# A Career in Hospital Medicine

## A Series of Fortunate Events?

*How to be ‘lucky’ in a disruptive environment*

MEDICAL CENTER

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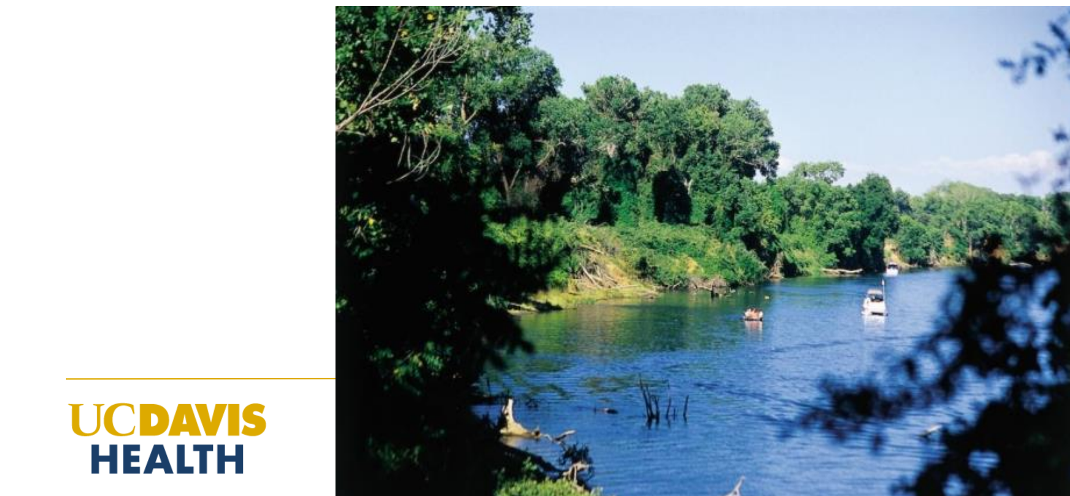
CQO, UC Davis Medical Center

Sacramento, CA

# Sacramento - City of Trees



UCDAVIS
MEDICAL CENTER

| | | | |
|---|---|---|---|
| Licensed Beds | 650 | Faculty | 1,342 |
| Admissions | 32,292 | Residents & Fellows | 882 |
| ED Visits | 82,500 | Students | 817 |
| Clinic Office Visits | 925,922 | Staff (FTE) | 9, 077 |

**Designated a "Most Wired" hospital as one of the nations top leaders in information technology.**

**The regions highest composite score for the best overall quality, best image and reputation, and best doctors and nurses.**

**The U.S. News & World Report ranked UC Davis Medical Center among America's best hospitals in 11 adult specialties and 5 pediatric specialties**

**UC Davis Medical Center is certified as an advanced primary stroke center by the Joint Commission, recognizing the medical center's exceptional efforts to foster better outcomes in stroke care.**

AMERICAN COLLEGE OF SURGEONS • QUALITY IMPROVEMENT PROGRAM
Children's Surgery
Verification™
VERIFIED CENTER

BEST
CHILDREN'S
HOSPITALS
U.S.News
& WORLD REPORT
RANKED IN 5 SPECIALTIES
2017-18

2018
WOMEN'S CHOICE AWARD®
BEST CHILDREN'S HOSPITALS

AWARD FOR EXCELLENCE IN LIFE SUPPORT
ELSO
CENTER OF EXCELLENCE
GOLD

# Outline

- 3 stories
  - Elements for success

  Unsolicited advice

# 3 stories

- Cheryl O’Malley hones my rounding technique
- Harvey Hsu at the Best Buy
- Kathy Wajdawojowiczkoway

# What the heck is a CQO (Chief Quality Officer)?

- Save lives and improve the quality, safety, and efficiency of care by:
  - Helping to set priorities and goals
  - Improve communication and culture
  - Intelligent use of data and frontline input
  - Build infrastructure to empower / enable / engage staff and patients
  - Mentor junior leaders

Frequent question – How do I get a job like yours!

