



# Curriculum – Culture = Failure

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Associate Professor of Medicine

Associate Dean, Clinical Affairs

Director, Institute for Healthcare Quality

Safety & Efficiency

University of Colorado Denver



# 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

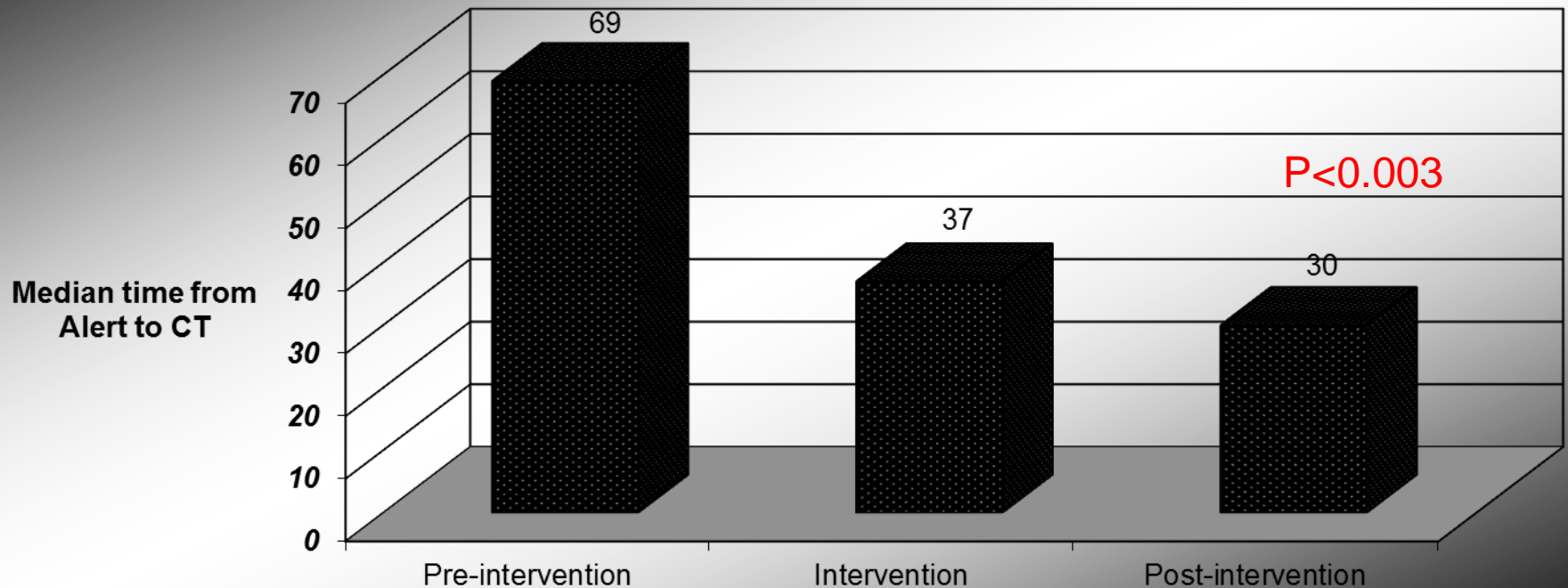


# Improving Inpatient Stroke

- 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

In-hospital Stroke Response Times







# 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

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# Learning Objective

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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?

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**A Story**

# Traditional Rounds



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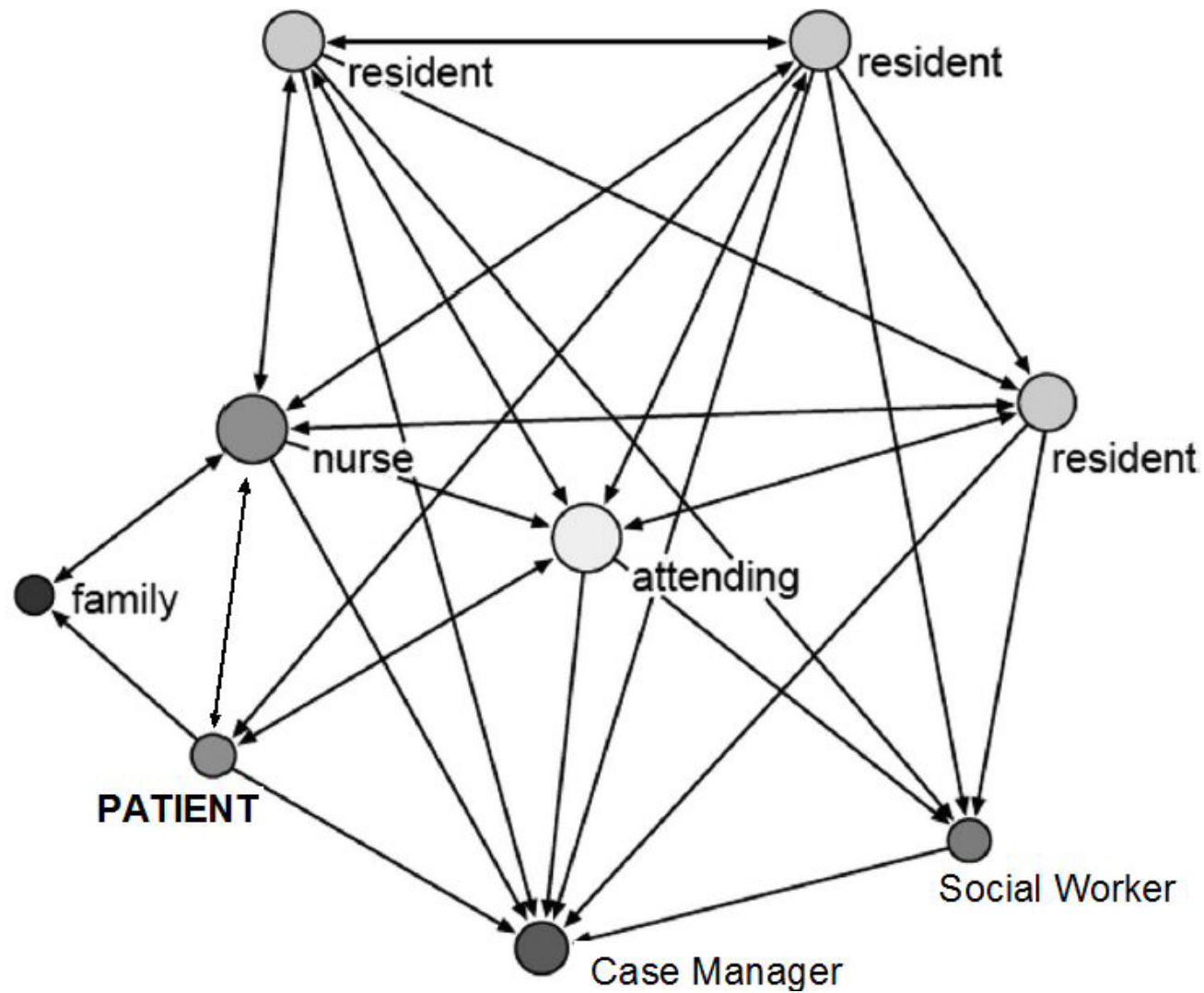
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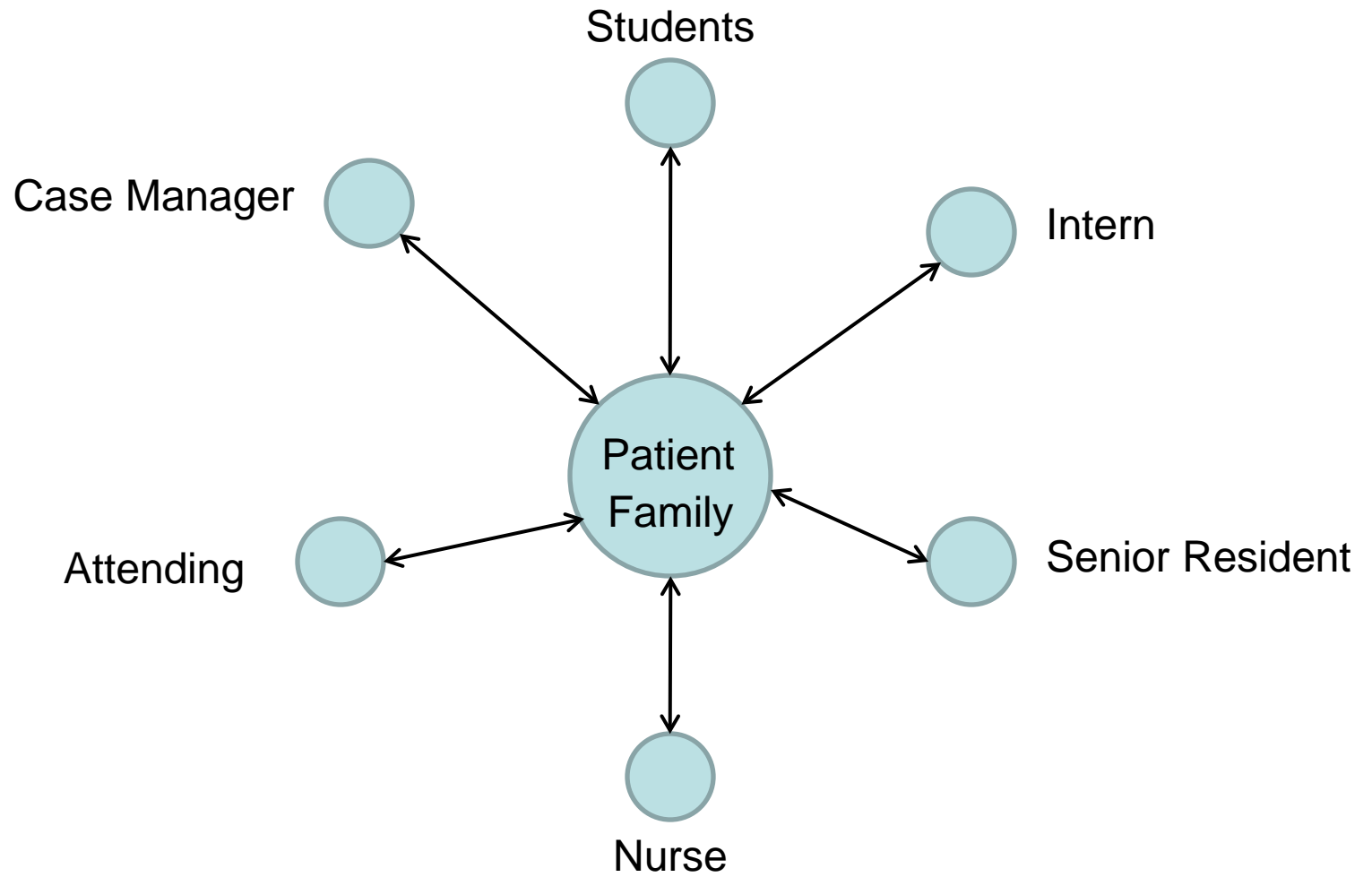


