



Centre for Healthcare Quality
Improvement

At The Change Foundation

Measurement: An End or The Means to An End?

GTA Rehab Network

March 7, 2011

Agenda

- Varying approaches/objectives to measurement for different purposes
- Linking data to improvement work & aligning from the board to the ward
- Releasing Time to Care, demonstrating the power of measurement as the means to an end

Purpose of Measurement	<i>Research</i>	<i>Comparison or Accountability</i>	<i>Improvement</i>
Key Question	“What is the truth?”	“Are we better or worse than?”	“Are we improving? “
Penalty for Being Wrong	Misdirection for profession	Misdirected reward or punishment	Misdirection for an initiative
Measurement Requirements & Characteristics	Complete, accurate, controlled, glacial pace, expensive	Risk-adjusted, with denominators, attributable to individuals or organizations, validity	Real time, raw counts, consistent operational definitions
Typical Displays	Comparison of control & experimental groups	Performance relative to benchmarks, standards	Run charts, control charts, time between events...

Snapshot of hospital report – organizations didn't necessarily do anything with the data

						Home	View Hospitals (A - Z)					
Hospitals (A - H)						Clinical Utilization and Outcomes						
View Hospitals (J - R)		View Hospitals (S - Y)		Show LHIN Map		Explain Indicators						
Hospitals	Area	LHIN	Average Total Function Change (All RCG)	Average Active Rehabilitation LOS (All RCG)	Length of Stay Efficiency (All RCG)	Average Total Function Change (Stroke)	Average Active Rehabilitation LOS (Stroke)	Length of Stay Efficiency (Stroke)	Average Total Function Change (Ortho)	Average Active Rehabilitation LOS (Ortho)	Length of Stay Efficiency (Ortho)	
PROVINCIAL AVERAGE			19.7	24.3	1.5	21.9	36.7	0.8	20.7	16.6	2.0	
Baycrest Centre for Geriatric Care	Toronto	7	17.2	34.4	0.6	20.8	39.5	0.5	22.7	35.5	0.7	
Bluewater Health	Sarnia	1	20.8	31.9	1.1	24.8	52.9	0.6	20.1	19.0	1.6	
Bridgepoint Health	Toronto	7	23.5	35.0	1.2	20.8	58.5	0.5	24.9	27.0	1.4	
Brockville General Hospital	Brockville	10	13.9	26.5	0.7	5.8	33.3	0.1	16.6	20.3	1.0	
Chatham-Kent Health Alliance	Chatham	1	15.9	19.9	1.0	17.0	23.6	0.9	15.2	15.9	1.1	
Cornwall Community Hospital	Cornwall	11	14.6	30.9	0.5	17.7	43.2	0.4	15.1	26.4	0.6	
Grand River Hospital	Kitchener	3	14.3	23.5	1.0	18.7	34.4	0.7	14.8	16.4	1.3	
Grey Bruce Health Services	Owen Sound	2	25.0	31.3	1.0	28.8	40.3	0.7	20.7	16.3	1.5	
Halton Healthcare	Oakville	6	19.4	20.5	1.6	24.7	45.5	0.8	19.3	15.5	1.9	
Hamilton Health Sciences Corporation	Hamilton	4	21.0	30.4	1.3	24.4	36.8	0.9	24.6	20.8	2.1	
Hôpital Montfort Hospital	Ottawa	11	15.1	14.2	1.1	13.0	14.4	1.0	17.7	13.5	1.4	
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	20.6	38.3	0.6	20.7	36.4	0.6	NR	NR	NR	
Hotel Dieu Shaver Health and Rehabilitation Centre	St. Catharines	4	26.4	37.6	0.9	28.2	39.5	0.9	25.4	26.8	1.1	
Hôtel-Dieu Grace Hospital	Windsor	1	21.2	9.4	3.2	13.6	10.1	1.8	23.6	7.7	4.2	
Humber River Regional Hospital	Toronto	8	24.4	9.5	3.1	17.7	14.8	1.4	25.1	8.3	3.4	
Huron Perth Healthcare Alliance	Stratford	2	22.5	30.5	1.3	24.6	46.7	0.7	25.7	20.3	1.9	

Above Average Performance

Average Performance

Below Average Performance

NR Non-Reportable: Insufficient Data or Data Quality Problems

Performance is evaluated against the provincial average for hospitals of a similar type. (Indicator values for an acute care hospital with rehabilitation units or beds or free standing rehabilitation hospital is compared to the provincial average for the similar type.) NR (non-reportable) indicates that there were insufficient data to make a comparison, or data quality problems were observed. Indicator values are adjusted to allow fairer comparisons.

Downside of using data for comparative purposes...

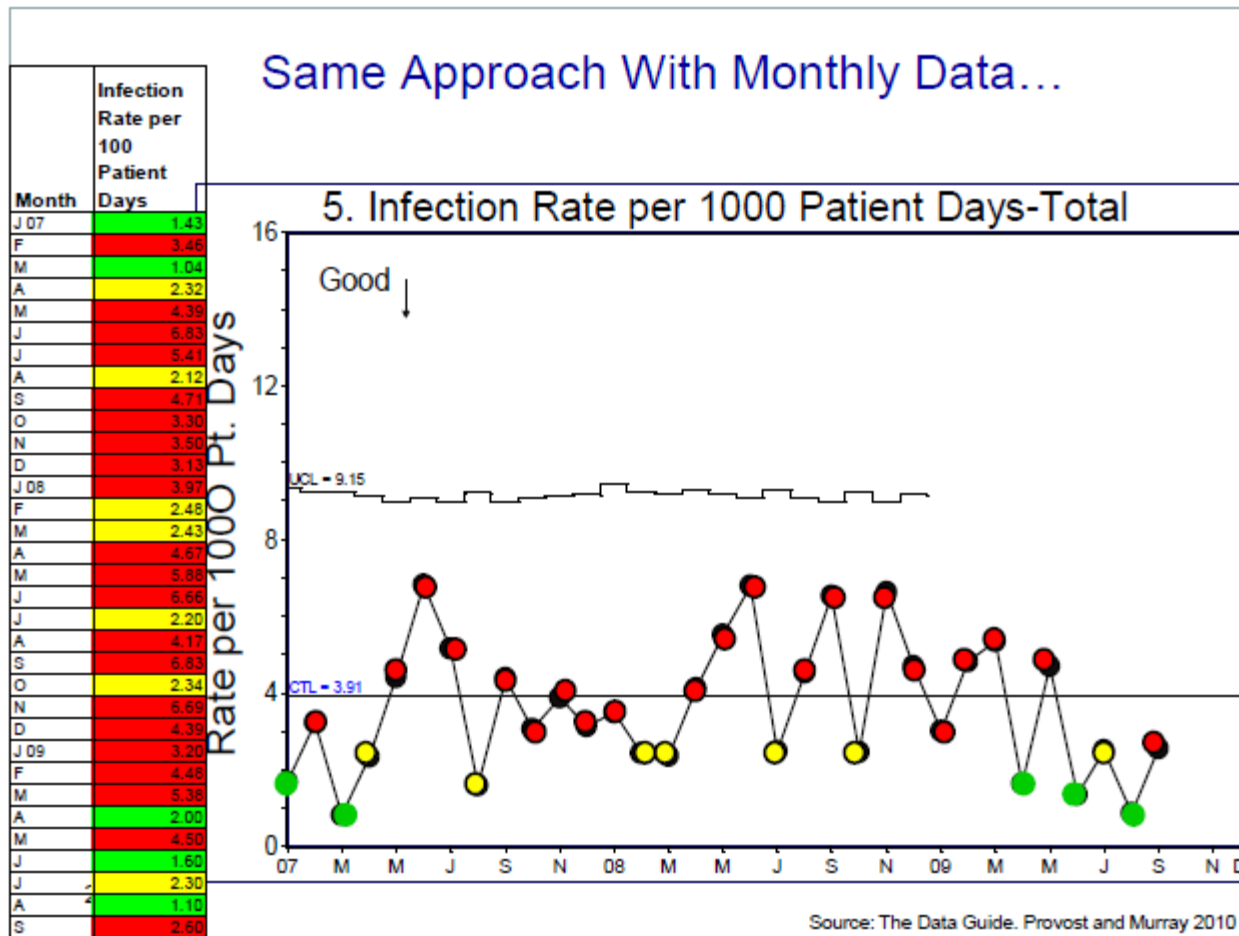
- It is static (no data over time)
- Usually a time lag in getting the data
- If you look bad, energy is spent on figuring out what's wrong with the data
- If you look good, you become complacent
- How you look is determined by how others perform
- Benchmarks are full of defects (ie “the cream of the crap”)