# Setting priorities for Quality and Safety

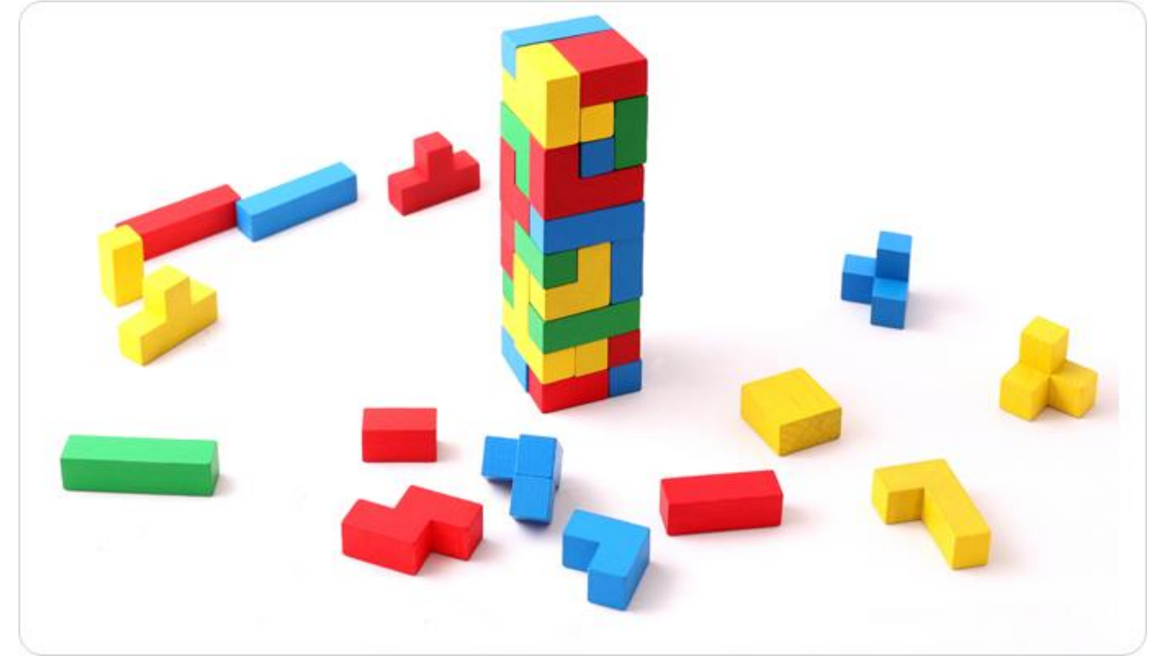
- Review **reams** of quality / safety scorecards
  - Vizient, CMS data, Leapfrog, internal data, benchmarking, insurance company data
- Which metrics, should we improve performance, would have the biggest impact on quality, efficiency, patient experience, or bottom line?
- Gap analysis – how heavy of a lift is this, are we ready? What is needed to excel?

# What keeps you up at night?

## Quality and Safety Concerns

## Some things on My List

1. Culture and Communication
2. Infections
3. Mental health / violence to staff
4. High risk ADEs
    1. Insulin
    2. Opioids
    3. Anticoagulants
5. Data flow and analytics
6. Transitions and handovers, readmissions
7. EMR / Order sets
8. Lab / imaging follow up
9. Patient Experience
10. Throughput

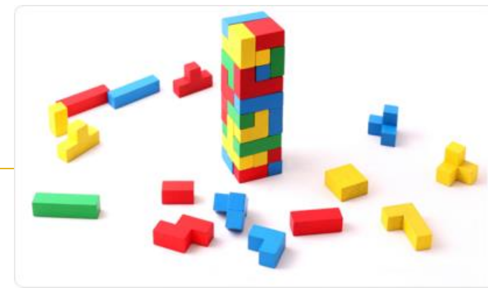


Infrastructure definition 1: underlying foundation or basic framework

….stuff that helps a lot of people do their job better or more efficiently

# Infrastructure for QI

- **Strategic leadership**
- **Data governance, availability, and analysis**
- **Measures to track performance**
- **Training and policies to reinforce culture and teamwork**
- **A framework and tools for quality improvement**
- **Wellness – take care of providers**



**Welcome** to the
Strategic Initiatives & Analytics
dashboards and reports site.
Below is a collection of dashboards
developed by the SIA team.

