Interprofessional Approach to Quality and Safety Improvement in Acute and Chronic Care

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Center of Excellence in Primary Care
Louis Stokes Cleveland VA

April 20, 2018

VAQS QUALITY SCHOLARS
DEVELOPING LEADERS & SCHOLARS TO IMPROVE HEALTHCARE

QSEN INSTITUTE
Quality and safety education for nurses

Veterans Affairs Quality Scholars

VA Quality Scholars

Fellowship, Scholarship, Mentorship

VA Quality Scholars Fellowship

The mission of the VA Quality Scholars program is to develop leaders, researchers, and educators who will lead the way in quality improvement healthcare.

The VA Quality Scholars program consists of eight sites across the United States, as well as an affiliate site in Toronto, Canada. Each site in the US consists of a partnership between a VA hospital and an academic institution.

VAQS.org

QSEN Institute

A collaborative of healthcare professionals focused on education, practice, and scholarship to improve quality and safety of healthcare systems.

Our vision is to inspire health care professionals to put quality and safety as core values to guide their work.

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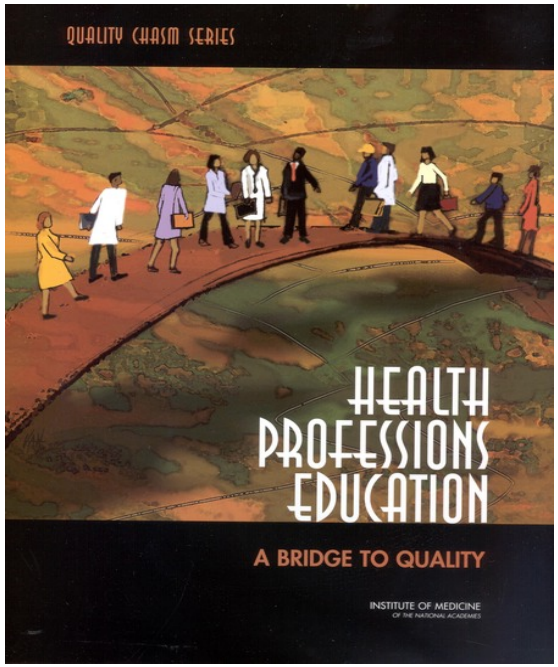
CASE WESTERN RESERVE UNIVERSITY

History of QSEN



Health professions education: A bridge to quality (2003)

QSEN (2005-2012)

- Funded by Robert Wood Johnson Foundation
- Developed competencies and teaching strategies
- Provided a focus for nurses to have the ***knowledge, skills*** and ***attitudes*** to ensure high quality and safe care

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Founder of QSEN

Linda Cronenwett, PhD, RN, FAAN (2/26/2009)

"Our health care system has significant safety and quality problems. To fix that, we need to redesign what and how we teach the next generation of health care professionals so that they understand what goes into ensuring good and safe care, and can identify and bridge the gaps between what is and what should be."

QSEN: Quality & Safety Education for Nurses

Goal of QSEN:

Provide comprehensive, competency based resources to empower nurses with the knowledge, skills and attitudes necessary to continuously improve the quality and safety of the healthcare systems in which they work.

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QSEN Competencies

- **Patient-centered care**
- **Teamwork & Collaboration**
- **Evidence-based Practice**
- **Quality Improvement**
- **Safety**
- **Informatics**

***pre-licensure and advanced practice nursing 2005

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QSEN Competencies

QUALITY IMPROVEMENT (QI)

Definition: Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.

KNOWLEDGE	SKILLS	ATTITUDE
s of care in the setting in which one is engaged in clinical practice	f care for populations served in care settingSeek information about quality improvement projects in the care setting	quality improvement is an essential part of the daily work of all health professionals
Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patients and familiesGive examples of the tension between professional autonomy and system functioning	Use tools (such as flow charts, cause-effect diagrams) to make processes of care explicitParticipate in a root cause analysis of a sentinel event	Value own and others' contributions to outcomes of care in local care settings
Explain the importance of variation and measurement in assessing quality of care	Use quality measures to understand performanceUse tools (such as control charts and run charts) that are helpful for understanding variation Identify gaps between local and best practice	Appreciate how unwanted variation affects careValue measurement and its role in good patient care
Describe approaches for changing processes of care	Design a small test of change in daily work (using an experiential learning method such as Plan-Do-Study-Act)Practice aligning the aims, measures and changes involved in improving care Use measures to evaluate the effect of change	Value local change (in individual practice or team practice on a unit) and its role in creating joy in workAppreciate the value of what individuals and teams can to do to improve care

QSEN Teaching Strategies

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TEACHING STRATEGIES

Below is a listing of the teaching strategies published on our site. You can scroll through the listing or search our records. The materials on the QSEN Web site are freely available for educational use, but original content such as the teaching strategies must be cited. Please read our Terms and Conditions before using this material.

Title	Submitter	Organization	Publish Date
Teaching Reflective Practice Through the Use of Reflection Papers	Gail Armstrong	University of Colorado Denver College of Nursing	12-2012
Clinical Conference and the One Minute Safety Check	Kim Amer	DePaul University	08-2012
Using Simulation to Introduce Beginning Students to Patient Centered Care and Communication	Celeste M. Alfes	Frances Payne Bolton School of Nursing	07-2012

2012- Present QSEN Institute Initiatives

- Regional Centers (UNC, UAB, CNJ, JU)
- Task forces
- Research- impact of education on practice
- Website: Dissemination of resources
  - Teaching strategies
  - Practice implementation strategies
- Annual International Conference

Quality and Safety Engagement Network


Take the Lead
on Healthcare Quality Improvement
Free Massive Open Online Course (MOOC)
FRANCES PAYNE BOLTON
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CASE WESTERN RESERVE
UNIVERSITY

9th QSEN International Forum

May 30- June 1

Bonita Springs, Florida

Transforming Outpatient Care "TOPC"

