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Br2 #qfbmj

Institute *for* Healthcare Improvement

BMJ

BMJ

Publishing QI Breakfast Session

Sophie Cook, Helen Crisp & Cat Chatfield

March 2019

Introductions & Declarations of Interest

Sophie

- I'm employed by The BMJ

Helen

- I have my own consultancy firm - Crisp QI
- I receive an honorarium from BMJ as Editor of BMJ Open Quality

Cat

- I'm employed by The BMJ
- My post is funded by The Health Foundation

BMJ

What we will cover

- Different types of articles you can publish
- Which is the right journal for your work
- The pathway of a paper through a medical journal, submission, policies and the peer review process
- The role of peer reviewers
- Common reasons for rejection
- What editors look for
- Tips for submission, how and when to reach out to editors

Why publish?

- Share your work
- Scale and spread
- Avoid reinventing the wheel
- Celebrate your success
- Start a debate
- Educate
- Career advancement / CV

BMJ

What types of content can I publish?

- Research studies / trials
- Opinion
- Debate / commentary
- Letters to the Editors / responses
- News
- Multimedia: podcasts, video
- Infographics
- Social media content

The BMJ - more than research

- Analysis
  - debates with data
- BMJ Opinion
  - highly readable compelling comment
  - appeals to international readership.
  - make a single strong well argues point
  - provide a personal take or critical view on a topical healthcare issue
- Education
  - Identifies gap in the literature for generalist clinicians
- Rapid responses
  - get involved with the post publication debate online

Which journal to choose?

- Impact factor
- Reach
- Open access
- Audience
- Processing time
- Rejection rate
- What the journal has published before
- How does the journal help make the most of your research?

BEWARE

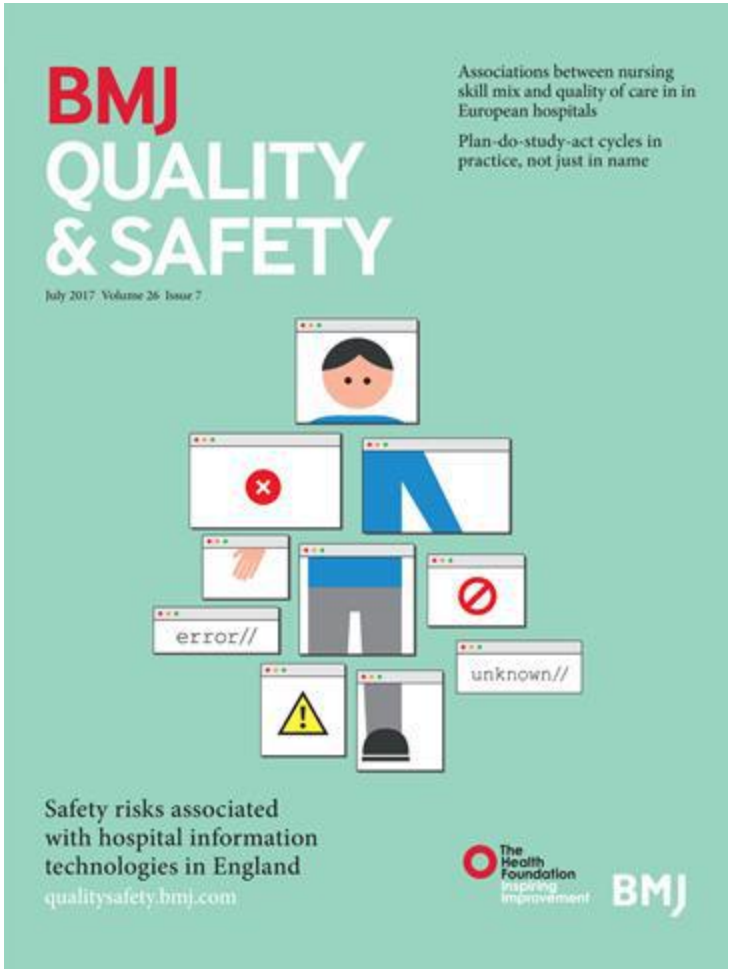
- Predatory journals

Where to publish - with BMJ

- BMJ has 3 main journals which publish on Quality Improvement & Safety plus The BMJ
- We also have more than 70 speciality subject journals

BMJ Quality and Safety

- Impact Factor 7.226
- Research, opinion, debate
- Acceptance rate 12%
- Triple blind peer review
- Some Open Access articles
- Online and print

