Physician Leadership Careers in Quality and Patient Safety

NONCLINICAL CAREERS FOR PHYSICIANS
SEAK
OCTOBER 23, 2016
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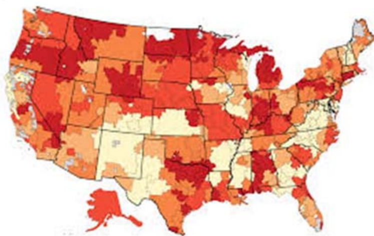
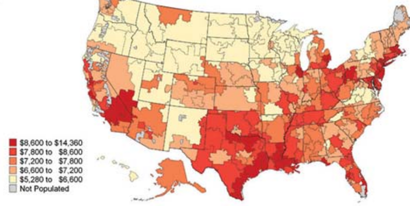
I'll briefly cover --

1. *What is the field of Quality and Patient safety?*
2. *What are the kinds of activities in this field?*
3. *Why would I want to be a physician leader in quality and patient safety?*
4. *What are the challenges in this career?*
5. *What is the day to day work life?*
6. *What does it pay?*
7. *How do I get involved in this career?*
8. *How can I get training in this career?*

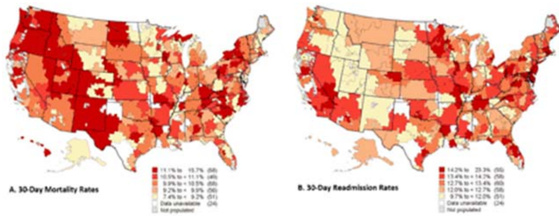
Surgical Complications



Variation in Medicare Spending Per Beneficiary



30 day readmission rates
30 day mortality rates



Clinical Process Measures- Core Measures

Effectiveness: Clinical Process Measures- Core Measures

Source: Outcomes- Get With the Guideline Database & Vizient Core Measure database

	Final Q4 2015	Final Q1 2016	Final Q2 2016	Preliminary Q3 2016	Threshold Vizient AAMC 50%ile	UH Weighted YTD Performance*		
STK-1 Venous Thromboembolism Prophylaxis	93.9	95.5	100.0	100.0	100.0	97.4	★	
STK-2 Discharged on Antithrombotic Therapy	100.0	100.0	98.5	100.0	100.0	99.6	★	
STK-3 Anticoagulation therapy for atrial Fib/Flutter	100.0	100.0	100.0	100.0	100.0	100.0	★	
STK-4 Thrombolytic Therapy	100.0	100.0	100.0	100.0	100.0	100.0	★	
STK-5 Antithrombotic therapy by end of Hosp Day 2	96.0	100.0	96.2	96.4	100.0	97.4	★	
STK-6 Discharged on Statin Medication	100.0	100.0	100.0	100.0	100.0	100.0	★	
STK-8 Stroke Education	100.0	100.0	97.1	100.0	100.0	99.3	★	
STK-10 Assessed for Rehabilitation	100.0	100.0	98.8	100.0	100.0	99.7	★	
IMM-2 Influenza Vaccination	82.9	90.9	NA	NA	95.1	87.0	★	
VTE-5 VTE Discharge Instructions	100.0	100.0	93.3	100.0	100.0	98.3	★	
VTE-6 Incidence of Potentially-Preventable Venous Thromboembolism *(Lower is better)*	0.0	0.0	0.0	0.0	0.0	0.0	★	
ED-1b Median time from ED Arrival to ED Departure for admitted ED patients *(Lower is better)*	540 min	660 min	553 min	486 min	340 min	562 min	★	
ED-2b Admit Decision time to ED Departure time for admitted patients *(Lower is better)*	168 min	255 min	158 min	186 min	134 min	193 min	★	
PCM-01 Elective Delivery (Lower is better)	0.0	0.0	0.0	0.0	0.0	0.0	★	
PCM-02 Cesarean Section (Lower is better)	29.4	25.0	23.5	23.5	41.4	23.9	★	
PCM-03 Antenatal Steroids (Higher is better)	100.0	100.0	100.0	100.0	100.0	100.0	★	
SEP-1^ Early Management Bundle, Severe Sepsis/Septic Shock								