Center of Excellence in Primary Care Education

Louis Stokes Cleveland VA Medical Center

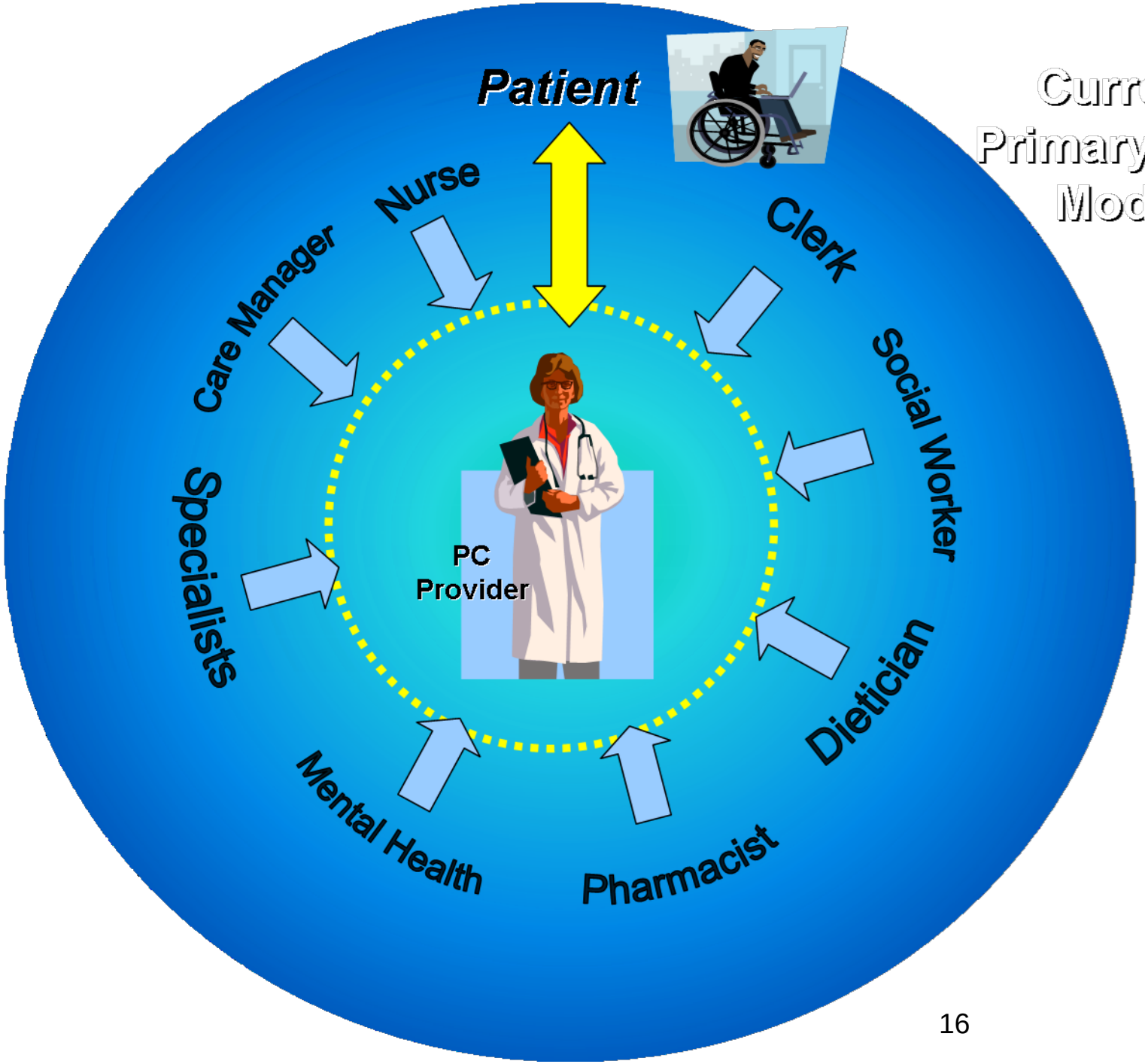
Patient Aligned Clinical Teams
PACT

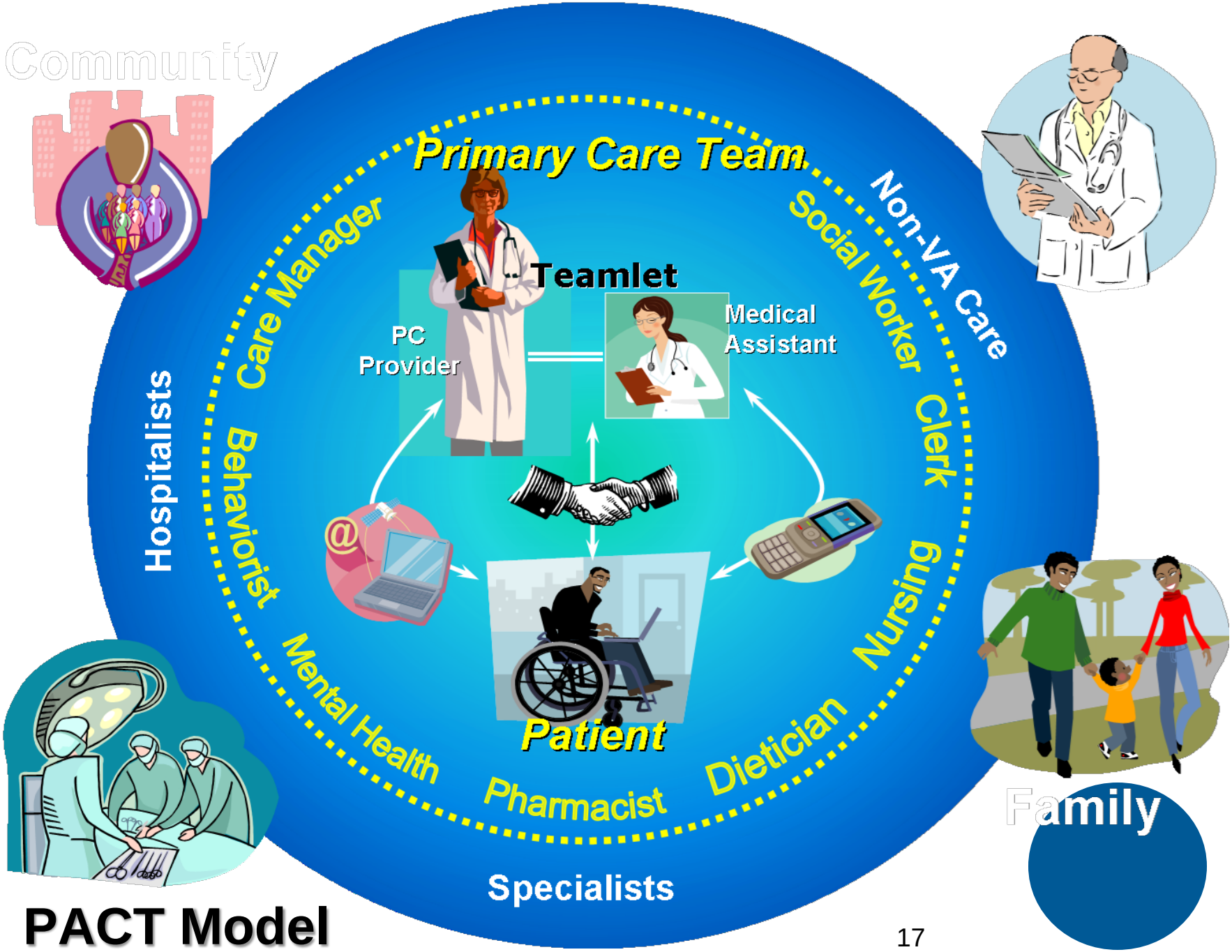
- Major systems redesign of delivery of primary care in all VHA facilities
- “Patient Centered Medical Home -PCMH”

