

Cultural Change – The Journey to Medical Staff Engagement in Performance Improvement

**2011 MMS and RIMS Directors of Medical Education Conference
November 18, 2011**

Marc S. Rubin M.D.



Cultural Change – Engaging Medical Staff in PI Disclosures

I do not have all the answers

Our medical staff is not fully engaged

I spend most of my time trying to find solutions to
this problem



Cultural Change – Engaging Medical Staff in PI

The Problem

- Adverse events happen that should be preventable
- Health care and hospital systems are complicated. Determining why something bad happened can be difficult and may require resources and skills that are limited at your institution
- Once the causes are identified you need clinician attention, buy-in and assistance to make the changes that will prevent these events from recurring
- MDs and other staff are focused on other important things (regulatory mandates, health system requirements and pay for performance goals) and have less time than ever to participate in what often are time consuming improvement efforts



3

Cultural Change – Engaging Medical Staff in PI

The NSMC story

- Where we started *circa* 2003
 - » Administrative leadership team more focused on operations than outcomes
 - » Physicians loosely affiliated with Medical Center and rarely asked to join strategic or operational planning efforts
 - » Medical staff and Departmental physician leadership determined by vote or seniority
 - » Small Performance Improvement Department with limited skills
 - » Belief that occasional adverse events were “the cost of doing business”



4

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- And then in 2004...
- Communication from the MA Board of Registration's Quality and Patient Safety Division to NSMC's new CEO:
 - » "NSMC could do better...regarding the timeliness, quality and depth of content of...safety and quality reviews (SQRs)"
 - » "There is much more internal analysis, action planning and learning possible from adverse events than [NSMC] has demonstrated"
 - » "You seem to have adopted a risk avoidance approach to reporting"
 - » "Unclear whether NSMC's quality assurance process [is] identifying weaknesses in prevention of harm and ensuring that all necessary steps are taken to prevent recurrence of adverse events"
- In Massachusetts, BoRM regulations require hospitals to have programs for risk management, quality assurance, peer review and identification and prevention of substandard care as a condition of licensure...This was a real wake up call!



5

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- NSMC Senior leadership analysis:
 - » Performance improvement not prominent enough on strategic agenda
 - » PI Department under-resourced and lacking necessary skills
 - » MDs not engaged in clinical improvement
- The solution:
 - » NSMC needs to establish a new PI structure and process*

* Donabedian, A: The Quality of Care, *JAMA* 1988;260:1743-1748



6

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Structural changes:
 - » Strategic goals adjusted to place clinical performance improvement at the same level as operational improvement
 - » Director of Performance Improvement elevated to Vice President and charged with developing annual PI plan
 - » PI Department enlarged and PI staff trained in process improvement (FMEA/RCA, rapid cycle improvement, high reliability, Healthcare Delivery Improvement*)
 - » Decision made to employ Department Chairs and to hold them accountable for engaging the members of their Departments in clinical improvement

* Intermountain Healthcare



7

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Process Change: Driving performance improvement through multidisciplinary peer review
 - » Peer review already developed in all clinical Departments at NSMC
 - » Peer review widely accepted by MDs as an important element in patient care and part of their responsibility as a professional
 - » With good event reporting NSMC could ensure that almost all adverse events would be analyzed at peer review in one of its clinical departments



8

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- But...
 - » Peer review was barely connected to the medical center and not connected at all to any formal improvement work at NSMC
 - » Peer review process would need to be redefined and redesigned:
 - To enhance event identification
 - To improve event analysis
 - To enable peer review across disciplines
 - To add accountability for improvement action
 - To follow cases until corrective changes enacted



9

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Critical element: motivating physician participation
 - » Vital for success of new PI process...but little written on how to do it
 - » What doesn't work:
 - Telling MDs they have to do something
 - Not being transparent about your motives
 - Making a case that is not supported by data
 - » What works sometimes:
 - Paying MDs for their time (works variably depending on implementation and has regulatory risks)
 - Creating hard stops that force participation (works, but best as a last resort)
 - » What does work
 - Addressing issues they care about (aka aligning incentives)
 - Patient outcomes and experience usually at the top of the list
 - Note: everyone does not care about the same things!
 - Leveraging fears
 - Leading by example/peer pressure
 - Sharing decision-making
 - Appealing to professionalism
 - Rewarding successes
 - Fairness



