Are we there yet?
Using data for measuring progress toward our goal

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Outline

- Process measures
- Outcome measures
- Some challenges
  - Prevention vs Rx
  - Small number
  - Surveillance vs Clinical Assessment
  - Culture
Process Data

- Process measures reflect the changes in utilization of the catheter.
- Are we changing our daily work activities regarding catheters in a way that reduces the risk of infection and makes care safer?
Outcome Data

- Outcome measures reflect the changes in CAUTIs
- What impact have we made on project goals?
  - Improving our unit’s culture of safety
  - Reducing the CAUTI rate by 25%
The (Problem) Challenge of Rx vs Prevention

The Story of Upstream and Downstream…
The Problem of Small Numbers

- An example from a critical access hospital...
## Critical Access Hospital Primary Inpatient Unit

<table>
<thead>
<tr>
<th>Location</th>
<th>Yr/Mos</th>
<th>Inf</th>
<th># Cath Days</th>
<th>Rate/Mean</th>
<th># Pt Days</th>
<th>Cath DU/Mean</th>
<th>Pctl</th>
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</thead>
<tbody>
<tr>
<td>Med-Surg</td>
<td>2012/12</td>
<td>0</td>
<td>709</td>
<td>0.0;1.5</td>
<td>4353</td>
<td>0.163; 0.19</td>
<td>42</td>
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<tr>
<td>Med-Surg</td>
<td>2011/07</td>
<td>1</td>
<td>330</td>
<td>3.0;1.5</td>
<td>2013</td>
<td>0.169; 0.19</td>
<td>42</td>
</tr>
</tbody>
</table>
Step 1: Create a sense of urgency

John Kotter
Defect Analysis

◆ What caused this infection?
  – Was there an appropriate reason for placing the catheter?
  – Was it inserted aseptically?
  – Was it removed as soon as possible (e.g. on patient transfer ICU ➔ Ward)
  – Was it cared for appropriately?
Don Berwick’s Stages of Facing Reality

◆ **Stage I:** "The data is wrong."

◆ **Stage II:** "The data is right, but it's not a problem. These things just happen."

◆ **Stage III:** "The data is right, there is a problem, but it's not my problem."

◆ **Stage IV:** The data is right and the problem won't go away until providers "take ownership" and take individual responsibility for efforts to build better systems of care. In other words, "I got it. It's my problem."
All infections are local…

◆ What keeps us mindful? Local data has meaning to folks in the situation
◆ Comparative data has meaning to folks taking a big picture view
The Problem of Clinical vs Surveillance Criteria
Two Types of Infection Criteria

**Clinical Criteria**
- Particular patient
- Subjective criteria
- Unique
- Art of medicine

**Surveillance Criteria**
- General patient
- Objective criteria
- Comparable
- Science of medicine
Infection Surveillance Criteria for LTCFs

- McGeer, 1991

NHSN for LTCF

- Release 14 September 2012
- Focus: UTI, *Clostridium difficile* and MDROs, Infection Practices
The Problem of Culture

Culture eats strategy for breakfast....
“Knowing the difference between adaptive and technical challenges is one of the key tasks of leadership.”

Ronald A. Heifetz

Technical work: activities with known solutions and science

Adaptive work: culture change; requires a change of values, attitudes, or beliefs
Definition

- Enduring, shared, LEARNED\(^1\) beliefs and behaviors that reflect an organization’s *willingness to learn from errors\(^2\)*
- Four beliefs present in a safe, informed culture
  - Our processes are designed to prevent failure
  - We are committed to detect and learn from error
  - We have a just culture that disciplines based on risk taking
  - People who work in teams make fewer errors
The Role of Organizational Culture

- Allow us to make sense of our environment
- Reflect common language (e.g. TeamSTEPPS tools) and behavior….thus is heard and observed
- Leaders create/teach culture as they reward/provide feedback/hold accountable
- Can be measured with self-report tools

We can not change what we do not measure!
Categories of Culture

- **Macroculture**
- **Organizational Culture**
- **Subculture**
- **Microculture**

Katherine Jones, Connecting the Dots: Improving Unit Safety Culture to STOP HAI
Three Levels of Organizational Culture

Behaviors

Beliefs & Values

Underlying Assumptions

“…in many organizations, values reflect *desired* behavior but are not reflected in *observed* behavior.”

(Schein, 2010, pp. 24, 27)

Katherine Jones, Connecting the Dots: Improving Unit Safety Culture to STOP HAI
Four Components of Safety Culture

1. Reporting Culture
2. Just Culture
3. Flexible (Teamwork) Culture
4. Learning Culture

- Effective reporting and just cultures create atmosphere of trust
- Sensemaking of patient safety events and high reliability result from an explicit plan to engineer behaviors from each component of safety culture
When Should you Measure Safety Culture?

- Baseline prior to patient safety intervention
- 12 – 24 month intervals to monitor change over time
Hospital Survey on Patient Safety Culture

- Survey tool kit available
  http://www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm

- Comparative Database for Benchmarking
  http://www.ahrq.gov/qual/hospsurvey12/
  - 1,128 hospitals; 567,703 respondents in 2012 database

- 42 items categorized in 12 composites/dimensions
  - 2 dimensions outcome measures at dept/unit level
  - 7 dimensions measure culture at dept/unit level
  - 3 dimensions measure culture at hospital level

- 2 additional outcome measures at dept/unit level
- Comments
Unit-Wide Areas in Need of Improvement

- Below State or National average
- Less than 75% positive
- Large “gap” between beliefs and behaviors within the composites

Katherine Jones, Connecting the Dots: Improving Unit Safety Culture to STOP HAI
Flexible Culture
Teamwork within Units

Four items elicit perceptions of teamwork within units. TeamSTEPPS Tools to bridge gap between belief and behavior: Briefs, Huddles, Debriefs; Situational Awareness, Mutual Support, Seeking & Offering Task Assistance

Katherine Jones, Connecting the Dots: Improving Unit Safety Culture to STOP HAI
Flexible Culture
Communication Openness

Three items elicit perceptions of communication openness. Team STEPPS Tools to Bridge the Gap between belief and behavior: Advocacy and Assertion, Two Challenge Rule, CUS

Katherine Jones, Connecting the Dots: Improving Unit Safety Culture to STOP HAI
When your people ask you, When are we going to be through this? Tell them, we’re not. The world wants to make things a movie. It is more like a soap opera.