Delivering Value Through Evidence-Based Practice
Cost reduction has been a top priority in health care for at least the past decade.

For hospital leaders, this traditionally meant coming up with ways to reduce costs by raising efficiency in particular areas.

Take length of stay, for example. Want a low—or zero—cost way to add beds to your hospital? Get patients out more efficiently. In fact, for a 400-bed hospital, reducing length of stay by one day can be the equivalent of adding 65 new beds.

But we may be reaching terminal velocity. Our research shows that average length of stay has plateaued since about 2000, which may indicate that organisations have maxed out traditional cost-savings opportunities.
Now health care executives are turning their attention to care delivery

They’re asking chief medical officers to find cost reduction opportunities at the system level. Obviously, the only acceptable changes are those that reduce costs without compromising quality. But we think the bar should be set higher.

The best acute care transformations improve both efficiency and care quality.

And we think reducing clinical variation through evidence-based practice (EBP) is one of the best ways to achieve both of these aims.
Aggressive treatments can create clinical variation.

Several studies point to clinical variation as a prime target for efficiency and care quality improvement initiatives.

Harvard and Dartmouth researchers, for example, classified 27% of practicing US cardiologists as “cowboys”, meaning they consistently recommended the most invasive care option available.

The researchers also found that doctors perform almost half of all cardiac catheterisations to fulfil colleagues’ expectations—not because they need to for clinical reasons.

“Cowboy” Cardiologists
Cardiologists Who Consistently Recommend Most Invasive Care Option

27% Recommend
Clinical variation is also costly. In certain settings, the same study found, end-of-life expenditures are roughly 40% higher than they might be if doctors followed standard clinical guidelines.

Many industries reduce variation by instituting standard procedures. This is a lot harder to do in health care, of course, but it’s not impossible. In the appropriate settings, evidence-based practice gives us a responsible, effective way forward.

**Evidence based practice is hard to define**

Organisations build protocols supported by a range of evidence, from randomised trials to clinical consensus. Here, we’re not going to limit our definition of evidence-based practice to a particular level of evidence.

Instead, we’ll use the term to describe an organisation’s defined standards of care in any given area. Regardless of whether these standards are based on clinical trials or common practice, they represent general agreement on how to deliver care and appropriately use resources within a given clinical area.
Many believe in evidence-based practice...

Support for evidence-based practice is generally strong. Several organisations tell us they have invested significant time and resources in creating and adopting clinical guidelines, such as those described below.

<table>
<thead>
<tr>
<th>System Efforts to Reduce Variation</th>
<th>Specialty Group Initiatives</th>
</tr>
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<tbody>
<tr>
<td>System convenes multidisciplinary groups to build clinical guidelines</td>
<td>Specialist groups select which order sets and care pathways to build</td>
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<table>
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<tr>
<th>Cross-Setting Care Pathway Implementation</th>
<th>Frontline Innovation</th>
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<tbody>
<tr>
<td>System builds care pathways for patient populations</td>
<td>Multidisciplinary staff participate in care redesign initiatives</td>
</tr>
</tbody>
</table>
The numbers bear this out. A 2013 Advisory Board survey found that 76% of chief medical officers reported broad cultural acceptance for evidence-based practice among the medical staff. Data we collected from over 2,400 doctors confirmed this—nearly 80% agreed they should adhere to cost-effective clinical guidelines.

“There Is Broad Cultural Buy-In for EBP Among Medical Staff”

n=18 CMOs

76% Agree

“Doctors Should Adhere to Cost-Effective Clinical Guidelines”

n=2,434 physicians

79% Agree
...but few implement it successfully.

While doctors may not be opposed to evidence-based practice in theory, most don’t make it part of their clinical routines. Over 70% of chief medical officers report that they have difficulty promoting evidence-based practice at their organisations.

**Doctors Who Do Not Use Available Guidelines Consistently**

n=231 physicians

56% Don’t Use Consistently

**“I Am Having Difficulty Successfully Promoting EBP”**

n=37 system-level CMOs

72% Agree
Why the gap between acceptance and implementation?

Some organisations may give up on a standardisation initiative that improves quality but fails to reduce costs. Elsewhere, separate groups within an organisation may unwittingly invest time developing overlapping guidelines. When they fail to see a return on that investment, they give up.