10

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Redesigning the peer review process at NSMC
 - » NSMC leadership:
 - Promoted adverse event reporting as “blame free” and the best way to identify improvement opportunities and prevent recurrences
 - Protected reporting by policy
 - Hired additional FTEs to PI Dept. and paid for improvement skills training
 - Added analytic support to each Department to provide data
 - Resourced improvements identified by Peer review/PCA process
 - » Department Chairs:
 - Made the case that many of the adverse events in their Dept. were preventable.
 - Showed data that most events were due to systems issues not practitioner issues.
 - Challenged MDs to be accountable for leading improvement “for their patients sake”
 - Mandated peer review attendance
 - Agreed to standardized peer review methodology, scoring and reporting and to transparency



11

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Redesigning the peer review process at NSMC *cont.*
 - » PI Department:
 - Added ways to identify/report adverse events – making it easy to do the right thing
 - Quality Specialists with clinical improvement skills assigned to each Dept.
 - Created tools and databases and provided improved access to them
 - SWAT team approach to serious adverse events with immediate huddle
 - Added risk management and peer support for MDs
 - » PCA Committee redefined
 - Highest level of peer review
 - Vehicle for positive change (including it's reporting function)
 - Members committed to multidisciplinary transparency, critical examination of each others cases
 - Inclusive (all Departments represented, all involved MDs invited)
 - Supportive PCA Coordinator with good working relationships with Chairs
 - Empowered to effect change
 - Shared accountability
 - Reporting to NSMC Board



12

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

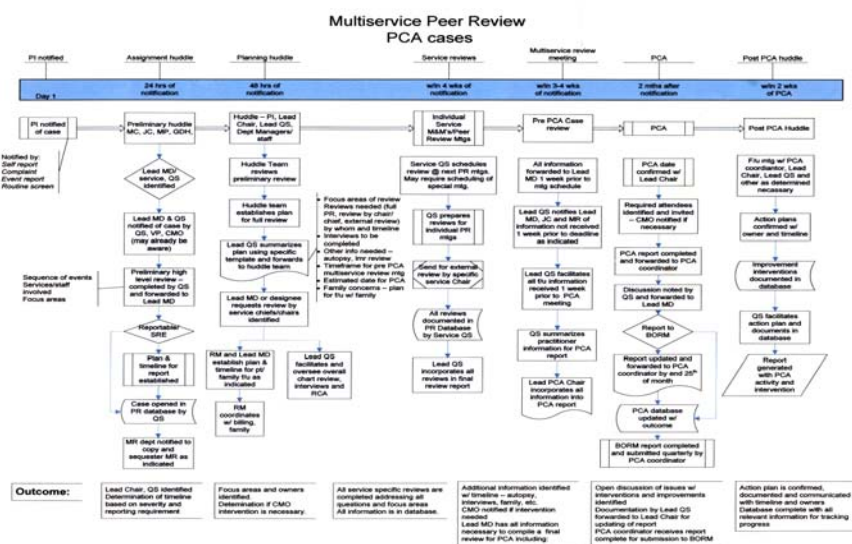
- Redesigning the peer review process at NSMC *cont.*
 - » Other keys in changing the culture
 - Value of new process showcased whenever possible
 - Improvement stories shared at Department and medical staff meetings
 - MD beneficiaries of new support efforts sharing their experiences
 - Feedback at staff meetings about reported events and what was done about them
 - Leadership walking the walk
 - Clinical leaders show the way when their cases are presented (cooperation, participation, transparency, willingness to report)
 - Administration values recommendations coming from PCA Committee and the peer review process and provides resources for safety and quality improvements
 - Blame free culture



