CAH Quality Summit
Change Management and Safety Culture

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The question before us…

How can rural health leaders manage change in their environment to achieve improved quality and efficiency?

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Who is Stratis Health?

- Independent, nonprofit, community-based Minnesota organization founded in 1971
  - Mission: Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Working at the intersection of research, policy, and practice
  - Medicare QIO and HIT Regional Extension Center
  - Service as Rural QIO Support Center and on the national RUPRI Health Panel

From the Field: Observations on Rural Quality & Safety

Challenges

- Limited resources
- Staff wear multiple hats
- "We've always done it this way"
- Lack of technology infrastructure
- Distance and time
- Limited access to specialty care
- Small patient volumes

Opportunities

- Low turnover, staff longevity and continuity
- Patient-centeredness because care is personal
- Rapid decisions and implementation
- Access to senior leaders and boards/trustees
- Collaborative, community oriented nature

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From the Field: Key Learnings in Rural Quality and Safety

- Clinical and technical changes are needed, but so are improved teamwork, leadership, communication, and organizational culture.

- Learning, networking, and best practices must be hard-wired into patient safety programs.

- Transparency and accountability, along with a fair and just culture, are drivers to achieve safety.

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Patient Safety Culture

- Patient safety is a critical component of health care quality. As health care organizations continually strive to improve, there is a growing recognition of the importance of establishing a culture of safety.

- Achieving a culture of safety requires an understanding of the values, beliefs, and norms about what is important in an organization and what attitudes and behaviors related to patient safety are expected and appropriate.

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Patient Safety Culture: Survey Tool

- Agency for Healthcare Research and Quality (AHRQ) developed survey tool, which assesses:

  - 7 domains (such as Supervisor/Manager Expectations, Communication Openness, Non-punitive Responses to Error, Staffing)

  - 3 hospital-level aspects of safety culture (Hospital Management Support for Patient Safety, Teamwork Across Hospital Units, Hospital Handoffs and Transition)

  - 4 outcome variables (Overall Perceptions of Safety, Frequency of Event Reporting, Patient Safety Grade, Number of Events Reported)

- www.ahrq.gov/qual/hospculture

Patient Safety Culture: Understanding Survey Results

- AHRQ Benchmarking Database
  - Data from nearly 900 U.S. hospitals
  - Includes a breakdown for hospitals with fewer than 25 beds
- Excel benchmarking tool
  - Includes comparisons for bed sizes 6 - 24, 25 - 49, and 50 - 99
  - http://medqic.org/dcs/ContentServer?cid=1182785151382&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools
- Rural-adapted AHRQ survey instrument
  - Part of University of Nebraska research project
  - www.unmc.edu/rural/patient-safety/culture%20survey/culture-survey.htm

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Rural Organizational Safety Culture (ROSC) Project

- **Rural Organizational Safety Culture (ROSC)**
  - National QIO-led project
  - 2005-2008
  - 383 rural PPS and Critical Access Hospitals participated across 45 states

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ROSC Hospitals: Interventions

- Leadership Focused – 217 reported
  - "Walkarounds" – 110
  - Board of Director Engagement – 64
- Non-punitive Error Reporting – 154 reported
  - Implementing Near Miss Reporting - 102
  - "Just Culture" – 22
- Communications/Handoffs – 171 reported
  - SBAR – 68
  - Huddles, briefings – 92
- Specific Safety Initiative – 273 reported (falls, medication safety, RRT)
- Implemented Staff Awareness Strategies – 238 reported.
- Staffing Strategies – 35 reported

ROSC Hospitals: High vs. Low Comparisons

- Compared top 10% and bottom 10%, as well as differences compared to "mid" performers

- Demographics:
  - Bed size, CAH status, system affiliation or ownership, JCAHO accreditation
  - Top 10% more often JCAHO accredited
  - Bottom 10% more often affiliated or owned by a larger system

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ROSC Hospitals: High vs. Low Comparisons (cont.)

- Area of focus (AHRQ survey dimensions):
  - Top 10% more often had focus on teamwork within units and non-punitive error reporting
  - Top 10% had twice the level of focus on staffing
- Leadership: Hospitals with high level of involvement of QI manager had more improvement
- Interventions: Twice as many of the top 10% implemented 'walkarounds' and 'near miss reporting'

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Organizations are Made Up of People…and Change is Personal

Faced with the choice between changing one's mind and proving that there is no need to do so, almost everybody gets busy on the proof.

- *John Kenneth Galbraith*

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Culture Change Comes Last, Not First

- Most alterations in norms and shared values come at the end of the transformation process
- New approaches sink in after success has been proven
- Feedback and reinforcement are crucial to buy-in
- Sometimes the only way to change culture is to change key people
- Individuals in leadership positions need to be on board
  - Otherwise, the old culture will reassert itself

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