Data reported by Vizient including outcomes (mortality, LOS, cost) and readmissions data:

- Mortality
- Length of Stay (LOS)
- Readmissions
- Cost

For more details see: INFO | FAQ

NHSN hospital acquired infection data including CAUTI, CLABSI, PVAP, VAP, and SSI:

- Institutional Goals
- CAUTI
- CLABSI
- PVAP and VAP
- Cdiff and MRSA
- SSI

For more details see: INFO | FAQ

Clarity transfusions data, including peri-op (pre, intra and post-op) and other inpatient transfusions:

- Institutional Overview
- Department/Service Details
- Raw Totals

For more details see: INFO | FAQ

Data related to the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program:

- Monthly Data View
- Historical View
- Raw Data View
- Gap & Cases Needed

Dashboard that provides focused information on patients with Sepsis at UCDMC:

- Outcomes

For more details see: INFO | FAQ

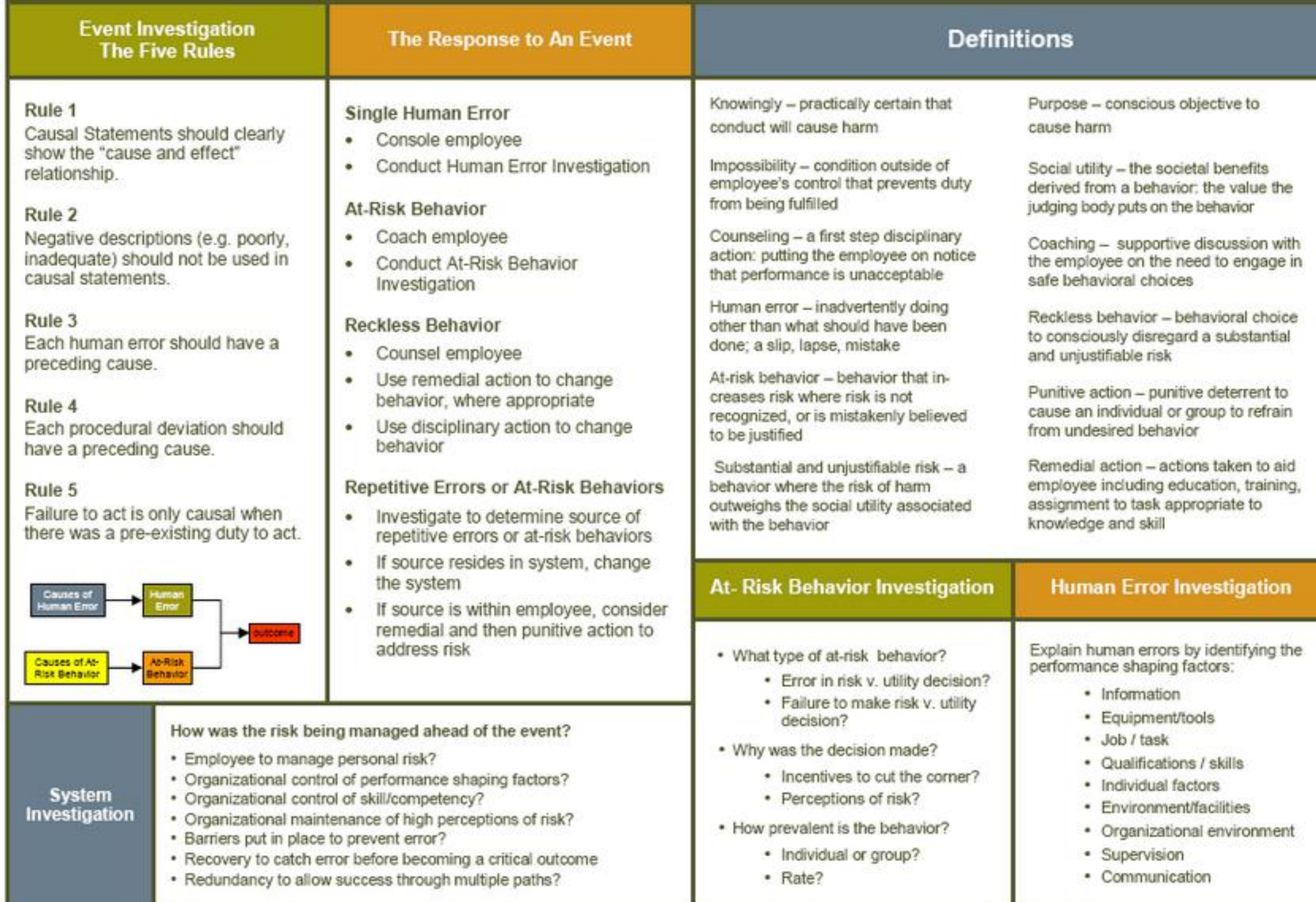
Dashboard that provides focused information on palliative care at UCDMC:

- Encounters/Discharges
- Hospice/Expired Details
- Patient Details
- Definitions

- Rapid Expansion of Online Dashboards and Scorecards
- Accessible to Clinical Groups on Demand
- Real time and month-to-month

# Patient Safety Culture trumps protocols

- **Strong association of outcomes and culture**
- **Culture is reflected locally**
- **Us vs Them…….getting to "We"**



The Just Culture Algorithm
Guide to the Just Culture Algorithm
www.justculture.org
Event Investigation The Five Rules
Rule 1
Causal Statements should clearly show the "cause and effect" relationship.
Rule 2
Negative descriptions (e.g. poorly, inadequate) should not be used in causal statements.
Rule 3
Each human error should have a preceding cause.
Rule 4
Each procedural deviation should have a preceding cause.
Rule 5
Failure to act is only causal when there was a pre-existing duty to act.
Causes of Human Error
Human Error
Causes of At-Risk Behavior
At-Risk Behavior
outcome
The Response to An Event
Single Human Error
• Console employee
• Conduct Human Error Investigation
At-Risk Behavior
• Coach employee
• Conduct At-Risk Behavior Investigation
Reckless Behavior
• Counsel employee
• Use remedial action to change behavior, where appropriate
• Use disciplinary action to change behavior
Repetitive Errors or At-Risk Behaviors
• Investigate to determine source of repetitive errors or at-risk behaviors
• If source resides in system, change the system
• If source is within employee, consider remedial and then punitive action to address risk
Definitions
Knowingly – practically certain that conduct will cause harm
Impossibility – condition outside of employee's control that prevents duty from being fulfilled
Counseling – a first step disciplinary action: putting the employee on notice that performance is unacceptable
Human error – inadvertently doing other than what should have been done; a slip, lapse, mistake
At-risk behavior – behavior that increases risk where risk is not recognized, or is mistakenly believed to be justified
Substantial and unjustifiable risk – a behavior where the risk of harm outweighs the social utility associated with the behavior
Purpose – conscious objective to cause harm
Social utility – the societal benefits derived from a behavior: the value the judging body puts on the behavior
Coaching – supportive discussion with the employee on the need to engage in safe behavioral choices
Reckless behavior – behavioral choice to consciously disregard a substantial and unjustifiable risk
Punitive action – punitive deterrent to cause an individual or group to refrain from undesired behavior
Remedial action – actions taken to aid employee including education, training, assignment to task appropriate to knowledge and skill
System Investigation
How was the risk being managed ahead of the event?
• Employee to manage personal risk?
• Organizational control of performance shaping factors?
• Organizational control of skill/competency?
• Organizational maintenance of high perceptions of risk?
• Barriers put in place to prevent error?
• Recovery to catch error before becoming a critical outcome
• Redundancy to allow success through multiple paths?
At- Risk Behavior Investigation
• What type of at-risk behavior?
• Error in risk v. utility decision?
• Failure to make risk v. utility decision?
• Why was the decision made?
• Incentives to cut the corner?
• Perceptions of risk?
• How prevalent is the behavior?
• Individual or group?
• Rate?
Human Error Investigation
Explain human errors by identifying the performance shaping factors:
• Information
• Equipment/tools
• Job / task
• Qualifications / skills
• Individual factors
• Environment/facilities
• Organizational environment
• Supervision
• Communication

