



A service of NATIONAL RESEARCH Corporation



Volume 12, No. 2, March 2015

Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute.

Using Data to Drive Culture Change

By Richard Corder, M.H.A., FACHE, CRICO Strategies

Sir Arthur Conan Doyle, the Scottish writer and physician most noted for his stories about the adventures of Sherlock Holmes and Dr. Watson, wrote, "The temptation to form premature theories upon insufficient data is the bane of our profession."

Whenever I read this quotation, I wonder to which of his professions he was referring. Was it the prolific writer of fantasy, science fiction, plays, romance, and poetry, or was it the practicing ophthalmologist in the heart of London? I'm inclined to think that it was a little bit of both. An observation that, as an author it was part of how he could enthrall a reader as he led them down the path of premature theory, and as a physician it reads as a reflection of the professional reality that without sufficient data, it is easy to form an inaccurate diagnosis or an inappropriate plan of care.

Through my experience at CRICO Strategies, I work with hospital and clinic leaders and executives to improve patient and provider safety. I hear numerous stories that relate to this temptation to form premature theories, or accounts of the data being ignored entirely. We are living and working in a world where access to outcome, clinical, harm, experience, and event data (and the information and knowledge that can be derived from it) is ubiquitous and can be used more effectively.

In an effort to strive for shared understanding, below are definitions of "data" and "culture" in healthcare, as well as an explanation around the power that data has to positively impact a hospital or health system's culture.

Data is a set of values of qualitative or quantitative variables; another way to think of data is as individual pieces of information. Data is measured, collected, reported, and analyzed. Data can be shared and can be visualized using graphs, images, pictures, and stories. Data as an abstract concept can be viewed as the lowest level of abstraction, from which information and then knowledge are derived.

Data can be gathered from listening to a patient or colleague as much as from reading a report or interpreting a graph. When presented in a way that we understand, data can be the feedback that connects us to the efficacy of our efforts and actions.

Organizational *culture* has many definitions, but is best captured by the somewhat informal, "How we do things around here." It is the way we behave, talk, and act; it is what we reward and how we hire, retain, promote, and fire. At a fundamental level, culture is made up by the habits and actions of those people that lead and work in the organization.

Culture in hospitals and other healthcare entities is often cited as an excuse as to why change is so difficult to come by. But if culture is a series of habits and behaviors, then it can therefore be measured, and hence changed. People can learn new habits, develop new patterns of work, and use different language.

Data must be a critical part of our discussions when we are talking about culture change. It should start the conversation, direct the course we take, and

ultimately be a way to determine whether we “got there.”

Culture as a Superordinate Goal

If organizational culture is a set of beliefs, habits, and behaviors that can be measured, then it is reasonable that improving or changing a culture can be set as a goal, with all the trappings of being specific, measurable, achievable, realistic, and timely (SMART). We can think of improving or changing culture as a superordinate goal and we can craft subordinate goals that we can communicate, measure, and share as we pursue our future state.

Below are three ways to measure culture. The question for healthcare leaders is what is going to be the best measure of their culture, and what is the appropriate mix of data sets, goals, and efforts against the backdrop of other competing priorities?

Three Types of Data for Measuring Culture

1. Perception Data

When we administer surveys that seek to capture the experience that a person had in a specific environment with a group of colleagues or caregivers, we are measuring perception—at the psychological level.

Examples of this include the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey that captures a patient’s perspective of aspects of care, and the surveys on patient safety culture from the Agency for Healthcare Research and Quality (AHRQ), a tool that assesses the physical and psychological “safety” of the work environment. There are also a growing number of organizations that have assessed stress and burnout using the Maslach Burnout Inventory (MBI).

These surveys provide valuable data regarding the perception of the care we provide, the environment we create, and the organizations that we lead.

2. Performance Data

Data to assess performance include measures of historical performance, such as serious reportable events, hand-washing compliance, fall rates, and employee turnover.

This level of data can be shared through performance dashboards, reports, and other

mechanisms. It can be frequently updated, benchmarked against, and reviewed over time. It also provides a record of facts that can be used to track performance.

3. Observing Practice Data

The observation or inspection of elements associated with design and practice includes the assessment of activity against agreed-upon practice. For example, if we have made the decision that as an organization we will adopt a “daily safety huddle,” we can inspect against this expectation. It either happens or it does not—the observation or inspection is binary in measurement.

There are many attributes associated with operating a safe, just, and transparent organization that have been “borrowed” from other industries. Crew Resource Management and the use of checklists are just two adapted from aviation. If, as an organization, we have been clear regarding the implementation of these practices, then we can observe whether they occur.

Data as a Catalyst for Change

My colleagues Dana Siegal, RN, CPHRM, and Gretchen Ruoff, M.P.H., CPHRM, recently published a series of data-driven stories about how specific system and process failures put providers and patients at risk.¹ These stories are drawn from the data-sharing community of CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions, Inc. CRICO’s data-driven strategy uses intelligence from thousands of medical malpractice cases across the country to examine what went wrong and why, and to help members and clients manage their risk and provide better care.

Data captured in CRICO’s Comparative Benchmarking System (CBS), a national database of more than 300,000 medical professional liability (MPL) claims from more than 400 hospitals and 165,000 physicians, demonstrate that many of the issues related to patient harm that were captured in the Institute of Medicine’s report, *To Err is Human*, still exist to this day.²

¹ Dana Siegal and Gretchen Ruoff, “Data as a Catalyst for Change: Stories from the Frontlines,” *Journal of Healthcare Risk Management*, Vol. 34, No. 3, January 2015.

² *To Err is Human: Building a Safer Health System*, Institute of Medicine, November 1999.

Here is a sample of the stories that Siegal and Ruoff share where data has been used as a catalyst for change:

- A study of diagnostic failures in the emergency department resulted in the development of strategies to improve doctor–nurse communication.
- A review and analysis of medical malpractice data from an obstetric service revealed variability in the interpretation of electronic fetal monitoring (EFM) readings between physicians and nurses—resulting in having the M.D.s and RNs attend the same class, together, to learn the same terminologies and communication expectations. The data also revealed that this service was faced with a larger proportion of prenatal-related malpractice claims than its peers, providing opportunities for better collaboration and follow up with patients, an opportunity that could have been lost were it not for the data.
- A deep analysis of surgery claims data revealed communication breakdowns in the post-operative period, specifically identifying resident–attending communication as a serious patient safety opportunity. The analysis and data presentation was the stimuli for the development of a pocket reminder card clearly articulating the expectations for contacting an attending, such as specific vital sign changes,

unplanned intubation, and transfer in/out of the ICU.

Using Your Data

Data is a powerful tool to start a conversation and tell a story because it allows us to be results-driven as well as to analyze what works and what doesn't, and, therefore, positions us to use that information to change our programs and organizations—to change our cultures.

While data cannot alone solve issues, data offers us the clarity to make resource allocation decisions more effectively and to drive results and performance. Indeed, as Atul Butte, M.D., Ph.D., the Director of the new Institute of Computational Health Sciences (ICHS) at the University of California, San Francisco, explained, “Hiding within those mounds of data is knowledge that could change the life of a patient, or change the world.”

That, for me, captures the value of data. In and of itself data has no use. But when we analyze it, share it, and use it as a part of the stories we tell, the goals we set, and as a measure against what we do, then it comes to life. With this insight and application, data can not only change a life, it has the power to save a life.

The Governance Institute thanks Richard Corder, M.H.A., FACHE, Assistant Vice President, Business Development, CRICO Strategies, for contributing this article. He can be reached at RCorder@rmf.harvard.edu.