**So.....only do this to help you set targets, perhaps annually
& compare to the best, not the 50th percentile**

There are two types of questions to ask of quality and safety data...

- How good is our care?
 - How do we compare to others like us?
- Is our care getting better?
 - Are we on track to achieve our key quality and safety objectives?
 - If not, why not? Is the strategy wrong, or is it not being executed effectively?

Dashboards vs run charts/statistical process control charts – interpretation is remarkably different...



Make data meaningful by removing the denominator...

C. Diff rate of 0.25/1000 patient days

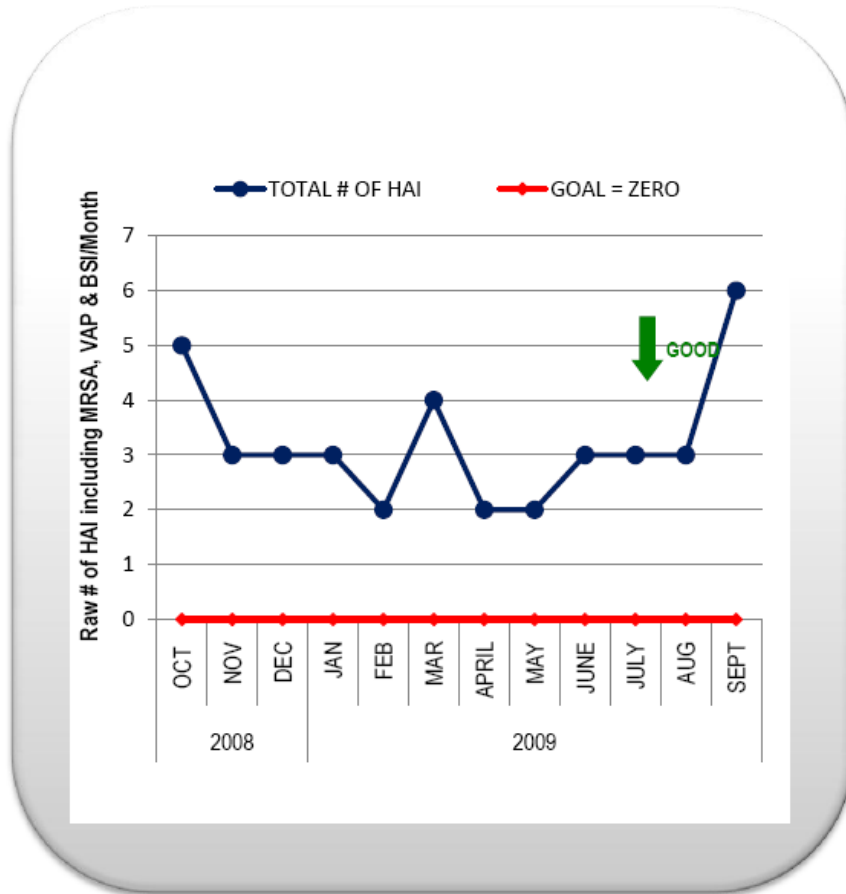
VS

3 cases last month
or
20 days since last new case

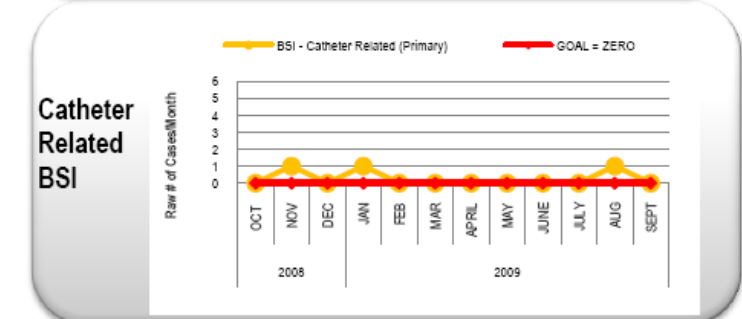
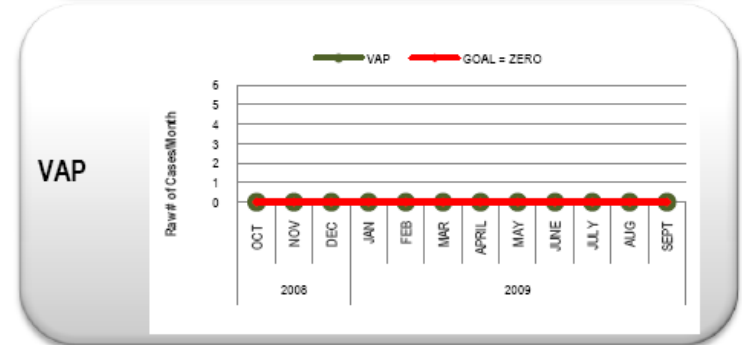
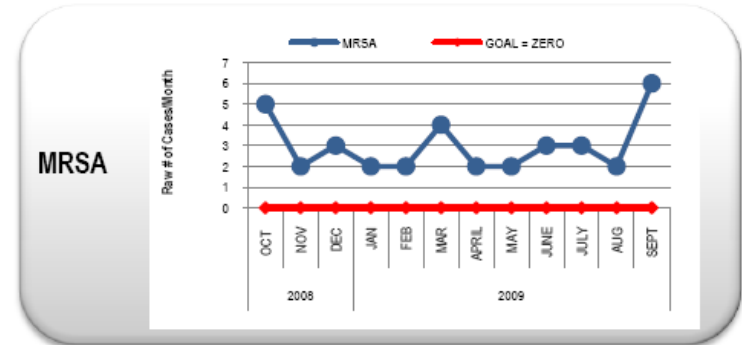
Strategic dashboard to track progress on organizational priorities....

