

KANSAS COLLECTORS USER'S GROUP
SRS Learning Center
June 13, 2007

Present: Kathy Forester, Lois Towster, Alvina Fant, Sara Compton, Sharon Gehring, Jackie Fremin, Debbie Helton.

Present via Conference Call: Shelly Nolting, Voncille Dirks, Barbara Jenista, Pat Lucke, Doreen Landau, Erlene Jezek-Fox, Darlene Bainbridge, Kathleen Yetter, Julie Violante, Jim Bowling.

Facilities Represented: Stormont-Vail RMC, Overland Park RMC, KUMC, Newton MC, Via Christi RMC, Providence MC, Hillsboro Community MC, Sumner Co. Dist #1 Hospital, Neosho Memorial RMC, Rawlins Co. HC, Olathe MC.

Welcome

Eric Cook-Wiens, Kansas Trauma Registry

Call to order, welcome, review of agenda.

Update on Critical Access Hospitals

Darlene Bainbridge, D. D. Bainbridge Associates

Please find a newsletter and copy of the presentation discussed appended to the minutes. Darlene Bainbridge reported on her work with Critical Access Hospitals with critical access hospitals in Kansas. She noted the importance of utilizing data rather than just collecting data in order to support PI. She advocates using the PACE (Plan, Act, Check, Enhance) model for performance improvement. She discussed the use of Quality Assurance Calendars and Quality Improvement calendars, stressing the differences between those two concepts and the necessity of both. She also introduced the notion of "shaking down" or analyzing data in order to support performance improvement noting that outside data sources must be integrated into each facilities core QA "change engine". Darlene is currently contracted to work with a number of Critical Access Hospitals, primarily located in western and northern Kansas. Facilities that are not currently involved in this performance improvement initiative are welcome to contact her. Her contact information is available through the Office of Local and Rural Health at KDHE, please call 785.296.1200.

Discussion on CV4 Software

Kathleen Yetter, Digital Innovation

The CV4 software has been distributed to ONLY facilities that use the locally installed version of Collector. Web-enabled Collector users do not have to install any updates at this time.

A patch will be distributed on Friday to correct several errors. NOTE: If software is not yet installed, please go through the installation before installing the patch.

The patch will address the following issues:

1. Users will now be able to log multiple users in at the same time.
2. Adding multiple procedures will no longer create too many procedure records.
3. If a procedure stop time occurs on the day after the procedure start time, this will no longer be flagged during the checks process.
4. Frequently used comorbidity codes will be correctly migrated from CVW to CV4.
5. ISS and TRISS will now be visible on the data entry screens.
6. Patient and Injury address will be correctly migrated from CVW to CV4 in situations where '/' or 'I' was entered for Zip code.
7. In the record manager, patients can be searched for using last name or both first and last name (but not first name alone). Logic will be added to make it evident that first name can be used in a search only if last name is already entered.
8. Data entry issues in PI-tracking will be resolved.

Further issues discussed:

- Sharon Gehring reported she had to contact DI because instructions didn't clearly demonstrate how to create user accounts to get started with data entry.
- Multiple Users requested that name and record status be added to the record status bar at the bottom of data entry screens in addition to trauma number.
- Jackie Fremin asked if there was an option to customize color and font size. There is not at this time.
- Alvina Fant asked that ED Arrival date automatically populate the corresponding field the intermediate facility tab.
- Sharon Gehring stated that when she was installing CV4 she was asked if report writer was installed, but she didn't know whether it was or not. She noted that before installing, it would be good to identify where CV3 is installed and whether the DI report writer has been installed already.
- Jackie Fremin asked that there be a method to access help files. Currently, help files are located on the install disc, but not easily accessed from the program.
- Debbie Helten asked whether "U" for unknown in CV3 will be correctly interpreted by the report writer after switching to CV4 which instead uses "?" for unknown. Kathleen Yetter from DI indicated that it will be interpreted correctly.
- Alvina Fant noted that it can take a long time to process saving a record. Jackie Fremin corroborated and added that the system sometimes freezes when shifting between programs. Jim Bowling from DI noted that these may be problems that can be fixed on a facility to facility basis. Certain installations work better for facilities that have large databases.
- Debbie Helten noted that it is confusing when a check executes for a field that is contained in a submenu because Collector doesn't open the submenu to make the change. Kathleen indicated that this issue can not be easily addressed—but certain data entry changes might make the problem less noticeable. Will discuss with Eric Cook-Wiens.
- Debbie Helten forwarded a question about the correct way to enter the Functional Independence Measure for a patient who is completely independent at discharge. Should the qualifier be "Permanent – will not improve", changed to "Permanent" or should a "/" be entered to indicate that the data element is inappropriate. Eric Cook-Wiens will research this issue and report back.
- It is impossible to enter Physician names for physicians that are not in the trauma-related departments. It would be nice to have an extra field to be able to enter the name for a physician that is given a broad non-

Trauma Program Update

Rosanne Rutkowski, Trauma Program Director

- Regulations approved for trauma levels 1, 2, 3.
- Five facilities in Kansas will be undergoing a pre-verification consultation with the American College of Surgeons for verification at the level-3 level.