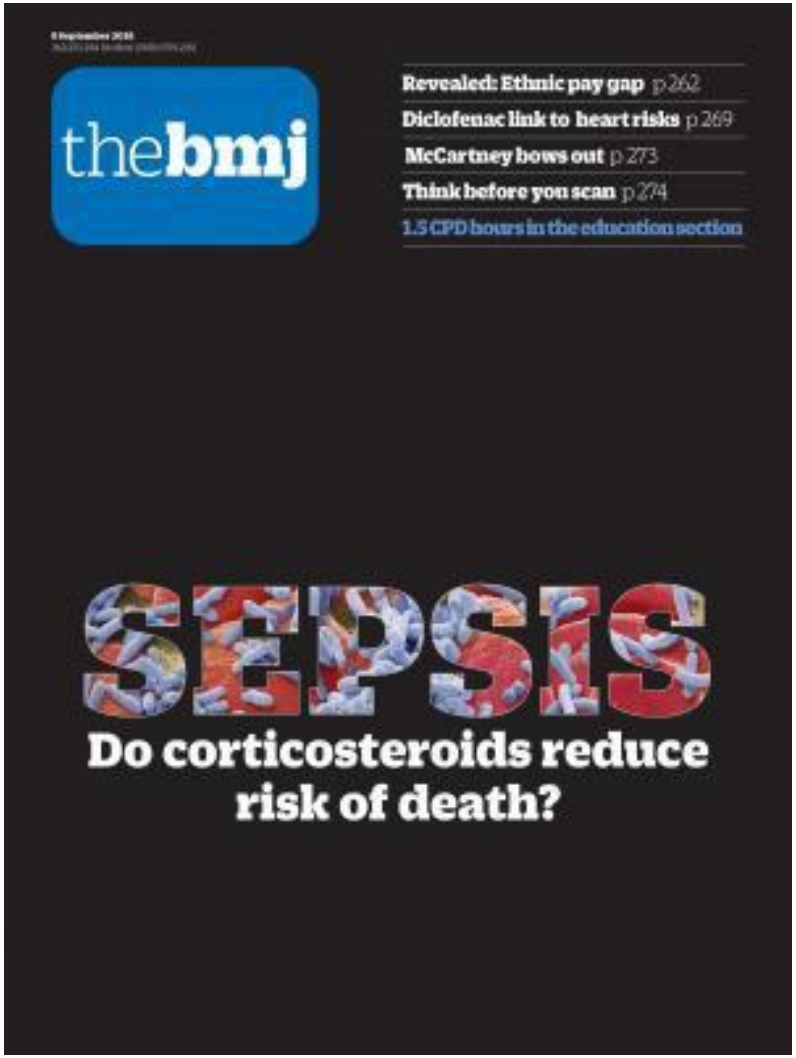


BMJ Open

- Impact Factor 2.413
- Research studies
- Acceptance rate 55%
- Open peer review
- Fully Open Access
- Online only

The BMJ

- Impact Factor 23.295
- Research, opinion, debate
- Acceptance rate 7%
- 4% of 4000 research
- Open peer review
- Research Open Access
- Online and print



BMJ Open Quality

- PubMed indexed
- Research, opinion, QI projects
- Acceptance rate 52%
- Single blind peer review
- Fully Open Access
- Online only

Open Access BMJ Quality improvement report

BMJ Open Quality

A local quality initiative to improve follow-up times for patients with heart failure

Toni Schofield,[1] Juan Duero Posada,[1] Farid Foroutan,[1] Ana Carolina Alba,[1] Michael McDonald,[1] Meredith Linghorne[2]

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ABSTRACT

Introduction Heart failure is the most common cause of hospital admission in patients >65 years and around 50% of patients will be readmitted within 6 months. Inability to achieve timely outpatient follow-up may contribute to the high rates of avoidable rehospitalisation for this group of patients. Canadian guidelines recommend patients with heart failure should be seen within 14 days of discharge.

Methods An audit demonstrated that less than half of advanced heart failure patients were being followed up within 14 days. In an effort to improve postdischarge follow-up in our heart function clinic, we used process mapping and applied a series of iterative changes to the appointment booking system using Plan–Do–Study–Act cycles to reduce waste and standardise.

Results The primary outcome measure, tracked over a period of 20 months, was percentage of patients booked within 14 days. At baseline, 37% of patients were seen within 14 days. After our series of interventions related to streamlining and standardising the appointment booking process, 77% of patients were seen within 14 days and 100% of patients were seen within 21 days.

