Curriculum – Culture = Failure

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Associate Dean, Clinical Affairs
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Meet Sarah

- 51 yo female
- Admitted to ICU with severe CAP
- Intubated, started on broad spectrum antibiotics
- Day 2 improving
- Day 3 off vent
- Day 5 severe sepsis from femoral line infection
- Day 6 line removed
- Day 10 on oral antibiotics
- Day 14 discharged to home

Keystone Project

- CRBSI common, deadly, costly
  - 80,000 CRBSI annually
  - Kills between 30,000-62,000 annually
  - CRBSI costs $2.3 billion annually
- 103 Michigan ICUs
  - Wash your hands
  - Clean skin with chlorhexidine soap
  - Cover yourself and patient when placing catheter
  - Avoid groin catheters
  - Take out unneeded catheters
- Median CRBSI per 1000 catheter-days
  - Before 2.7
  - 3 months 0
  - 18 months 0

But Most Often Don’t

- Social and cultural reasons
- Physicians are famously autonomous
- Technical solution (checklist) can’t solve a social/cultural problem
- Work when inserted into a culture of safety

Burning Platform

Burning Platform

- People need to think there is a problem
- Need a sense of urgency to change

Quality Needs Leadership

- Leadership is not being in charge, a position of power, autocratic
- Not just the Dean, Chair, hospital CEO
- Keystone Leadership Team
  - Senior executive, provided resources
  - Nurse and MD leader per ICU
  - ICU staff

Translate Urgency to Vision

- Vision should inspire
  - Power of collective vision
  - Overcome barriers
  - Should be inspirational and aspirational

BIDMC Vision

- BIDMC will eliminate all preventable harm.

Translate Vision into Strategies

- Square Pegs…Round Holes
  - Only 20% of medical schools are adopting comprehensive QI/PS curriculum
    - Engineering concepts
    - Systems thinking
    - Safety science
    - QI
    - Human factors
    - Teamwork
  - Even fewer offer chance to experience examination of patient care processes

Hospitalist Training Program

- Commenced 2004
- Comprehensive clinical program
- Focused on skills around QI/PS
  - 50 hours of curriculum—QI science, HC finance, leadership, teamwork
  - Development of mentored QI project
  - One month of dedicated project time
  - Longitudinal—1.5 year project time

Meet Rory

- 63 yo male HTN and DM
- Acute right sided weakness for 45 minutes
- Symptoms improved
- Admitted with TIA at 9am

Later that day…

- 5pm
  - R-sided hemiplegia & aphasia
- 530pm
  - Nurse calls physician, no answer x 3
  - Realizes different physician covering after 5pm
- 550pm
  - Physician evaluates, orders non-con HCT
  - Transport unavailable
- 620pm
  - To CT but patient in scanner
- 645pm
  - HCT completed
- 715pm
  - HCT read by rads; no bleed
- 730pm
  - Rads alerts MD of findings
- 735pm
  - Neurology consulted
- 800pm
  - Neurology sees Rory

Rory's symptoms do not improve. Eventually transferred to a nursing home.