AIM: SAFE

Goal: Zero Patients with Healthcare Associated Infections

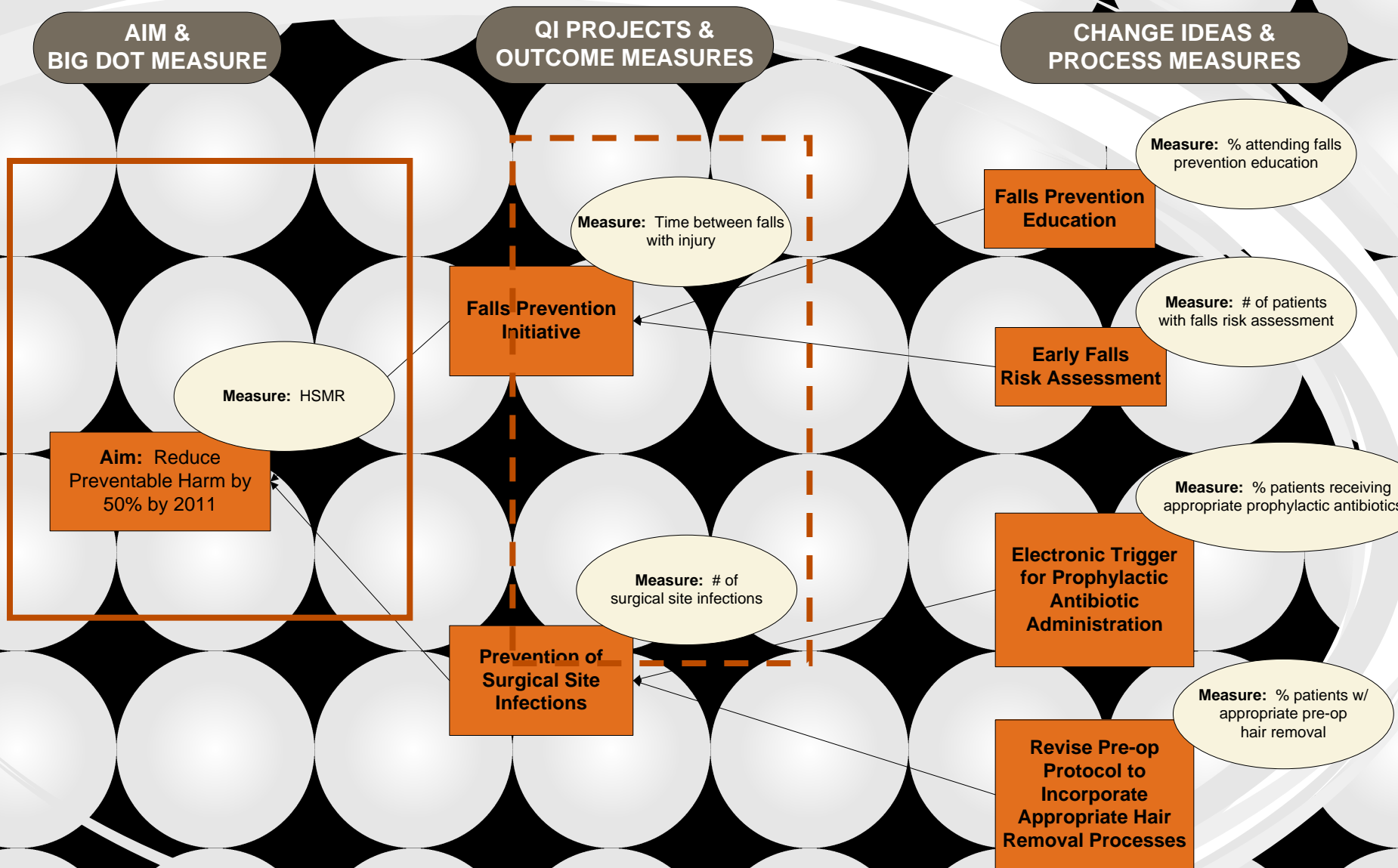


Drivers

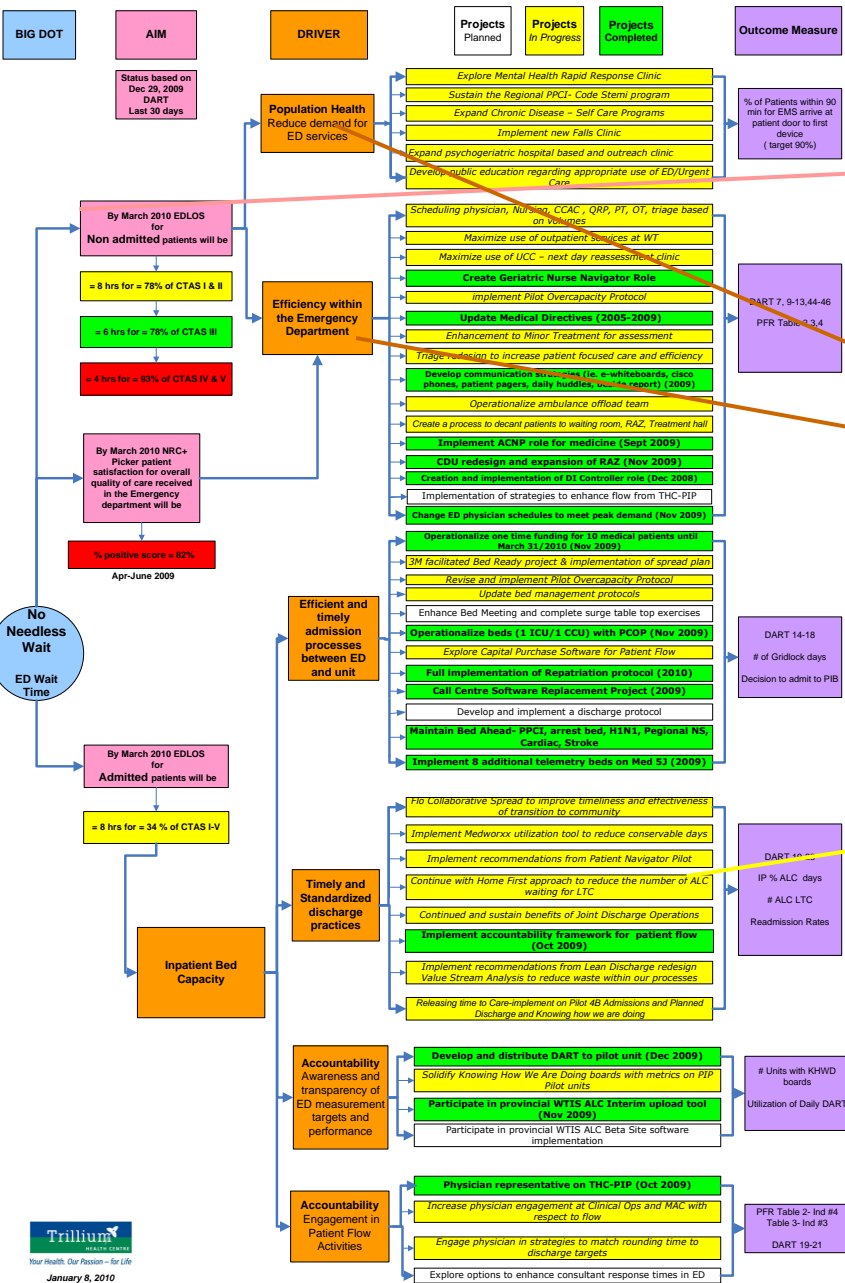


(Source: Shepherd Centre, Atlanta)

Sample Big Dot Aim with Related Projects and Measures