Conclusion The changes made to the appointment booking process were reproducible, sustainable, effective and required no additional resources or funding.

INTRODUCTION

Local problem and rationale

At our institution, patients with acute decompensated heart failure (HF) can be admitted to General Cardiology or Internal Medicine. Of those admitted to Cardiology, a smaller number are managed directly by the HF service. These patients are generally younger, with more advanced disease and being evaluated for advanced therapies such as left ventricular assist devices or transplantation.

We noticed that we were not always meeting the Canadian Cardiovascular Society (CCS) guidelines for follow-up within 14 days. Patients were either being seen an extended time after discharge, or being readmitted before their next clinic appointment, and alarmingly, occasional patients reported not receiving an appointment at all and following up themselves with the clinic. The method for booking appointments was non-standardised and unclear. An appointment request was sent to a centralised fax number or to an email address that was accessed by several staff. There was no communication back to the requesting provider that the fax/email had been received or processed and patients were leaving hospital trusting that someone would call them or send them an appointment in the mail.

Available knowledge

HF is a chronic disease of epidemic proportion. In Canada, there are an estimated 600 000 people living with HF and 50 000 new cases diagnosed each year.[1] It is the most common reason for hospitalisation in people >65 years of age despite advances in HF pharmacotherapy and devices. Patients with HF have high rates of readmission quoted between 10% and 50%[2] and up to 75% of these may be avoidable.[3] Readmissions are more prevalent in the period after hospital discharge as well as in in advanced disease, at the preterminal phase.[4] Patients are vulnerable during transitions of care[5] and problems can arise in the postdischarge period relating to the understanding of discharge instructions, medication changes and side effects, and the early identification of warning signs and symptoms.[6] Emphasis has been placed on the timing of follow-up after recognition that nearly half of readmissions occur before the first ambulatory visit.[7] Following patients in a timely manner in an ambulatory setting gives the care provider an opportunity to check for complications of treatment, titrate medications, reinforce activity limitations and lifestyle instructions and discuss goals of care. Moreover, timely access to care is one of the Institute of Medicine's 6 domains of quality targeted for healthcare improvement.[8] Multidisciplinary heart function clinics provide this opportunity, are cost-effective and have been shown to reduce rehospitalisation and mortality.[7 9] The use of multidisciplinary heart function clinics has been incorporated

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Introducing BMJ Open Quality

- Open-access, on-line only journal
- Main role: publication of well-written, useful QI reports
- All papers peer reviewed
- Open access model is funded by Article Publishing Charges (APC): £1,000 for a QI Report, £1,350 for other types of paper
- Health Foundation will cover APC for 'Q' members

BMJ Open Quality

Welcome to BMJ Open Quality. The journal is dedicated to publishing high quality, peer reviewed healthcare improvement work. Articles covering original research, local, national and international QI projects, value-based healthcare improvement initiatives and educational improvement work are all considered. BMJ Open Quality adheres to the highest possible industry standards concerning publication ethics. To read the journal's detailed guidelines please see our policies.

Our website provides resources to support you in your quality improvement work such as templates to help you run and write up quality improvement projects.

BMJ Open Quality uses continuous publication online to ensure timely, up-to-date knowledge is available worldwide. The journal adheres to a rigorous and transparent peer review process and papers are considered on the basis of methodological soundness rather than priority or novelty.

Latest Articles

ORIGINAL ARTICLE:
Quantifying patient satisfaction with process metrics using a weighted bundle approach 9 March, 2019

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BMJ QUALITY IMPROVEMENT REPORT:
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ORIGINAL ARTICLE:
Managing alarm systems for quality and safety in the hospital setting 25 July, 2018

ORIGINAL ARTICLE:
Using lean thinking to improve hypertension in a community health centre: a quality improvement report 8 February, 2019

BMJ QUALITY IMPROVEMENT REPORT:

BMJ Open Quality publishes a range of paper types:

- Original research
- Systematic review
- Narrative review
- Research and reporting methodology
- Short report
- Quality education report
- Quality improvement report

Quality Improvement Reports

Papers on the set-up, measurable benefits and lessons learnt from QI programmes

- Authors are strongly encouraged to consult the SQUIRE guidelines
- **Word count**: up to 3000 words, **Abstract:** 300, **Figures/Tables:** up to 3 tables or figures