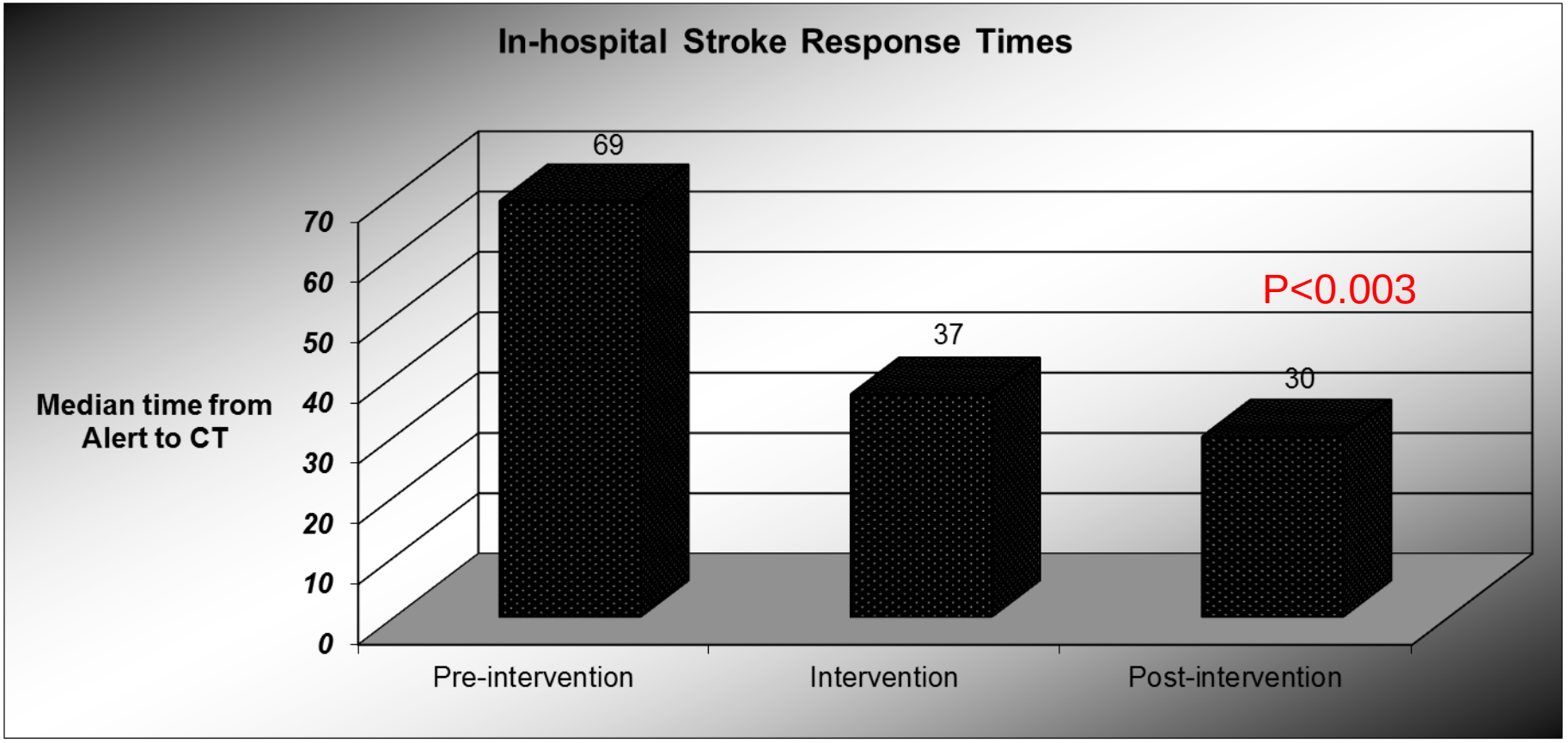
Improving Inpatient Stroke

- Root Cause Analysis of current process
  - Identify the problems
    - Delay to recognition
    - Delay to call MD
    - Delay to CT
    - Delay to therapy

Improving Inpatient Stroke

- Improve process
- Communication pathways
  - Algorithm – who gets called first, how and by whom
- Convert serial actions to occur in parallel
  - Notification of radiology to prepare for CT scan
- Transportation
  - Who, when, how
- Checklist cards
- Continuous Quality Improvement
  - Real time feedback

Improving Inpatient Stroke



Remove Obstacles

- Why aren’t people already doing this?
- What systems or structures are undermining the vision/strategy?
- How can you remove these barriers?
- Take it a step further—how can you make it easier to do the right thing?

Generate Short-term Wins

- Plan and create these; reward the “changers”
- What rewards will motivate behavior change?

Consolidate Gains into Culture

- Use credibility for more change
  - What next steps to try will extend gains?
  - What other structures/systems could be changed to make this even more successful—beyond the short-term win?
- Anchor new approaches in the culture
  - Begin to hire/promote/develop people who believe in this type of culture?
  - Develop future goals that tie into your new culture.

The Change Process

- Establish a sense of urgency
  - People need to think there is a problem
- Create a guiding coalition
  - Find the thought leaders and engage
- Translate urgency to vision
  - “Why” and “how” things will change
- Translate vision into strategies
  - Tie strategies back to vision
- Remove obstacles
  - Empower broad-based action
- Generate short-term wins
  - Plan and create these; reward the “changers”
- Consolidate gains, produce more change
  - Use credibility for more change
- Anchor new approaches in culture
  - Make this part of the culture

Meet Florence

- 68 yo female h/o afib on warfarin
- Admitted with altered mental status
- CT revealed massive intracerebral bleed
- INR 7.2
- Review of chart shows TMP/SMX given for UTI one week prior
- No INR check in past 3 months
- Care withdrawn, Florence passed away

Curriculum minus Culture = Failure (pt. 2)

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Program Director, Internal Medicine
Richard W. and Sue P. Vilter Professor of Medicine
University of Cincinnati College of Medicine

Learning Objective

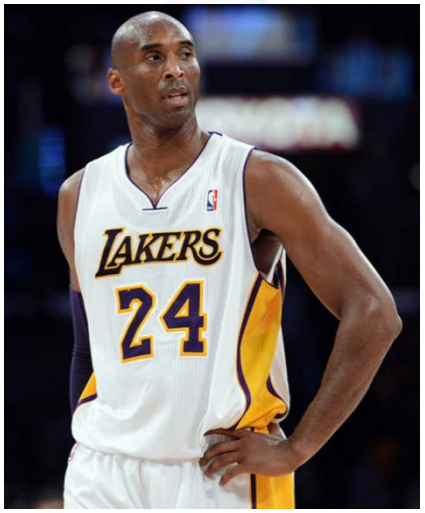
After this session you should be able to:

1. Recognize hidden barriers to change

- I have no disclosures...

QUESTION: Should you consider yourself a high quality physician if you work in an organization that is not systematically trying to improve the care it provides?