Next meeting September 12, 2007, same location.

The meeting adjourned 2:20.

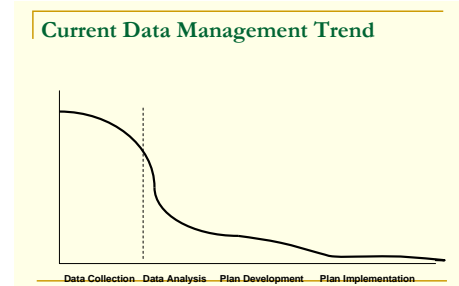


Bridging the Healthcare Performance Gap

Dealing with the Data

Health care is a data rich industry. It may be short on professional staff and other key resources, but it does not lack for data. The critical question is what does all that data do to improve performance, reduce errors that can cause patient harm, and plan for a healthier future. This is a very important question for providers to answer because current trends indicate that data will only continue to proliferate as the industry works to achieve a reputation for healthcare quality and providers look to build stronger futures.

This abundance of data is, in part, due to two things. The first is that there is a need to capture a wide range and large quantity of data to increase the likelihood of capturing the meaningful data. "Opportunity hunting" is one of the primary reasons for collecting data. In opportunity hunting, a healthcare organization, department or team member does not always know what will prove to be value-adding until the information is found. This is one of the primary reasons audit-type studies that collect a wide range of information are commonplace. For example, if a hospital wants to make sure that it is giving adequate written discharge instructions, the first step would be to audit the content of the entire discharge instruction document to determine completeness from a big picture perspective. From that initial audit, the hospital would "shake down the data" and determine the primary areas that would require more focused attention. If the only areas where the discharge instructions don't meet the standards of excellence are diet and activities, the next step is to develop quality activities that focus on those areas. This type of broad sweep data collection is common because it can be an easy, efficient and effective way to identify opportunities for improvement when used properly. It can foster the delivery of high quality care and the identification of strategic opportunities to secure an organization's future while being respectful of the people and resources.

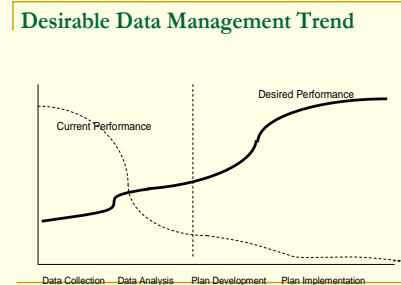
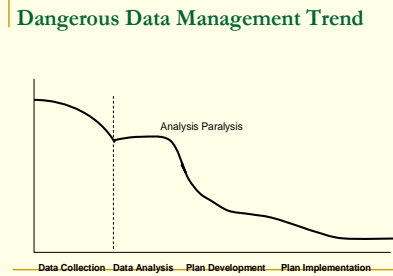


The second, and less healthy, reason for so much data in health care is the fact that the industry has evolved into one that

tends to focus more on process than on outcomes. Too often, the practices of the industry result in activities where we believe that as long as there is a lot of activity going on we must be accomplishing something. As long as we are collecting a lot of data, we must be changing something or demonstrating our commitment to improvement. Unfortunately, only about 20% or less of the data collected in health care actually fosters value-adding change at a given point in time.

A problem faced by many healthcare organizations is finding healthy ways to shake down the volumes of data that are available to them and find the data that is value-adding to them. As depicted in these charts, the current trend in health care is to have an abundance of data without good systems for quick analysis (opportunity hunting), plan development that will lead to improved performance and plan implementation.

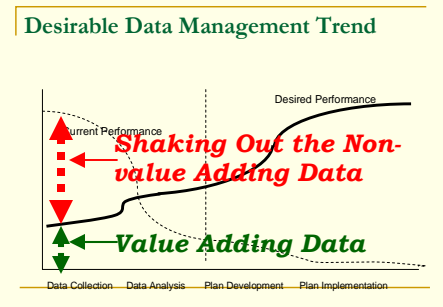
The process of collecting and reporting data has become such a major activity in many sectors of health care that it has become the outcome. Without healthy processes for shaking the data down and coming up with meaningful qual-



ity and performance improvement opportunities, people are coming to resent the time and energy that has to go into the activities. Unless providers can find ways to use the data to create value-adding change, it will become increasingly difficult to gain the support of a stressed and tired workforce.

People do what they perceive to have value. Only when providers have healthy systems for shaking down data, opportunity hunting and creating change through healthy change-engines will they be able to create quality and performance improvement efforts that yield the kind of value-adding results that people are looking for and today's market is demanding. It is time

that healthcare organizations take a hard look at the data they are collecting and determine whether the information adds any value. As much as 50% of the data that an



average healthcare organization collects could go away tomorrow and have no negative impact on patient care delivery and operations. A healthy quality program includes systems that allow a healthcare organization or department to get to that data that represents an opportunity to take the performance to the next level and eventual excellence.

