has addressed performance gaps and arrived at a place where inconsistencies in practicing the behavior aren’t tolerated, the behavior becomes truly standardized. At that point it can innovate to move outcomes faster.

What’s more, when the EBL framework has been established and the organization is focused on the mission and knows the why, any improvement can be achieved. Regardless of the initiative, the process is the same.

A Practical Application: EBL and Handwashing

Let’s say that you want to decrease infections. You know that one behavior that will help you achieve this goal is handwashing. Here’s how you would use the principles of EBL to implement and reinforce this tactic:

1. Your organization sets a very specific target metric and monitors it monthly.
2. Hold the staff accountable for performance on this goal by including the handwashing metric on their evaluations and giving it the proper “weight” so that it becomes their priority. Objective, weighted leader evaluations — rather than the subjective ones many organizations use — are a critical piece of the equation.
3. Train leaders on the proper handwashing technique and on how to cascade this technique to the staff members they lead.
4. As you train, convey the why. It’s important that people understand how handwashing impacts patients and even saves lives — so they will feel sufficiently motivated to address those not practicing the behavior.
5. Validate! It is critical to make sure staff members are doing what you’ve asked them to do, doing it correctly (following every step), and doing it every time. (Even when people say, “Yes, we’re all washing our hands,” they may not be. Perception isn’t always reality.) Here are two ways to validate:

Nurse Leader Rounding: In general, leader rounding on patients allows leaders to reinforce desirable behaviors and to “close the loop” with feedback when they discover that a staff member is not practicing them. As nurse leaders round on patients and family members, they might ask, “Are all staff washing their hands every time they come into your room?”

Rounding on Staff: This is the other type of rounding leaders do, and it provides a built-in opportunity to connect with employees on how their efforts are going. It’s a chance to ask, “What is going well with
the handwashing initiative? Is there anything I can do to help you with this?” It’s also a good opportunity for leaders to pass along any words of recognition or praise on the person’s good performance in this area.

A Matter of Focus

Of course, hospital-acquired infections are only a small part of the picture. The changing healthcare environment demands that organizations heighten their focus on a number of measures. And let’s not forget HCAHPS results. Given that new measures and process are added and removed each fiscal year, it can at times feel like we’re jumping from one goal to another.

We recommend our partners identify the two or three process of care measures and perception of care measures they struggle with the most. We focus in on and hold leaders accountable for improving those measures. While we continue to monitor other measures as well, our main focus remains on moving up those that are lagging.

Let’s say your organization is struggling to bring up one of the process of care measures for pneumonia. The requirement is that blood cultures be obtained before the initiation of antibiotics for the pneumonia patients in the emergency department. While this may sound simple, if the nursing, pharmacy, and lab staff aren’t working together, the two procedures may happen in the opposite order. We see this occur in EDs across the nation. Effective identification of patients with pneumonia, workflow processes that support multi-department care collaboration, and a system that holds care providers accountable are needed to ensure this process of care measure occurs 100 percent of the time.

Any department that impacts this process of care measure at all needs to have goals that are heavily focused on moving it. Departments that don’t impact this metric, as well as those that do have a connection but are excelling in that area, need to focus on their lowest items. (Of course, everyone should be aware of where the organization as a whole is not doing well, and of the plan to improve in this area, so they can support the effort.)

To sum up, all units pick the measures in which they aren’t hitting goals and focus in on those. Everyone focuses in on the crucial behaviors proven to move these goals as well as the why behind them. Validation occurs and feedback is given to those not practicing the behaviors it all takes place in a cyclical way until the outcomes move.

In a study by Studer Group’s former research subsidiary, the Alliance for Health Care Research, nurses who rounded hourly on telemetry, surgical, and medical-surgical patients reduced call lights by 4,901 in a four-week period. This study, published in September of 2006 in the American Journal of Nursing, showed that Hourly Rounding will:

• Decrease call lights by 37.8 percent
• Decrease falls by 50 percent
• Decrease hospital-acquired decubiti by 14 percent
• Improve patient satisfaction by an average of 12 mean points

Because of the reduction in call lights, Hourly Rounding potentially saves nurses 326 hours per month or 81.5 hours per week — time that can be spent proactively managing workflow and delivering better clinical outcomes.

When a new behavior is hardwired, people will keep doing it automatically — even after the organization moves on to its next focus. It has become second nature.

You may have to coach heavily at first as you validate, but that is a small and short-lived part of the process. Eventually you’ll need to check in only for refreshers and course corrections. By using EBL principles to get people engaged and keep them engaged, you’ve set them up for success with minimal coaching long term (except, perhaps, in a few very rare instances).

One of the great things about taking a cultural approach to quality is that people want to get better and better. In fact, they’re passionate about it. A deeply held belief in doing what’s right is what energizes a leader to lead and inspires others to follow no matter what obstacles they may encounter.

The knowledge that you’re creating better conditions for the patient is what keeps people pushing forward. It’s always there in front of them, motivating and inspiring them to do their best work. Keep everyone’s eyes focused on that sense of purpose, and excellent quality will be the natural outcome.