The Hospital Leadership and Quality Assessment Tool (HLQAT): Leadership Tools for Improving Clinical Practice

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At this session you will ---

- Describe how HLQAT identifies leadership activities that have opportunity for improvement and for closing quality gaps
- Explore how a work group of hospitals have linked their HLQAT results with performance
- Identify how leaders can use the HLQAT as a tool for improvement
• Your Needs –
  — What questions do you have?
  — What opportunities and issues have you encountered?
  — What other work with leaders have you done?
  — Where do you go from here?

ACHE Annual Top 3 Survey
Top Issues Confronting Hospital CEOs

<table>
<thead>
<tr>
<th>Issue</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial challenges</td>
<td>73%</td>
<td>71%</td>
<td>67%</td>
<td>72%</td>
<td>70%</td>
<td>77%</td>
</tr>
<tr>
<td>Pt Safety &amp; Quality</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>43%</td>
</tr>
<tr>
<td>Care— uninsured</td>
<td>26%</td>
<td>36%</td>
<td>35%</td>
<td>37%</td>
<td>38%</td>
<td>41%</td>
</tr>
<tr>
<td>MD/hosp. relations</td>
<td>26%</td>
<td>32%</td>
<td>33%</td>
<td>40%</td>
<td>35%</td>
<td>32%</td>
</tr>
<tr>
<td>Quality</td>
<td>17%</td>
<td>18%</td>
<td>23%</td>
<td>29%</td>
<td>33%</td>
<td>--</td>
</tr>
<tr>
<td>Pers. Shortages</td>
<td>58%</td>
<td>33%</td>
<td>36%</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Patient safety</td>
<td>9%</td>
<td>16%</td>
<td>20%</td>
<td>27%</td>
<td>29%</td>
<td>--</td>
</tr>
<tr>
<td>Gov. mandates</td>
<td>18%</td>
<td>19%</td>
<td>16%</td>
<td>23%</td>
<td>22%</td>
<td>26%</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>7%</td>
<td>13%</td>
<td>18%</td>
<td>16%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>Capacity</td>
<td>28%</td>
<td>16%</td>
<td>17%</td>
<td>11%</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>Malpractice ins.</td>
<td>24%</td>
<td>25%</td>
<td>11%</td>
<td>3%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

Notes: QI and Safety combined in 2008, Others below 10% in 2008 included technology, NFP status, and disaster preparedness.
HLQAT Basics

HLQAT Background

What is it?
Why does it work?
Who developed it?
How was it validated?

What Is HLQAT?

- A tool to help hospitals identify and improve those structures, processes, and leadership activities that are associated with high performance in clinical quality
- Completed by a mix of executives, board members, and clinical leadership at both the senior and middle levels of the organization
- Identifies leadership actions in twelve domains
HLQAT Domains

1. Knowledge seeking
2. Established goals and priorities
3. Effective communication
4. Collaboration
5. Clear roles
6. Supportive culture
7. Public reporting
8. Process improvement tools and techniques
9. Adequate resource allocation
10. QI education
11. Monitoring and evaluation
12. Rewards/recognition

What Is HLQAT?

• Why does it work?
  — Highlights strengths and gaps in leadership activities
  — Provides perspectives from key stakeholders
  — Offers interventions targeted at identified gaps
  — Offers the potential to shorten the time to get started on improvement
HLQAT Survey Component

The Hospital Leadership and Quality Assessment Tool (HLQAT) is designed to assess the experiences of hospital-based employees, providers, and managers about important areas of clinical care and their engagement in clinical quality improvement activities within their organizations. The current version is designed by the Institute of Healthcare Improvement (IHI), the Joint Commission, and the Ochsner Health System. This version will be used in this study. Earlier versions of the survey were piloted with participating hospitals and found to be helpful in identifying areas for improvement. The current HLQAT is the result of rigorous analysis of results from previous surveys.

Instructions for completing the HLQAT:

This gap assessment is designed to provide your organization with information about the strengths and weaknesses of your organization in terms of areas supporting quality improvement. In addition, it can point to areas where you can make improvements to your organization. It is important to consider these areas in the context of your organization's goals and objectives. The survey is divided into several sections, each with specific questions about different aspects of your organization's quality improvement efforts. It is recommended that you review each section, and then indicate your response to each question.

**Description of the HLQAT Survey**

**Title/Roles of Hospital Staff Who Should Complete the HLQAT**

**Senior Leadership Survey**

- **Clinical Management Survey**

The Hospital Leadership and Quality Assessment Tool (HLQAT) is designed to assess the experiences of hospital-based employees, providers, and managers about important areas of clinical care and their engagement in clinical quality improvement activities within their organizations. The current version is designed by the Institute of Healthcare Improvement (IHI), the Joint Commission, and the Ochsner Health System. This version will be used in this study. Earlier versions of the survey were piloted with participating hospitals and found to be helpful in identifying areas for improvement. The current HLQAT is the result of rigorous analysis of results from previous surveys.

