



Moving the Clinical Needle - Changing Culture and Attitude

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Plenary Session – Healthcare Associated Infection





Where We Are Headed

- Organizational culture
- Change (transformation of culture)
- Moving the organizational needle
 - Providing leadership “culturally”
 - Connecting with clinicians



What is meant by “Culture”?

- The network of internal conversations
- The glue that holds an organization together
- Lines of force which influence thinking which then guides people’s actions
- Influenced by prevailing culture in society at large



How many cultures are there?

- Culture of Safety ... of Quality ... of Improvement ... Patient-focused ...
- Culture is one thing (vs. multiple silos)
- Not in the average manager's toolkit ... not taught in business or clinical schools

Organizational culture (cont.)

- Most culture is developed unawaredly
- Currently in organizations ...
 - Quiet resignation
 - OR
 - Brutal moves (chainsaw Al Dunlop)
- Humans bond by gossip
(cf. monkey's bond by grooming)



Leading change that lasts (culture transformation)

■ Principles

- Leadership can be cultivated
- Genuine participative management is necessary to achieve sustainable results
- Facility staff are capable of generating most if not all of the answers



Principles for leading change that lasts

■ Principles (cont.)

- Trust is essential and attainable regardless of history
- Culture shapes thinking, which determines action
- Significant positive change is a natural process once the opportunity is properly designed and the needed knowledge/skill imparted



Leading change that lasts

- Successful change/transformation must be led by a facility's leadership team
(Admin, DON, Medical Director ...)
- Begins with strategy ... followed by design ...
...ends with connecting it all to the (clinical) staff

Leading change that lasts (cont.)

- Harvard: professional services (healthcare)
 - 10% strategy (services, care processes, etc.)
 - 90% people and culture
 - Most culture research from anthropology
(observing culture but not intervening)
- Tempting to address obvious issues and overlook their root causes

Resistance to change?

- People do not resist change ... they resist being changed (manipulated, coerced)
 - A car when properly assembled does not resist being driven
 - Does not work well to press change on them “until they succumb”



What is “proper assembly” of change?

■ Key elements

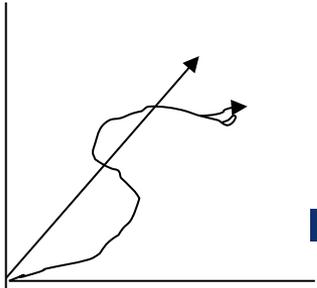
- Sufficient foundation of relationship
- Inspiring idea
- Right gradient
- Structures for communication
- Let them see/judge the evidence for themselves

Leading change that lasts

- Get your support lined up
 - Have preliminary meetings (convert allies 1st)
 - Inspire the change (convincing is not inspiring)
 - Need both inspiration and feasibility
- Most important culture-shaping force:
 - Legends and heros
 - Celebrating heros as coin-of-the-realm
- Best villains are qualities/habits (not people)
 - e.g. complacency
 - What needs disruption → the villain

Leading change that lasts

- Phases (beginning, middle, end)
- Formulation
 - What feasible part of the “Big Game” could we accomplish, with what resources, in what timing?
- Initiation/Startup
 - Care and feeding of an infant system
- Problem-solving/course correction
 - Re-condition project when world changes
- Periodic debrief
 - What’s been accomplished, what next goal?



Structuring for communication

- Structure for <project> staying alive thru time
- All organizations are structured (cf. the body)
- Lots of structures/systems are messed up
 - e.g. using e-mail to inspire or manage
 - cc: list if I only need to know
To: list only if I need to respond
- Periodicities: meetings, conference calls, “white papers”
- Predictive measures, intervention methods and structures



Moving the Organizational Needle

- Providing leadership “culturally”
- Connecting it all to the clinical staff/clinicians
- Quality – it doesn’t mean anything till you start measuring something (you can tell when something’s better or worse)

Clinical in-service(s) – key points

- New germ theory
- Stewardship-focused SBAR form
- Prescriber announcement letter
<medical director>
- Quarterly report (QA/transmittal memo)



(Draft prescriber announcement letter)

Dear <facility name> prescriber,

As long-term care providers, we aspire to provide our residents with the highest quality care. To accomplish this goal, the <facility name> community depends on us to provide care while adhering to recommended standards of evidence-based practice.