# Value Team Dyads

- **Nurse / physician dyads**
- **Collaborate on quality / safety projects aligned with institutional goals**
- **Teamwork / communication**
- **Identify and spread ‘positive deviance’**

# Positive Deviance Methodology- 5 Ds

1. **Define the problem, causes and common practices, and desired outcome**
2. **Determine presence of positive deviance**
3. **Discover uncommon but successful strategies and behaviors**
4. **Develop activities based on inquiry findings**
5. **Discern (monitor and evaluate) the results**

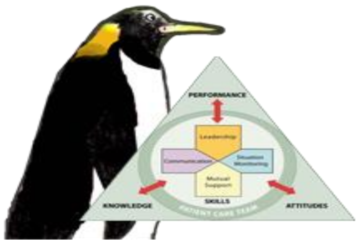
**Example - Paging guidelines and protocols**

# CUS

I am CONCERNED!

I am UNCOMFORTABLE!

This is a SAFETY ISSUE!




*As seen in TeamSTEPPS®*

# SBAR

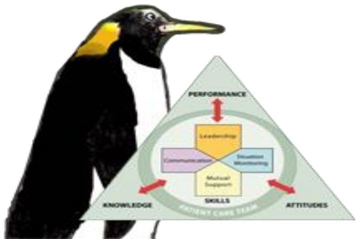
Provides a framework for effective communication between team members for the following information:

**S**ituation—What is happening with the patient?

**B**ackground—What is the clinical background or context?

**A**ssessment—What do I think the problem is?

**R**ecommendation—What would I recommend?




*As seen in TeamSTEPPS®*

# Tiered Escalation Huddles:
# Link Between Management & Improvement Systems

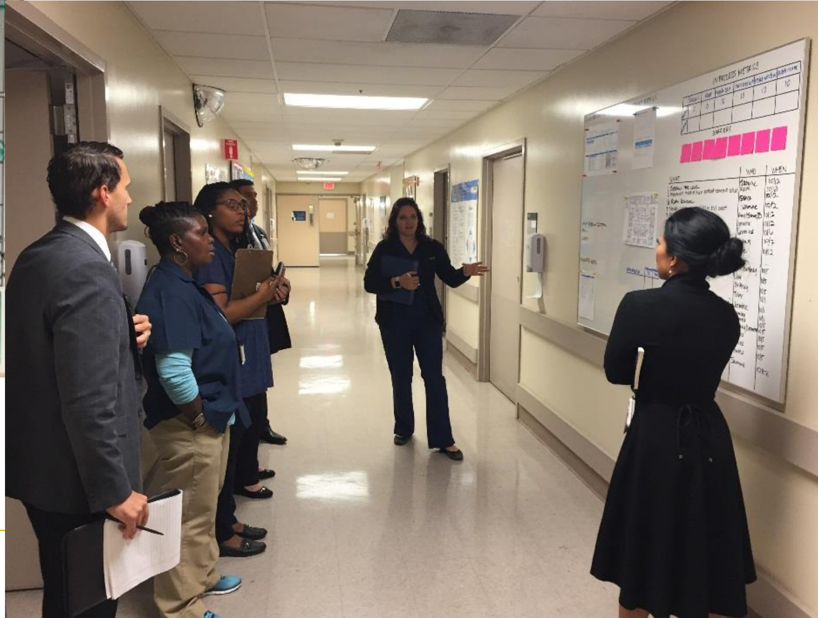
**MANAGEMENT**
**(Set Standards, Monitor, Maintain)**