Shaking Down Your Data

Data is an important ingredient in helping to make the right business and patient care decisions. When managed properly, it can help to point us in the right direction, measure our progress and tell us when we have achieved success. It can also serve as an early warning alert that we are not achieving the desired outcomes or may be headed in the wrong direction. It can be a powerful tool in helping us to motivate people by helping them to see their contributions. When used and managed properly, data can be a powerful component in healthy quality and performance improvement activities.

On the other hand, when managed inappropriately, data can create confusion. It can easily overwhelm people, paralyze progress and drive busy work into our buildings. It can discourage the willingness for people to engage in change. When it is not refined in a way that identifies value-adding opportunities to create improvement, it can contribute to poor choices.

The goal of effective data management is to get to the value-adding data that will yield meaningful understanding so that we have the best potential to make the best choices the first time. Effective data management is about “shaking down your data” to get to the valuable nuggets of information that reside inside the masses of data that exists.

Effective data management involves first casting your data net. Just as fishermen cast their nets to capture as many fish as they can on their first throw and then throw back those they don't want, healthcare organizations need to have systems where they collect masses of information in order to increase their potential for capturing the right data. Numerous data collection systems exist inside and outside of a healthcare

organization. A good quality program has effective mechanisms for taking that data in, shaking the data down in a way that allows for timely analysis and opportunity hunting and then moves the identified opportunities into the change-engine within the quality continuum.

While on some occasions, organizations will know exactly what they are looking for, most of the time they engage in an activity called “opportunity hunting”. This is why large data sets commonly plays an important role. Somewhere inside the mass of data collected resides valuable information that has the potential to create opportunities to create improvement. Once an organization has cast its net and collected the mass of data, the next step is to sift through it and find those precious pieces of information that identify opportunities for improvement and greater success. This step resembles the miner who fills up his or her pan with a pile of dirt from the riverbed and methodically shakes it down looking for those few nuggets of gold that have value or the fisherman that is looking for

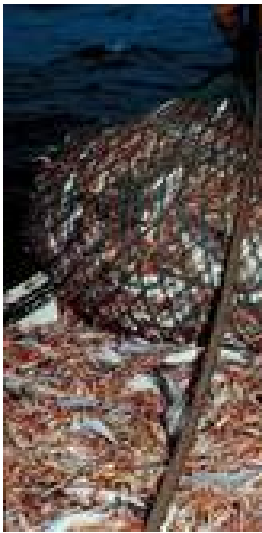
that great catch in the vast sea of fish that makes his or her product the one of choice.

Two of the most common mistakes made in health care are to believe that the value is found in having the data and that all data has value. The real question of success and value is found in what we can do

with our data. Simply collecting it rarely changes anything by itself. The potential to create meaningful change rests in being able to use the data to lead the organization to a higher level of performance.

Shaking down data can be a multi-step process. For example, a hospital may identify that its nosocomial infection rate is higher than national trends. Deeper data analysis shows that it has a high incidence of post-operative infections. Even deeper data analysis shows that the majority of those infections come from one unit and involve MRSA. Even deeper analysis shows that 80% of those patients are managed by one physician who uses an antibiotic regimen that is very different than that of the other physicians.

Once this level and specificity of information is available it becomes very easy to wisely direct resources and energy. This level of analysis is extremely important in today's health-care environment for multiple reasons. Health care is an industry with strained resources and a workforce that is “change-fatigued”. In this setting, organizations need to have healthy change-engines that have a very high potential of creating meaningful and value-adding change the first time around. When change is too big or too ill-defined, there is a much greater chance of failure. That failure usually occurs because people won't commit as if it seems too overwhelming, the lack of clear focus encourages the effort to head down the wrong path or the change takes so long that commitments wane. Too often, by the time the change happens it is no longer strategic or meaningful.



Reducing Medication Errors

Reducing medication errors is a great example of the benefits that come with shaking down an organization's data. A hospital could put a lot of time, resources and energy into its efforts to reduce medication errors without much benefit if it doesn't appropriately manage and work with its data.

Most healthcare organizations utilize some system of incident reporting to identify and collect data on medication errors. As there are a number of system and people-oriented factors that could contribute to medication errors, it would be very dangerous to stop analyzing data at this level. By analyzing the data associated with the errors and shaking it down for value-adding specifics, an organization has a much better chance of reducing its errors.

For example, consider a nursing department that has had 240 medication errors in the past quarter. The nursing director, Mary Jo, makes it a priority to reduce those errors by two-thirds over the next six months. She could address each error individually and hope that increased awareness on the part of the staff would create the necessary reduction but this approach often overlooks the presence of system-oriented issues that contribute to error occurrence. She could go with assumptions about what might be driving the rate but that approach generally carries a very high potential of not coming up with the best plan the first time.

