Creating a Culture of Quality Among Direct Service Providers

August 5, 2014

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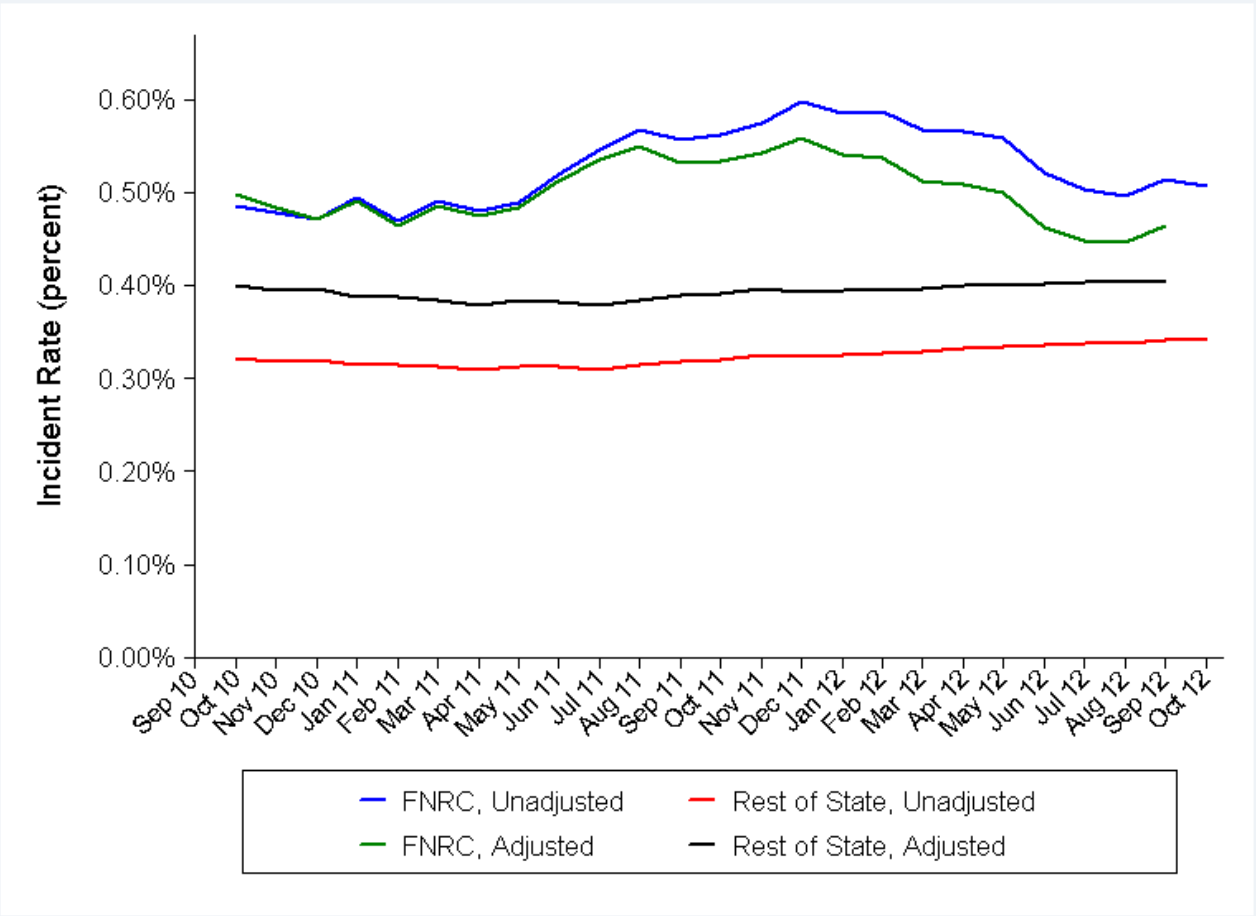
In 2011, medication errors were increasing fast in Northern California.