Targets Source: Vizient UHC Q4 2015 Core Measure Comparison Report	Below Threshold	Threshold	Target
Core Measures	Below Vizient-UHC 50%ile	Between Vizient-UHC 50%ile - top decile	Meets or exceeds Vizient-UHC top decile

^ SEP-1 Measure criteria changed starting for July 2016 discharges

** The target is set at 100% compliance for STK, IMM, & VTE core measures*

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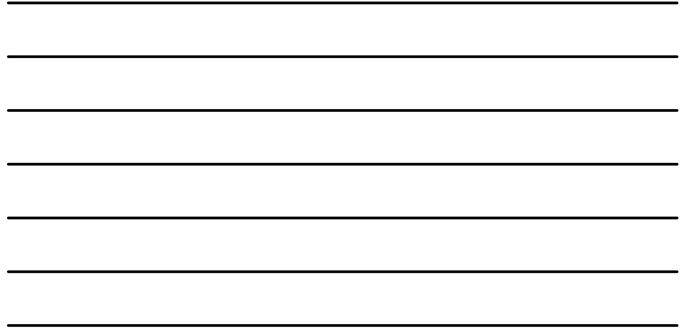
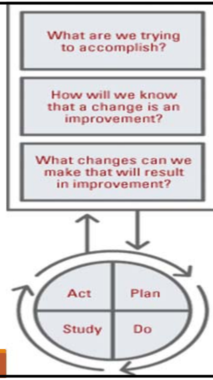
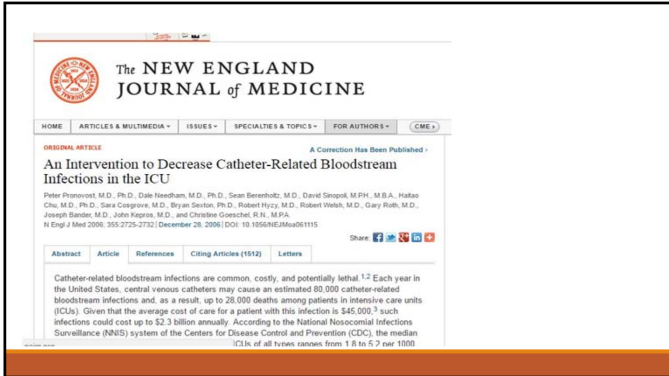


Standardize - Line Cart Contents





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ORIGINAL ARTICLE

A Correction Has Been Published

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

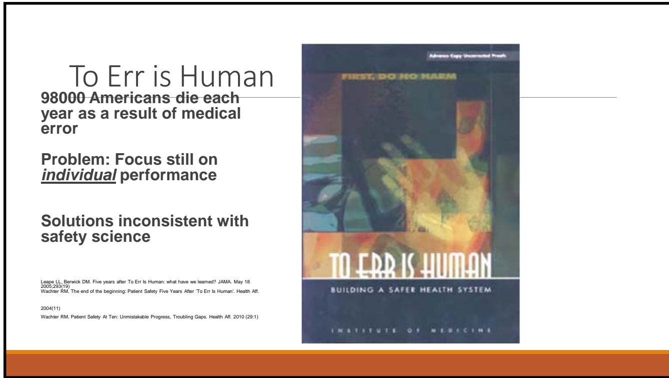
Peter Pronovost, M.D., Ph.D., Dale Needham, M.D., Ph.D., Sean Berenholtz, M.D., David Sinopoli, M.P.H., M.B.A., Haitao Chu, M.D., Ph.D., Sara Cosgrove, M.D., Bryan Sexton, Ph.D., Robert Hyzy, M.D., Robert Welsh, M.D., Gary Roth, M.D., Joseph Bander, M.D., John Kepros, M.D., and Christine Goeschel, R.N., M.P.A.