The best approach for the nursing director is to reduce the data contained in the incident reports to meaningful subsets where she can shake out the data that will lead to value-adding improvement opportunities that will create a high probability of success while maximizing the wise utilization of resources. The first step is to identify any errors that represent high risk threats to the patients and to immediately address them. These are issues that may be low in volume or even isolated events but they easily stand out as a single event that has a very high potential for placing patients in harm's way. They are issues that do not warrant waiting for a pattern or trend to address because of

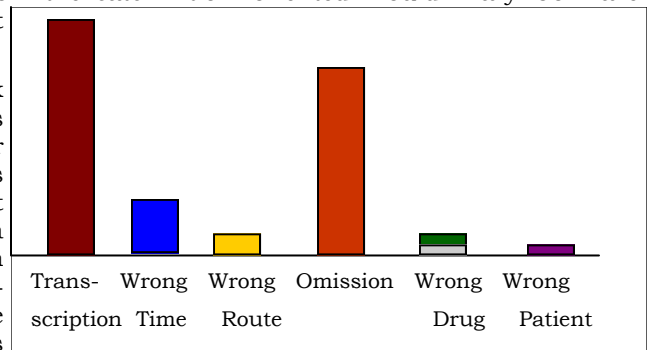
the seriousness and risk for harm. Issues with look-a-like or sound-a-like drugs are great examples of this as one of those drugs frequently places patients at much greater risk if inappropriately administered. Thus one medication error in this category could warrant the development of a system-wide intervention that would prevent this error from happening again. An organization's responsibility and accountability to patients would dictate a strong and immediate intervention. It would be the equivalent of the fishermen on the previous page catching a shark when they cast their net. The wisest and safest move would be to immediately remove it from the catch before they started to sort the rest.

Once the high risk issues are dealt with, it is time to start looking for those other opportunities to create improvement and drive for the goal of a two-thirds reduction in errors. This is accomplished by sorting the data into different groups and looking for those clusters that may contain value-adding opportunities because errors cluster there. In this first shake-down, Mary Jo would more than likely sort the data into some sort of high level sort such as "type of error".

If you look at the graphic on this page, it is easy to see that transcription errors and omissions account for three-fourths of the medication errors in the hospital. If the nursing department could reduce just those two types of errors, it could easily achieve its goal. It could direct its strained resources to those two areas, concentrate its change-engine in this area and create very tangible change that is easily communicated and monitored.

This kind of analysis is extremely important. Too often, organizations focus on the wrong activities because they shoot in the dark and hope they hit a meaningful target rather than taking the time to achieve value-adding focus. For example, Mary Jo's initial intention was to focus on wrong drug and wrong patient categories until she looked at the data.

Many managers don't engage in this level of analysis because they say they don't have time. What they fail to realize is that they can actually increase their productivity, reduce resource consumption and increase their potential for success (reducing their potential for failure) by investing a little more time up front to make sure that they are aiming at the right target. Too often the pace of today's healthcare environment encourages leaders to make this very serious error because they believe that they need action. While they do need action, the wrong action can be just as damaging as no action. Just how action oriented would Mary Jo have



looked if she had focused her time, energy and resources on the fixing the wrong drug and wrong patient categories. Over time as medication errors did not decline because of poor focus (and could actually have increased), she would have appeared pretty ineffective in her role. These kind of errors frequently place leaders in jeopardy because while they are taking action, they don't appear to be the people who can get the results.

Also, the identification of this initial data clearly demonstrates the rational for the actions to be taken and makes it easier to achieve support for the plan and the resulting changes. It also reduces the amount of time and resources that need to go into future monitoring activities, Mary Jo's reports will drill down on transcription and omission errors. This is important because the more focused the reporting, the easier it is for people to stay focused.

The next most common mistake results because leaders stop shaking down their data at this point. Mary Jo

Reducing Medication Errors (con't)

now knows that reducing transcription errors and omissions are her tickets to success but there are many variables that can contribute to these two types of errors. Is she going to change the entire transcription system? Is she going to rely on discipline for the nurses every time they omit a patient's medication and use guilt as her primary change engine? Is she going to keep trying different things until she finally hits the right answer? Unfortunately, these approaches are used too frequently and can be very damaging.

Two of the most common complaints that come from the healthcare workforce today center around their frustration with "busy work" and the

were to shake the data down further and determine why these areas are such a problem. In this level of shake-down, leaders are likely to reduce the number of people impacted by the change or activity. This is big in protecting employee relationships.

Mary Jo would want to know the answer to questions such as: Do the majority of the transcription errors occur on weekends when there is no unit secretary? Do most occur on a particular shift, in relation to a particular activity or at a particular time? Is there not enough structure in the transcription procedure to promote consistency from staff members? Does the structure of the new medication administration record promote omissions? Do the routine times for medication administration as set by policy promote omission errors because they force too many medications to be delivered too close to shift changes? Are there nurses who have difficulty with their organizational skills and are responsible for the majority of the omission errors?

to the "heart of the matter" and get results. They are commonly people who know how to use data to get results.

In this example, the director of nursing found that the majority of the transcription errors were occurring on the night shift between the hours of 11:00 p.m. and 4:00 a.m. and were associated with one particular physician. He was a practitioner that commonly made rounds during the night because he suffered from insomnia. A high percentage of those errors were also associated with nurse 167. The corrective action plan became pretty focused at this point in time. Mary Jo could work with the medical director and quality director to put a report together for the medical staff on the impact of the late night rounds by one physician. She could also put together a plan to work with nurse 167 on the process of transcription.