And, of course, there are always groups and individuals who simply fear change. They resist things that disrupt the tried-and-true workflow they’ve established over years of clinical experience.
The clinical leadership team is uniquely positioned to build the evidence-based organisation.

They understand, and can represent, the organisational mandate to advance efficiency and quality.

At the same time, clinical leaders understand how hard it can be to change clinical practice patterns. They deeply respect the core doctor mission of providing each patient with the best treatment, and they can ensure this mission underpins all evidence-based practice efforts.

This will engender trust among the medical staff.

Hospital Leader, Medical Staff Trust Model

- Input into Resource Allocation
- Oversight of Doctor Performance Improvement
- Voice in System Strategy Discussions
- Clinical Credentials
- Knowledge of Doctor Culture
- Insight into Clinical Issues
Organisations that successfully and consistently implement evidence-based practice employ these three strategies:

1. They **assess** and identify gaps in evidence-based practice support.

2. They use a multifaceted approach to **earn clinician adherence**.

3. They **capitalise on their system advantage** by leading and supporting standardisation across all sites.

In this briefing, we’ll first tell you about a tool we’ve developed to help you assess evidence-based practices. Then, we’ll provide you with nine lessons for driving evidence-based practice at your organisation.
Assessing evidence-based practice performance has always involved a lot of guesswork. Until now.

Our Evidence Based Practice Leadership Audit is a short, interactive assessment that delivers a customised list of the big opportunities for your evidence-based practice adoption gains.

You can learn more about how we developed the audit on the next page, and we encourage you to take it as soon as possible.

“It really forces you to self-evaluate”, one system chief medical officer told us. “It is easy to think you are doing something well, but this makes you face the facts.”

We think the tactics used to promote evidence-based practice adoption fit into four performance areas.

**Prioritisation**: Do we prioritise our standardisation efforts based on our greatest opportunities?

**Correctness**: Are our guidelines from trustworthy sources of the most up-to-date clinical evidence?

**Adherence**: Do we surround our doctors with effective messaging, data, and other supports that promote evidence-based practice?

**Scalability**: Looking across the organisation, does our evidence-based practice leadership infrastructure efficiently support standardisation across all our services and sites?

Our research shows that you won’t get a full return on your evidence-based practice investment without executing on all of these, and the audit will help you do that.
In Need of a Standard Evaluation Approach

Sources That Guided Development of Our EBP Leadership Audit

Advisory Board Research Expertise
- Built upon past Advisory Board best practice research on EBP
- Vetted with internal EBP experts

Industry Literature
- Reviewed and incorporated research on organisational attributes common to high-quality organisations

Advisory Board Performance Technologies
- Tapped into expertise of Advisory Board performance technology staff who analyse doctor practice patterns at over 1,500 hospitals

Pilot Physician Executive Cohort
- Vetted audit framework with doctor executives
- Piloted audit with 30 chief medical officers
- Extensive revisions made based on executive feedback

Take the audit at advisory.com/cob/ebpaudit
Organisations with high levels of guideline adoption use several tactics to achieve it.

A 2013 *Journal of the American Medical Association* study found that most doctors believe cost reduction is a part of their role, but they don’t want those reductions to come at the expense of patients.

Again, this helps explain the evidence-based practice adherence gap we mentioned earlier—doctors simply have an ingrained scepticism of any guideline that requires them to change how they practice, particularly if that guideline asks them to do less.

The six lessons in this section will help you earn clinician adherence to evidence-based practice.

**Six Lessons for Overcoming the Adherence Challenge**

1. Craft an EBP marketing campaign
2. Collect doctor input into guidelines
3. Use noncompliance to drive guideline evolution
4. Ensure guideline use is path of least resistance
5. Share data to maximise performance
6. Make doctors champions of rationalising resource use
Lesson 1: Craft the right evidence-based practice marketing campaign

Evidence-based practice promotion campaigns usually focus on specific initiatives. But these campaigns often fail to explain how standardisation produces better results for patients.

**We think a broader campaign is better.** California’s MemorialCare Health System, for example, uses an expansive, dedicated evidence-based practice branding campaign to promote adoption and adherence. Leaders broadcast the campaign through several traditional and creative channels, including videos starring doctor leaders.