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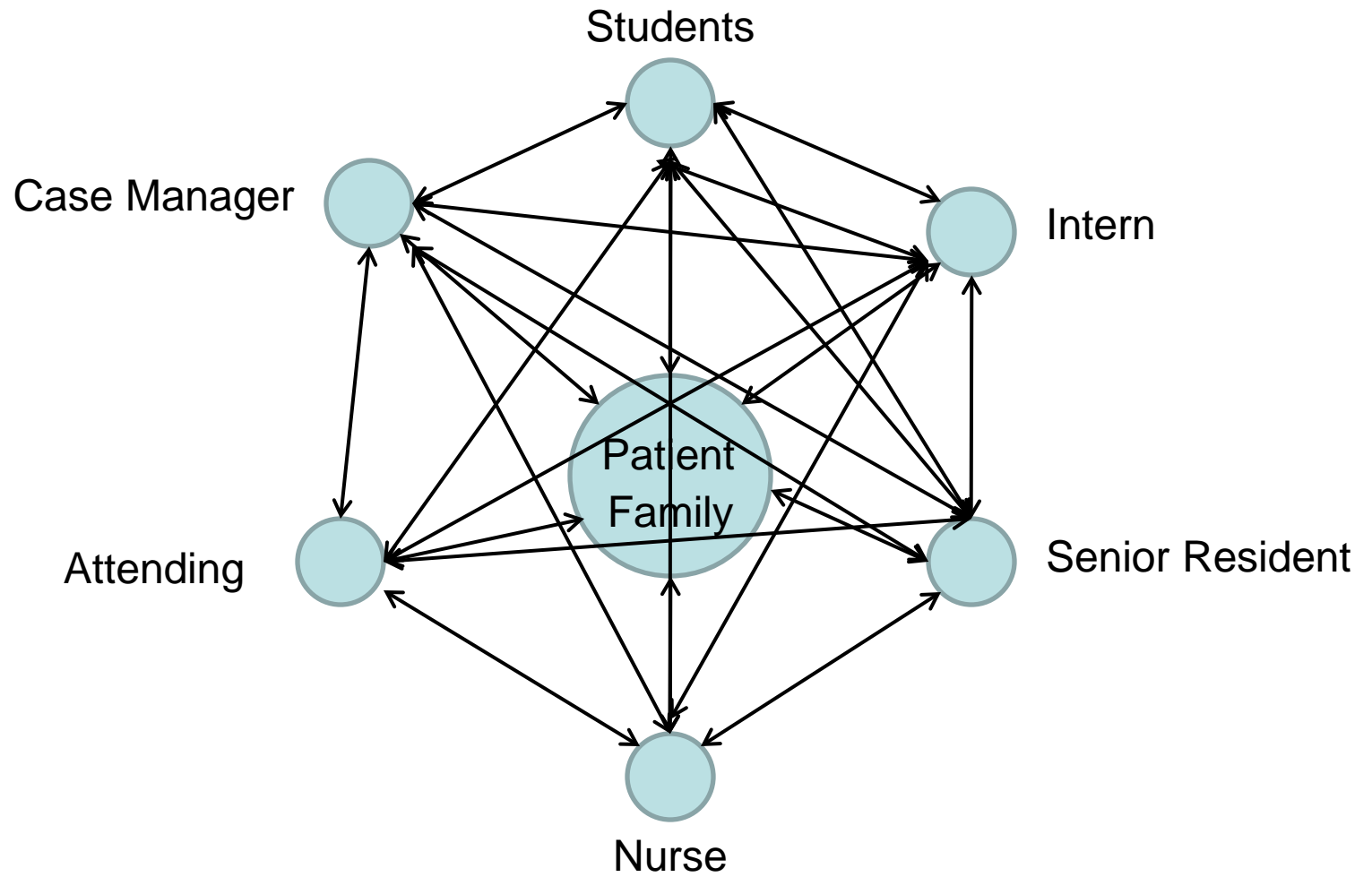