Patient Aligned Clinical Teams

- Several Demonstration Projects
- One year after PCMH implementation
- Sample size of 9200 patients
  - 29% reduction in ER visits
  - 11% decrease in hospitalizations
  - 6% reduction in inpatient visits
- Improved patient and provider satisfaction

Current Primary Care Model




Community
Primary Care Team
Care Manager
Social Worker
Non-VA Care
Clerk
Nursing
Dietician
Pharmacist
Mental Health
Behaviorist
Hospitalists
Teamlet
PC Provider
Medical Assistant
Patient
Specialists
Family

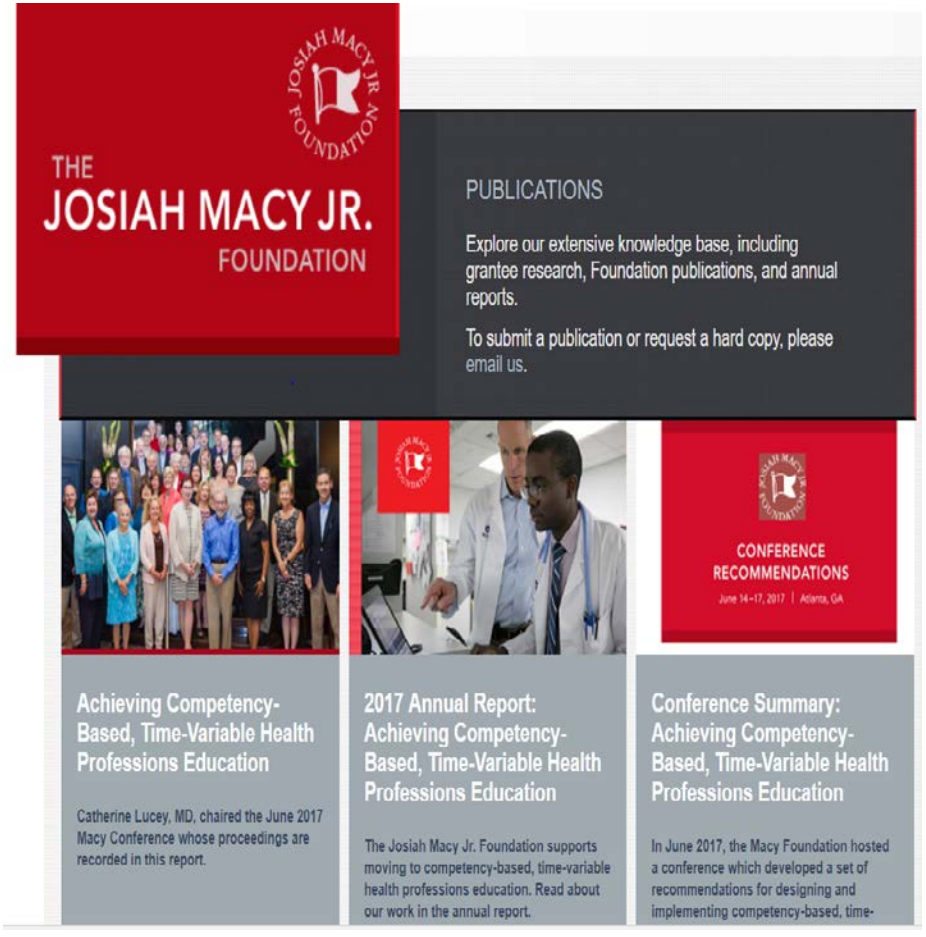
PACT Model

Current Approach to Ambulatory Education

Current approaches to ambulatory education will not work.

Chronic disease management team approach.

Josiah Macy Foundation Consensus Statement Learning Environment-April 2018



- Governance
- Organization
- Learning platforms
- Faculty Development
- Policy
- Research

Overview

Interprofessional Collaboration In Quality and Safety

- Review the state of healthcare today
- Consider the forest view of changes needed
- Consider the tree view of changes needed

State of Healthcare Today

Solutions: Forest

Solutions: Trees

What is Quality?
IOM's Six Aims for Improvement

1. **<u>Safe</u>: Care in healthcare facilities should be as safe as at home.**

   ***3rd leading cause of death**

2. **<u>Effective</u>: Care should be science based and evidence based.**

3. **<u>Efficient</u>: Care and service should be cost effective.**

IOM= Institute of Medicine

IOM's Six Aims for Improvement (cont.)