Quality Improvement Reports

Criteria for a Quality Improvement Report

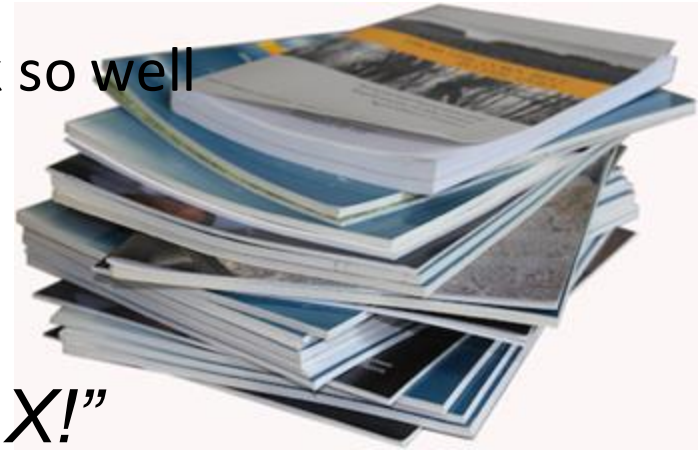
- Describes and evaluates an intervention that aims to improve an aspect of healthcare
- The project may not show improvement, but must demonstrate an attempt to improve
- Not just audit: measurement, improvement, and repeated measurement, at least twice
- PDSA model for improvement is suggested but we are open to different models
- Evaluation of education interventions need to consider changes in learners' knowledge or behaviours - just reporting learner satisfaction is not sufficient
- Consider sustainability of the intervention and be clear how sustainability has been assessed
- If don't meet all criteria, address this in the 'limitations'

We require a statement of how patients/service users have been involved in the work

Reporting bias

Papers tend to get written up when the improvement is 'successful'

We can learn a lot from what didn't work so well



Content bias

Reports over-focus on results:

"We achieved 14% reduction of X!"

Little information on methods and the experience of implementation:

"How we planned and adapted what we did to achieve 14% reduction of X"

Utility of Quality Improvement reports

Improvement reports need to provide enough detail:

- to convey credibly that something worked
- to give insight on the action needed to replicate the results in another setting

What happens after you've submitted

*A BMJ perspective

Peer reviewers

- critically appraise the manuscript in light expertise and knowledge of existing evidence
- help editors to decide which papers to publish
- observe confidentiality
- be objective, declare conflicts of interest
- be constructive, aiming to help authors improve the manuscript for the next journal,
- respond quickly or decline the assignment

- Blinded
- **Open**
- Post publication

Reviewer(s)' Comments to Authors:
Reviewer: 1

Recommendation:

Comments:
Pain and its control is of the greatest importance to patients. As a sign of current or developing heath problems it is a key factor in prompting patients to seek medical attention. It is widely understood among the general population that good, effective tools (drugs, etc.) for the relief of many kinds of pain are available, so expectancy for relief is high. Optimising use of these tools clearly makes sense as part of good clinical care and to enhance patient comfort and satisfaction. The best patient care often results from patient and clinician working in partnership with professional staff relinquishing some of their authority to better meet the patient's perceived needs. Wherever possible, patients should be given the opportunity of choice in treatments, although for some patients (those who are gravely ill or uncomfortable in making decisions) this might inflict an additional burden and they would prefer to have their health managed entirely by experts.

This study, where participants are randomised to one arm where standard treatment is applied (TAU group) or to another which permits a measure of personal control in their own therapy (PCA group), in some ways reflects this no choice/choice scenario, albeit group allocation was imposed by the researchers. What is gratifying in the outcome is that where partial patient control was exercised, pain relief appears to have been superior and patient satisfaction higher. More analgesic was used by the PCA group which could be a downside. There are several possible reasons for the favourable reaction in the PCA patients which are not discussed but which may include a feeling of "ownership" in the intervention and of satisfaction that they had contributed personally to their treatment.

No overt statement in the text is made to the role, if any, of patient/public/carer input to the development, etc of the project, but perhaps this is made in the separate protocol paper (no. 22 in ref. list)?