**IMPROVEMENT**
**(Problem Solving)**

## Visibility Wall

## Simple A3 & Problem Solving Board

Communication



# the Huddle → daily tiered escalation huddles

**the Huddle**
*Learn from Today, Be Better Tomorrow*

**AIM:** Zero Harm to Patients, Families and Staff

**OBJECTIVE:** Escalate and address safety, quality, flow and operational issues in order to (long term) improve value while keeping our patients and staff safe.

Are there any **recognitions** or **gratitude** to share today?

Zero Harm — Are there any **safety/patient concerns** or **incident reports** that require an immediate response?

**Daily Flow Report-Out:**
- Summary Statistics
- Delays
- Escalations

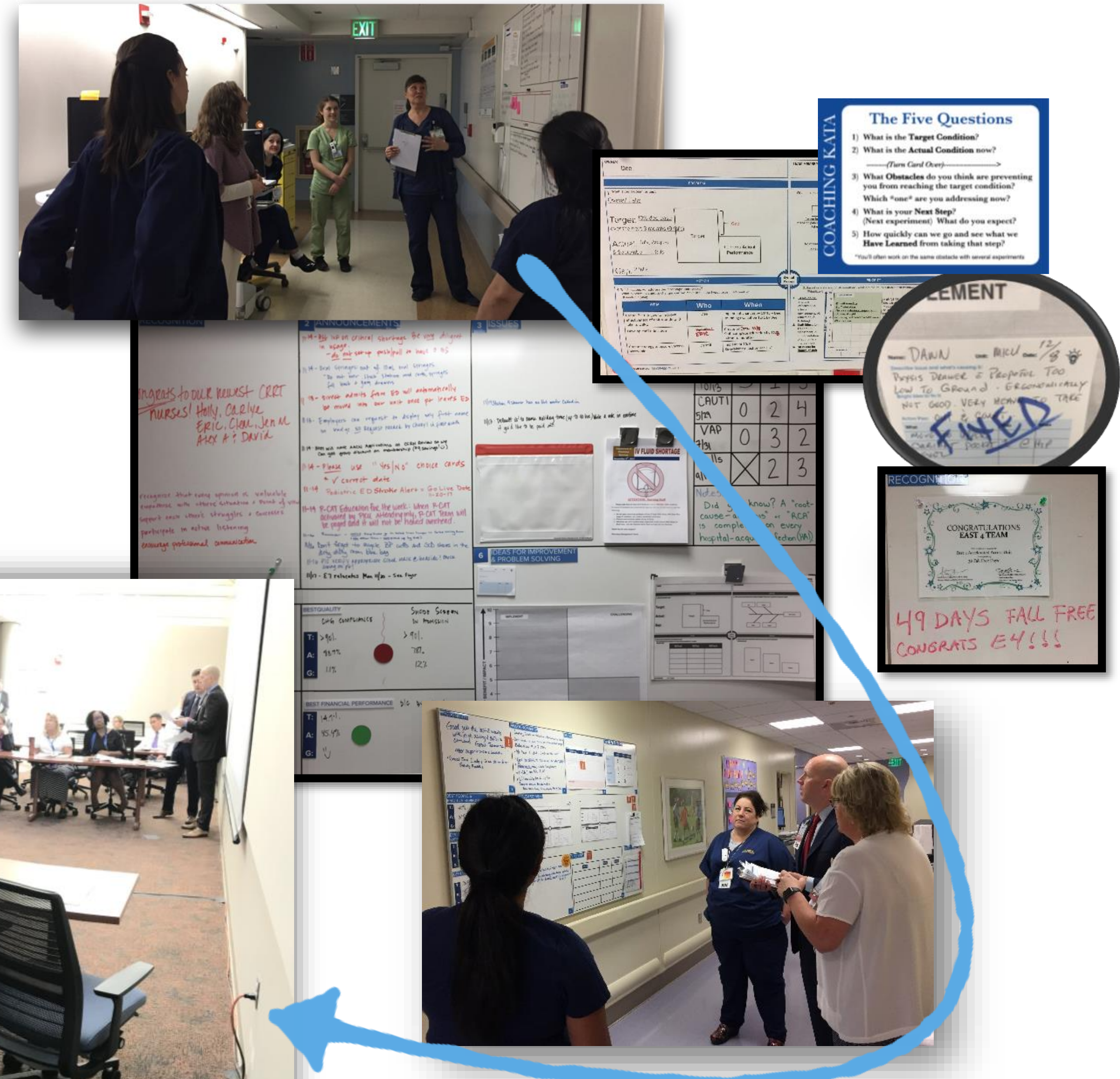
Any **other issues or announcements** for the day?

