Teaching QI at the Bedside

Facilitators: Rebecca Jaffe MD, Bracken Babula MD
Department of Medicine
Objectives

• Discuss importance of integrating Quality Improvement Education into clinical arena.

• Present methods for teaching QI “at the bedside.”

• Brainstorm application to your clinical/educational environment.
Intros

• Rebecca Jaffe, MD
  • Dept of Medicine, Div of Hospital Med
  • Assistant Patient Safety Officer
• Bracken Babula, MD
  • Dept of Medicine, Div of GIM
• Audience
Why Teach QI?

• Mandated by the ACGME
• Milestones and Clinical Learning Environment Review (CLER)
Why Teach QI?

- NAS
- CLER
  - Engagement
  - Institutional Alignment
- Milestones
  - Demonstrate Competency
Why Teach QI?

• Milestones
• You will be asked to assess your learners
• CLER
• Practice what we preach
Why Teach QI?

- Clinical Practice Realities
- Yours (!) and your learners’ futures
  - Reimbursement
  - Evolving practice structures
  - Maintenance of Certification
Why Teach QI?

• “50% of reimbursement will be tied to quality”
  • Sylvia Burwell - HHS

• US Health System ranks last in access, quality, equity
  • Commonwealth Fund

• Jefferson - part of the largest ACO in the region, success of which will be directly related to quality of care we provide.
Why Teach QI?

- Sumant Ranji MD. What Gets Measured Gets (Micro)managed. *JAMA 2014; 312*(16)
Why Teach QI?

What Gets Measured Gets (Micro)managed

When I became an attending physician in 2002, the rules were unwritten but clear: The residents ran the service, and I knew where I stood—in the background. I was to get involved only when necessary, usually meaning if a consultant was being particularly unhelpful, if there was a thorny goals-of-care discussion, or if a patient directly asked for the attending’s opinion. Anything else would result in receiving the worst label you could get as an attending: “micromanager.”

Micromangers were guilty of a variety of sins—calling unnecessary consultations, holding up discharges, challenging medication choices—that boiled down to meddling in decisions rightly made by residents. During residency, we all swapped stories of the furosemide dose—yet—but I intercede on any number of management decisions: check a lactate value for the patient with sepsis, discontinue telemetry for the patient whose arrhythmia seems to have resolved, change the asthma patient’s nebulizers to inhalers, get the discharge summary done on the day of discharge. This is not because the residents are less capable or the patients vastly more complex than they were 10 years ago. Rather, the clinical environment has become one in which these seemingly minor, “resident-level” decisions are now closely scrutinized quality metrics, tied to meaningful changes in payment and accreditation. At the same time, fragmentation of the traditional team structure has eroded the resident’s role as the primary decision-maker.
Why Teach QI?

What Gets Measured Gets (Micro)managed

With the advent of CMS Measure in 2002, the rules of medical practice changed. Clinicians, who had been trained to treat patients, were now expected to achieve certain outcomes. I remember a patient with sepsis who arrived in the emergency room and I knew where I stood—right there in the background. I was to be involved only when necessary, usually meaning if a consultant was being particularly unhelpful, if there was a thorny goals-of-care discussion, or if a patient directly asked for the attending’s opinion. Anything else would result in receiving the worst label you could get as an attending: “micromanager.”

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Micromanagement became the white elephant of sins—calling unnecessary consultations; calling unnecessary discharges, challenging the decisions that boiled down to meddling with decisions made by residents. During residency, we all swapped stories of the furosemide dose—yet—but I intercede on any number of management decisions: check a lactate value for the patient with sepsis, discontinue telemetry for the patient whose arrhythmia seems to have resolved, change the asthma patient’s nebulizers to inhalers, get the discharge summary done on the day of discharge. This is not because the residents are less capable or the patients vastly more complex than they were 10 years ago. Rather, the clinical environment has become one in which these seemingly minor, “resident-level” decisions are now closely scrutinized quality metrics, tied to meaningful changes in payment and accreditation. At the same time, fragmentation of the traditional team structure has eroded the resident’s role as the primary decision-maker.
Resident have always been incredibly dedicated to caring for the sickest patients, but I know that in my training era, we thought “high-quality care” consisted only of accurately diagnosing and treating the patients while they were hospitalized. As a result, we paid little attention to patient safety or resource utilization and often dropped the ball on more routine parts of care, like ensuring a safe discharge plan.
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Definition of “High Quality Care” and context of care has broadened.
Why Teach QI?