13

Cultural Change – Engaging Medical Staff in PI

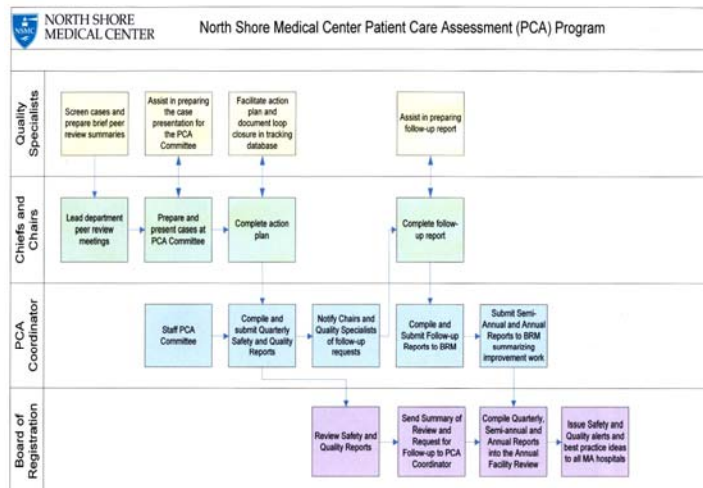
The NSMC story *continued*



14

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*



Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

MRA: PEER REVIEW SCORES

Outcome Score (circle one):

A No adverse outcome
 B Minor adverse outcome (eg. minor transient impairment)
 C Moderate adverse outcome (eg. prolonged transient or mild permanent impairment)
 D Major adverse outcome (eg. permanent significant impairment)
 E Catastrophic adverse outcome (eg. loss of life)

Physician Score (circle one):

P0 Commendable care
 P1 Evidence based or accepted practice followed (includes supported approaches that are controversial)
 P2 Minor variation from evidence based or accepted practice
 P3 Significant variation from evidence based or accepted practice
 P4 Unacceptable variation from evidence based or accepted practice

Physician deficiency(ies) (check one or more):

☐ Fund of knowledge
☐ Judgment
☐ Diagnosis
☐ Technical skill
☐ Behavior
☐ Documentation
☐ Supervision
☐ Hospital policy compliance
☐ Other

System Score (circle one):

S1 No systems issues
 S2 Minor systems issues
 S3 Moderate systems issues
 S4 Major systems issues

Systems failure(s) (check one or more):

☐ Process failure
☐ Communication/ Handoff
☐ Responsiveness
☐ Coverage
☐ Service assignment
☐ Chain of command
☐ Conflict resolution
☐ Documentation
☐ Resource availability
☐ Equipment failure
☐ Other

Risk Score (2 - 6 total, circle one complexity level and one risk level):

1pt cases required clinical judgment/skills of low complexity
 2pts cases required clinical judgment/skills of moderate complexity
 3pts cases required clinical judgment/skills of high complexity
 PLUS
 1pts low risk (ASA 1)
 2pts moderate risk (ASA 2 - 3)
 3pts high risk (ASA 4 - 5)

Disposition (check one or more):

☐ No action required
☐ Refer to SEC
☐ Refer to PCA
☐ Report to BRM
☐ Reassessment/ focused review
☐ Discuss with practitioner
☐ Outside case review
☐ Refer to _____ (department/committee/administrator)
☐ Reassessment educational program for _____ (department)

Comments:

Section Chief Signature/Date

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

NSMC Dept. of Surgery Guidelines for Reporting an Adverse Event to SEC or PCA

- Physician Score >2
- System Score >2
- Major or permanent impairment or death (outcome score D or E) which fulfills either one of the following
 - Event was **not probable** in light of the patient's admitting diagnosis and condition
 - Event may have been **preventable**
- Significant adverse outcome (score C,D or E) despite low risk (score 2 or 3)
- Death or impairment from unexpected or rare cause
- Serious Reportable Events (see list below)
- Serious patient/family complaint to NSMC or outside organization
- Affirmative answer to a generic peer review question (see list below)

NSMC Department of Surgery Generic Peer Review Questions

- Was the outcome/event preventable or potentially preventable?
- Could or should something have been done differently?
- Were there systems or interdisciplinary issues that compromised care?
- Should a guideline/protocol/policy be instituted by the Section, Department or Medical Center to prevent the adverse event from happening again?
- Was there a component of care that was not delivered in the fashion in which you would teach it?