4. **<u>Timely</u>: No waits or delays should occur in receiving care.**

5. **<u>Patient centered</u>: System of care revolves around patient and family.**

6. **<u>Equitable</u>: Disparities in care should be eradicated- Geographic.**

STEEEP

- Patient Centered
- Efficiencyiy
- Equity
- Effectiveness
- Timeliness
- safety

Critical Problems

- Diagnostic Errors

The global burden of diagnostic errors in primary care

Hardeep Singh,[1] Gordon D Schiff,[2] Mark L Graber,[3,4] Igho Onakpoya,[5] Matthew J Thompson[6]

ABSTRACT

Diagnosis is one of the most important tasks performed by primary care physicians. The World Health Organization (WHO) recently prioritized patient safety areas in primary care, and included diagnostic errors as a high-priority problem. In addition, a recent report from the Institute of Medicine in the USA, *'Improving Diagnosis in Health Care'*, concluded that most people will likely experience a diagnostic error in their lifetime. In this narrative review, we discuss the global significance, burden and contributory factors related to diagnostic errors in primary care. We synthesize available literature to discuss the types of presenting symptoms and conditions

Organization (WHO) recently prioritised safety areas in primary care and recognised the importance of errors in diagnosis.[1] Recognising the paucity of literature,[2–4] WHO set up a Safer Primary Care Expert Working Group to compile key lessons and topics for further research. This initiative led to the development of the 2016 Technical Series on Safer Primary Care, a series of 9 monographs to promote good practices and to implement systems changes to improve safety. This narrative review informed the development of the monograph focused on diagnostic errors, expected to be released by

2nd study: Medical errors 3rd-leading cause of death in U.S.

Jayne O'Donnell, USA Today 9:23 a.m. EDT May 4, 2016

Medical errors kill about 250,000 people a year, a new study from a well-known Johns Hopkins medical school professor and author said Tuesday.

The study by surgeon and Johns Hopkins professor Martin Makary is the second to report the mistakes represent the third-leading cause of deaths in the U.S.

Death certificates in this country don't have a place for hospitals to acknowledge medical error, which

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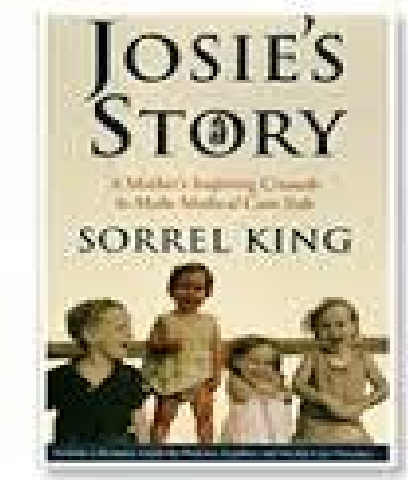
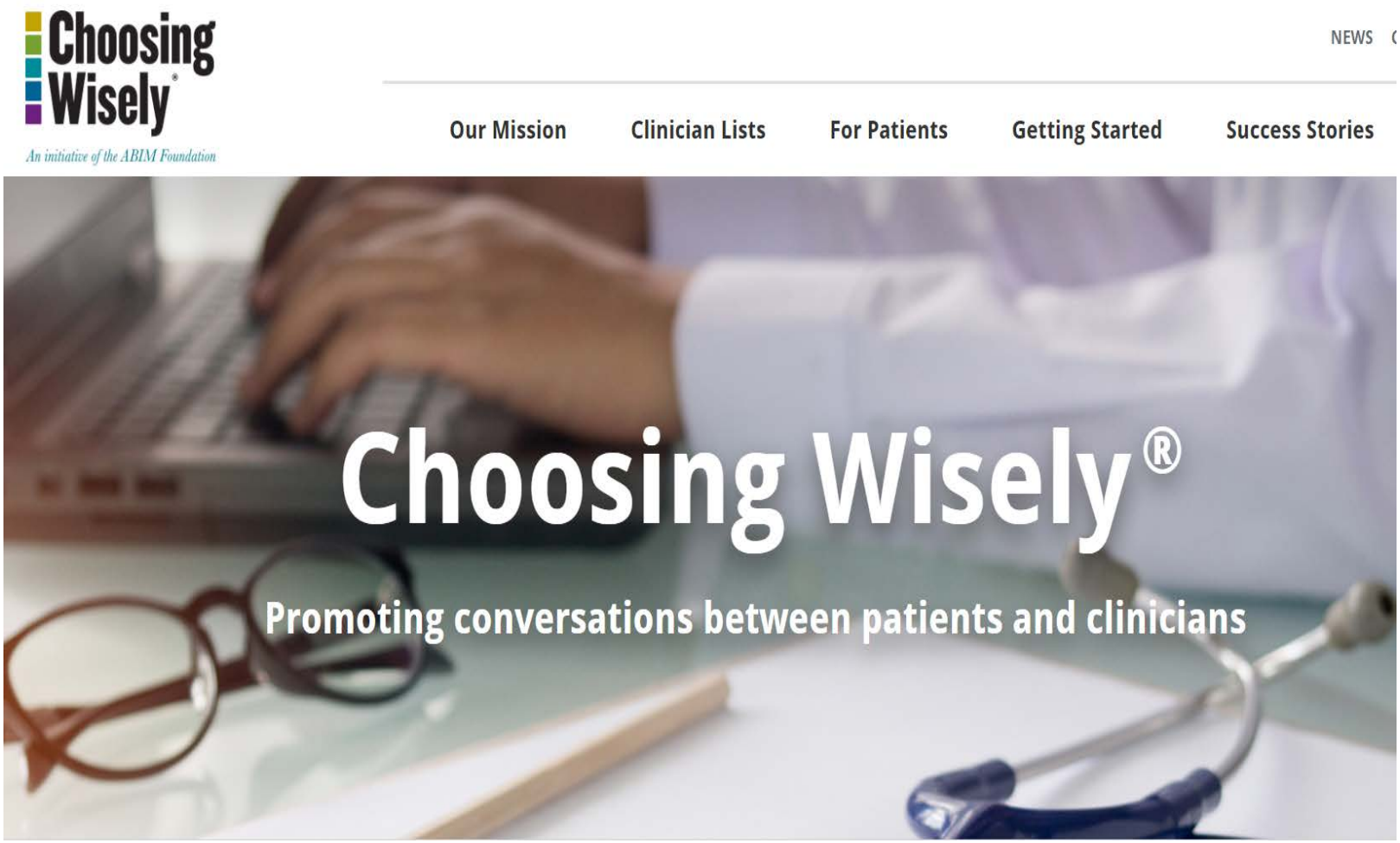