It’s hard to argue that the push to improve quality, safety, and value is a bad development, and more consistent supervision of residents should have benefits for education as well as patient care. But as the organizational management truism goes, “What gets measured gets managed.” There are currently more than a dozen quality improvement projects running concurrently on the medical service at my hospital. I can’t even remember all of them at this point. All of these efforts are important, but each brings a set of metrics that must be met. **On the other hand, there is no easy way to measure the desired output of residency training:** physicians who can independently provide safe and high-quality care. Naturally, attendings now (micro)manage what we know is being measured, so we default toward simply dictating clinical management instead of allowing residents the space to hone their own skills. We’ve all become micromangers.
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It's hard to argue that the push to improve quality, safety, and value is a bad development, and more consistent supervision of residents should have benefits for education as well as patient care. But as the organizational management truism goes, “What gets measured gets managed.” There are currently more than a dozen quality improvement projects running concurrently on the medical service at my hospital. I can’t even remember all of them at this point. All of these efforts are important, but each brings a set of metrics that must be met. On the other hand, there is no easy way to measure the desired output of residency training: physicians who can independently provide safe and high-quality care. Naturally, attendings now (micro)manage what we know is being measured, so we default toward simply dictating clinical management instead of allowing residents the space to hone their own skills. We’ve all become micromanagers.

What gets measured gets managed: If we aren’t measuring “resident autonomy” it won’t be prioritized…
Why Teach QI?

Building these relationships will stimulate grassroots interest in quality and safety and will facilitate development of resident-driven QI projects that also meet educational goals. For their part, residency programs and academic departments will need to embrace QI initiatives as learning experiences for residents and continue to broaden the traditional definition of academic scholarship to include QI and patient safety activities. Development of physician faculty with QI expertise will facilitate integration of these efforts into resident curricula and help make quality a shared team responsibility, thus alleviating the pressure on attendings to feel solely responsible for making sure quality metrics are met.
Why Teach QI?

One answer: Integrate Quality education into Clinical Education and hand the reins back to the residents.
Why Teach QI?

House of God
Why Teach QI?

Current:
Increased Supervision
Why Teach QI?

Bad Outcomes
Why Teach QI?

Unbalanced Incentives → Bad Outcomes

X
Why Teach QI?

Developing:
Resident Observing
Why Teach QI?

God Forbid:
Resident Distant or Absent
Why at the Bedside?

• Scarcity of resources
  • Learner: Duty hours, conference time, competing mandates
  • Educator: Trained and available faculty, data, support

• Principles of adult learning
  • Learning in context
  • Integrating and applying skills
  • Repetition

• Make it real! - “It’s just better that way”
Why me?

- We all have differing clinical expertise:
  - Diverse clinical problems to solve
  - Diverse interests within QI
  - Different access to resources
- Reinforces tie between clinical medicine and delivery systems:
  - Mentors modeling “good behavior”
  - A new “hidden curriculum”?
Why is this difficult?

- Barriers
  - Knowledge of the subject matter
  - Time, time, time
  - Faculty buy-in
  - Fear
What you need

• Get to know your “quality people”
• Align with departmental educators
• Find ways to make time
• Stay one step ahead of your learners
• Capitalize on eLearning
Methods

Increasing:

- Buy In
- Integration
- Knowledge
- Time/planning
Methods

Talks

Become a “micro-expert”

Become a Champion

“We’re gonna learn this together…”

QI/Clinical Chalk
“We’re gonna learn this together...”

• Examples:
  • Fill out an error report as a team
  • Look up data on a quality metric
  • Find guidelines, policies, local data, etc
“We’re gonna learn this together...”

- Many opportunities for eLearning
  - Apps: ACP clinical guidelines, AHRQ ePSS, ASCVD Risk Calculator
  - Online: Dartmouth atlas, County Health Rankings, Healthcare Blue Book, Gapminder
“We’re gonna learn this together…”
"We’re gonna learn this together..."
“We’re gonna learn this together...”

In PA, compared to $11,187 in Fisher Island,

**Vaginal Delivery**

| Total Fair Price: | $14,041 |

**Fair Price Fee Details**

**Choosing Wisely®**  
Why Scheduling Early Delivery Of Your Baby Is Not A Good Idea

It may be better to let nature take its course when it comes to inducing labor before 39 weeks. Risk for postpartum depression increases and babies delivered before 39 weeks by C-section may have breathing and feeding problems.