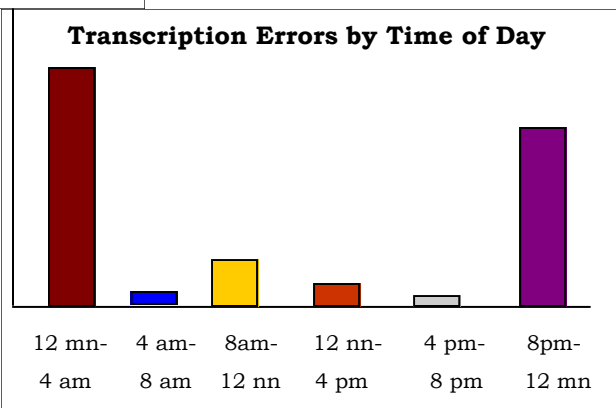
As she worked through a similar process for omissions, she found that the majority of errors occurred with medication deliveries at shift change and when split doses were dispensed by the pharmacist to reduce inventory (i.e. dispensing 2-20 mg Lasix instead of 1-40 mg).

Shaking down data is one of the most important skills that leaders in today's healthcare market need to develop. They need to be able to create value-adding change while maximizing resources and reducing the stress on their people. They need to increase the potential of getting it right the first time.

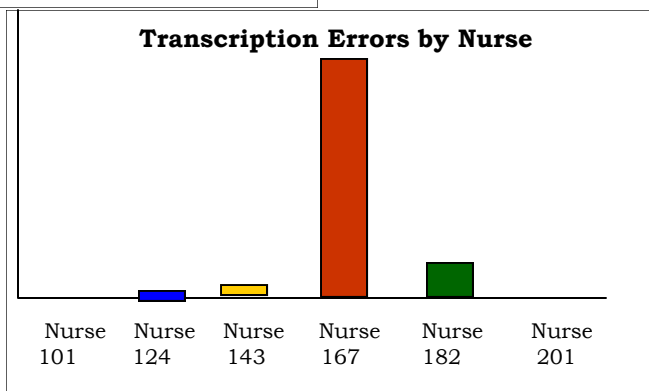
demoralizing way they feel they are treated in our efforts to achieve quality. Trial and error when it is not necessary and relying too heavily on negative approaches such as discipline as corrective action tools are two of the most common practices that feed frustrations for the workforce.

Imagine the value that could be communicated and the potential buy-in that could be achieved if Mary Jo shared the data on the previous page so the staff could see the potential impact of their efforts if they could simply figure out how to reduce transcription and omission errors. How much better and easier could their lives be with just those two outcomes? People would be much more willing to commit their time and energy when the focus and potential impact can be made this real for them.

Mary Jo would be even more likely to achieve support and buy-in if she



Shaking down the data further and further allows a leader to get his or her hands around the areas that will make the most difference. Highly respected leaders are frequently those who are known for their ability to get things done. These are people who can get



Achieving the Right Focus

As people work with data, there a number of important points to remember. Some of the more important considerations are:

1. **Not all data is value-adding all of the time, but that does not mean it is not important.** Data

is value-adding when it contains information that allows a healthcare organization to create change that leads to improvement. The value-adding benefit of data is different in different situations. A healthcare organization may have a large pool of data where some of that data is important in addressing issues that are determined to be important for today while other data in the set will not become important until later in the year when the organization is focused on new issues. This is one of the primary reason why it is important to maintain and feed important data sets. In many ways they serve as a bank where the data is stored until it is needed.



2. **It is important to weed out non-essential data.** Many times

healthcare organizations continue to collect data out of habit rather than necessity. Every organization should have a mechanism for periodically evaluating the data sets that they feed data into to determine data that might have been important in the past but has no value in the current market. That mechanism should also make sure that resources are not being wasted in the data collection efforts. For example, having three different departments collecting the same data is not a good use of time and people. There should only be one repository and everyone should know where it is.

3. **Healthy data analysis and opportunity hunting requires an open mind and a willingness to**

go wherever it will take you.

Many times people go into data analysis with preconceived ideas of what they will find only to find something totally different. This can be particularly tough when people assume that the data will show that someone else will need to change and the change actually resides inside the investigating department. Mary Jo's trip through her medication error data is a great example of that. She

went into the analysis knowing that the staff were complaining about the physician who was making rounds on the night shift and that there were errors associated with the pharmacy dispensing split doses while not doing anything to alert the nursing personnel. She believed the data would support her arguments that something needed

to be done in those areas. When she found the high rate of errors on the part of one night nurse and the high rate of omissions at shift change because of the way nursing had set up delivery times for medications, she had a dilemma because she wasn't prepared to share in the ownership of the issues. Her choice was to only focus on the two issues that she wanted to or to focus on all four. Her best chance at creating meaningful change and demonstrating responsible leadership rested in addressing the nursing issues at the same time she works with the pharmacy and medical staff to address those activities that required their participation.