JOSIE'S STORY
SORREL KING


ジョージィの物語


A Pharmacy Tech's Deadly Mistake: Emily Jerry
Emily Jerry
Two-Year-Old Emily Jerry Was Diagnosed w/ an Abdominal Tumor
Treatment at Rainbow Babies and Children's Hospital in Cleveland, OH


World Health Organization
Helen Haskell – President, Mothers Against Medical Error and Consumers Advancing Patient Safety; Steering Group, World Health Organization Global Patient Safety Challenge on Medication Safety

Over Treatment



Healthcare Professional Burnout

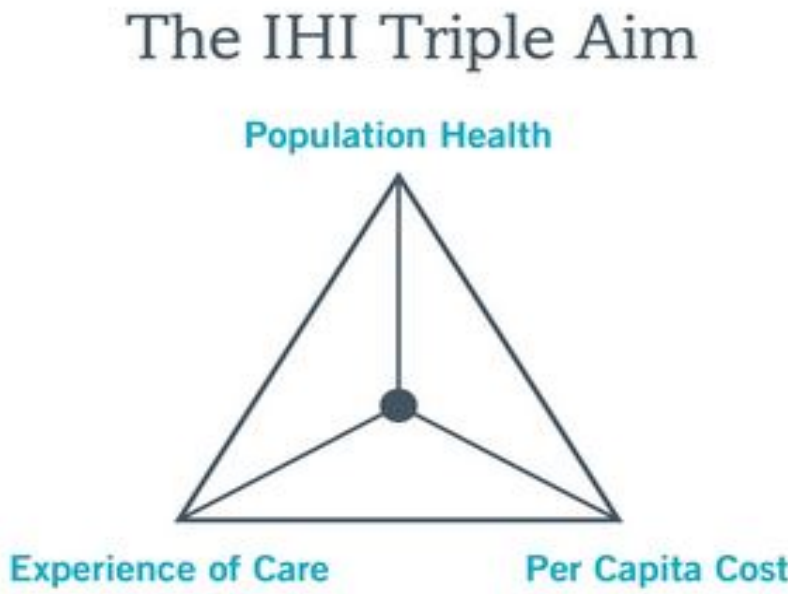
Burnout and suicidal ideation among U.S. medical students

Liselotte N. Dyrbye, Matthew R. Thomas, F. Stanford Massie, David V. Power, Anne Eacker, William Harper, Steven Dur
Christine Moutier, Daniel W. Szydlo, Paul J. Novotny, Jeff A. Sloan, Tait D. Shanafelt

Family Medicine and Community Health (TMED)

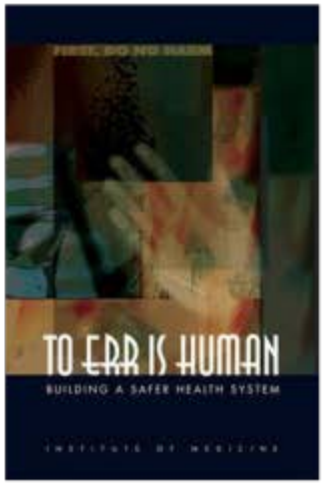
- Burnout was reported by 49.6% (95% CI, 47.5% to 51.8%) of students, and 11.2% (CI, 9.9% to 12.6%) reported suicidal ideation within the past year

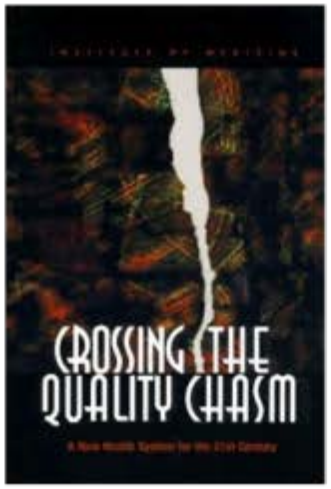
Aim of Healthcare



Quadruple Aim

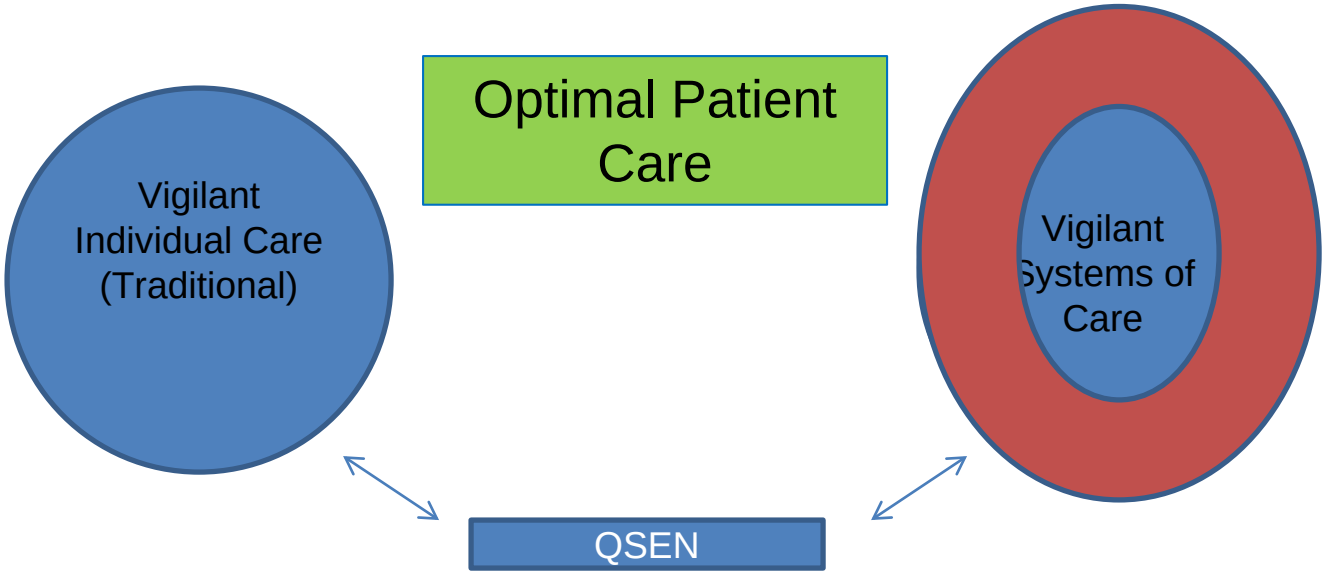
Are we Improving in Quality and Safety?