The campaign connects the dots for doctors—they see how their day-to-day practice contributes to the overall goal of providing more consistent clinical care.

**Key Elements of Medical Staff Communication at MemorialCare**

<table>
<thead>
<tr>
<th>Campaign Branding</th>
<th>Crafted communication plan around theme, “Data is for learning, not judgement,” to emphasise opportunity for collective improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Channels</td>
<td>Coupled broader communication strategies such as emails and newsletters with more personalised doctor meetings</td>
</tr>
<tr>
<td>Creative Communication</td>
<td>Medical staff members star in videos to signal their support for, and explain, performance improvement initiative</td>
</tr>
</tbody>
</table>

A top-down approach here is certainly important for signaling organisational commitment, but our research shows that this strategy works best in tandem with a grassroots approach among the medical staff.
Lesson 2: **Collect doctor input on guidelines**

Once an organisation communicates its evidence-based practice vision, the next challenge is to involve doctors in its execution without taking up too much of their time.

The diagram below describes what we think is the best way to achieve this. The left circle represents a model that creates guidelines too quickly and without sufficient clinical input, and the right circle represents a model that over-utilises doctors.

Organisations need to find the middle sweet spot, in which select doctors contribute optimal input but are not overtaxed.

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**The Sweet Spot of Doctor Participation**

- **The Factory Model**
  - Promotes efficiency at the expense of doctor involvement
  - Representative activity: Implements vendor-built order sets, guidelines

- **Optimal Doctor Involvement**
  - Judiciously leverages doctor participation in EBP efforts
  - Representative activity: Small group of clinical experts vets predrafted clinical guidelines

- **Too Many Cooks in the Kitchen**
  - Over-utilises doctors in guideline development and rollout
  - Representative activity: Clinicians are free to edit order sets, yielding lack of standardisation
Lesson 3: Learn from doctors who opt out of guidelines

When your doctors don’t comply with a particular guideline, they’re telling you something about it. The guideline could be ineffective, but it might also signal that a doctor has found an innovative way of doing something. Deviations from established guidelines aren’t necessarily bad things—they’re opportunities for learning.

Adherence should fall into what we call the “innovation-friendly” zone, where doctors follow best practice standards consistently but also have the freedom to try new things when appropriate.

Target Levels for Guideline Adherence

- **No Guideline Use 0%**
  - No defined standard of care; variability likely to yield wide cost and quality variation

- **Strict Protocol Adherence 100%**
  - No innovation; doctors simply comply with protocol

- **70%–90%**
  - Broad adherence to care standards drives consistency, outcomes improvement
  - Allows sufficient flexibility for doctors to improve on existing methods
Lesson 4: Ensure guidelines provide path of least resistance

Doctors simply won’t use guidelines that are hard to follow. We’ve come up with three ways to minimise distributions to doctor workflow due to evidence-based practice.

1. Shift some of the responsibility for following protocols from doctors to non-doctor providers.
2. Make it easier to follow the protocol than to deviate from it.
3. Improve point-of-care technologies to facilitate evidence-based, real-time decision making.
Lesson 5: **Share data to maximise performance**

Transparent performance data benefits everyone—it recognises those who excel, motivates those who don’t, and gives the entire staff models to emulate.

To impact performance, leaders should establish trust in the data’s legitimacy, ensure staff understand the reasons for transparency, and build personal accountability among doctors for adherence.

### Keys to Data-Sharing Success

<table>
<thead>
<tr>
<th>Secure Doctor Trust in Data</th>
<th>Make Principled Migration to Transparency</th>
<th>Build Personal Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Audit and improve attribution policy</td>
<td>• Acclimate doctors to transparency through gradual unblinding of individual performance data</td>
<td>• Implement escalating intervention protocol for doctor underperformance</td>
</tr>
<tr>
<td>• Effectively communicate value of individual-level data</td>
<td>• Offer drill-down functionality</td>
<td>• Recognise top performers</td>
</tr>
<tr>
<td>• Offer drill-down functionality</td>
<td></td>
<td>• Link adherence to doctor financial incentives</td>
</tr>
</tbody>
</table>
Lesson 6: Empower doctors to curb resource waste

Clinical guidelines tend to ignore unnecessary resource use. But simply announcing utilisation targets won’t produce change.