4. **When used properly, data can help to create positive change.** Data can be

a very powerful tool in creating positive change when it is used to build people up instead of tearing them

down. How data is used and presented can have a significant impact on how willingly people embrace change and how far they are willing to reach. Some of the important lessons that Mary Jo learned were:

- a. The data allowed her to focus on those things that had the greatest potential for success with the least impact on the workforce and herself. Too many leaders are victims of their own hard work because they fail to recognize the importance of working smarter not harder. In the past, Mary Jo would have relied heavily on data that was much higher up in the data tree that is displayed on pages 6 & 7. As a result, she would have relied on corrective action plans that were much more comprehensive and resource intensive such as mass education, memos, the creation of new forms, the creation of new policies and procedures and discipline. All of these would have had little impact in moving performance in the best direction and it would have probably negatively impacted her relationship with the majority of the workforce. One of the most importance lessons to be learned in this area is the fact that the more people that the corrective action has to unnecessarily touch, the greater the potential for failure. Another important lesson is that the more people that perceive they are being belittled for good performance at the expense of a system issue or someone else's performance, the more resentful and resistant they will become.



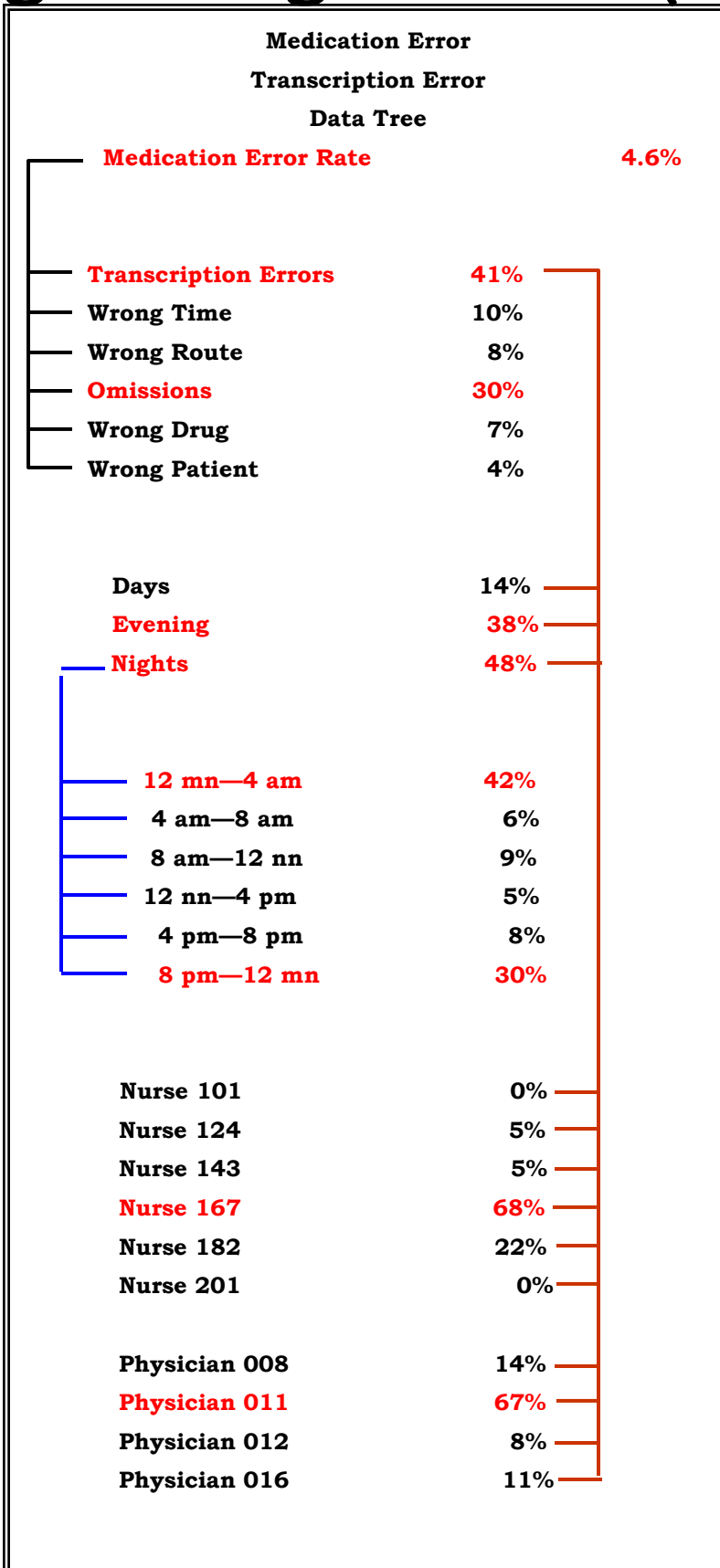
- b. Mary Jo also learned that the right data makes it much easier to come up with the best plan the first time and have one that is appropriately action oriented.