**Follow-up** (see escalations – flip page over)

- Recognitions/Gratitude
- Safety/Patient Concerns
- Daily Flow Report Out
- Announcements
- Leader standard work

Daily Census

| 546 CENSUS | 605 CAPACITY | 90.7% OCCUPANCY RATE |
| --- | --- | --- |



# Antimicrobial Stewardship and Infection Prevention

# ANTIBIOTIC STEWARDSHIP

IN YOUR FACILITY WILL

## DECREASE

- ANTIBIOTIC RESISTANCE
- C. DIFFICILE INFECTIONS
- COSTS

## INCREASE

- GOOD PATIENT OUTCOMES

onment

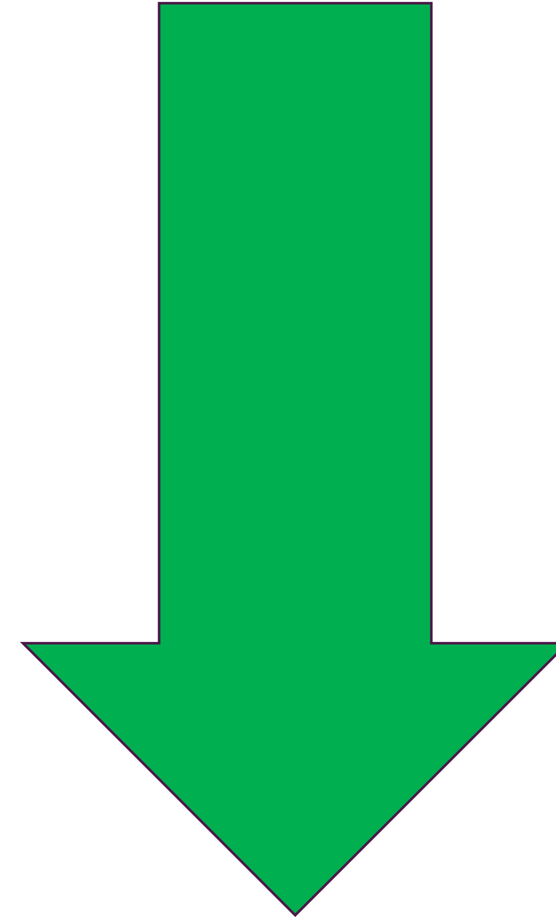
# Hospital Acquired Infections on the Run