– Larry Casalino



A Story

Traditional Rounds

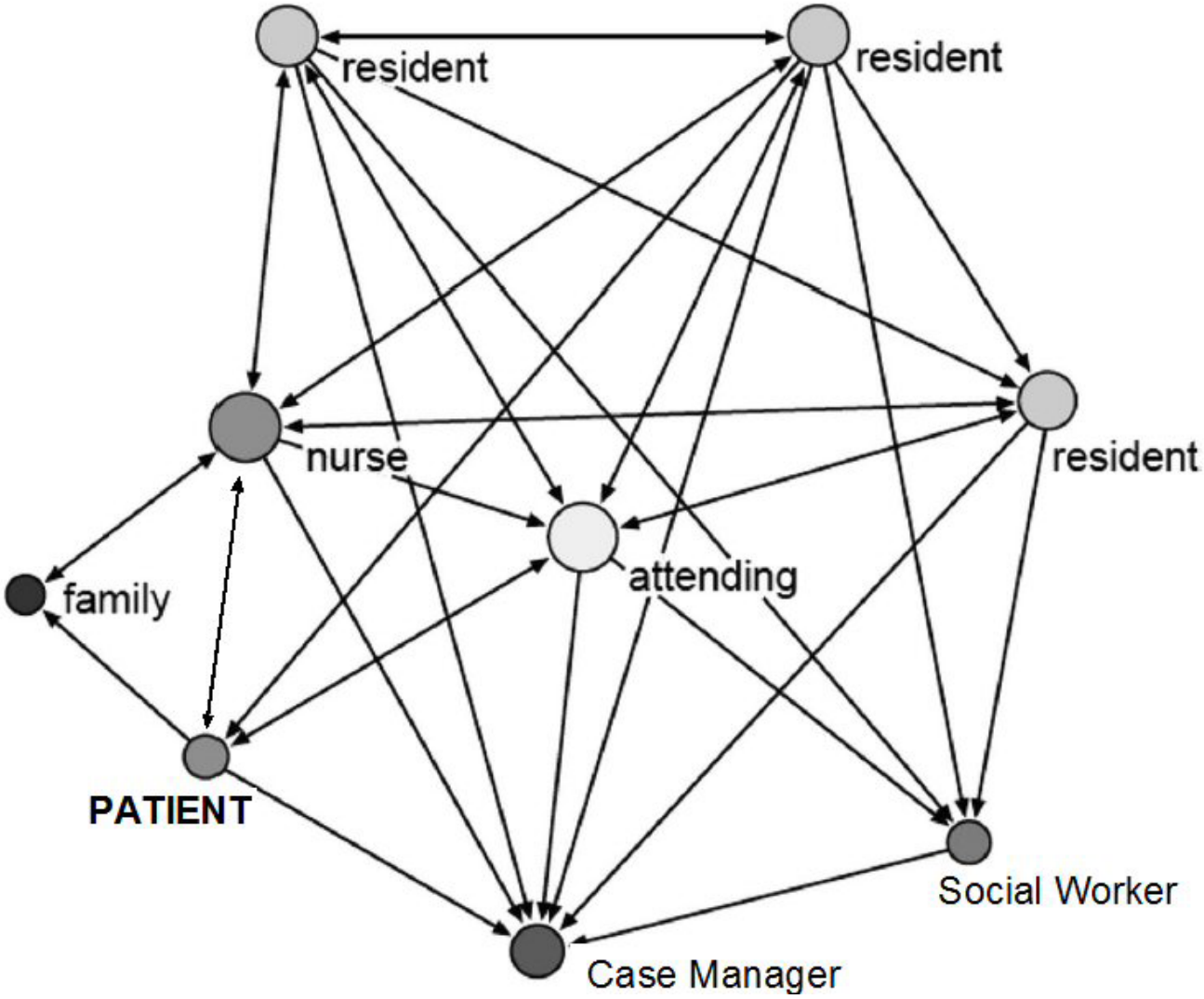
What skill is the resident demonstrating?