**HLQAT Senior Leadership Survey**

**SECTION A: Your Board**

1. The term board refers to your organization's Board of Directors. If your organization operates under only a systemwide Board, or if you are more familiar with the systemwide Board, please answer about your systemwide Board. For questions that specifically refer to Board activities, indicate which board you will be thinking about in the survey.

   - ○ Hospital Board
   - ○ Systemwide Board

**SECTION B: Knowledge Seeking Organization**

1. During the past 12 months, how often did your hospital leadership seek input about quality and patient safety issues by doing the following activities?

<table>
<thead>
<tr>
<th>Conducting community focus groups</th>
<th>Not in the past 12 months</th>
<th>Once or twice in the past 12 months</th>
<th>Several times in the past 12 months</th>
<th>Monthly</th>
<th>More than once a month</th>
<th>Does Not Apply or Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Conducting community focus groups</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Reviewing patient satisfaction data/report</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Encouraging the sharing of patients stories about their experiences in the hospital (in-person stories, letters, or both)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Surveying employees about clinical quality improvement and/or patient safety</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Other (Please specify)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
# Domain 9 – QI Resources

## SECTION II: Adequate Resource Allocation to Quality Improvement

How much do you agree or disagree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Does Not Apply or Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sufficient staff are available to provide care that meets the organization’s expectations for quality</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. This hospital’s annual operating budget includes sufficient funding for clinical quality improvement activities</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. Leaders of clinical quality improvement initiatives receive sufficient funds for their improvement activities</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. Adequate time is dedicated to clinical quality improvement activities in this hospital</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. This hospital has all the experts it needs to support clinical quality improvement</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. How much do you agree or disagree that this hospital devotes adequate resources to quality improvement?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

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## Who Developed the HLQAT?

### The Project Team

- **University of Iowa**: Dr. Barry Greene, Dr. Samuel Levey, Dr. Tom Vaughn
- **OFMQ**: Dr. Dale Bratzler, Shannon Archer
- **Premier|CareScience**: Dr. Eugene Kroch
- **Brandeis University**: Dr. Chris Tompkins
- **Dot.Comments**: Chris Hatcher
- **IFMC**: Mark Koepke
- **ActiveStrategy**: Tim Mueller
- **HSAG**: Andrea Silvey

### Oversight

- **IHI** – Jim Conway (via IHI IMPACT Network, Boards on Board)
- **AHA** – Steve Mayfield, AHA, VP of Center for Excellence
A Brief History

- **October ’05** – Core Research Team is formed around conducting a “Short Leadership Survey” (next slide) – precursor to HLQAT
- **March ’06** - Initial study on board quality dashboards and hospital executive engagement published
- **September ’06** – Oklahoma Foundation for Medical Quality (OFMQ) assumes leadership role
- **Summer/Fall ’07** – 13 regional “HLQAT Dialog Sessions” held; Web-based version of HLQAT created
- **Winter ’07** – Commonwealth Fund grant process underway; grant effective May ’08
- **April – June ’08** – Pilot testing within 58 hospitals; analysis and survey revised
- **August - December ’08** – Development of HLQAT Resources for Leadership Interventions (RLIs)
- **Jan – June ’09** – Testing of in selected hospitals; link to IHI Improvement Map

Descriptive Findings from Short Survey & other studies

- **24%** of boards interact with the medical staff “a great amount” in setting hospital quality strategy.
- **27%** of boards spend more than one fourth of their time on quality issues.
- **66%** of hospitals base some type of executive compensation on measurable Quality Improvement.
- **BUT** only **13%** of hospitals tie quality improvement to executive base compensation packages
- **80%** of responding hospitals use a formal quality performance measurement “dashboard” for reporting to their boards.
- Lake Wobegon: Board members of low performing hospitals all thought their performance was at or above average
Linking Leadership Survey to CareScience Quality Index (Qx)

• Measures the risk-adjusted overall rate of adverse outcomes
  —Mortality
  —Morbidity
  —Complications
• Uses the Corporate Hospital Rating Project* utility weights to construct an index (Qx)
• Responses were matched to Qx derived from H.A. “all-patient” data and MedPAR 2004 data


Findings

Better outcomes found in hospitals where...

1. The board spends >25% of time on quality issues (p = 0.009)
2. The board receives a formal quality performance measurement report (p=0.005)
3. There is a high level of interaction between the board and the medical staff on quality strategy (p=0.021)
4. The senior executives’ compensation is based in part on QI performance (p=0.008)
5. The CEO is identified as the person with the greatest impact on QI (p=0.01), especially when so identified by the QI executive (p<0.001)

Transitioning to HLQAT

The Short Survey provided good insights, but it highlighted:

- Needs for a more comprehensive survey tool
  AND
- Need for improved ability to correlate findings to comparative quality data

How was it validated?