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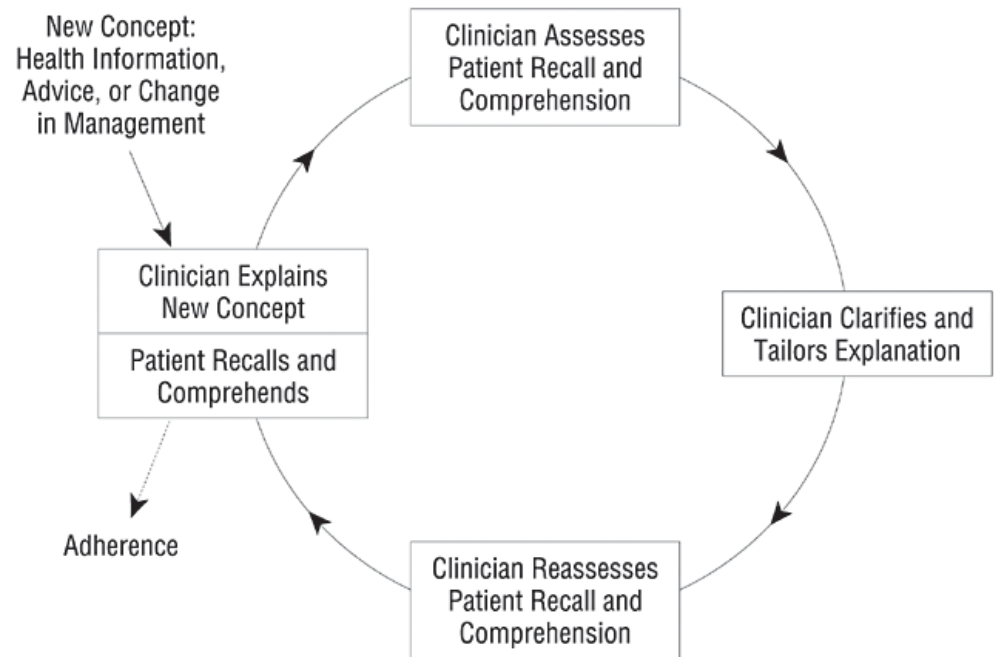
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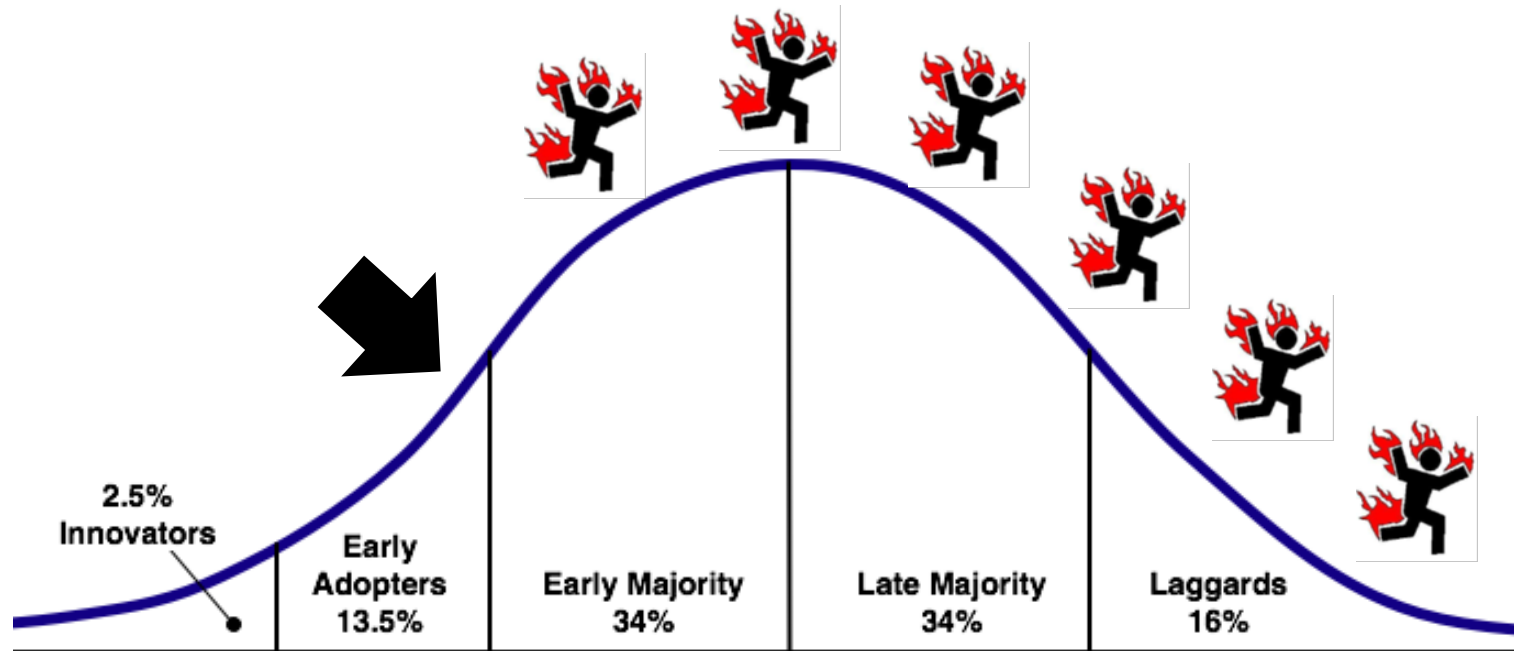