- Far Northern Regional Center (FNRC) asked DDS for help.
- Using data from FNRC, Mission
  - Discovered that the increase came from the population in Supported Living
  - Recommended that providers change their practices for managing medications.
- FNRC put a plan in place in late 2011.

And this is what happened.



The path to FNRC's success began in 2002, when DDS:

- Introduced
  - Regulations requiring regional centers to report incidents to DDS
  - Regulations requiring regional centers to review individual incidents and look at trends
  - A centralized system for reporting incidents.
- Hired a risk management contractor (Mission's predecessor) to
  - Offer clinical advice to regional centers
  - Provide data analysis and technical support.
- Invested $800K/year and three staff.

During the first few years, this effort:

- Generated a lot of data.
- Monitored numbers of incidents—i.e. *counts*—by regional center, type of incident, and year.
- Sent clinical experts to regional centers with high numbers.

This was not a success.

- Analyzing counts was nearly useless:
  - A region with a larger population usually *will have more incidents* even if risk is lower—because there are *more people*.
  - So, lower counts do not indicate better practices—and that's what DDS wanted to identify.
- Clinical technical support did not integrate well with practice:
  - Tools were developed from the top down, and
  - Provided to all regional centers.

In 2005, DDS hired a new contractor, who:

- Shifted focus away from counts and toward *rates*.
- Reported rates that DDS could compare
  - Across regions—were rates higher in one region?
  - Over time—was a rate increasing somewhere?
- Set benchmarks for performance:
  - Are rates higher in one region than in others?
  - Are rates in one region higher than in the recent past?

This, too, was something of a false start.

- Monitoring focused on increases in *quarterly incident rates:*
  - These usually do not last into the next quarter
  - So, no one should really care about them very much.
- So, DDS altered its focus toward *long-term* rates that
  - Increase over time
  - Are higher than the statewide average rate.
- At that point DDS was measuring quality of services at last.

There were two key obstacles to overcome.

- Regional centers did not all report data in the same way, so
  - Rates were not comparable across regions
  - Low rates did not imply better practices.
- Using data was not part of practitioners' *professional culture*.
  - They did not understand data or know how to use them.
  - Data are about populations; case workers focus on *individuals*.

DDS removed these obstacles by:

- Persuading regional centers to establish uniform reporting
- Presenting data in simple, clear tables and graphs
- Providing technical support to help centers interpret their data
- Producing results using data that are helpful and surprising to practitioners.

The next step was a turn toward qualitative analysis.

- We can use data to identify and explain trends.
- But only rarely will data alone tell us how to solve a problem.
- So, DDS uses qualitative methods as well, including
  - Site visits to regional centers, providers, and facilities
  - Case reviews
  - Analysis of how providers deliver services.

Qualitative methods also meant a turn toward direct care staff—this, too, was a change in organizational culture. At FNRC:

- Direct care staff knew could identify
  - Practices that led to medication errors
  - Ways to prevent errors from recurring.
- QA and direct care staff worked on a tool that providers use to
  - Analyze their practices for managing medications
  - Identify ways to make them less prone to error.

At this point, there was a third obstacle.

- Providers respond to incidents by re-training their staff.
- This is a version of blaming the staff for bad outcomes.
- But weak *processes* are just as likely to cause incidents.
- And no amount of training will solve that problem.
- So, DDS has made the case to providers that
  - *Weak processes* are a key cause of bad incidents
  - They can fix weak practices simply and inexpensively.