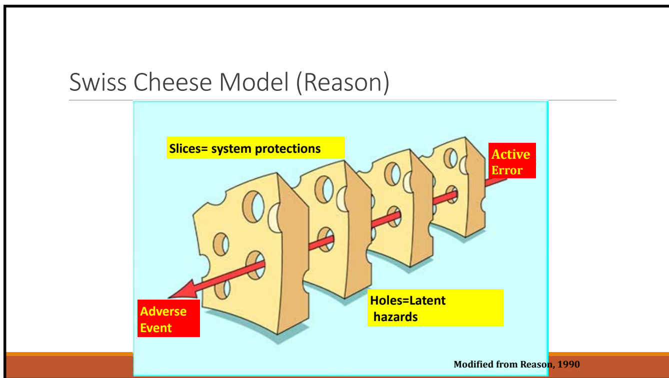
N Engl J Med 2006; 355:2725-2732 | December 28, 2006 | DOI: 10.1056/NEJMoa061115

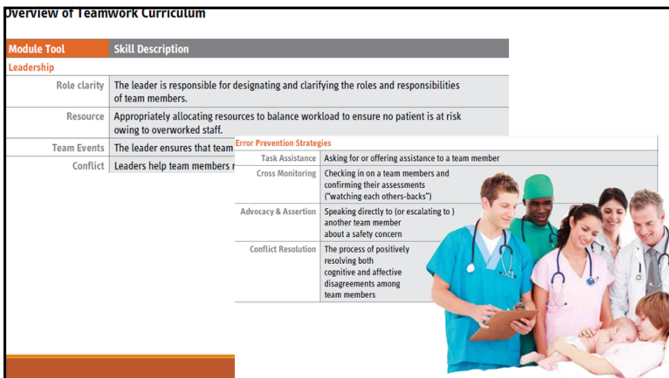
Share:

Abstract | Article | References | Citing Articles (1512) | Letters

Catheter-related bloodstream infections are common, costly, and potentially lethal.[1,2] Each year in the United States, central venous catheters may cause an estimated 80,000 catheter-related bloodstream infections and, as a result, up to 28,000 deaths among patients in intensive care units (ICUs). Given that the average cost of care for a patient with this infection is $45,000,[3] such infections could cost up to $2.3 billion annually. According to the National Nosocomial Infections Surveillance (NNIS) system of the Centers for Disease Control and Prevention (CDC), the median ... ICUs of all types ranges from 1.8 to 5.2 per 1000


To Err is Human
98000 Americans die each year as a result of medical error
Problem: Focus still on individual performance
Solutions inconsistent with safety science
Leape LL, Berwick DM. Five years after To Err Is Human: what have we learned? JAMA. May 18 2005;293(19)
Wachter RM. The end of the beginning: Patient Safety Five Years After 'To Err Is Human'. Health Aff. 2004(11)
Wachter RM. Patient Safety At Ten: Unmistakable Progress, Troubling Gaps. Health Aff. 2010 (29:1)
FIRST, DO NO HARM
TO ERR IS HUMAN
BUILDING A SAFER HEALTH SYSTEM
INSTITUTE OF MEDICINE


Swiss Cheese Model (Reason)
Slices= system protections
Active Error
Holes=Latent hazards
Adverse Event
Modified from Reason, 1990


Overview of Teamwork Curriculum
Module Tool
Skill Description
Leadership
Role clarity
The leader is responsible for designating and clarifying the roles and responsibilities of team members.
Resource
Appropriately allocating resources to balance workload to ensure no patient is at risk owing to overworked staff.
Team Events
The leader ensures that team
Conflict
Leaders help team members
Error Prevention Strategies
Task Assistance
Asking for or offering assistance to a team member
Cross Monitoring
Checking in on a team members and confirming their assessments ("watching each others-backs")
Advocacy & Assertion
Speaking directly to (or escalating to) another team member about a safety concern
Conflict Resolution
The process of positively resolving both cognitive and affective disagreements among team members