- Ability to recite a history and plan

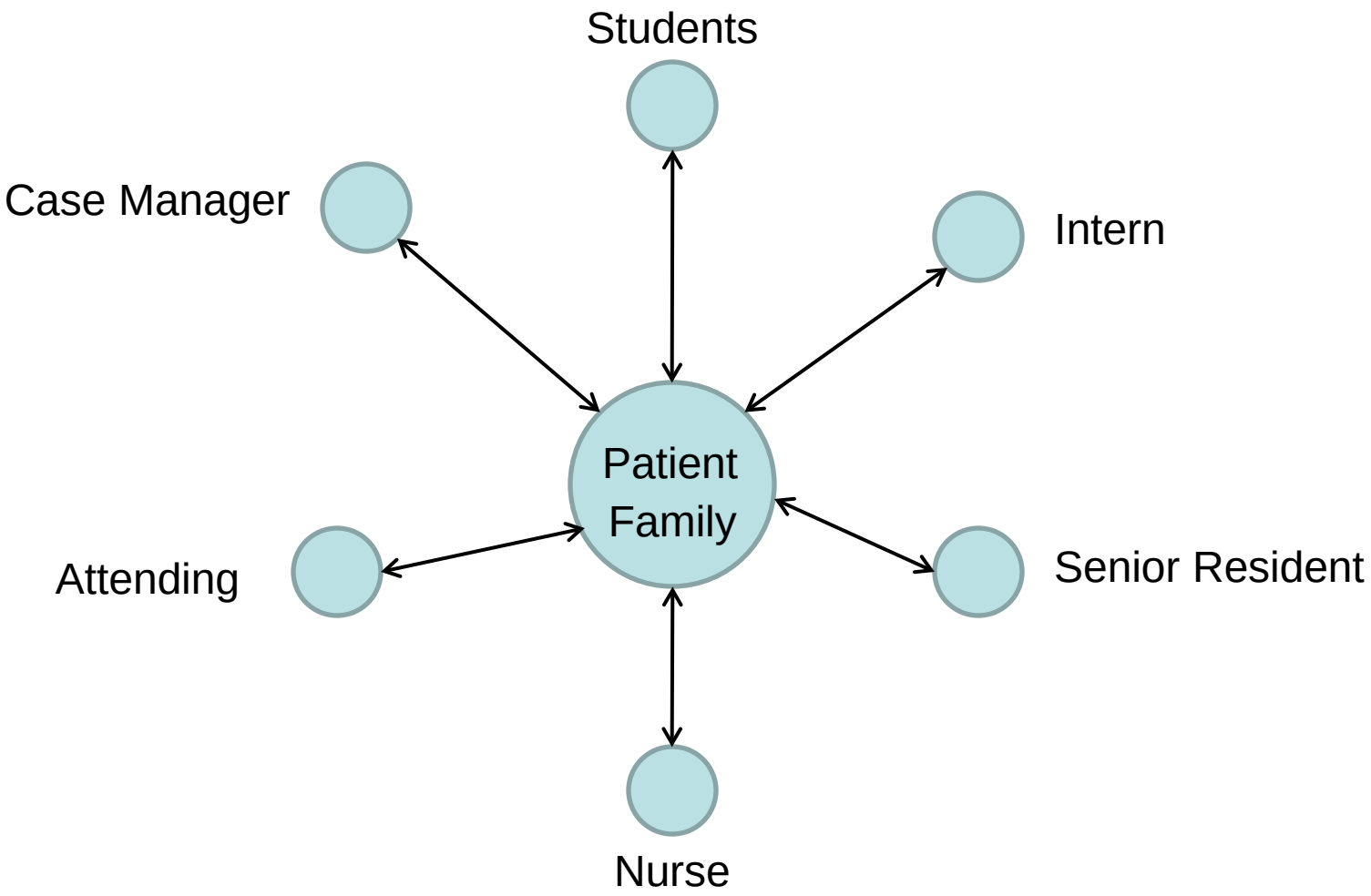
What learning is best done at the bedside?

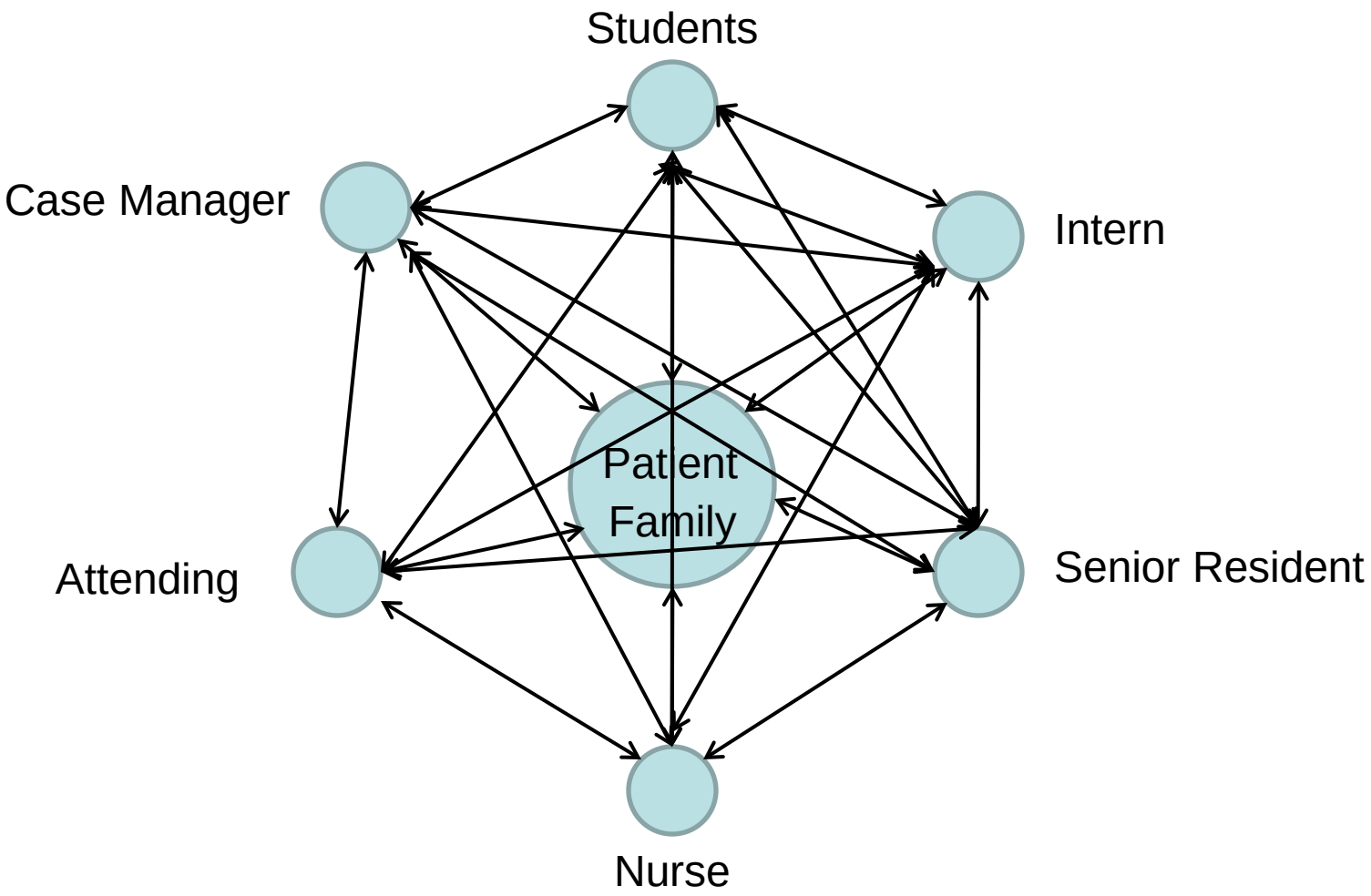
- History-Taking
- Physical Exam
- Communication
- **Clinical reasoning**
  - problem solving with the patient