No Needless Wait

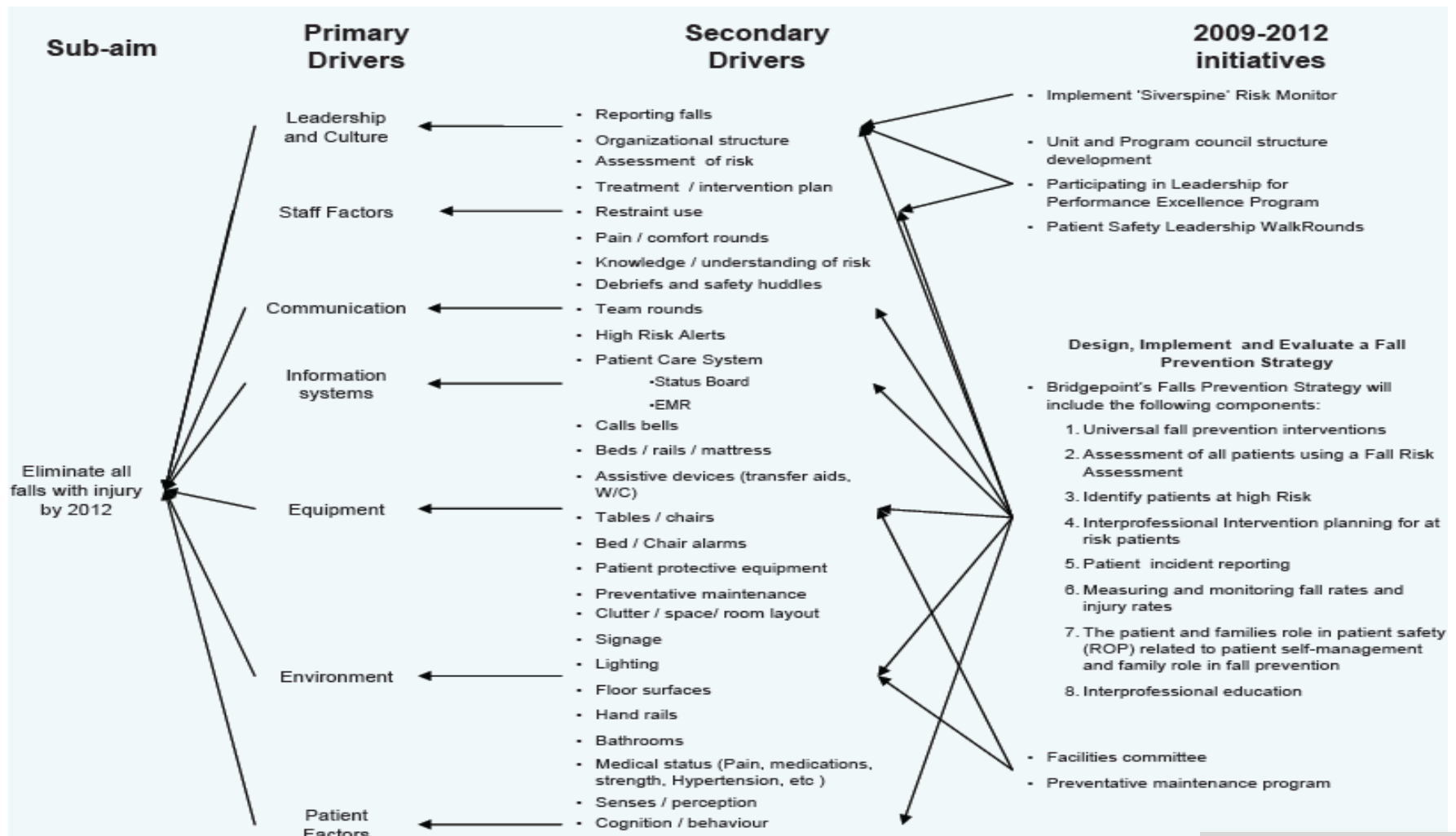


High level aim: ED wait times = provincial targets by March 2010

Drivers: Reduced demand for service & efficiencies in dept

Example projects: Expand CDM self-care programs; Match staff scheduling to demand