Sometimes it may be necessary to induce labor before 39 weeks to ensure the health and safety of both mom and baby if there are complications with the pregnancy.

**Source:** Choosing Wisely

For full report see: Consumer Reports
“We’re gonna learn this together…”

• Pros:
  • Good use of “interstitial time”
  • Highly applicable to ad hoc issues that arise
  • Great launching point for more involved discussion
  • Great for Med Student presentations (delegate)

• Con:
  • Doesn’t build on faculty expertise or engagement
  • May lack context for learner
  • Relies on saying “I don’t know”
Become a Champion

• Be “That Guy”
  • The one who is always talking about that one issue....
  • Can be clinical metrics
  • Can be Quality/Safety issues
Become a Champion

• High Value Care - Gretchen Diemer

• Noon conference with residents and faculty

• Work it into rounds - “Start the conversation”

• Feedback of results
Become a Champion

- Why we overttest (diagnostic uncertainty)
- What is Value?
- How is healthcare paid for?
- What can you do?
Become a Champion

Graph: Graph showing data points for different weeks.
- Week 1 (3/10)
- Week 2 (3/16)
- Week 3 (3/23: no intervention)

Legend:
- Resident Talk
- Attending Talk
Become a Champion

• Error Reporting - Rebecca Jaffe
• Work it into rounds - Daily debrief
• Mentored resident project
• Built publicity - Near Miss RCA and spokesman contest
Become a Champion

Have you reported?

Not safe? Report it!
Become a Champion

Got problems? Report them!

Don’t forget error reporting

Or else what?

BOOM

AUGH!
Become a Champion

Event reports by Residents/Fellows
Total reports 2014 = 94  = 0.8%

CS STARS implementation
Become a Champion

Reported Characteristics: Clinical Service

Legend:
- Resident
- Faculty
Become a Champion

• Pro
  • Capitalize on your expertise/involvement
  • With more time/resources you can turn this into something more

• Con
  • May feel like you are beating a dead horse
Become a “Micro Expert” in a QI tool

- Choose a QI or Safety tool you are comfortable with:
  - Use/teach the tool for lots of kinds of clinical, process issues
  - ** Can be applied to personal improvement goals for learners as well!"
Become a “Micro expert” in a QI tool

• Pro
  • Demonstrates utility of QI process
  • Interactive/engaging

• Con
  • Can be difficult to incorporate into times of active patient care
  • Relies on learners having or obtaining working knowledge of the tool
QI tools: PDSA cycle
QI tools: Process Map

Start -> Action

Decision

Action -> Stop

Con't off page
QI tools: Fishbone
QI tools: Prioritization Matrix

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**High impact**
- Easy to do: IMPLEMENT
- Hard to do: CHALLENGE

**Low impact**
- Easy to do: POSSIBLE
- Hard to do: KILL
QI tools: Intervention Strength

- Forcing functions
- Automation/Computerization
- Standardization/protocols
- Checklists[Double Checks]
- Rules/Policies
- Education/information
- Exhortation
QI tools: Measures

I need stuff… → To do things… → So good things happen.

STRUCTURE → PROCESS

& bad things don’t happen

OUTCOME

BALANCING
QI tools: Run Charts

Number of Times Hit Snooze

- Snoozes
- Goal

Data points shown over time.
QI tools

- Specific
- Measurable
- Actionable/appropriate
- Relevant
- Time Limited
QI tools

• Many Others:
  • Briefing, Huddles, Debriefing
  • Checklists
  • Registries/Dashboards
Next Level: Linking “Champion” to QI Tools

• So you have identified a problem...
• Can you sneak QI tools into discussions about that problem?
• ie: I really care about transfusion safety!
• Exercise: Get the team to create a fishbone for reasons for over utilization of blood products.
Next Level

• You picked an issue earlier…
  • Where in your day with learners could you discuss this issue?
  • How much time would you have?
  • What QI tool could you incorporate?
  • How might this go?
Conclusions

• Incorporation of QI topics and methods into bedside care is necessary in order to reach educational and clinical goals.

• Personal style will be important, just as with traditional bedside education.

• Barriers exist, but are not insurmountable