David Britt

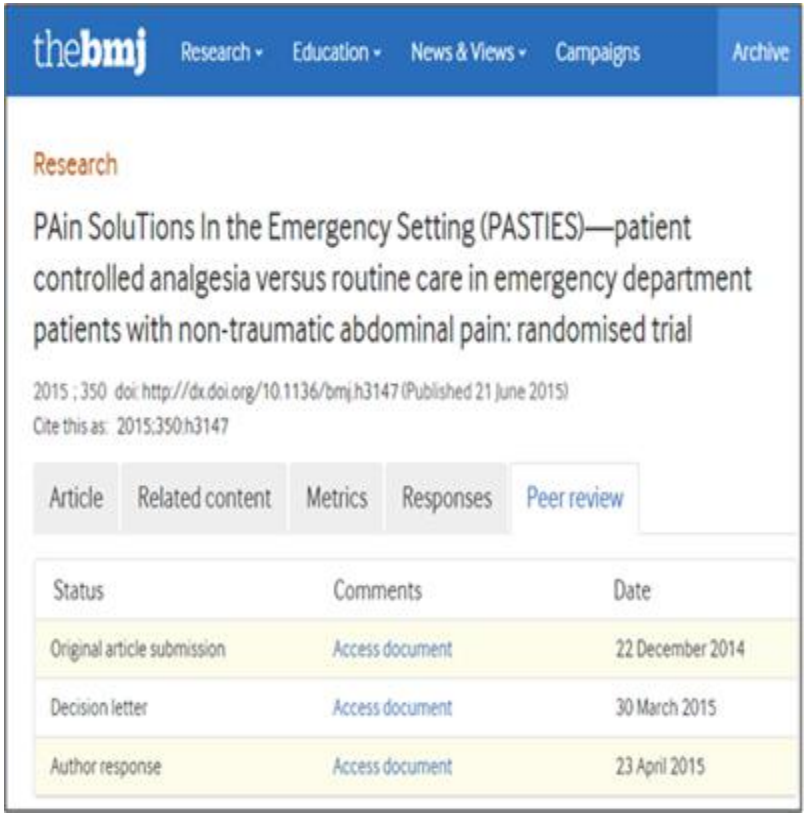
Additional Questions:
Please enter your name: David Britt

Job Title: Retired (Patient Reviewer)

Institution: N/A

Reimbursement for attending a symposium?: No

A fee for speaking?: No



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Research

PAin SoluTions In the Emergency Setting (PASTIES)—patient controlled analgesia versus routine care in emergency department patients with non-traumatic abdominal pain: randomised trial

2015 ; 350 doi: http://dx.doi.org/10.1136/bmj.h3147 (Published 21 June 2015)
Cite this as: 2015;350:h3147

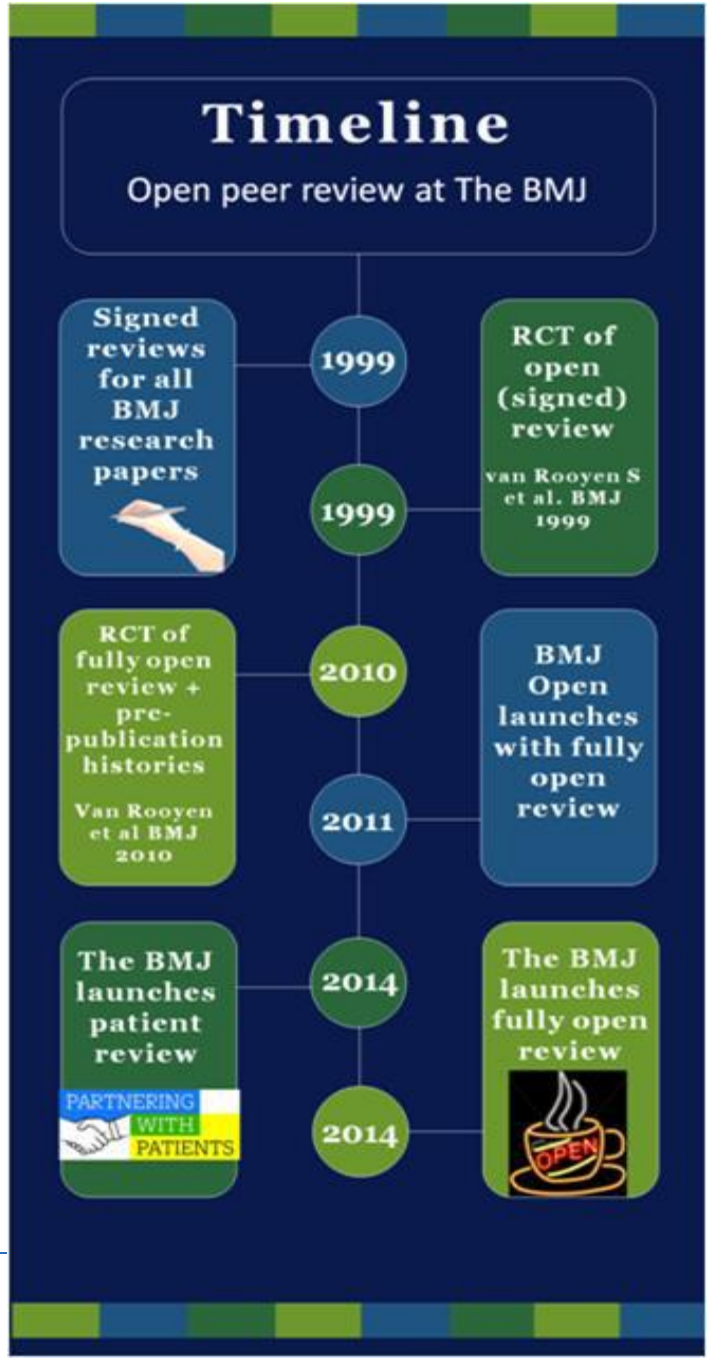
Article | Related content | Metrics | Responses | Peer review