Traditional Rounds



Adapted from: Lurie SJ, Fogg TT, Dozier AM. Social network analysis as a method of assessing institutional culture: Three case studies. *Acad Med*. 2009;84:1029-1035.


Students
Case Manager
Intern
Patient
Family
Attending
Senior Resident
Nurse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Patient Centered Care: Vision

- Patient preparation (night before)
- Rounding card
- Team introduction
- Bedside presentation
- Team discussion
- Patient teachback

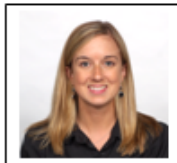
UC Health

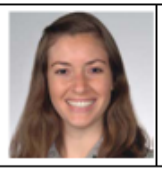
Department of Internal Medicine
Blue Medicine Team

Attending:
Dr. Leasure

The team of doctors taking care of you is the Blue Medicine Team. Those primarily responsible for your care are circled.

Resident Doctors:


Dr Jacobs


Dr Lombardo


Dr Clark


Dr Wilkes

Student Doctors:

Brad Budde
Jesse Capone

Erika Osterholzer

Notes: _____

Patient Centered Care: Vision

- Patient preparation (night before)
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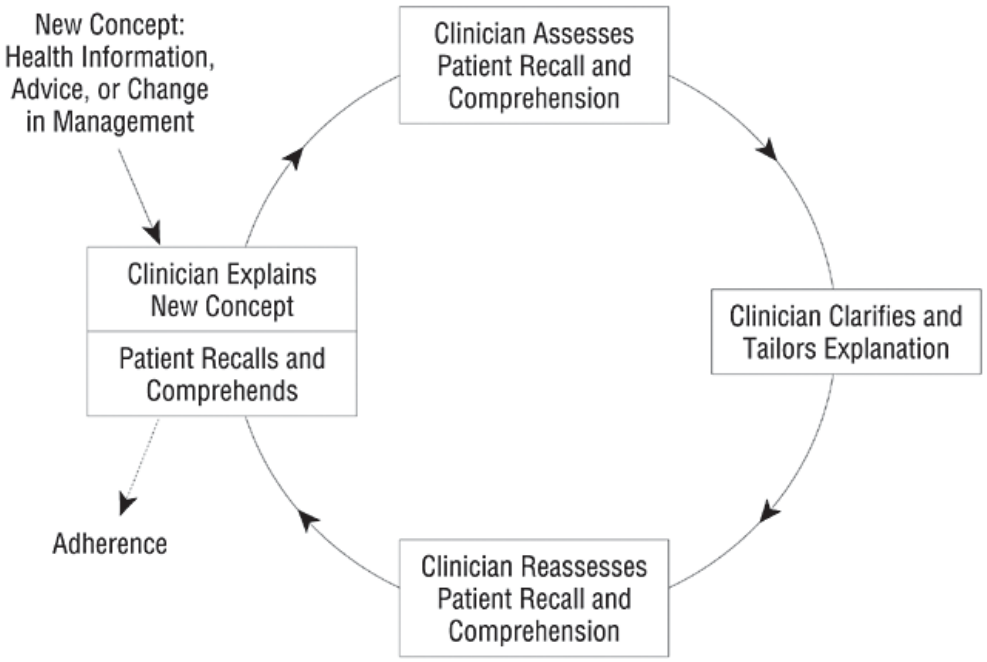
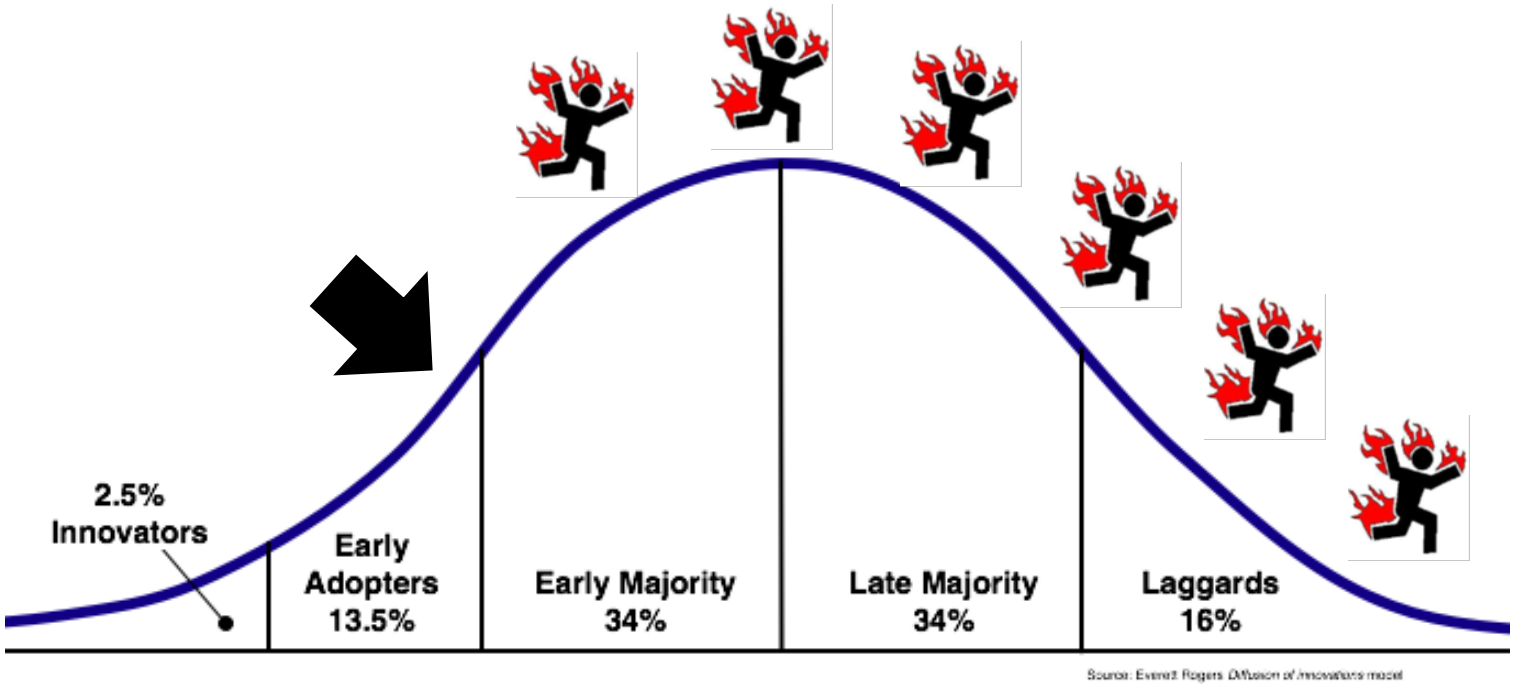