QUALITY GRAND ROUNDS
Series Editors: Robert M. Wachter, MD; Kaveh G. Shojania, MD; Sanjay Saint, MD, MPH; Amy J. Markowitz, JD; and Mark Smith, MD, MBA

ACADEMIA AND CLINIC

The Wrong Patient

Mark R. Chassin, MD, MPP, MPH, and Elise C. Becher, MD, MA*

Among all types of medical errors, cases in which the wrong patient undergoes an invasive procedure are sufficiently distressing to warrant special attention. Nevertheless, institutions underreport such procedures, and the medical literature contains no discussions about them. This article examines the case of a patient who was mistakenly taken for another patient's invasive electrophysiology procedure. After reviewing the case and the results of the institution's "root-cause analysis," the discussants discovered at least 17 distinct errors, no single one of which could have caused this adverse event by itself. The discussants illustrate how these specific "active" errors interacted with a few underlying "latent conditions" (system weaknesses) to cause harm. The most remediable of these were absent or misused protocols for patient identification and informed consent, systematically faulty exchange of information among caregivers, and poorly functioning teams.

Ann Intern Med. 2002;136:826-833. www.annals.org
For author affiliations, see end of text.
See editorial comment on pp 850-852.
An expanded version of the text is available at www.annals.org.

"Quality Grand Rounds" is a series of articles and companion conferences designed to explore a range of quality issues and medical errors. Presenting actual cases drawn ... *taken for an invasive cardiac electrophysiology study. Approximately 1 hour into the procedure, it became apparent that Ms. Morris was the wrong patient. The study was*

Human Factors

VF cardiac arrest
- nurse with patient
- charges unit…
- clears patient…
- **presses "on" button**
- Machine powers down
  - 2-3 minute delay in shock

What kinds of activities do physicians do in this field?

- Quality measurement
- Quality improvement
- Patient safety
- Systems analysis and design
- Financial analysis
- Driving Outcomes
- Team training
- Cognitive psychology
- Evidence based medicine
- Policy
- Payment reform

Why would I want to be a physician leader in quality and patient safety?

Fun

Varied

Challenging

Change-oriented

"Clinical"

Front Row seat on rapidly evolving health care reform

Healing the 'system' of healthcare

No call!

What are the challenges of being a leader in this field? Is this a fit for me?

FIT?

Like change?

OK with conflict?

Much more analytical than clinical medicine

Multiple things at one time

No 2 days are alike

Big picture and little picture

SKILLS?

Quantitative
- Analytical
- System Design
- Finance

Qualitative
- Excellent Communicator
- Tolerant of conflict
- Tolerant of constant change
- Policy

What is day to day life like?

Meetings – teams working on mortality, hospital acquired infections

Assessing data and improvement plans

Working with physicians to improve systems of practice

Unit-based leadership

LEAN design teams

Analysis of systems failure in health care delivery

Participating in planning for 'value' and policy

Will I have to take a pay cut?

Salary Range –
- Variation across country
- OK for Internists.
- Pay cut for ortho, neurosurgeons etc

Chief Quality Officers – $2xxK- $3xxK (Not an official)

Chief Medical Officers - $3xxK- $4xxK

Definitely more in some places and less in others

Will my specialty apply to this field?

ED:
- Door to needle time for stroke
- ED Flow
- Improving Triage
- Early sepsis recognition

Critical Care
- Rapid Response
- Central Line Infection Prevention
- High Reliability

Medicine
- Sepsis
- Team Training

Surgery
- Prevention of wrong site surgery
- Team Training

All: High Value Care
- Evidence-based Practice
- Changing long habits (e.g. daily CXR in the ICU)

How do I get involved in this career?

How do I get training in this field?

Training
- MPH
- MHA, MBA
- LEAN
- IHI
- CPHQ
- Virginia Mason Institute
- NPSF (CPPS)
- HMS Fellowship in Quality and Patient Safety

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