People who can not turn data into action-oriented activities

Achieving the Right Focus (con't)

that yield value-adding outcomes can easily find themselves as victims of their own efforts. Mary Jo is a great example of someone who learned the value of focus and using data to achieve it. In looking at the transcription error data tree on this page it is easy to see the shake down of the data and isolate out those areas that would have the greatest impact on improving the overall medication error rate. Graphics, data trees and presentations in the form of images are some of the best communication tools that a leader can use. People think in images. When people hear words like dog, cat, thirty-seven, snow, or improvement, they create an image in their minds. People think in images instead of words. They can process information faster and better when it is conveyed in an image. Images also leave less room for interpretation or argument as long as the data is sound. As Mary Jo built her data tree, it became very easy to see where she should focus resources and energy in order to have the greatest impact. It also made it very easy for others to see the same thing and support her plans.

c. Mary Jo also learned the importance of data in helping people to see their progress and to feel good about their involvement. She learned the value of data in motivating people to reach for a better



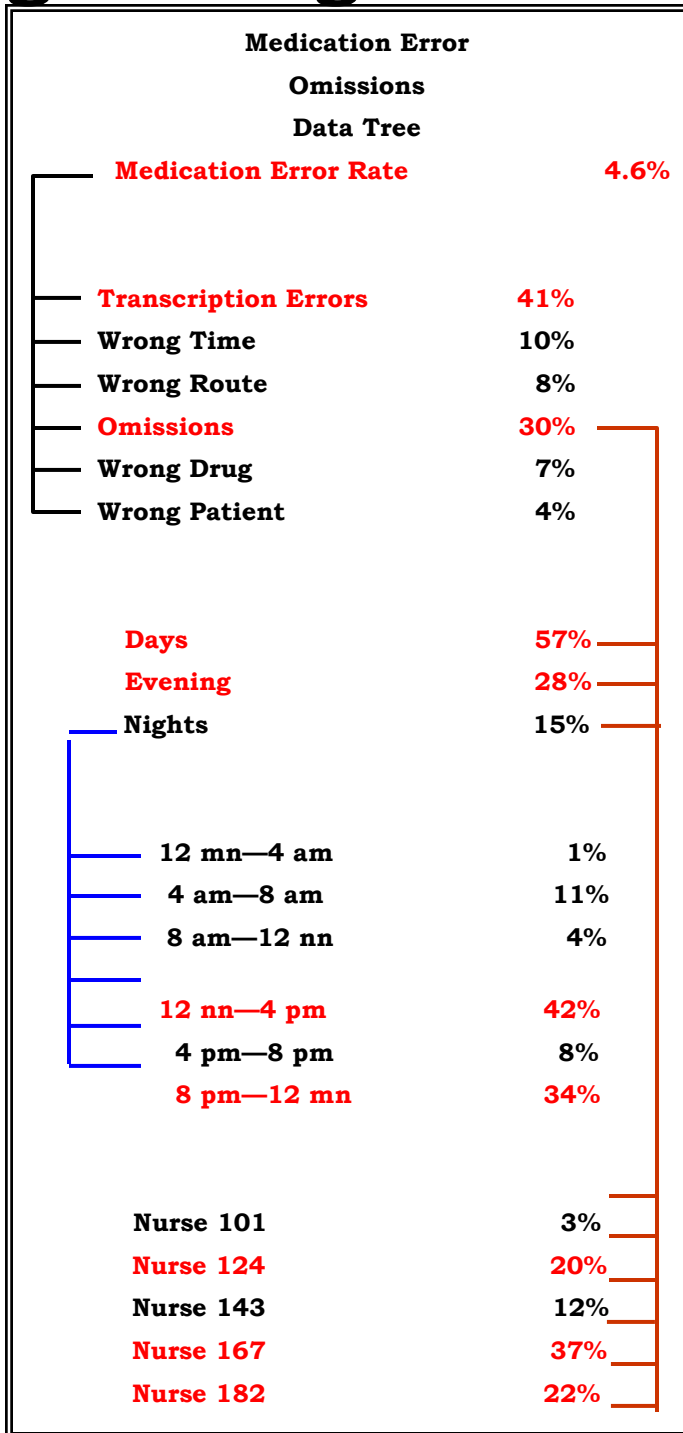
level of performance. One of her concerns was that people would see a goal of a 41% reduction in transcription errors to be too overwhelming. So she set an initial goal of a 10% reduction in 60 days. When the people achieved the goal, she shared the data and celebrated their success. She then incrementally set new targets. With each success, the staff moved faster and with more confidence until they were able to reduce transcription errors to 4%. The data was a critical piece of the plan in walking the staff to success. It is very difficult to push people to a higher level of success. It is much easier to lead them and measures of that success are important leadership tools in doing that. **5. Data can be a very powerful leadership tool.** Mary Jo also realized the power of being a "change-agent". She learned the power that comes with knowing the data and being the first to act on making it better. She became much more effective in creating change because she could demonstrate her willingness to go first. For example, being the first to know that she had a nurse on the night shift who was having trouble in transcribing orders and proactively taking steps to improve that nurse's performance placed Mary Jo in a position of power because she could demonstrate that she was proactively working to

Achieving the Right Focus (con't)

improvement her own department so she and her staff could maximize their contribution to patient safety and well-being. The willingness of a leader to set the example makes it much more difficult for others to refuse to do their part. When Mary Jo was willing to go first and share the data to prove it, it removed many of the barriers that had gotten in her way in the past. Rather than viewing data as a burden, Mary Jo learned that it could be a very valuable asset. It allowed her to be heard and to focus people on the right issues. It allowed her to focus on value-adding change that created meaningful outcomes. It allowed her to build healthier relationships with her staff and co-workers while moving more quickly and with a greater sense of what was right. It allowed her to become a much stronger leader who was respected and appreciated.