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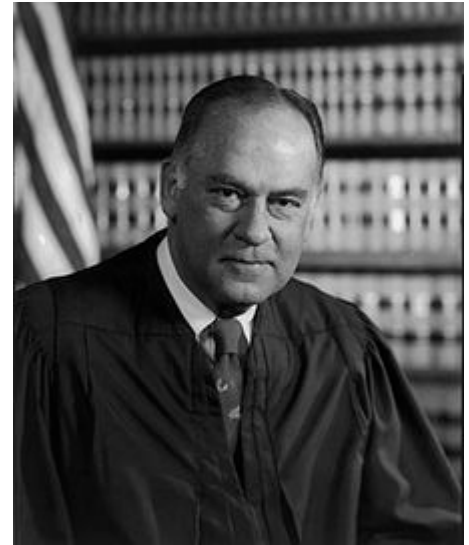
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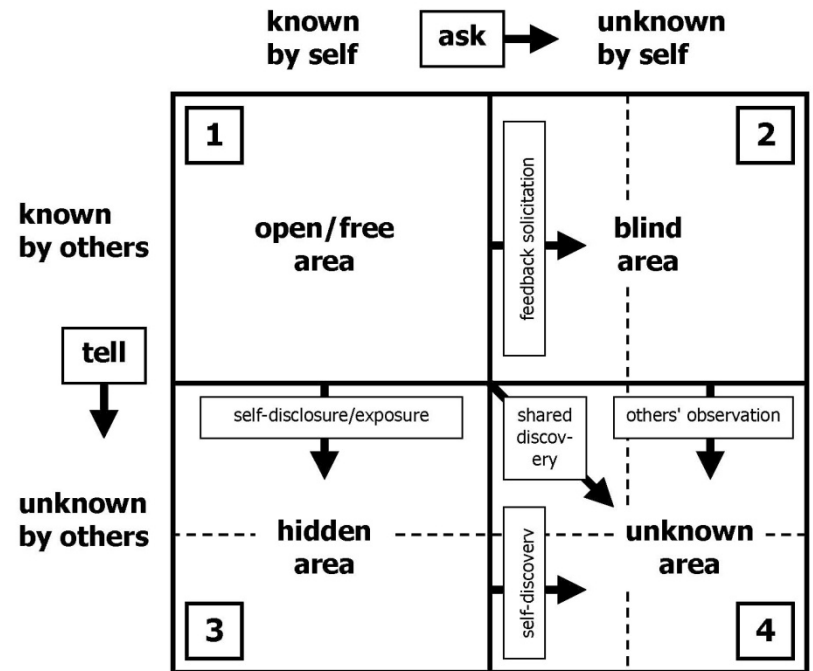
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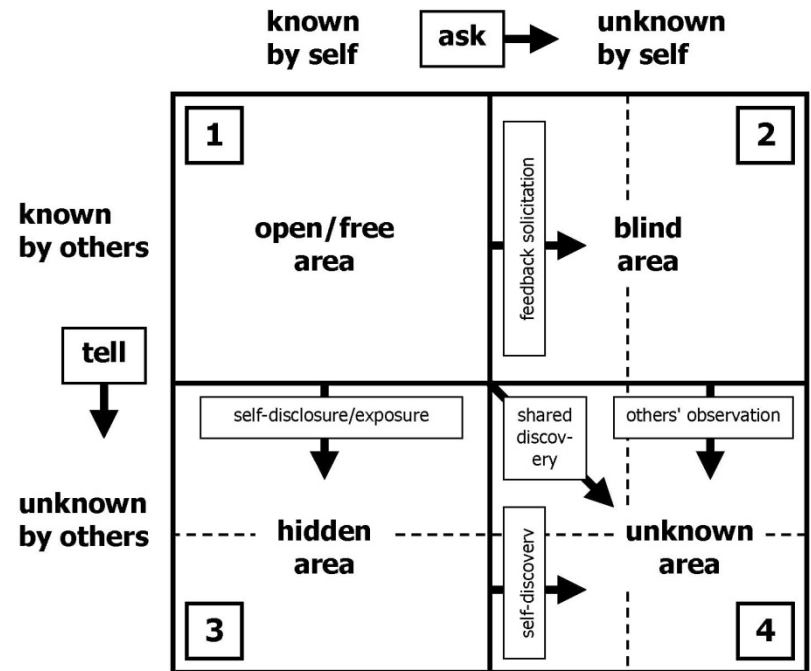
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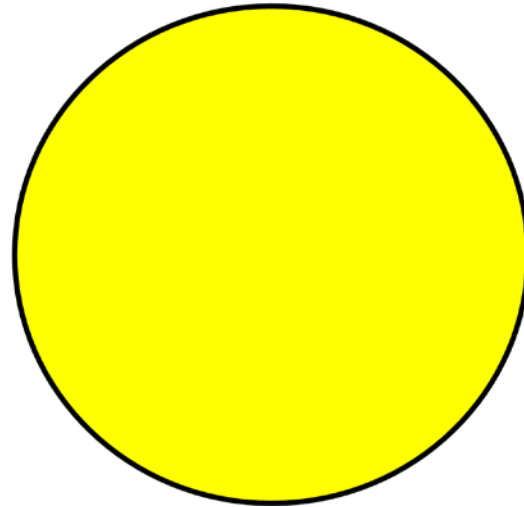
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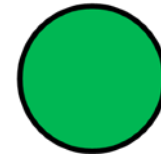
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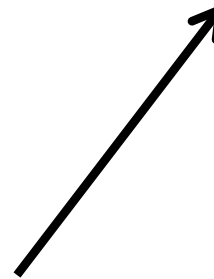
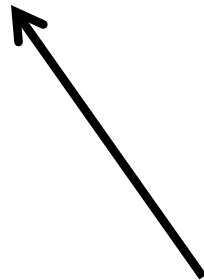
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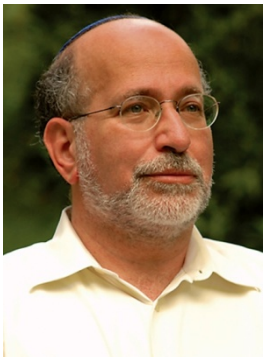
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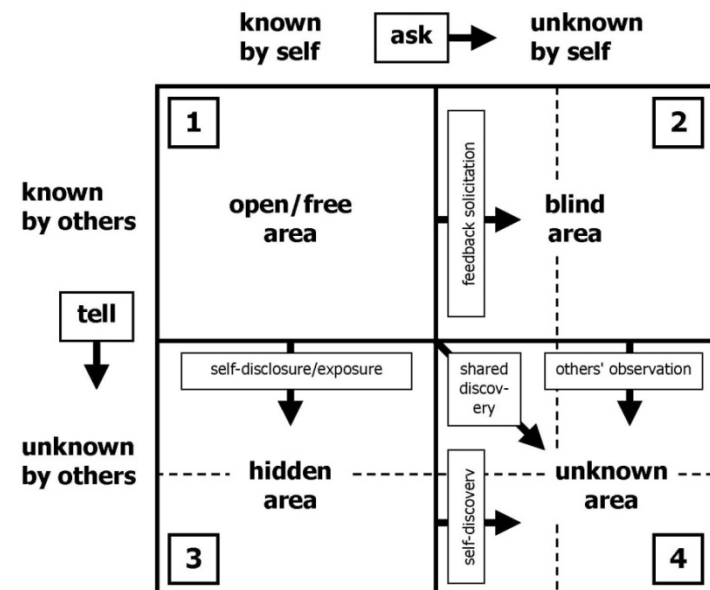
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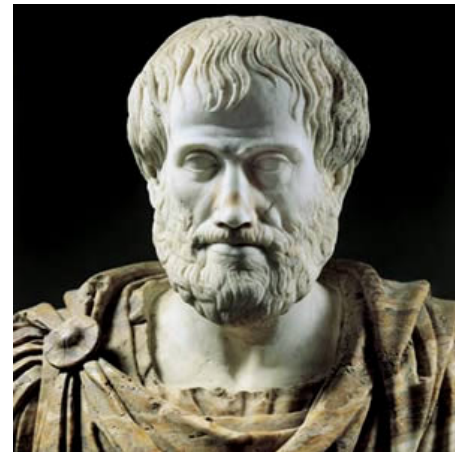


Aristotle



# Professionalism emanates from actions, not virtues

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What is it that YOU repeatedly do?

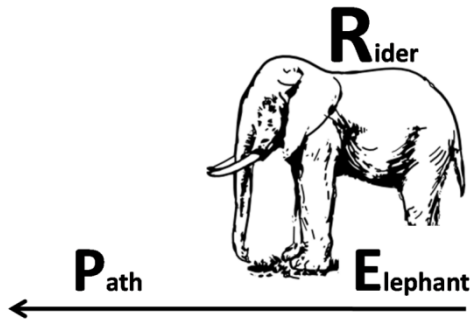


What are the results of what we repeatedly do?