A few years ago, for example, Danbury Hospital in Connecticut launched an efficiency initiative to reduce variation for eight high-cost, high-volume care pathways. This was a great first step.

But then the organisation went further: Danbury’s chief medical officer assigned doctor champions to each pathway and paired them with analytics experts to review performance data.

Together they created dashboards with utilisation targets and action steps to curb over-utilisation. Such targets typically don’t exist in research literature, so the doctors set them based on clinical experience and consensus.

Doctor Champions Create, Promote Utilisation Targets Among Peers

*Partnership Between Data Analysts and Doctor Champions*

- Doctor champion, data analyst pairs dedicated to specific diagnosis to evaluate utilisation trends, identify improvement opportunities
- Doctors and analysts work together to create an “opportunity dashboard” with explicit goals for improving utilisation
- Utilisation goals established based on evidence and clinical consensus
Across all of its evidence-based practice initiatives, Danbury Hospital achieved roughly $2.9 million in reductions over one fiscal year, and the team continues to pursue enhanced quality and efficiency through these types of initiatives.

Gains like that can make a huge difference for any institution. In the next section, we’ll look at how to multiply them throughout an entire health system.

### Representative Opportunities Dashboard

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>RATIONALE</th>
<th>ACTION PLAN</th>
<th>CURRENT UTILISATION</th>
<th>UTILISATION GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Echo</td>
<td>Not needed if recent study or well identified</td>
<td>Educate house staff, track trends</td>
<td>43%</td>
<td>35%</td>
</tr>
<tr>
<td>Telemetry for over 48 hours</td>
<td>Not indicated in uncomplicated heart failure</td>
<td>Educate house staff, track trends; change order set</td>
<td>42%</td>
<td>25%</td>
</tr>
</tbody>
</table>
Evidence-based practice can reduce costs and improve quality throughout the health system.

The best way to achieve these aims, we think, is for organisations to embed evidence-based practices across all services and sites.

In some instances, this is easier said than done due to geographic dispersion, unique facility cultures, clinical skill mix, and available resources. But we think the potential gains here make the effort worthwhile.

The three techniques in this section may apply to individual hospitals as well. Like any health care system, a hospital has many silos to navigate: treatment specialties, organisational structure silos, staff silos, and initiatives.

Three Lessons for Capitalising on System Advantages

1. Utilise a data-driven approach
2. Hold leaders accountable for EBP advancements
3. Spread best practices across the system
Lesson 1: Use a centralised, data-driven approach to prioritise system-wide opportunities

Health care organisations structured as systems usually don’t take advantage of that system structure to prioritise evidence-based practice efforts. This means they may miss system-wide cost and quality improvement opportunities.

Your evidence-based practice prioritisation efforts should include the three components described below.

**Three Keys to Prioritising Efforts**

- **Centralised Prioritisation Process or Group**
  System-level process or group evaluates organisation-wide EBP opportunities and sets system EBP priorities

- **Uniform Prioritisation Criteria**
  Selection process uses defensible prioritisation method and set criteria

- **Ongoing System-Wide Opportunity Assessments**
  Analytics compare system- and facility-specific performance; data made regularly available to clinical leaders to monitor areas of greatest opportunity

System-level prioritisation efforts should not, however, impede local innovation or execution. Broad, top-down ideas can seem less relevant at individual care sites, so organisations must remember to encourage principled frontline innovation wherever appropriate.
Lesson 2: Hold executive leaders accountable for advancing evidence-based practice

Once organisations select the right evidence-based practice priorities, leaders must execute them on a broad scale. Here, we offer two ways to hold executive leaders accountable for doing so.

Utah’s Intermountain Hospital in the US maintains goal-alignment through a financial incentive program. As you can see below, each group has a fairly significant portion of pay linked to the hospital’s “dimensions of care” goals, including clinical excellence.

Intermountain Leadership Incentive Opportunity
Incentive as a Percentage of Base Pay

<table>
<thead>
<tr>
<th>System Executives</th>
<th>Clinical Program Doctor Leader</th>
<th>Admin/Ops Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>5%–10%</td>
<td>5%–20%</td>
</tr>
</tbody>
</table>

“Dimensions of Care” Goals Linked to Incentives

- Clinical excellence
- Patient engagement
- Physician engagement
- Operational effectiveness
- Employee engagement
- Community stewardship

Banner Health, a US health system based in Arizona, takes a different approach. The facility’s chief medical officer has formal evidence-based practice responsibilities.