Status	Comments	Date
Original article submission	Access document	22 December 2014
Decision letter	Access document	30 March 2015
Author response	Access document	23 April 2015

thebmj

Patient peer review

- 2014, The BMJ introduced patient peer review for all article types



Why do journals reject work?

Reasons for rejection

Research question

- Lacks novelty, interest/relevance to journal audience

Outcomes

- Not sufficiently clinical or important to patients

Study design

- is not the best possible choice to answer the study question, so the results may be unreliable
- the population is not representative/generalisable to a wider setting or the sample is small/biased/ lacks sufficient power to determine effect
- Incomplete or inappropriate statistics

Study Answer

- is unlikely to impact on practice, policy or research
- over interpretation of results

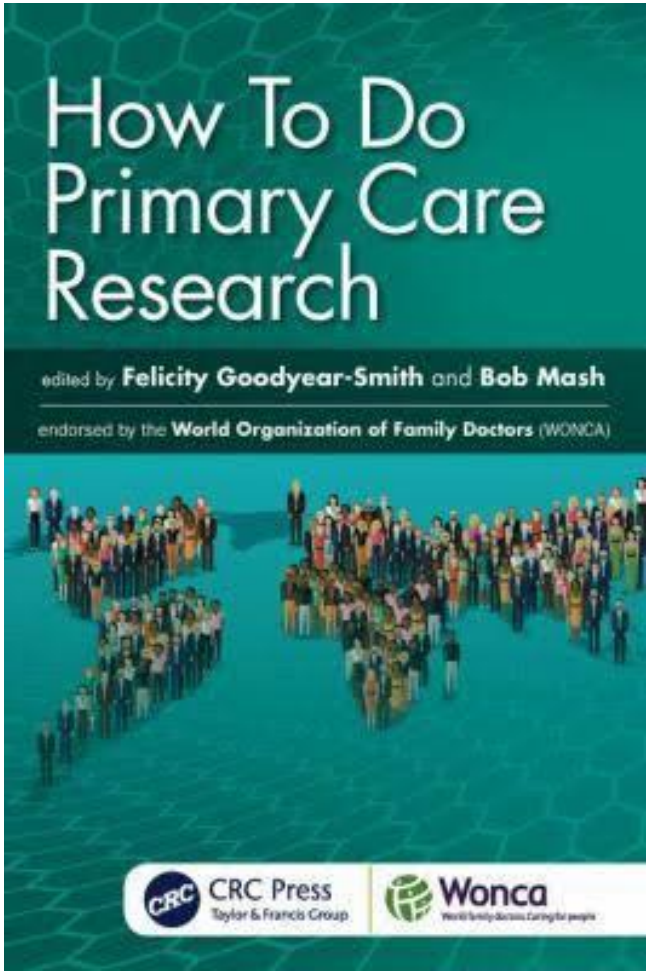
Tips for submission

- check journal policies and advice to authors before submission
- use the cover letter to convey the importance of the study question, what it adds, how it will change practice/policy, is it topical and whether previous work on the topic has been well cited and accessed
- be brief, clear and evidence based and write in plain English
- ensure all authors have seen and approved the draft before submission
- include all required statements and supplementary files eg copyright, conflicts of interest, guarantors, checklist, registration.
- Reach out to editors before submission if you have specific queries
- Tell journals if your paper has been considered and rejected from elsewhere, provide reviews if you can
- Demonstrate meaningful patient involvement (including in write-up!) and communicate details in your manuscript

Any questions?

Resources

- EQUATOR network
- ICMJE
- Ask colleagues
- Journal Author Guidelines
- Publications on research in QI



Thank You

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