1999 2001 2008 2014 2015

What is needed?



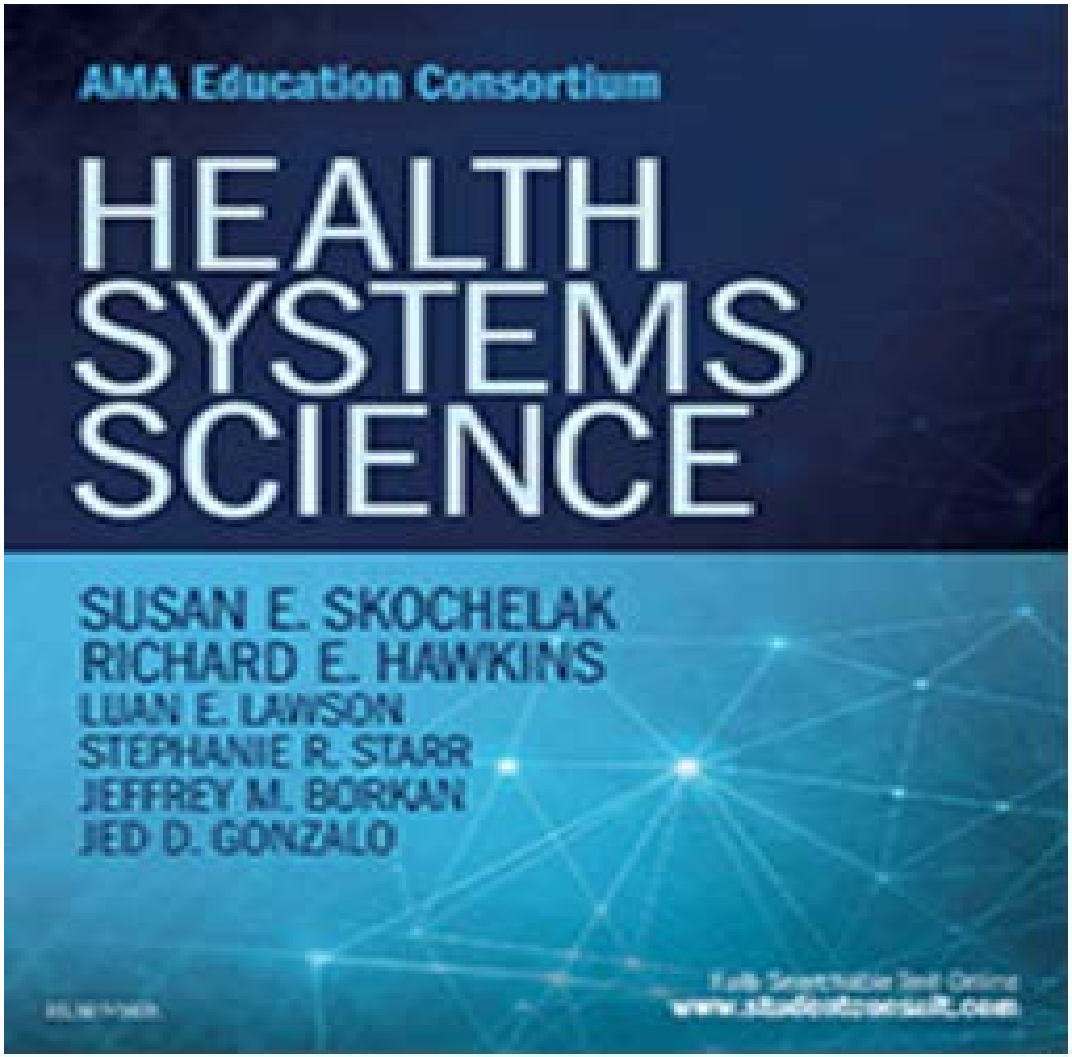
- Patient Centered Care
- Teamwork & Collaboration
- Evidenced Based Practice
- Safety
- Quality Improvement
- Informatics

The Online Journal of Issues in Nursing
A Scholarly Journal of the American Nurses Association

Quality and Safety Education for Nurses (QSEN): The Key is Systems Thinking

Mary A. Dolansky, PhD, RN
Shirley M. Moore, PhD, RN, FAAN

Medicine


AMA Education Consortium
HEALTH SYSTEMS SCIENCE
SUSAN E. SKOCHELAK
RICHARD E. HAWKINS
LUAN E. LAWSON
STEPHANIE R. STARR
JEFFREY M. BORKAN
JED D. GONZALO

Summary: Current Status

- Attaining the Quadruple Aim requires interprofessional collaboration in both acute and chronic care delivery.
- VA Center of excellence in primary care.

**What we have learned is that the interprofessional space unveils the power of our efforts to work collaboratively in teams with agreed upon goals, roles, and expectations and the courage to provide feedback.