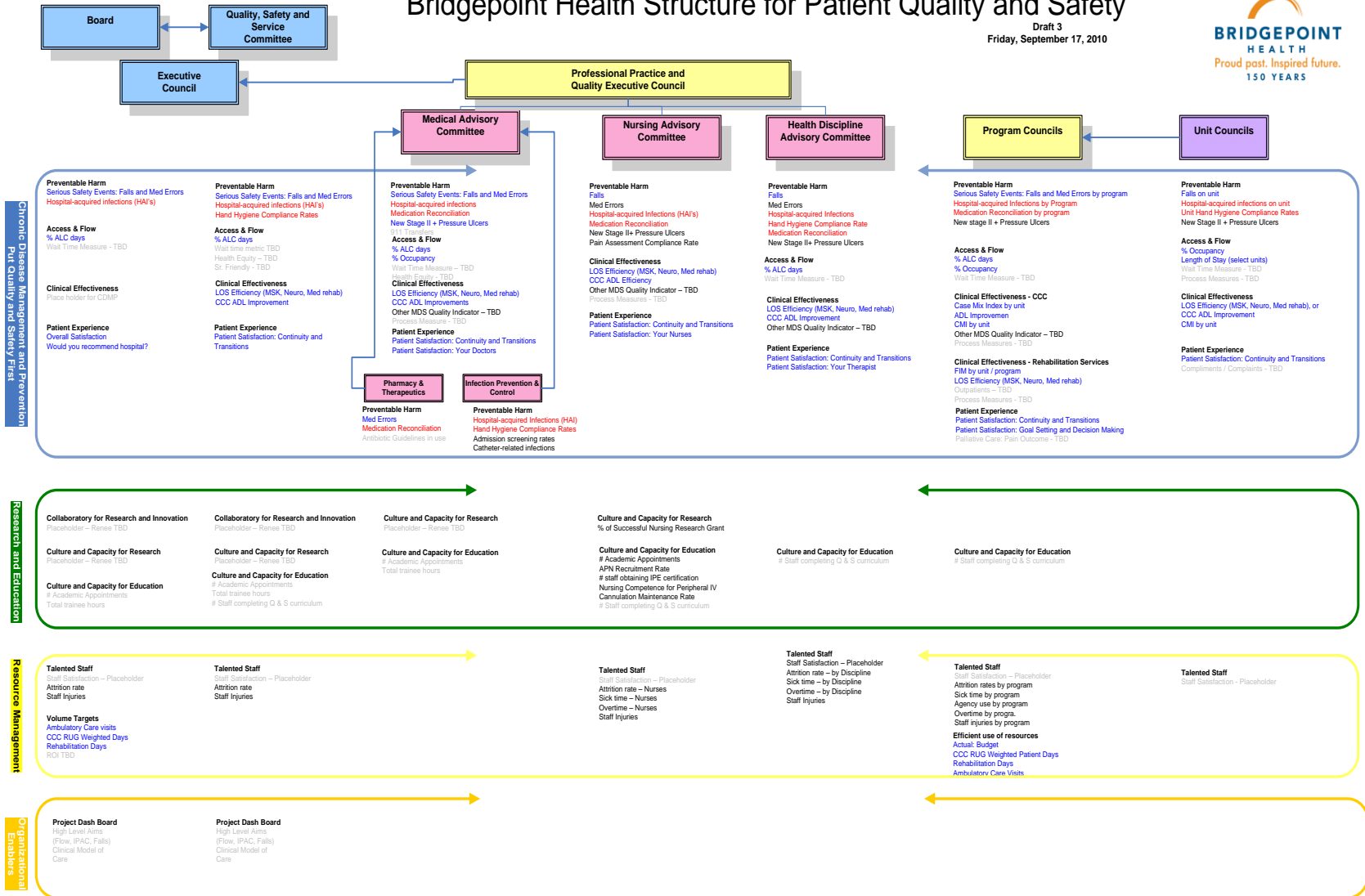
A driver diagram can also be used to generate change ideas for a project...



Establishing accountability from the board to the ward...

Bridgepoint Health Structure for Patient Quality and Safety

Draft 3
Friday, September 17, 2010



Legend
Regulatory / Reportable
Bridgepoint Strategic Aims
To be developed

Translating metrics and accountabilities to the front line...

Visual Tracking Center



Releasing Time to Care

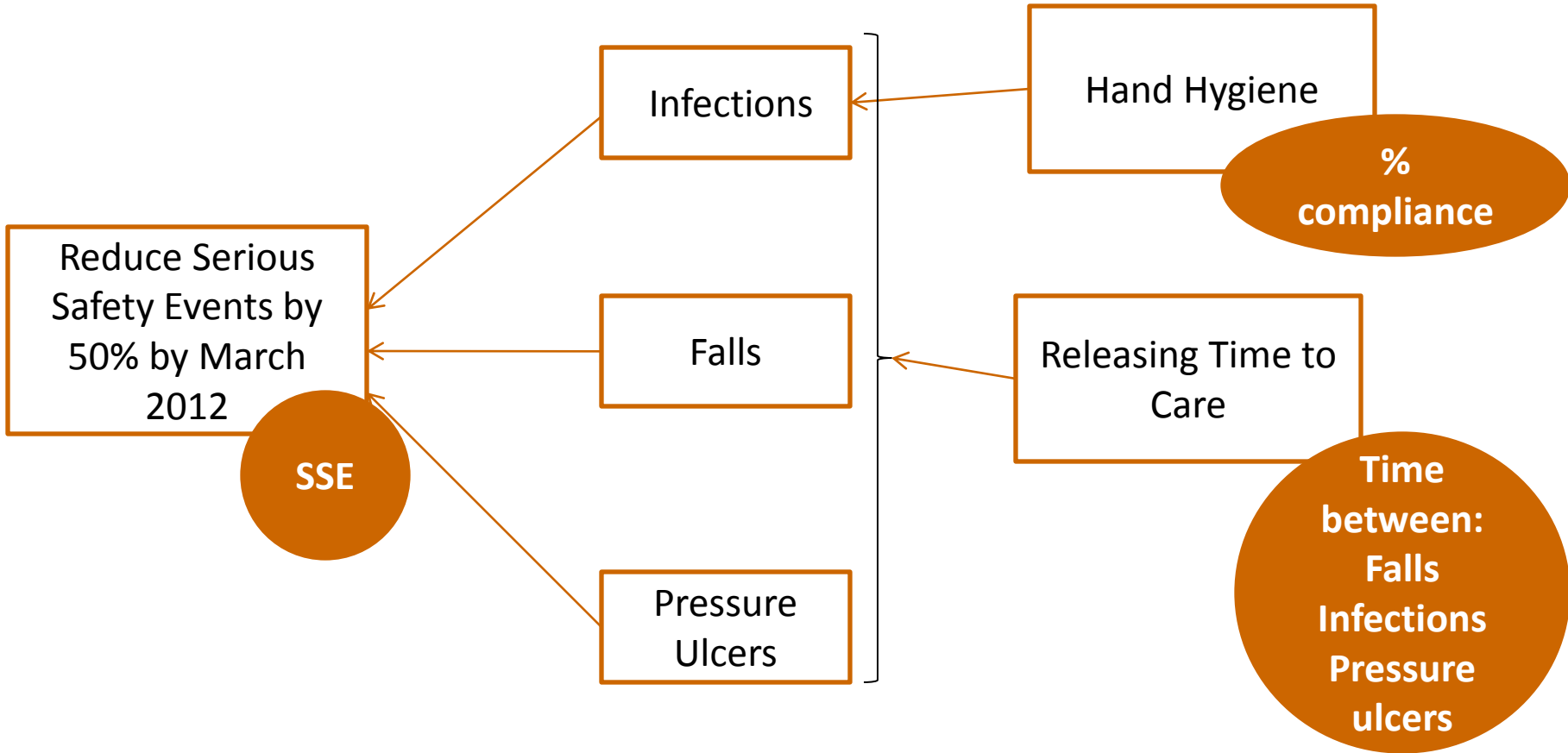
*Linking measurement to improvement work:
The means to an end...*