17

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

Template for Reports to SEC and PCA

CONFIDENTIAL – PEER REVIEW

PATIENT CARE ASSESSMENT PROGRAM SAFETY AND QUALITY REPORT

North Shore Medical Center (NSMC) – XXXX Hospital Campus
Date of Incident:
Medical Record #:

NARRATIVE DESCRIPTION:

What happened in 1 sentence

HISTORY, ASSESSMENT, AND HOSPITAL COURSE:

The detailed course of events

DEPARTMENTAL PEER REVIEW:

The discussion at your Section's Peer Review meeting

PRACTITIONER PERFORMANCE REVIEW:

Any relevant issues involving the practitioner's performance historically e.g. pattern of adverse events, deviations from standards of practice etc.

PATIENT AND FAMILY:

How were they involved after the event

SYSTEMS ISSUES:

Your assessment of any problems that may have contributed to the event

PRACTITIONER ISSUES:

Your assessment of any problems that may have contributed to the event

SAFETY AND QUALITY IMPROVEMENT MEASURES:

Your action plan to prevent the occurrence of similar events. Presented in the following format:

1. The Chief and Associate Chief will develop a program to review....

Responsible parties:

Timeline for completion:

Status at the time of this report:

2. The surgeon involved in this case will....

Responsible parties:

Timeline for completion:

Status at the time of this report:



18

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

■ Outcomes

- » 2005-2010 NSMC PCA Committee
 - 155 cases reviewed
 - 364 Action items
 - Over 70% completed/closed
- » 2010 NSMC Departmental peer review:
 - 511 Cases underwent peer review at departmental level
 - 26 Cases brought to PCA Committee
 - Department of Surgery
 - 11 sections reviewed 231 cases
 - 15 cases presented at PCA Committee

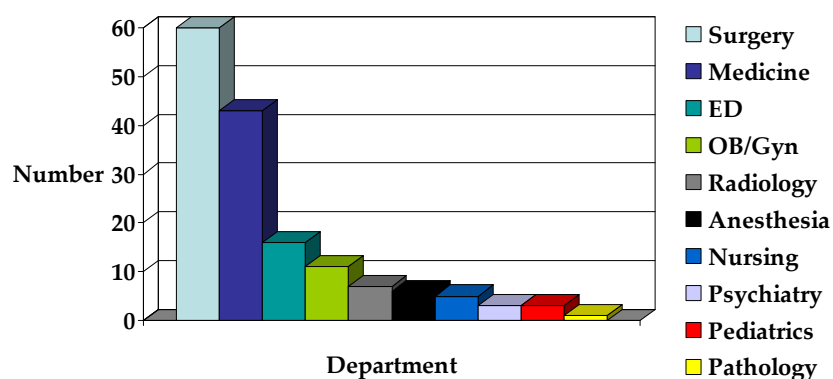


19

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

PCA CASES BY DEPARTMENT 2005-2010

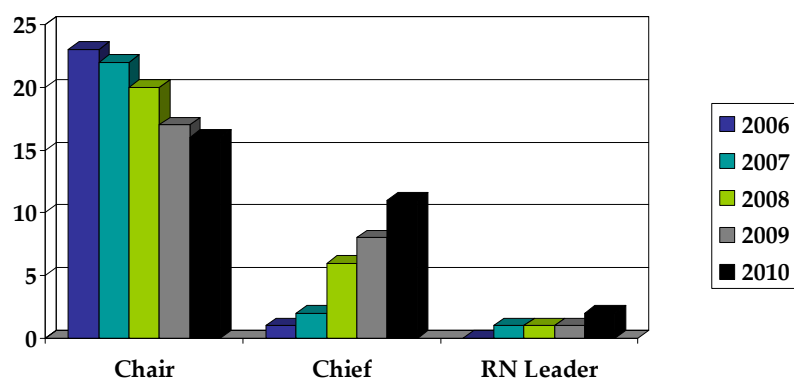


20

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

PCA COMMITTEE CASE OWNERSHIP 2006-2010



Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Outcomes *cont.*
 - » Case Example #1
 - Date: 2/23/06
 - Adverse event: Retained foreign body at laparotomy
 - Action Item: Revise count policy to ensure accurate counts and reduce retained foreign bodies to zero
 - Responsible Parties: Chair of Surgery, Director of Surgical Services
 - Process: Immediate implementation of X-ray policy...Review of NSMC experience (6 retained FBs over past 4 years – 4 lap pads, 2 pieces from disposable staplers)...Quality specialist performs failure modes and effects analysis...Literature review...Workgroup of frontline staff and surgeons convened...Major policy revision (pause prior to closure, mandatory X-ray for high risk cases, limits on reliefs, communication and documentation of FBs in body cavities, counting of disposables)...Recommendation for addition of technology...Pilot and universal implementation of bar coded sponge counter.
 - Outcome: No retained foreign bodies for 4 years