# Explore core values



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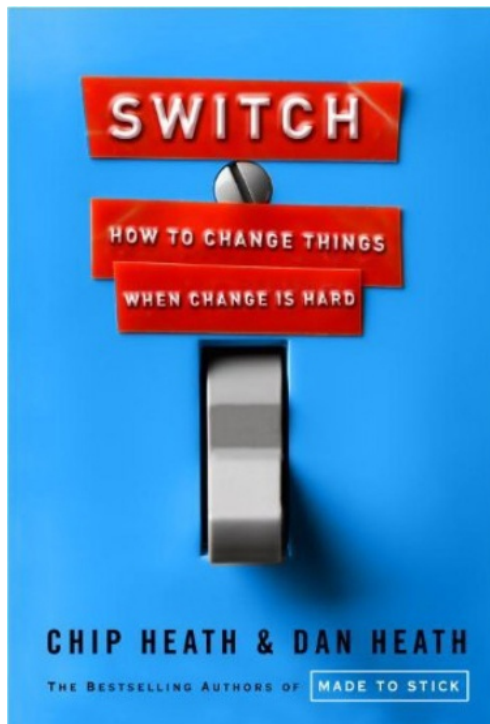


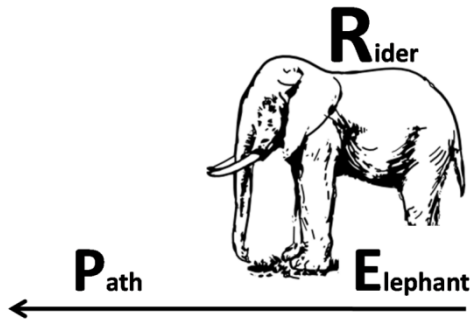
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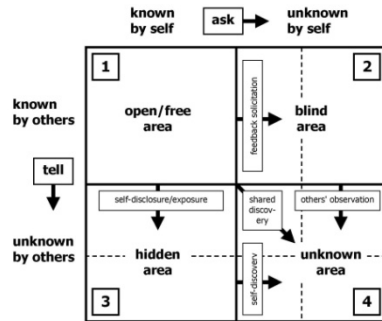
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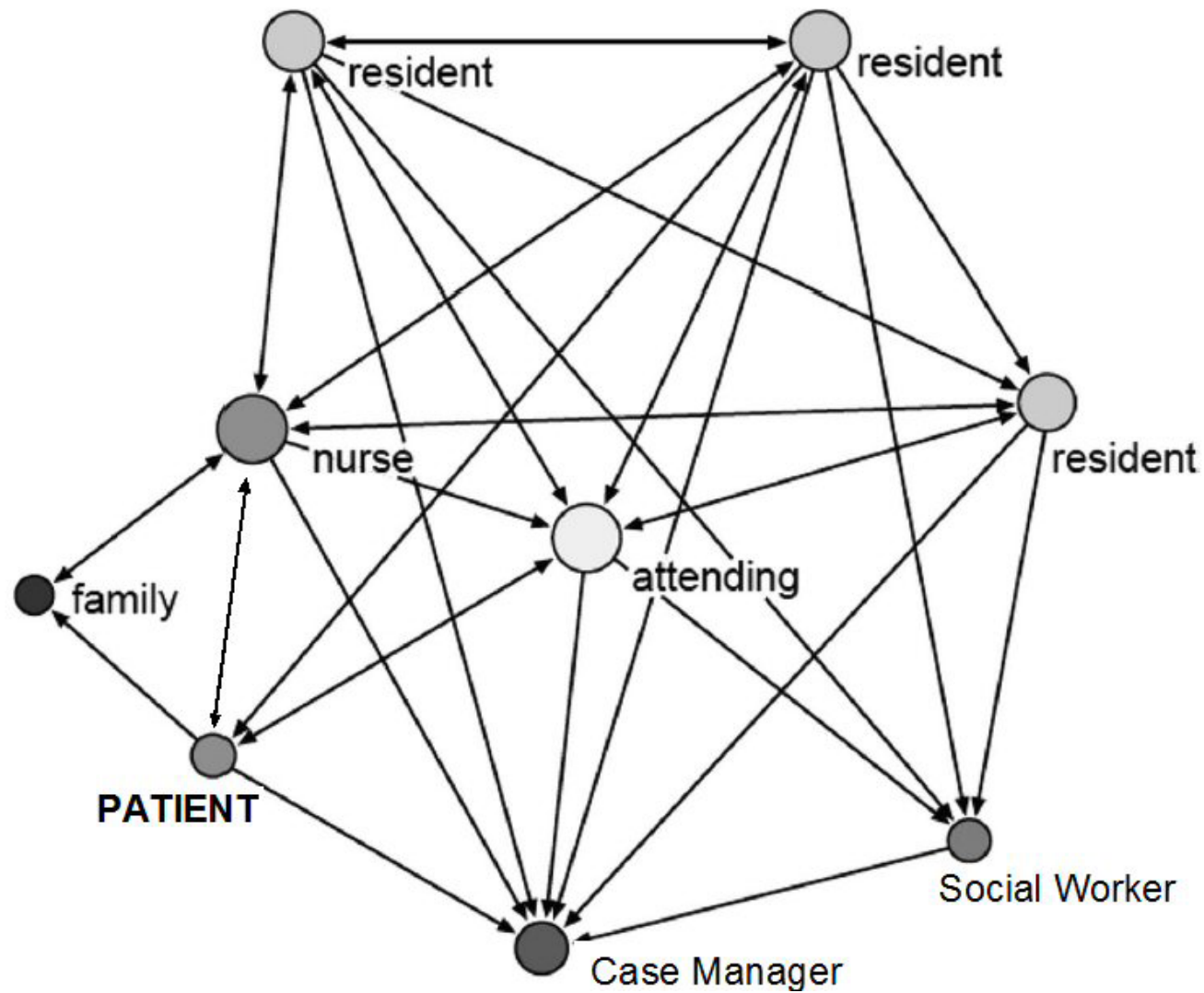
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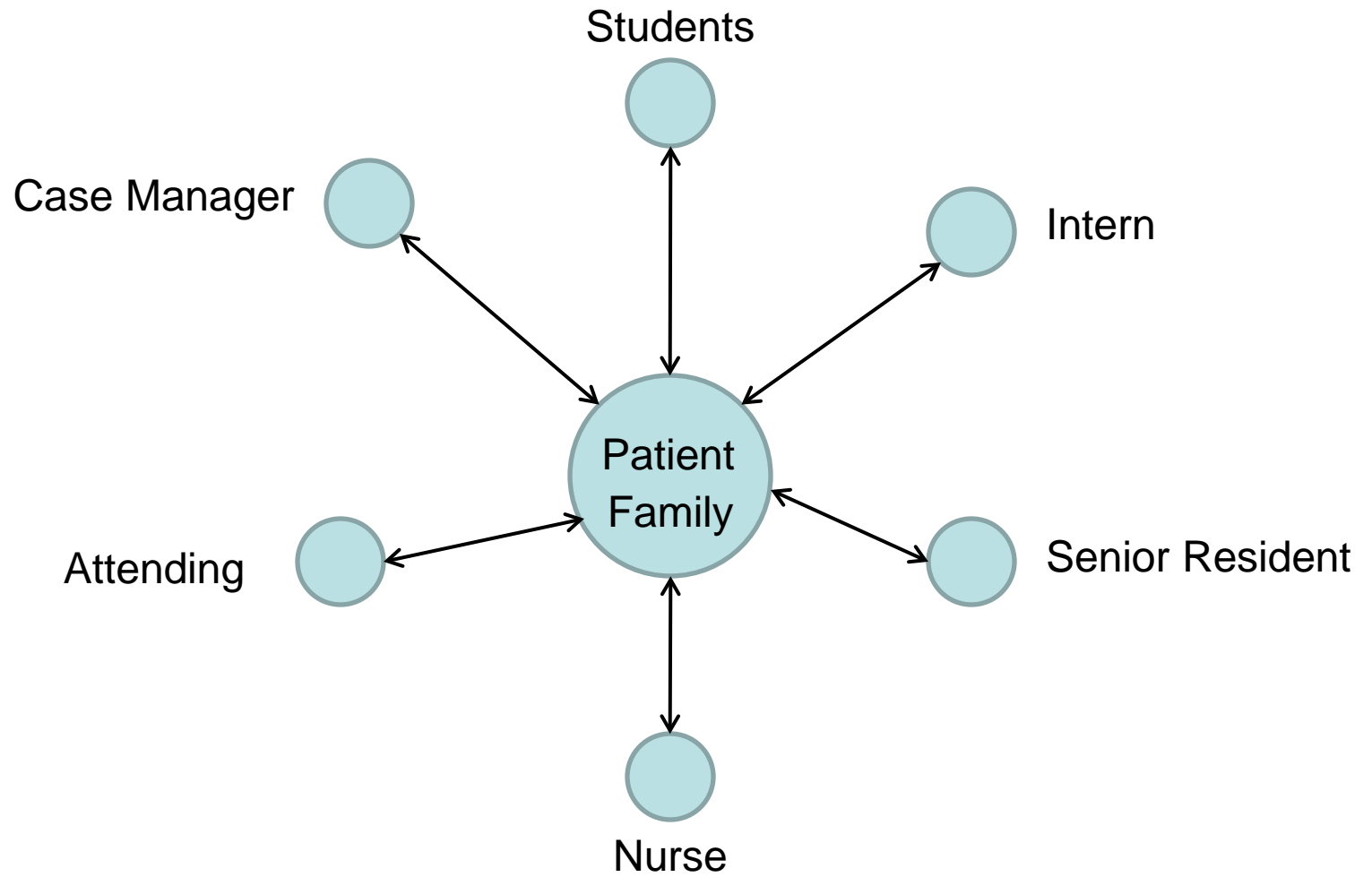
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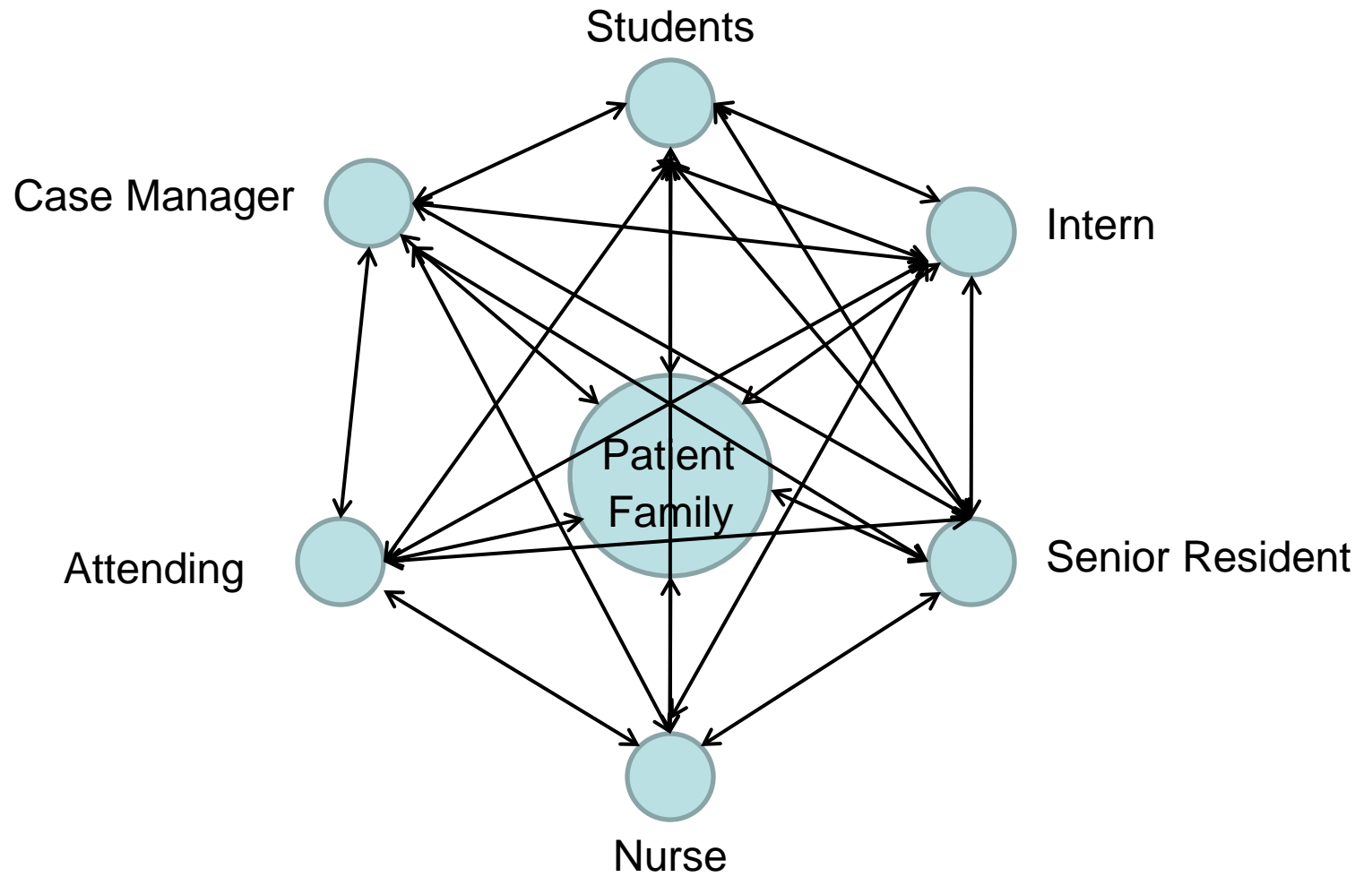