Aim and Big Dot Measure

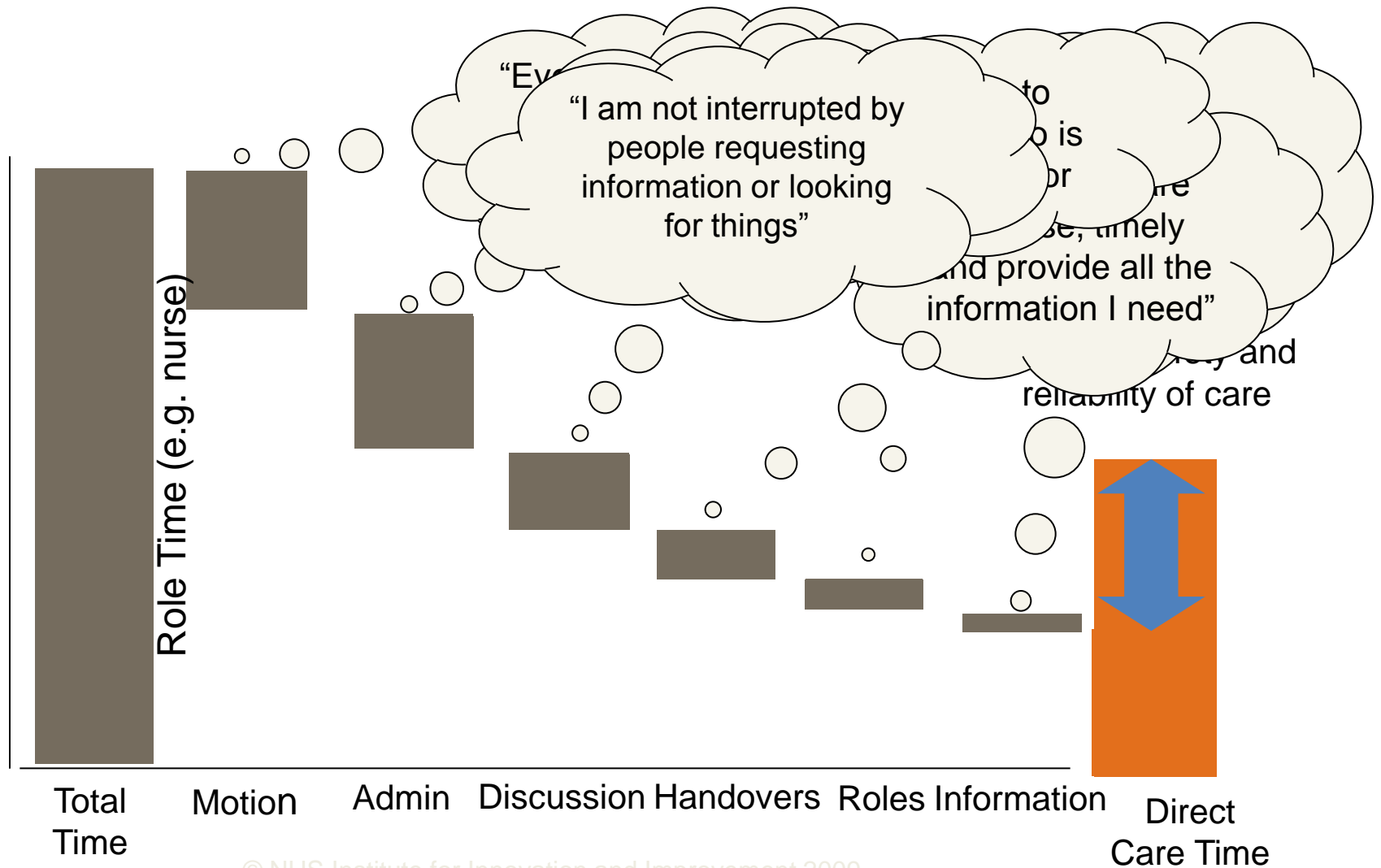
Drivers

Projects

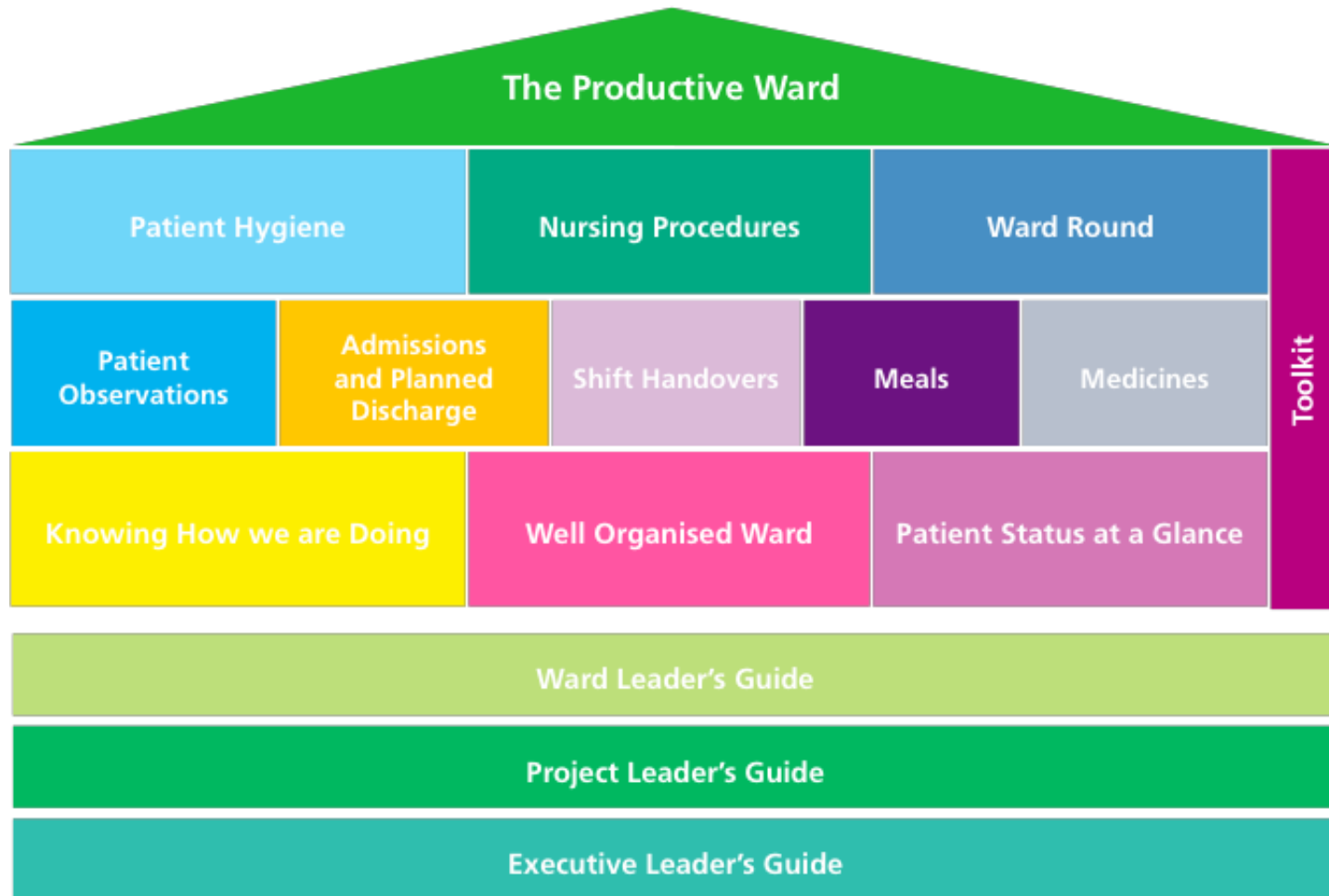
Change Ideas



An underlying hypothesis is that by increasing direct care time, there is more time to focus on improving quality & safety



The Releasing Time to Care[©] “House”



RTC[©] Core Objectives and Measures

Improve Patient Safety & Reliability of Care

- 1) Patient observations
- 2) Interruption rate

Plus minimum one of:

- 1) MRSA infection rate
- 2) C. difficile infection rate
- 3) Pressure sores rate
- 4) Falls rate

Improve Staff Well-being

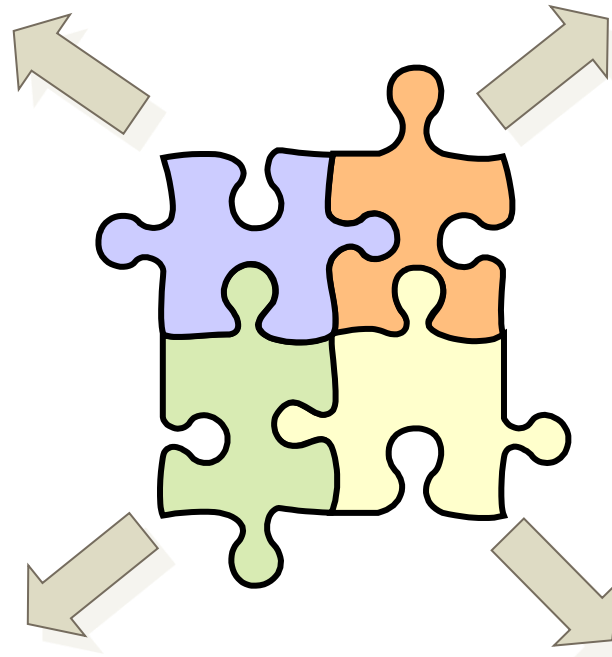
- 1) Staff Satisfaction
- 2) Unplanned absence rate

Improve the Patient Experience

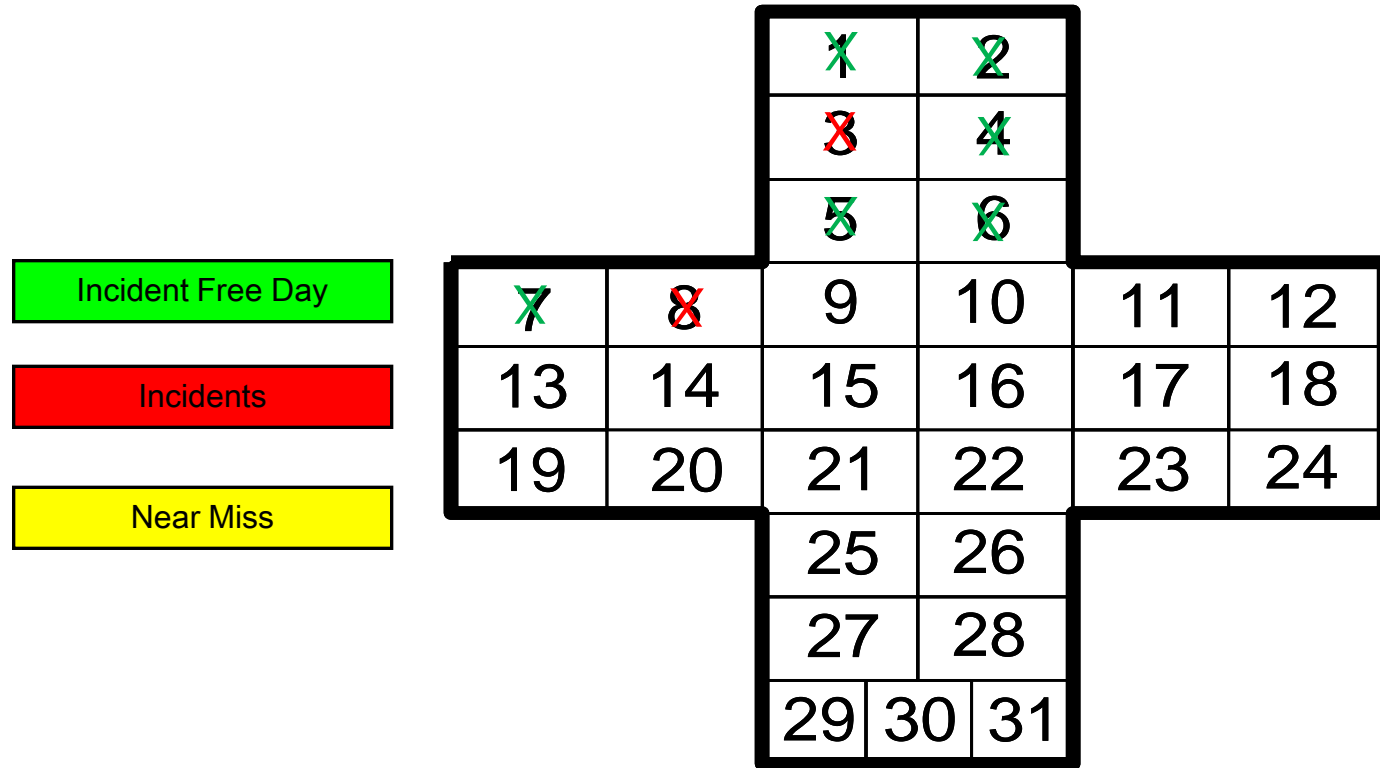
E.g. Patient Satisfaction

Improve Efficiency of Care

E.g. Direct Care Time



Making performance visible in order to support real-time problem solving...