State of Healthcare Today

Solutions: Forest

Solutions: Trees

Josiah Macy Foundation Consensus Statement Learning Environment

- Governance
- Organization
- Learning platforms
- Faculty Development
- Policy
- Research

1. Collaborative Leadership

- Multiple professionals co-leading
  - Role model the behavior
  - Live and learn the facilitators and barriers

2. Supportive Structures & Routines in Learning Environment

- Transforming Domains
  - IPC, shared decision making, continuity of care, and quality care improvement
- Huddles
- Dyads
- RCA after events
- Safety rounds
- Bedside reporting integrating the patient

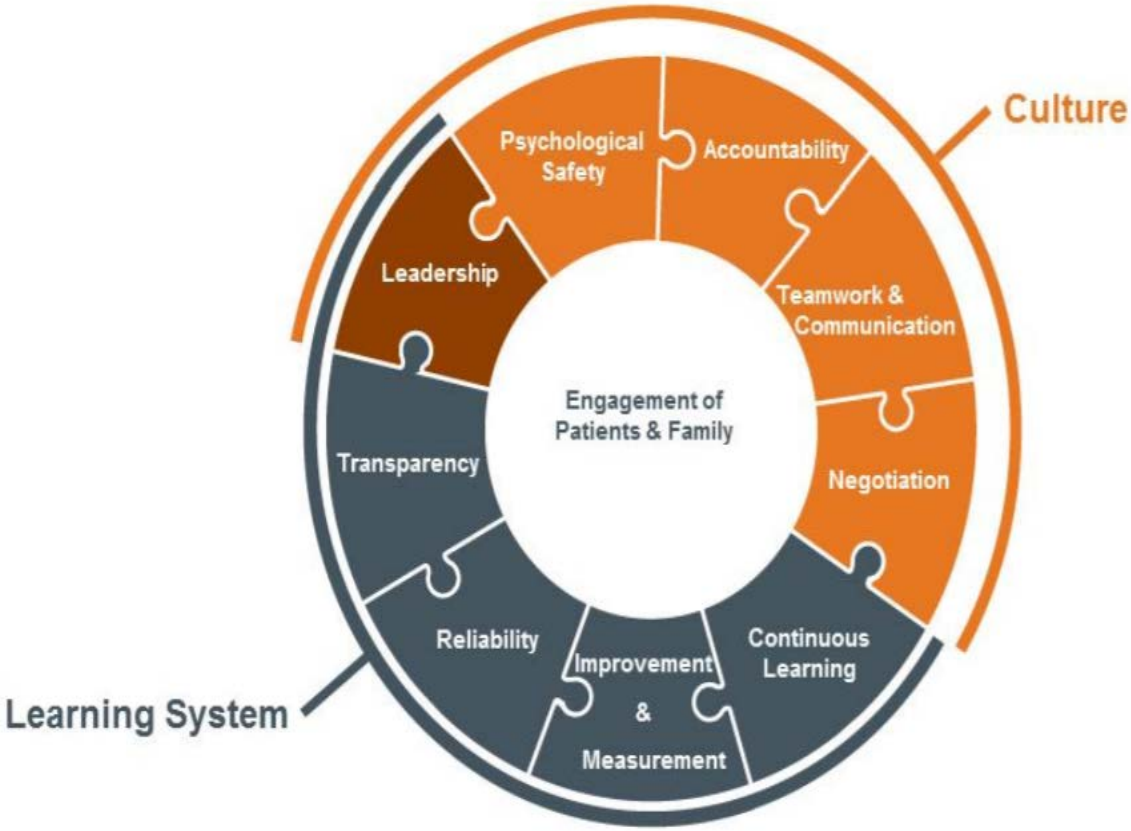
3. Organizational Commitment

- Space for learning
- Accountable to the target
  - –Address incivility
- Time for learning
  - –didactic, workplace, reflective
- High reliability organization

Figure 1. Framework for Safe, Reliable, and Effective Care

Institute for Healthcare Improvement

NPSF
National Patient Safety Foundation®



Academic-Practice Partnerships

- Sharing quality and safety data, error-reporting tools, access to electronic records
- Student participation in root cause analyses, evidence-based practice and quality improvement projects
- Simulation sharing – equipment, cases, evaluation tools
- Observations of safety risks and workarounds
- Use of teamwork cues and tools (SBAR, CUS) in action
- Use of QSEN KSAs in student and staff performance evaluations

Academic-Practice Partnerships

Teaching Quality Improvement to the Next Generation of Nurses: What Nurse Managers Can Do to Help

- Ellen Odell

The Journal of Nursing Administration, Volume 41(12), December 2011, pp, 553–557

- A win-win venture that assists healthcare agencies in improving current quality improvement activities while actively teaching and vetting students in the process
- Students appreciated that assignments were reality based; they see firsthand—at the bedside—how the continuous QI process works simultaneously with EBP to address real clinical issues and improve patient outcomes and safety

Faculty-Staff Development

Designing Nursing Excellence Through a National Quality Forum Nurse Scholar Program

- Julie Neumann, Katherine Brady-Schluttner, Jacqueline Attlesey-Pries & Diane Twedell

Journal of Nursing Care Quality, Volume 25(4), Oct/Dec 2010, pp. 327–333

- Curriculum anchored in 3 content areas: quality improvement (QI), evidence-based practice, and informatics
- Chose RNs who were informal leaders, able to lead change in the work environment, professional role models, articulate, and who enjoyed QI and patient safety issues

Summary of Forrest

- Collaborative Leadership
- Supportive Structures
- Organizational Commitment

State of Healthcare Today

Solutions: Forest

Solutions: Trees

1. Communication

- Everyone is at the table
- All voices are heard
- Honor relationship building (respect)
- Everyone speaks up

Change the way we Communicate

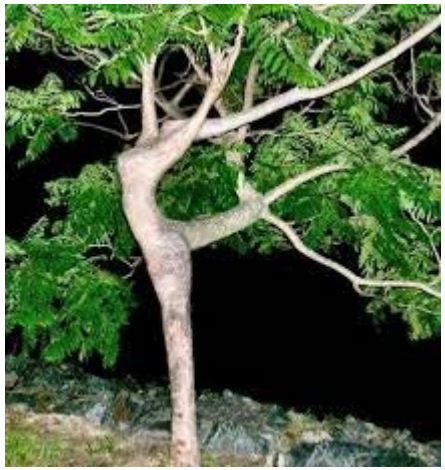
Thumb Wrestling

Goal:

- Pin your partner 5 times in the next 60 seconds

2. Providing Feedback Psychological Safety

- Preceptor/Faculty to student
- Faculty to faculty
- Student to student
- Patient to healthcare professional



* Not easy….especially when interprofessional

National Study of Student Errors and Near Misses

Jane Barnsteiner, Joanne Disch, Judith Warren, Susan Connor, Fabiana Brogren, Amogha Gundavaram, Apoorv Hombali (in progress)