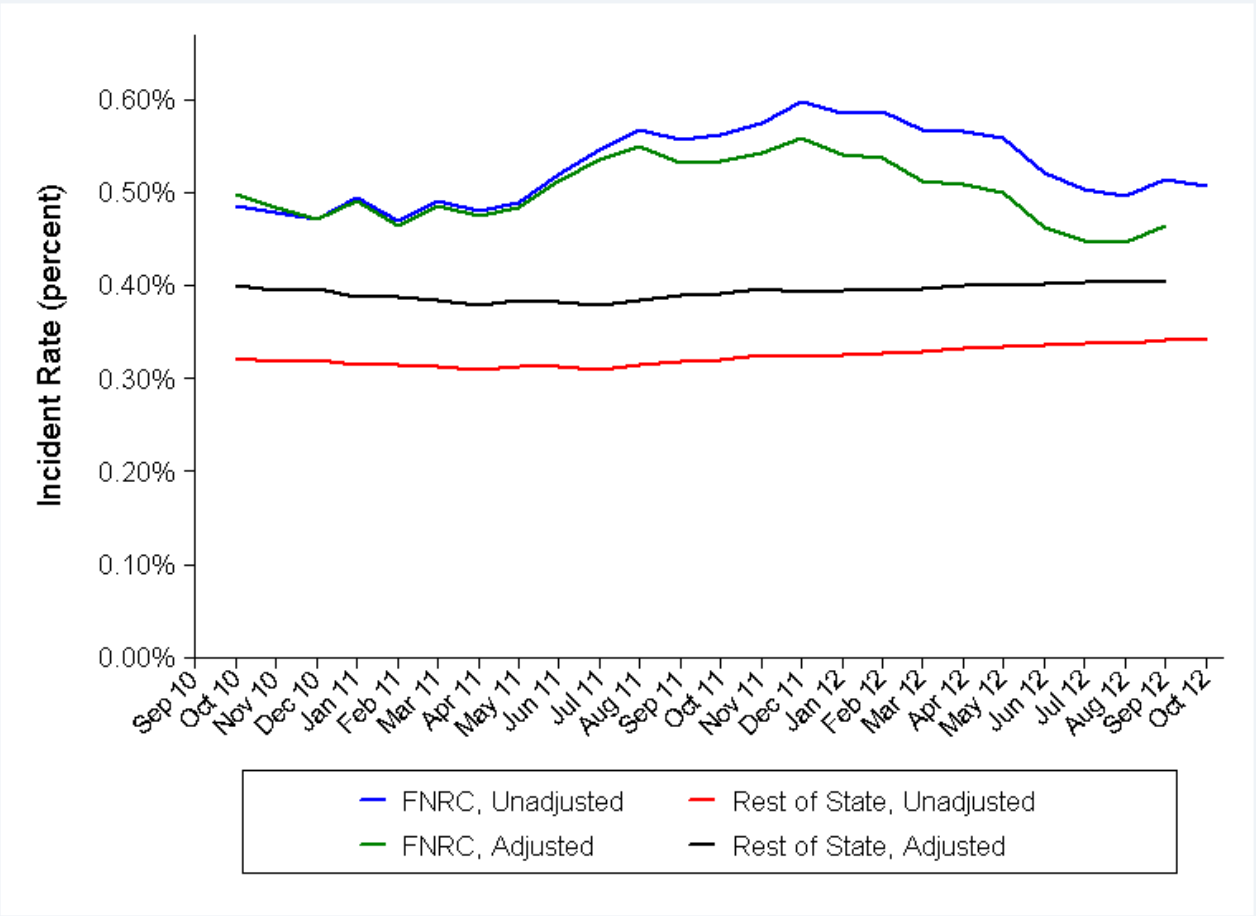
So, here's how to create a culture of quality:

- Engage the right people in the process
- Sustain the effort over time
- Rely on
  - Desire to prove good services
  - Need to comply with regulation
- Make the system transparent
- Hold everyone accountable
- Make it safe for decision makers

So, here's how to create a culture of quality:

- Have a numerical measures that capture what you care about—not just numbers for the sake of having numbers.
- Set benchmarks: Numbers are meaningless otherwise.
- Monitor changes in quality.
- Use qualitative and quantitative methods to understand trends.
- Report on trends regularly.
- Create reports that help line staff do their jobs *as they see them*.
- Make the reports accessible—this is *very hard*.
- Start by assuming that incidents are evidence of weak processes.
- Involve line staff in designing better processes.

And here is what can happen.



Anyone wishing to contact the presenters is welcome to do so here:

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