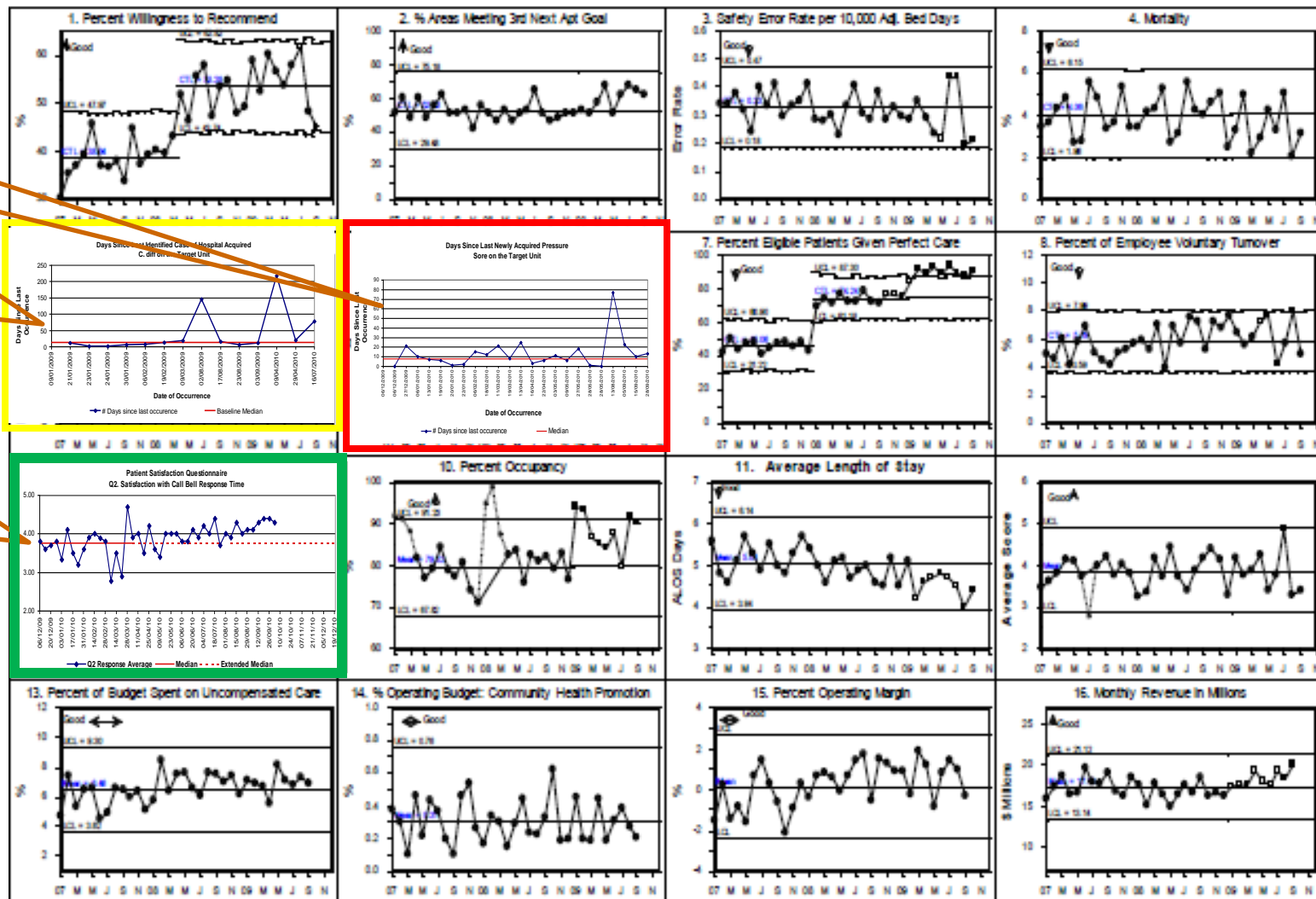
Used to record incidence of falls, pressure sores, MRSA and C. difficile

Board dashboard that includes key outcomes from RTC

Time b/n
Pressure
Ulcers

Time b/n
Infections

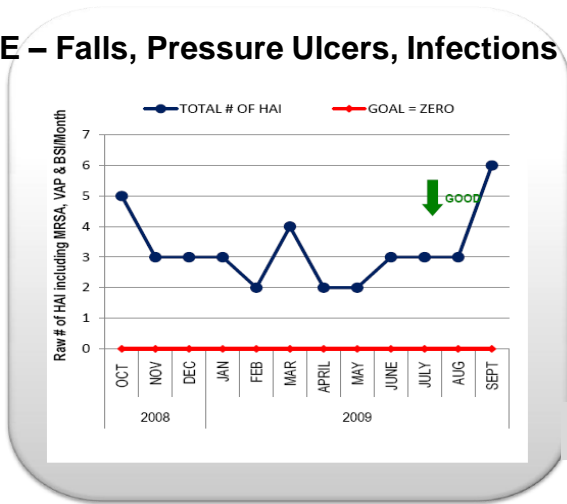
Patient
Satisfaction



Quality Committee of the Board – Strategic scorecard for high level aims...

Big Dot

SSE – Falls, Pressure Ulcers, Infections

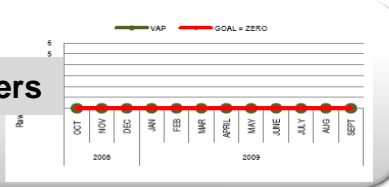


Outcome Measures

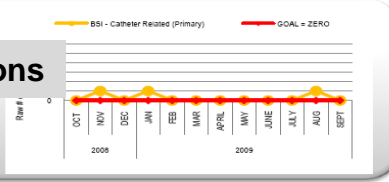
Falls



P. Ulcers



Infections



Process Measures



Unit measurement boards that drive improvement...



Staff huddle at measurement boards, both formally and informally...



A couple of testimonials on the impact of the measurement system supporting RTC...

“The transparency in Releasing Time to Care© is tremendous,” Patti Cochrane of Trillium told fellow executives January 26 at a CHQI [Leadership for Performance Excellence](#) forum, a leadership-for-quality program in which the pilot hospitals and five other organizations are participating. “It makes you reach under the rock, and you can’t ignore what you find.”

The impact is immediate. “Staff on the unit huddle at the end of each day and talk about what happened, why, and what can we do differently,” Cochrane said. Families notice too, noted Sue Roger, Business Director of Medical Programs with Bluewater Health, at the Releasing Time to Care© Learning Session on January 25. “They study the measurement board and ask the nurses to explain. It’s very positive.”



Building on lessons from high performing health care systems around the world, the **Centre for Healthcare Quality Improvement at The Change Foundation (CHQI)** aims to assist organizations to achieve breakthrough results in quality outcomes in areas of provincial strategic priority. The Centre will accomplish this by working with senior health care leaders to build the case for improvement as a business strategy, by initiating and coordinating large scale improvement initiatives, and by using action-based learning to strengthen the capacity and capability for quality improvement among leaders and providers in the system.

If you have questions, please contact:

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