6. Change without focus and a good sense that it has a high probability of being the best change can be very dangerous.

As we have already discussed, this can be very dangerous for the leader. It can also be dangerous for the patient and for the delivery of high quality, safe patient care. Random change and shooting from the hip always runs the risk of placing patients at risk and reducing quality. While data is important in helping to make the best choice, it is also extremely important in monitoring for suc-



cess. It is critical in the creation of early alert systems to let us know that we are headed down the wrong path or are in trouble. The data that monitors for success and provides for early alert must be strong and occur very soon in the change process. The old systems of retrospective auditing will not

yield the kind of support and information that a healthy change-engine requires or that will protect the organization.

7. When an organization shakes down the data far enough to get to the root cause, it can significantly reduce the resources invested in symptom control.

Many healthcare organizations waste tremendous resources on symptom control. This occurs in part because they never identify that one change or small group of changes that will make the problem go away. In many cases, never-ending systems for constantly monitoring compliance becomes commonplace. Tremendous time and energy is invested in “did ya” systems. These are systems where leaders spend a significant amount of time asking questions about whether people have done their jobs on that day and every subsequent day. This is one of the primary factors that feed the staff perception that quality is a “police-state” activity designed to find fault. In very unhealthy situations, managers spend most of their day policing performance in an effort to control for system and people problems in the organization. One of the great dangers in this type of an environment is that these organizations commonly struggle to reach for performance beyond minimal compliance because they use up all their resources to maintain the minimum. It is the equivalent of treating bacterial pneumonia with Aspirin. Aspirin may reduce the fever and some of the other symptoms but it is highly unlikely that the patient will get better until the bacteria causing this infection is dealt with. If the illness goes on too long, the patient may never recover. Similarly, sick healthcare delivery systems can rarely be cured by simply putting band-aids on them through stronger compliance monitoring systems.

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*Getting people to work
with us is simply the other
side of us working with
them.*



Quality is Defined in the Eyes of the Beholder!

Quality is defined in the eyes of the recipient of those services. A healthcare organization's reputation is defined by the jury of public opinion. Patient and community perceptions are a healthcare organization's strongest forms of marketing. Life is great when the stories are great and those stories can be the organization's worst enemy if they are bad. Every healthcare provider must understand that their reputations are found in the stories that their stakeholders tell.

Many providers make the mistake of believing that their definitions of quality prevail and they generally pay the price for that perception if it does not match market perception. If their own perceptions of their performance are significantly greater than what stakeholders (our patients and communities) are looking for or believe to exist, that price can be pretty steep. These commonly are the organizations that will find themselves as casualties along the highway to health care's future because they fail to recognize the power of public perception in selecting a healthcare provider.

Quality inside our organizations is a choice. The choices made today decide tomorrow's outcomes. What most providers fail to understand is that it only remains a choice until tomorrow comes and then those choices made yesterday become today's reality. Once this happens, there is no one to blame for the outcomes but themselves.

Systems versus People

One of the greater controversies in healthcare quality improvement centers around whether we focus on people problems or system problems. The answer is *both* and data is key in helping to always maintain the right focus. It is dangerous to punish the workforce for issues that they have no real control over if a poorly functioning system forces them into situations that increase their potential for error. It is the equivalent of an organization asking its people to assure quality in spite of itself.

It can be equally as dangerous to blame the system when the issues rest with an individual's skill sets. Forcing an entire organization or a large group to change for the potential benefit of improving the performance of one person creates an unreasonable hardship on the workforce-at-large and generally raises the potential for error.

The first and most important responsibility of a healthcare organization is to assure the delivery of high

quality patient care in an environment that promotes safety and creates great patient experiences. A multitude of opportunities for improvement reside inside every organization every day and the real question is what do those organizations do with those opportunities improve both their systems and people.

Roughly 80% of those opportunities reside inside the systems of the organizations while the other 20% rest with the people. An organization that chooses to address only one or the other is an organization that will never realize the potential for greatness. Shaking down data is the best way to determine the difference between systems issues and people issues.

Demanding more of the people in a healthcare organization where system weaknesses prevail will rarely create sustainable improvement. In most situations, the people will not be able to sustain the extra level of performance that is necessary to

compensate for weak systems because the needed performance is too energy and time intensive. These are commonly situations that create a roller coaster effect for quality.

In turn, changing systems when the real issue rests in the skills and abilities a person or a small group of people will commonly have little positive impact. Again, it creates a situation that is too energy intensive for the workforce-at-large and fosters change-resistant behaviors. Healthcare is a fast paced, intense industry that demands a lot from its people. That means that it might not be the right fit for some people or some people might need more help than others in developing the needed skills. Because of that pace, it is important that there are mechanisms to help people keep pace with the changes.

Effective data systems help organizations to proactively focus on both their systems and people. They help to achieve the right focus and monitor for success.

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Outside Data Sources

- Hospital Compare
- Trauma Registry
- Maryland Project

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