Each facility chief medical officer is expected to spend 80% of their time on traditional responsibilities and 20% of their time overseeing one of their Clinical Consensus Groups, which are groups that standardise clinical practice.
This approach drives evidence-based practice adoption in three ways:

1. Every chief medical officer has to create and implement guidelines.

2. The peer dynamic ensures high guideline quality.

Putting facility chief medical officers in charge of the Clinical Consensus Groups boosts credibility and signals that Banner expects every facility to participate in system-wide clinical standardisation.

3. Division of CMO EBP Responsibilities

- Time Dedicated to Facility Obligations: 80%
- Time Dedicated to Clinical Consensus Group (Tasked with Creating Standard Clinical Practice): 20%
Lesson 3: Spread best practices across the system

The advantage of being in a system is to spread best practices across all care sites. To do so, organisations need a way to turn pilot efforts into full-scale rollouts.

Here are five critical steps that we think will work in almost any system:

- **First:** Communicate the organisation’s ambition clearly from the start
- **Second:** Support pilot teams and create a consistent structure for measuring performance
- **Third:** Shift the organisation’s attention from innovation to implementation
- **Fourth:** Reward early adopters
- **Fifth:** Evaluate lessons learned to inform future rollouts

We think these are the areas where you should invest your time and energy in order to help your system realise the greatest gains from adopting evidence-based practice.
Key questions for doctor leaders.

Defining and adopting a standard of care is hard because it’s a moving target. As the evidence base grows and evolves, and organisations find innovative ways to curb unnecessary utilisation, the “right answer” to care may look completely different in the future.

We expect to partner with executives in more research on this topic in coming years. But it is clear that for success in a value-based market, organisations must build the infrastructure now that will support evolving guidelines into the future.

We’ll leave you with what we think are the key questions to guide leaders in these efforts.

The questions on the following page should prompt discussion on how to advance evidence-based practice and prepare for future challenges.

Use them to guide a conversation among your leadership team about challenges in a proactive and collaborative way.
Capitalising on Today’s Opportunities

• Do system leaders articulate a common vision for adopting evidence-based practice? Is evidence-based practice a core value among the medical staff?

• What are our next steps to bolster the underleveraged evidence-based practice support tactics identified in the Leadership Audit?

• Do we have a standard method for determining evidence-based practice initiatives to pursue organisation-wide?

• Are we enfranchising doctors to promote practices that follow the evidence and are cost-effective, in order to reduce unnecessary utilisation?

• Do we have sufficient coordination across our care sites to promote the standardisation and dissemination of proven clinical practices?

Preparing for Future Challenges

• Are we developing leadership structures and communication methods to promote consistent priorities and messaging across the mixed medical staff?

• Are we considering how to standardise the care experience for comorbid patients, both from a clinical and care coordination perspective?

• Do we have formal mechanisms to promote collaboration between clinical leadership in the inpatient and outpatient space? Are we translating lessons learned from evidence-based practice adoption in the inpatient setting to other care settings?

• Are we starting to convene cross-continuum stakeholders to build care pathways that offer consistent, coordinated transitions between care settings?

Start answering these questions with our recent study, *Building the Evidence-Based Organization*, at advisory.com/cob/ebpstudy.
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The Clinical Operations Board is dedicated to supporting clinical and operational leaders at hospitals, health systems, and health care organisations around the world to achieve high-quality, safe, effective, and efficient care.

How we help

Our insights help members answer the industry’s most pressing strategic and operational questions, such as:

• How can we streamline clinical operations to improve patient throughput?
• What immediate steps we can take to reduce hospital-acquired infections?
• How can we work more effectively with doctors to create a high-performing medical staff?
• How can we better coordinate transitions from acute care and prevent unnecessary readmissions?
• What are the hallmarks of a best-in-class quality infrastructure?
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Project Director
Daniel Dellaferreira

Contributing Consultants
Erin Rehel
Ryan Wilber

Project Editor
John Wilwol

Designer
Haley Chapman

Managing Director
Andrew Rosen

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