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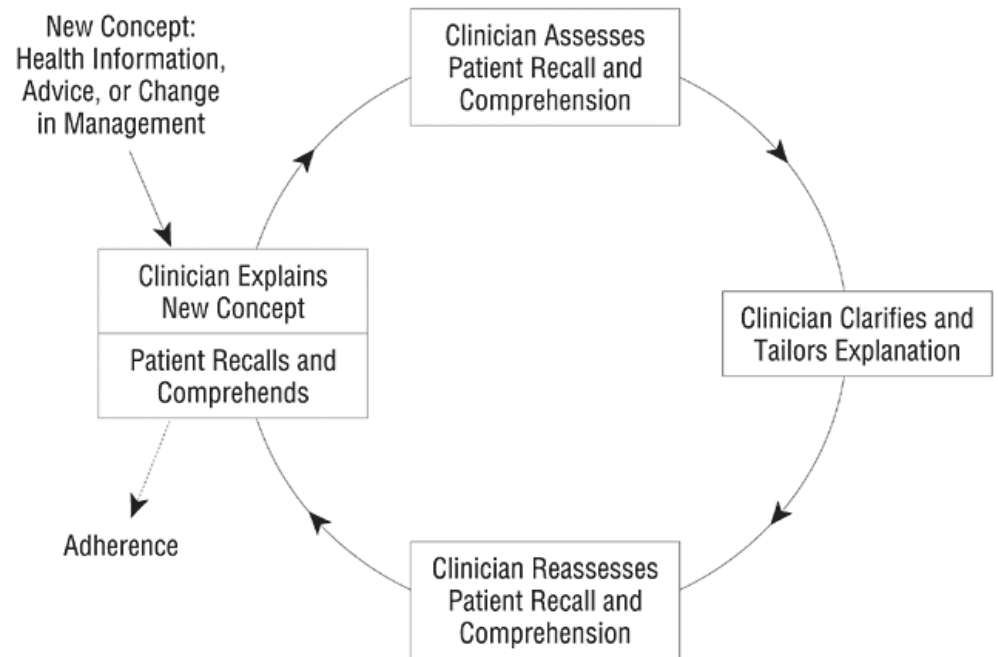
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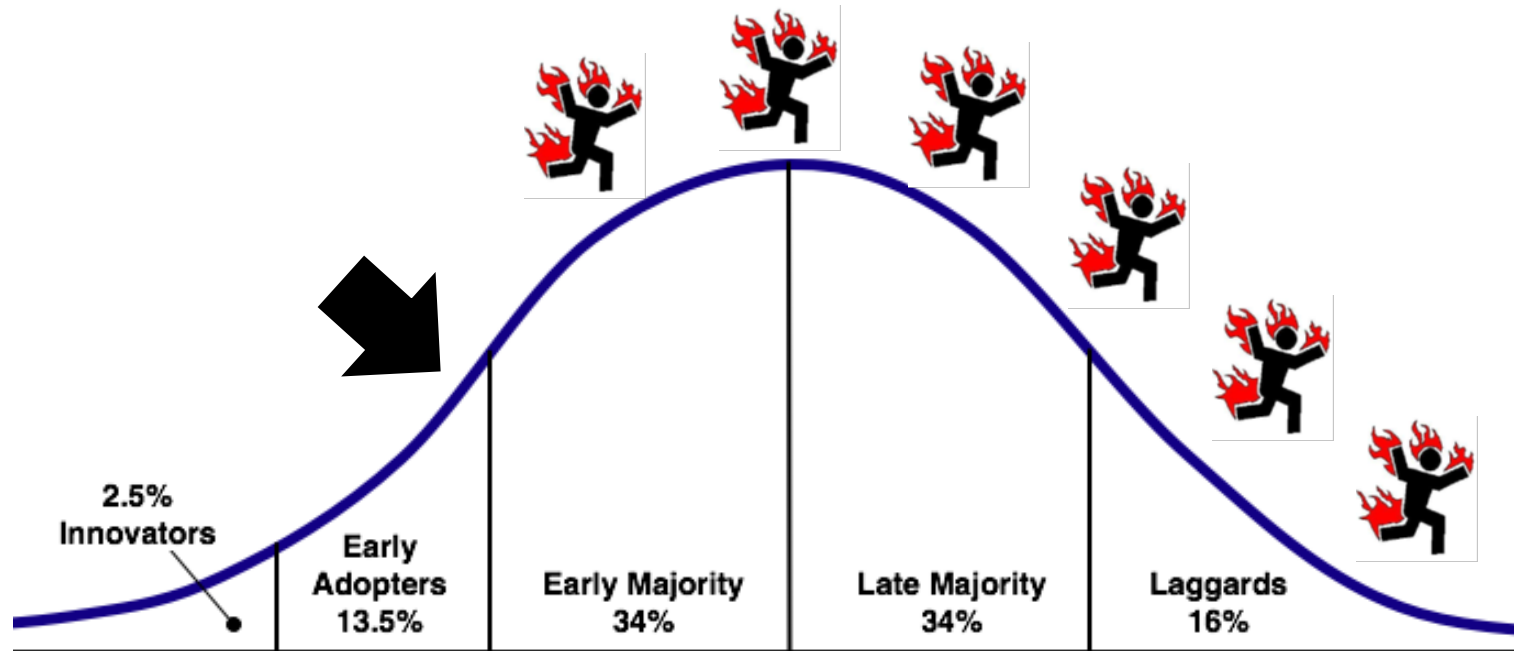