- Collect and analyze information on current practices and policies for reporting and trending errors and near-misses by pre-licensure students in schools of nursing

Funding: National Council of State Boards of Nursing

National Study of Student Errors and Near Misses

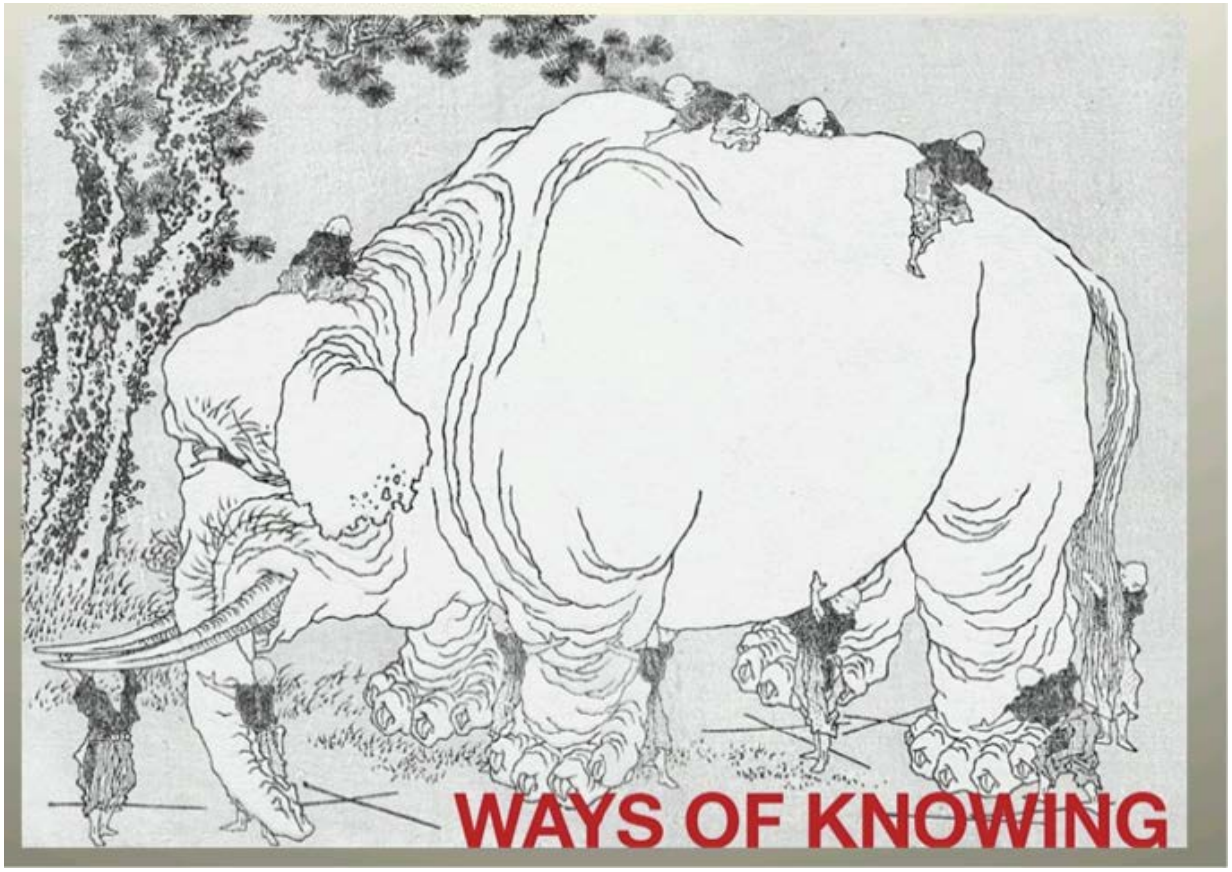
Web-based survey sent to 1667 schools

- 557 responded (33%)

- Few schools (16%) have a policy or a reporting tool
- Majority of schools with a policy do not reflect the philosophy of a Just Culture
- A majority of faculty do not understand components of a Just Culture

3. TRUST

We are all see the world differently……



Conflict

Collaboration and Teamwork in the Health Professions: Rethinking the Role of Conflict

Quentin Eichbaum, MD, PhD, MPH, MFA, MMHC

Abstract

Whereas the business professions have long recognized that conflict can be a source of learning and innovation, the health professions still tend to view conflict negatively as being disruptive, inefficient, and unprofessional. As a consequence, the health professions tend to avoid conflict or resolve it quickly. This neglect to appreciate conflict's positive attributes appears to be driven in part by (1) individuals' fears about being negatively perceived and the potential negative consequences in an organization of being implicated in conflict, (2) constrained views and approaches to professionalism and to evaluation and assessment, and (3) lingering autocracies and hierarchies of power that view conflict as a disruptive threat.

The author describes changing perspectives on collaboration and teamwork in the health professions, discusses how the health professions have neglected to appreciate the positive attributes of conflict, and presents three alternative approaches to more effectively integrating conflict into collaboration and teamwork in the health professions. These three approaches are (1) cultivating psychological safety on teams to make space for safe interpersonal risk taking, (2) viewing conflict as a source of expansive learning and innovation (via models such as activity theory), and (3) democratizing hierarchies of power through health humanities education ideally by advancing the health humanities to the core of the curriculum.

The author suggests that understanding conflict's inevitability and its innovative potential, and integrating it into collaboration and teamwork, may have a reassuring and emancipating impact on individuals and teams. This may ultimately improve performance in health care organizations.

Acad Med. 2017 Nov 14. doi: 10.1097/ACM.0000000000002015. [Epub ahead of print]

4. Everyone in the Game
Working with Patients & Families

5. Embrace a Spirit of Trying

Summary of Trees

- Communication
- Feedback
- Trust
- Patient and Family
- Spirit of Trying

Benefit of Interprofessional Alignment

- Increased power with a common “Light”
- Partnerships with Interprofessional teams
- Reduce duplication of efforts- learn from each other

Much more research and evaluation is needed

State of Healthcare Today

Solutions: Forest

Solutions: Trees

Real change does not come from decree, pressure, permission or persuasion.
Real change comes from people who are passionately and personally committed to a decision or direction that they helped to shape.

Margaret Wheatley