Antibiotic resistance is now considered one of the most urgent national and global public health threats. Antibiotic use is receiving considerable national and Arizona state attention. In response to new requirements of CMS and AZDHS we have been mandated to regularly review antibiotic utilization and to have programs in place to promote optimal prescribing practices.

Our initial step will be to gather utilization data from the medical record, laboratory and pharmacy systems. Beginning in early 2015 facility-wide antibiotic patterns of practice will be reported quarterly to prescribers, the QA Committee and to Administration. The initial focus will be urine cultures and antibiotics prescribed for UTI. We anticipate provision of these data each quarter will prove valuable to prescribers as an objective professional benchmark.

Thank you for your support of these new initiatives.

<medical director name>

Medical Director



Moving the Organizational Needle

- Tracking progress (are we getting there?)
 - Metrics, display
- Periodic progress reports (e.g. quarterly)
- If you can't see it ...
 - you can't move it ...
 - If you can't move it ...
 - you can't <transform> it
- Reporting at multiple levels
 - Admin, QA committee, prescribers, external partners (referring hospitals)

Antibiotic Stewardship – Pilot Project

■ Facility sequential steps

- Meet with facility senior team
(Admin, DON, Medical Director, ...)
- Start-up clinical in-services
- Facility medical director issues announcement
- Assemble monthly 3-streams worksheets into quarterly summary report
- Quarterly report reviewed at QA Committee
- Facility medical director issues quarterly report/transmittal memo to prescribers



Moving the Organizational Needle

- Information only has value if it alters clinical actions/practices
- The essence of (organization) learning is investigating surprises
- Pilot program – surprises → investigate/discern → altered action



Antibiotic Stewardship Metrics

Scottsdale XXXX XXXXX – YYYY

4th Quarter 2014

<u>Metric</u>	<u>Results</u>
# Urine C&S orders	56
# Urine C&S positive	39
# Antibiotic Rx	24
# Rx with low colony count or >1 organisms	10
# Meeting standardized clinical criteria	1 **
# Days of Antibiotic Therapy (DOT)	186
# Days of Inappropriate Therapy (IDOT)	TBA
# Antibiotic Rx - empiric	TBA
# C. difficile orders	10
# C. difficile positive	0

** Documentation often missing ... SBAR starting 1-2015

(Draft quarterly report transmittal memo)

Dear <facility name> prescriber,

Over the past few months <facility name> has been accumulating data on antibiotic prescribing practices in urinary tract cultures as announced previously.

Attached is a report covering the <quarter> of <year>. This is aggregate data from all prescribers. Future quarterly reports will also be produced showing individual prescriber practices as well as the aggregate peer data.

The most important findings in this quarter are the following:

1. Nearly half (40%) of patients receiving antibiotics have low colony counts (25,000-50,000).
2. The majority (>90%) of antibiotics are being prescribed to treat asymptomatic bacteriuria.

Current prescribing guidelines recommend against treating asymptomatic bacteriuria generally and low colony counts in particular. Our goal over the next quarter is to substantially eliminate the practices listed above. This is consistent with current guidelines from both American Medical Directors Association (AMDA) and Infectious Disease Society of America (IDSA).

Thank you for your continued support of the Antibiotic Stewardship initiative.
<medical director name> Medical Director



Moving the Clinical Needle: Key Points

- Organizational culture is one thing ... and it's malleable
- People do not resist change ... they resist being changed
- Leading change that lasts - principles
- Structures for communication keep the change process alive through time
- Providing leadership “culturally” connects it all to the facility clinicians and staff

Thank You!

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