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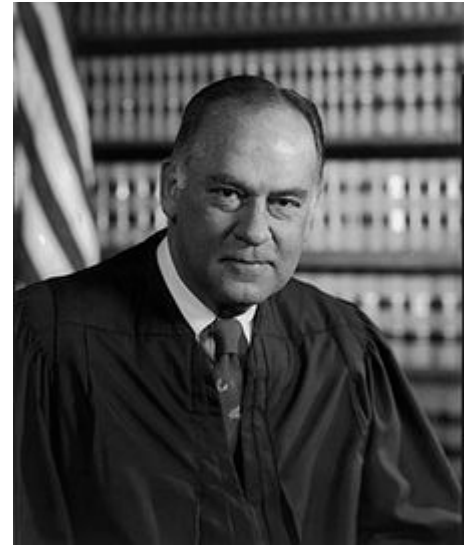
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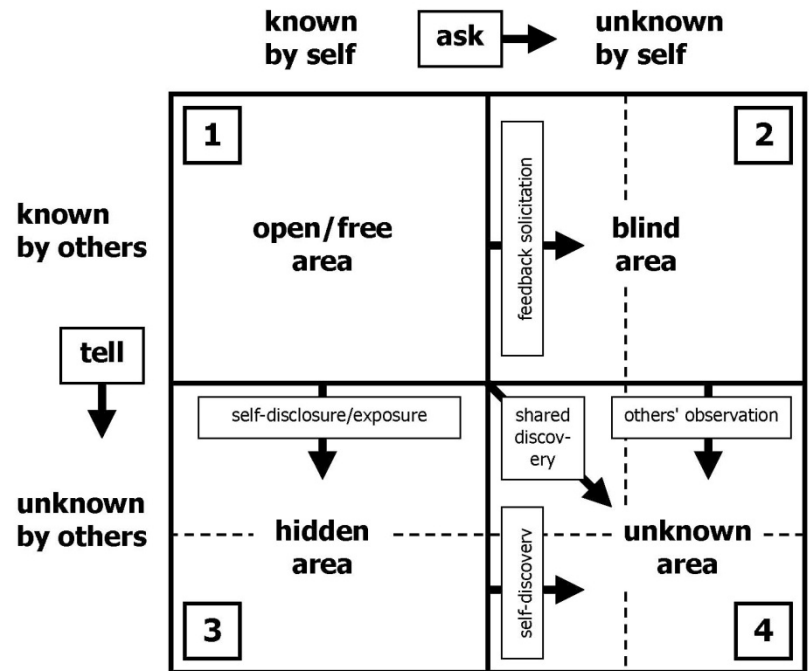


