The measurement challenge

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• Quality improvement theory suggests the critical nature of measurement for improvement
• Many barriers make this difficult for teams and senior leaders
• Improved design and greater attention to measurement is likely to contribute to safer care
'If you cannot MEASURE it, you cannot IMPROVE it'.

Lord Kelvin, International Electrotechnical Commission’s first President (1906)
Why measure?

• How we know a change is an improvement
• Measurement is only a handmaiden to improvement, but improvement cannot act without it
• In our work measurement is not for the purposes of judgment
• Rather it is for purposes of learning
The three faces of performance measurement: improvement, accountability, and research.

... many clinicians have become uncomfortable with any efforts to create measurement systems

... measurements are absolutely essential to efforts for improving the processes of medical care

... distinguish between measurement for improvement [research] and for accountability

Solberg LI, Mosser G, McDonald S.

SO NOW WHAT?
A suggested action plan

• Use your first PCS results to define the starting point or baseline.
• Share the results widely – the board to the front line
• Encourage discussion
• As an organization agree a target that you and your colleagues want to achieve
• Use tools like those we will give you
• Monitor your progress
EXAMPLE II
HSMR

- Hospital Standardized Mortality Ratio
- Methodology developed by Sir Brian Jarman in the UK
- Widely used in the UK (Dr. Foster) and increasingly in other jurisdictions
- The methodology
  - Ratio of actual deaths to expected deaths in acute care hospitals
  - Based on 80 diagnoses that account for most in-hospital deaths
Luton & Dunstable Hospital

• Concern with measurement of ADEs
• Learning from ADE work need to widen approach to a system base
• HSMR 111 (higher than national average)
• Management & Executive agreed the need to change the approach to quality with safety at the heart
Agreed Direction

- Adopt patient safety as a core strategy
- Aim for culture change across the Trust
- Continue collaborative approach to spread learning
- Ensure clinical leadership
- Emphasise safety at all levels
Key Themes

• Improved openness, communication and safety culture
• System changes & technology to reduce variability and improve reliability
• Education & training in safety and Effectiveness
Commitment to safety

• Reduce Hospital Standardised Mortality Rate (HSMR) to below 80
• Deliver the aims of the Safer Patients Initiative:
  – reduce adverse events by 50%
  – create a culture that puts patients at the centre of everything we do

Stephen Ramsden Chief Executive
HSMR FROM 111 TO 85 IN THREE YEARS
<table>
<thead>
<tr>
<th>Organization Setting</th>
<th>Intervention</th>
<th>Selected Results</th>
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| Sentara Norfolk General Hospital, Norfolk, Va.                                       | Accelerate patient safety improvement through a multifaceted culture change program involving setting and monitoring behavioral expectations, enhancing analytic capabilities, and streamlining and focusing on critical policies | 42% increase in expected communications behaviors  
50% reduction in events of harm per 10,000 adjusted patient days when culture change strategies were applied system-wide |
| U.S. Dept. of Veterans Affairs, National Center of Patient Safety, Ann Arbor, Mich.   | Lead organizational cultural change by empowering local facilities and frontline staff with proven tools, methods, and initiatives for patient safety improvement | 30-fold increase in internal safety incident reporting  
100% increase in perceived preventability of safety events studied by root cause analysis teams |
Conclusion

• Early empirical evidence supports the claim that culture and outcomes are strongly related
  – Both strength and uniformity of safety climate matter
  – Senior managers may misperceive important aspects of safety climate

• Presence of blame and unwillingness to seek help suggest interventions that address deeply-ingrained beliefs are needed to improve hospital safety culture
The Bottom Line

• Trying to improve without measurement is like trying to sail without a compass

• You may think you know where you are when you don’t and even if you do know where you are you don’t know what direction to go