- Testing summer of 2008 with 58 hospitals and 939 respondents.
- Item, reliability, and factor analyses resulted in questions being dropped.
- Associations were found between HLQAT scores and certain quality scores.
- Most correlations are positive and small
Variation across Domains

Respondent Variation by Domain
Ongoing Validation

- HLQAT Testing – 12/08 – 5/09
  - IHI IMPACT Network Workgroup
    - Test HLQAT and link to Improvement Map actions
    - Test correlations with Whole System Measures
      - HSMR
      - CS Quality Index (for adverse outcomes)
      - HCAHPS
    - Identify resources for interventions – existing or new

- Your work

IMPACT Workgroup

- HLQAT Workgroup
  - Members: Volunteers from IMPACT Network
  - January – May 2009 with follow-up October 2009

- Commit to:
  - Administering the survey to key stakeholders in leadership roles; a mix of executives, board members, and clinical leadership
  - Data transparency for workgroup learning
  - Participate in 6-7 calls over 90 days to share assessments, planned actions, and ongoing learning
  - Contribute to June 09 IMPACT Leadership session regarding shared learning

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IMPACT Workgroup

• HLQAT Workgroup Members:
  – UH Case Medical Center
  – Henry Ford Health System
  – Winchester Hospital
  – Gundersen Lutheran
  – Carondelet Health
  – Via Christi
  – University of Kansas Hospital
  – Iowa Health System
  – Florida Hospital Flagler
  – HealthEast
  – CAMC Health System

HLQAT Workgroup Purpose

• Provide IMPACT members an opportunity to test a new tool to gain insight into leadership strengths and opportunities for improvement
• accelerate results based on HLQAT use
  – Identify actions to close gaps
  – Useful tools/resources to accelerate improvement
• Identify links from the HLQAT to the Whole System Measures
• Contribute to the IHI Improvement Map through survey results and identified actions
• Share learnings from the workgroup with the IMPACT Leadership Community for improved leadership for quality
Summary HLQAT Results – 18 Hospitals

National Average

56.7
68.0
84.6
75.9
79.7
50.2
72.1
66.7
73.9
75.6
86.3
72.7
83.8

Each symbol represents up to 2 observations.
What We Know Right Now

• *Not* a direct test of the value of HLQAT in guiding hospital performance improvement
• Not correlated with Whole System Measures
• So…Can HLQAT and resources to improve lead to improvement in hospital leadership and clinical quality scores?

How Used

• Board, senior management, and middle management presentations
• Stimulated conversations and different perspectives on what was in place, effective, or useful
• A learning tool with the three different perspectives – board, senior leaders, and middle managers
How Used

• Putting a face to the numbers
  — The concepts in action
  — What does it look like

Fiscal Year 2009 Goal: Reduce preventable harm by 50%
Tales from the Trenches

• What we learned or re-learned
  — Survey preparation takes time and is essential
    ➢ Why are we doing it and how will we use the results?
    ➢ Survey fatigue?
    ➢ Who is accountable for the survey and results?
  — The conversations were as important (perhaps more important) than the results
  — A workgroup of eager learners contributed to everyone’s gain
  — Boards embraced it

Tales from the Trenches (cont)

• What we learned or re-learned (cont)
  — Leaders are eager to figure out ‘how are we doing?’
  — It affirmed concerns or focus – reinforced strategy
  — Linked to Safety Culture and Engagement Surveys
  — Ongoing concern about Senior Leaders’ attention
Insights

• This work helped participants to think broadly about how the definition of leadership for quality and all the different aspects that go into it
• We believe we are doing good work but this challenged us to say “how do we know?”
• Do not worry if it is not perfect – that’s part of the learning

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Insights

• More information like this is needed – more evidence-based leadership information to test the theories out there
• This helped to understand the key factors that influence quality in the organization
• Improvement Map Gap Analysis and Resources can provide useful tools

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IHI Improvement Map

Explore the Map

Your destination is a customized collection of processes. These processes will be the ideal fit for your aims and circumstances.

- **BY DOMAIN**
  - Explore by the type of processes, including patient care processes, support care processes, and leadership and management processes.

- **BY AIM**
  - Explore by alignment with the six Institute of Medicine (IOM) dimensions of quality: Safety, Effectiveness, Patient-Centeredness, Efficiency, Equity, and Integrity.

- **BROWSE ALL PROCESSES**
  - View all processes on the Improvement Map or search by typing a keyword in the box below.

IHI has also designed a portfolio of programs to help hospitals make the most of the Improvement Map.
Where Are You Now?
Gap Analysis

*Hospitals that show the greatest improvement are those that know where they are and where they are going.*
The Improvement Map can help you to understand both.

- Go to [http://www.ihi.org/ImprovementMap](http://www.ihi.org/ImprovementMap) and click on the Gap Analysis link in the gray “Take Action” box
- Identify the number of processes you have in place, and the number of processes you have started
- Share your learning by completing the Survey

### Gap Analysis Results

<table>
<thead>
<tr>
<th></th>
<th>No. of Processes in Place</th>
<th>No. of Processes Started</th>
<th>% in this Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Care Processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership and Management Processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Total Processes</td>
<td></td>
<td></td>
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</tbody>
</table>
Improvement Map Resources

Evaluation

• Please evaluate this presentation at:
  http://www.surveymonkey.com/s/BarbaraBal
  ik

• For questions:
  —Contact Barbara@TheCommonFire.com
  —Thank you!