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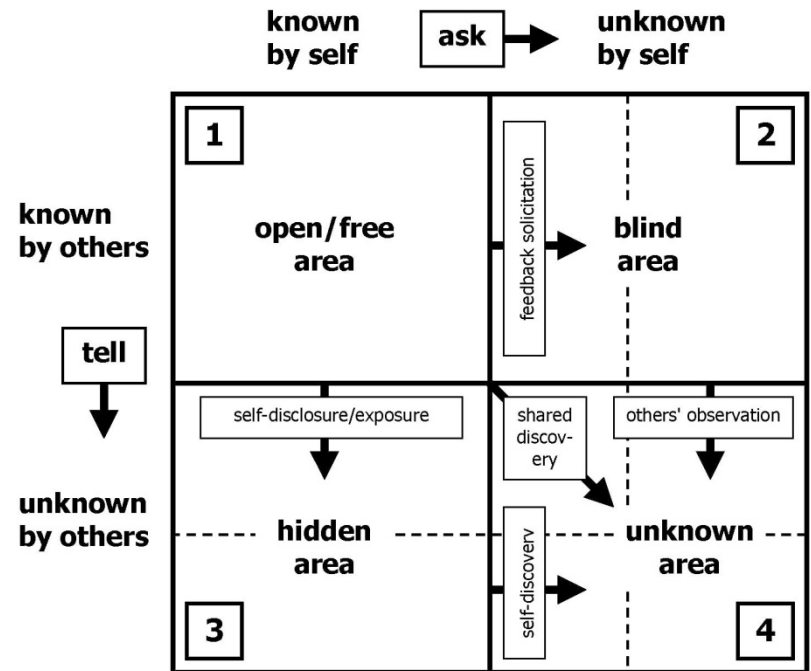
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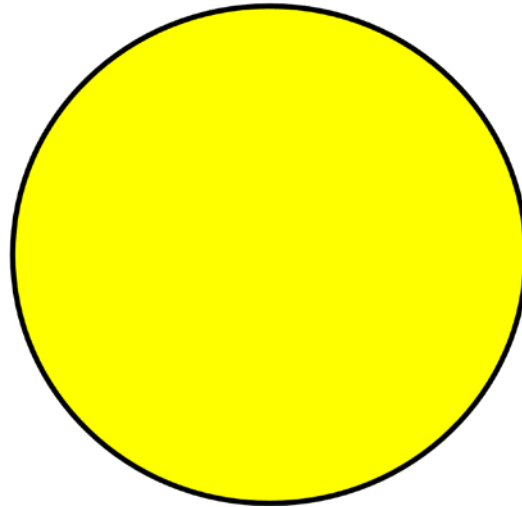
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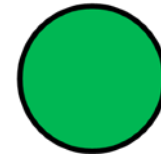
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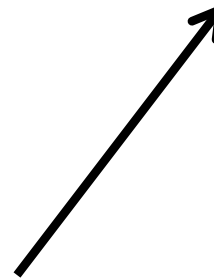
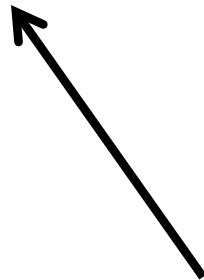
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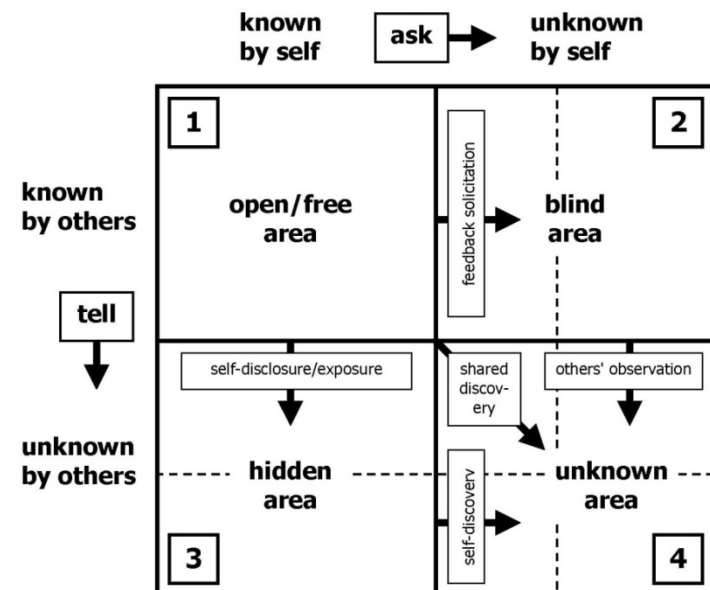
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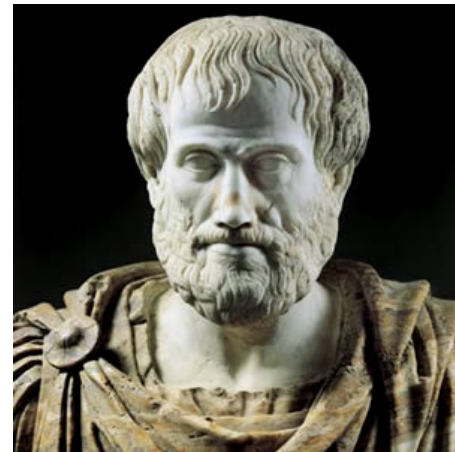
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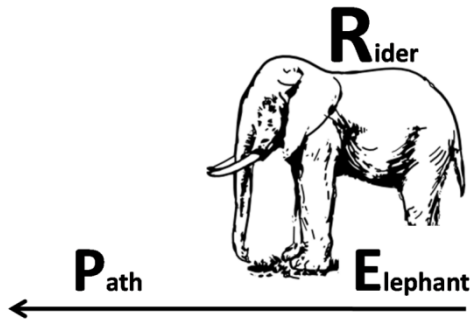
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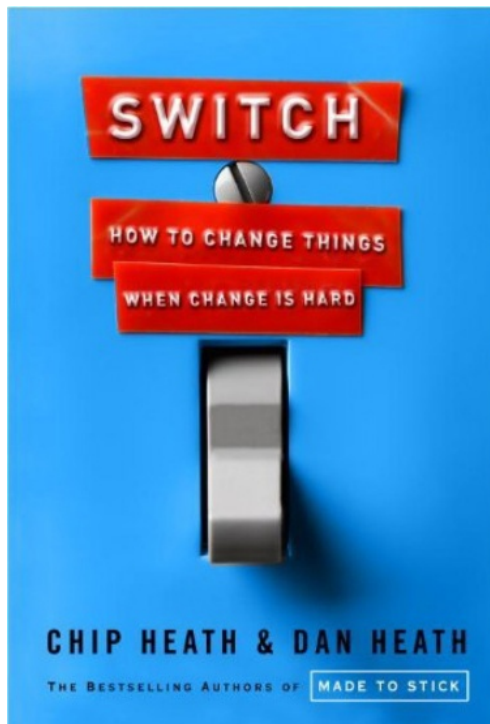


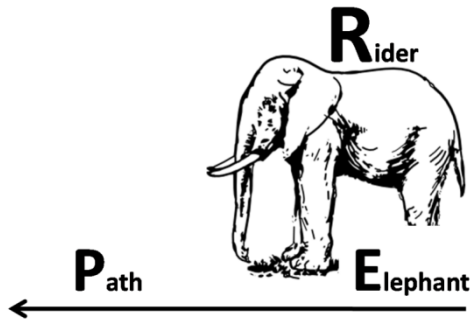
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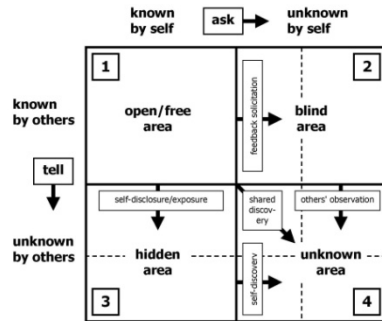
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