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Outcomes *cont.*
 - » Case Example #2
 - Date: 8/29/08
 - Adverse Event: Wrong level kyphoplasty
 - Action Item: Develop guidelines for accurate assessment of spine anatomy prior to kyphoplasty whether performed by Neurosurgery, Orthopedics or Radiology
 - Responsible party: Chief of Neurosurgery, Chair of Radiology
 - Process: Convened task force of stakeholders...Quality specialist review failures or near misses in both surgery and radiology...Front line staff interviewed...QS performs root cause analysis...Surgery Chiefs and Radiology Chair agree on guideline and implement as standard of practice
 - Outcome: No wrong level kyphoplasties since implementation of guideline



23

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Outcomes *cont.*
 - » Case Example #3
 - Date: 9/1/09
 - Adverse event: Delay in notifying MD of a post-CEA change in mental status
 - Action Item #1: Improve communication between RNs and MDs in the event of a deterioration in patient's condition
 - Responsible Parties: Chair of Surgery, Associate Chief Nurse
 - Process: Quality specialist interviews staff, identifies communication barriers and perform RCA ...Workgroup of RNs, MDs creates list of events/signs/symptoms for which RNs should contact MD...List vetted and approved by medical staff...Guideline created for use on all units.
 - Outcome: Pending
 - Action Item #2: Ensure that all staff that care for patients with increased risk of neurologic deterioration have the competencies and support to perform adequate assessment
 - Responsible party: Associate Chief Nurse
 - Process: Protocol for neuro assessment developed and made policy...Group of RNs identified to update neuro assessment skills...Assignments tailored to provide neuro RNs adequate volume of experience and reduced load
 - Outcome: Pending



24

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Outcomes *cont.*
 - » Case Example #4
 - Date: 2/24/10
 - Adverse event: Respiratory arrest and death following elective hip replacement
 - Action Item: Improve monitoring of post-operative patients to prevent or allow early identification of respiratory depression
 - Responsible party: Chair of Anesthesia
 - Process: Quality specialist reviews all reported post-op respiratory depression/ near misses and performs FMEA...Multidisciplinary team formed to devise interventions (Surgeons, Anesthesiologists, PACU and med/surg RNs, Pharmacist, Pulmonary and Critical Care MDs) ...Patient education process for post-op pain management implemented...Hi risk analgesics dosing controls put in place...Screening tool for OSA implemented in pre-surgical testing with patients post-op monitoring based on OSA...Handoffs between PACU and surgical unit RNs standardized...Capnography monitors piloted and purchased for use in high risk patients...Barriers to nursing assessment identified and reduced/eliminated
 - Outcome: Pending



25

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

- Next steps:
 - » Continue to drive peer review improvement process deeper into organization so that improvement can be driven at the Department, Section and Unit level
 - » Add to provider support
 - » Continue to enhance the PCA Committee and its role in NSMC's overall strategy
 - » Involve patients, families, patient advocates



26

Cultural Change – Engaging Medical Staff in PI Conclusions

- Cultural change happens slowly and it's iterative. Start with what you have that's good and build on it
- Invest in getting the structure right. Then putting a good process in place will help you achieve your desired outcome
- When trying to connect with MDs and other clinicians it's always best to have an honest, transparent dialogue
- Engaging clinicians requires aligning incentives which means understanding what they care about
- High quality data is a powerful tool in convincing MDs to change
- If you hope to have credibility with MDs you need to "walk the walk" - including demonstrating your commitment with resources.
- Fortunately, better patient outcomes and experience is at the top of the list for both doctors and hospitals
- Consider making clinical improvement a core business strategy.