UNIVERSITY OF Cincinnati

Innovation



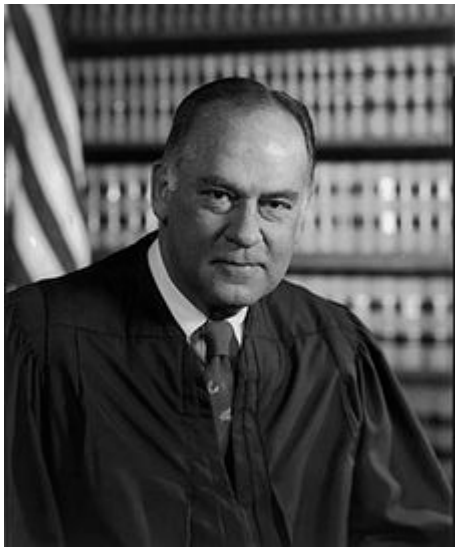
My job is_____,

and I give good care! Dammit!

Professionalism

"I know it when I see it."

"I know it when I don't see it."

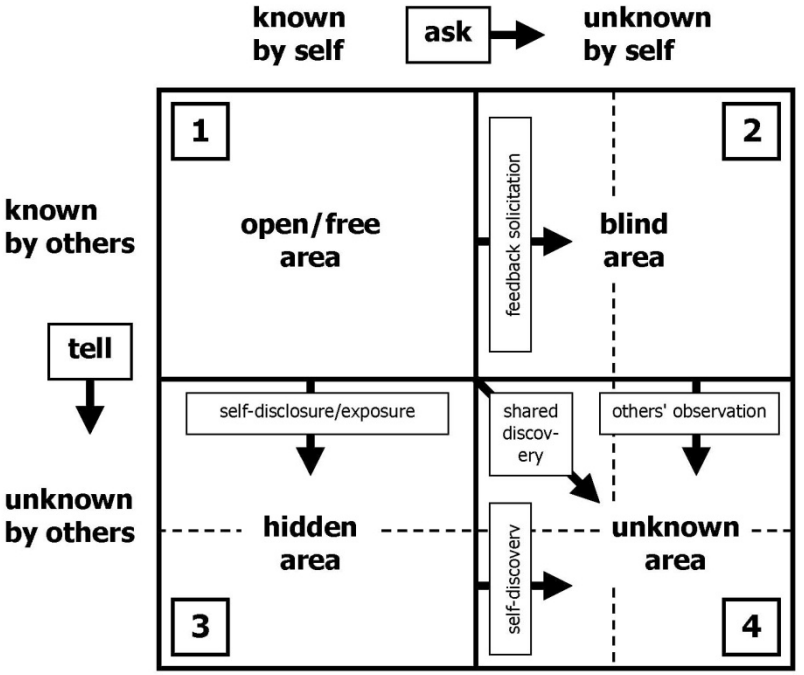


Potter Stewart

Professionalism

"I know it when I see it."

"I know it when I don't see it."



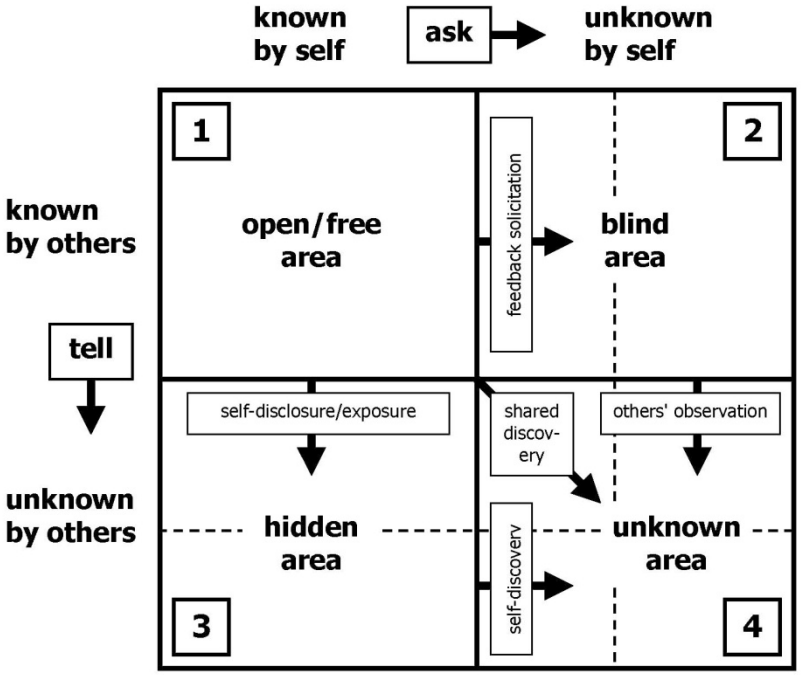
Johari Window

Luft, J.; Ingham, H. (1955). "The Johari window, a graphic model of interpersonal awareness". *Proceedings of the western training laboratory in group development* (Los Angeles: UCLA).

Professionalism

"I don't know when I see it."

"I don't know it when I don't see it."



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Systems View of Professionalism

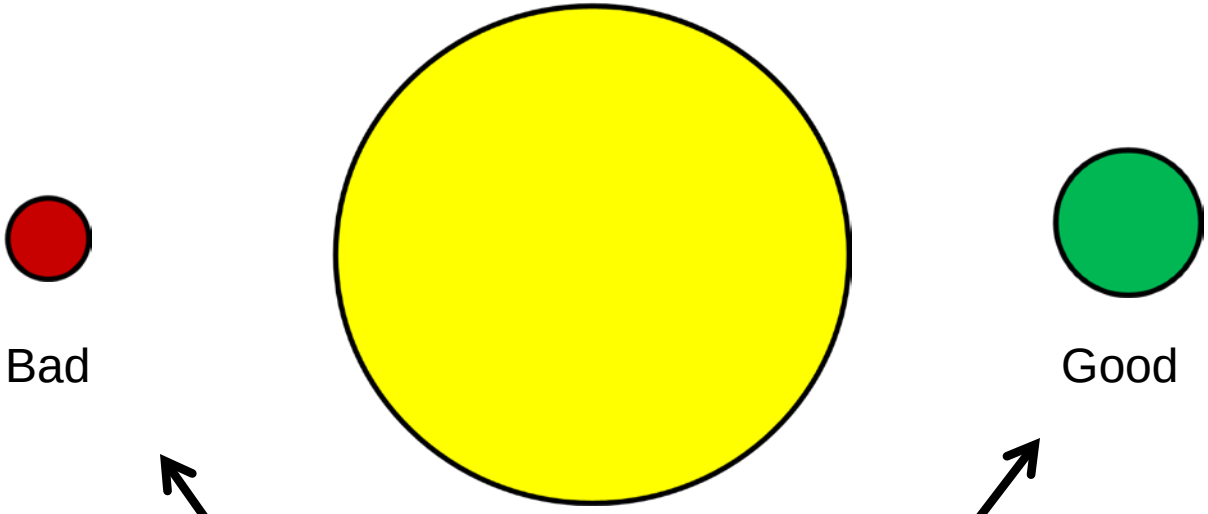
- Professionalism is expressed in observable behaviors
- These behaviors are profoundly influenced by organizational and environmental context
- Professionalism is not a static quality ‘that if strong enough should transcend or withstand the pressure of negative influences’

JAMA. 2010;304(24):2732-2737

Micro

Meso

Macro



Context

Macro

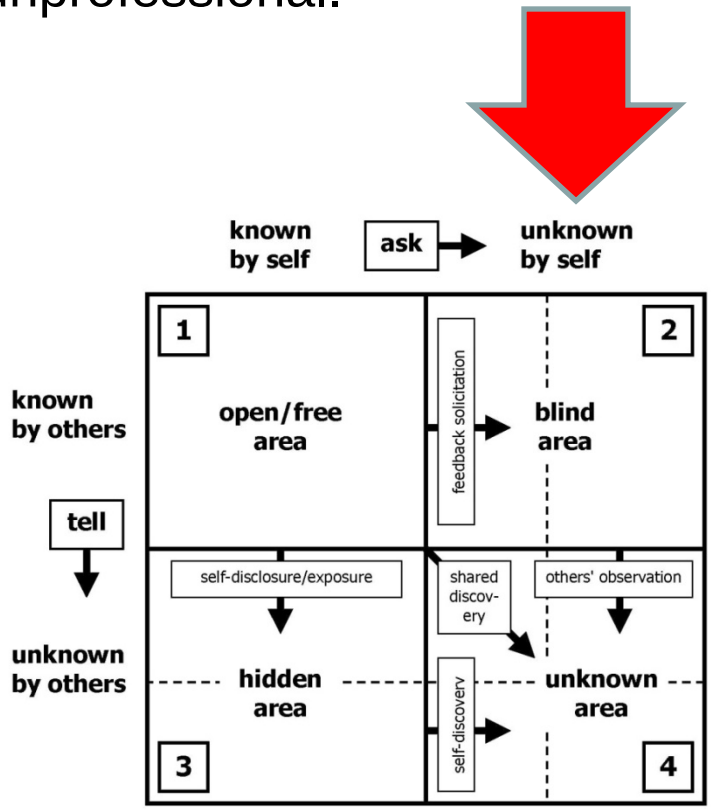
Joseph Telushkin

Macro

Meso

Micro

These people don't come to work thinking they're unprofessional.



Statement

"We do not act rightly because we have virtue or excellence but rather we have those because we have acted rightly. **We are what we repeatedly do."**

Aristotle

Professionalism emanates from actions, not virtues

- We must create care environments that support healthcare providers to act in a professional manner

- Challenging individuals without also engaging the overall care environment is not sustainable

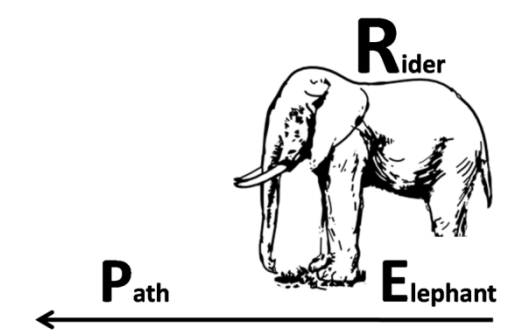
Aristotle

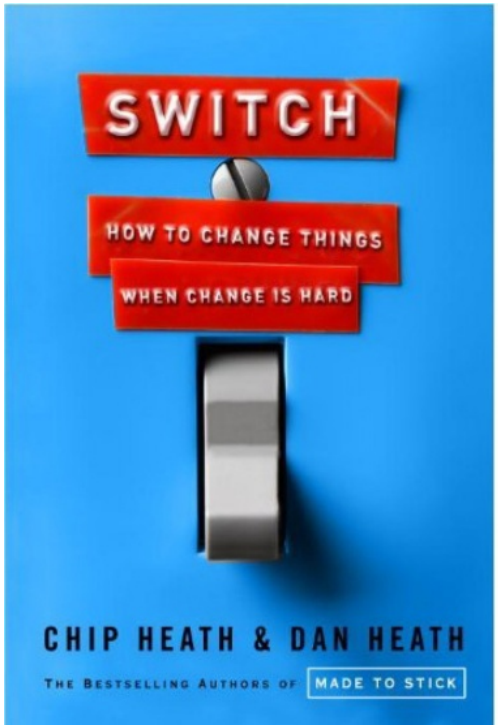
What is it that YOU repeatedly do?

What are the <u>results</u> of what <u>we</u> repeatedly <u>do</u>?

Explore core values

What is it that <u>we</u> repeatedly <u>do</u>?



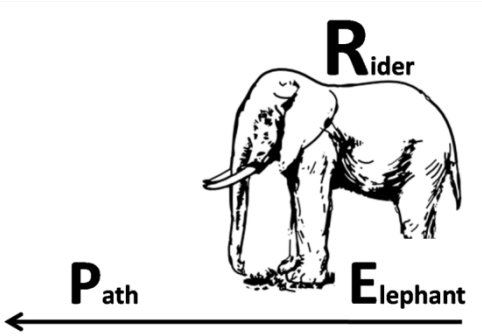


Three surprises about change:

1. What looks like resistance is often lack of clarity

2. What looks like laziness is actually exhaustion

3. What looks like a people problem is often a situation problem



Provide Clarity
Direct the Rider

Overcome Exhaustion
Motivate the Elephant

Improve the Situation
Shape the Path

Three surprises about change:

1. What looks like resistance is often lack of clarity

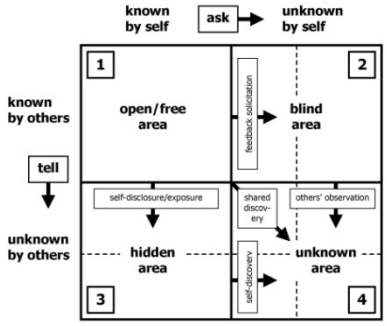
Do they know the true outcomes?

2. What looks like laziness is actually exhaustion

What can be removed?

3. What looks like a people problem is often a situation problem

What are the forces shaping the current path?



Three surprises about change:

1. What looks like resistance is often lack of clarity

I'm doing fine!

2. What looks like laziness is actually exhaustion

Are you calling me lazy?

3. What looks like a people problem is often a situation problem

No one could do better in my situation.

QUESTION: Should you consider yourself a high quality physician if you work in an organization that is not systematically trying to improve the care it provides?

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