CAUTI

CLABSI

*C. Difficile*

Sepsis Mortality



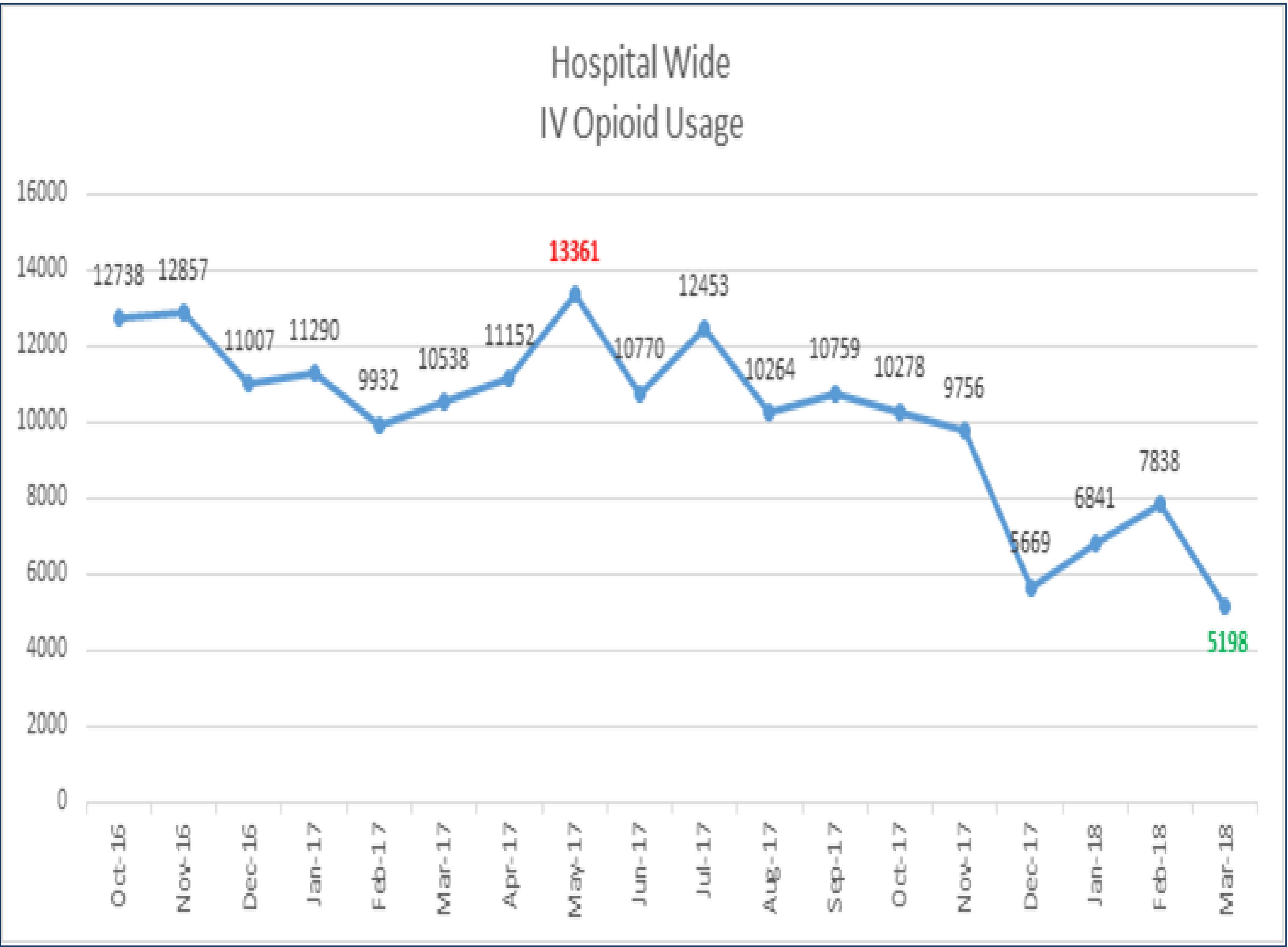
# Institutional performance better than ever in last two quarters.

**UC Davis Medical Center**

**Infection Prevention - Quarterly Review**
**Healthcare-associated Infections**

| Healthcare-Associated Infection (HAI) | | Infections Observed | Infections Predicted | SIR | p Value | MD Notified | Interpretation / Analysis / Comments |
|---|---|---|---|---|---|---|---|
| CAUTI | 2018Q1 | 11 | 15.50 | 0.710 | 0.250 | | |
| | 2018Q2 | 6 | 15.77 | 0.380 | 0.006 | | Statistically Significant! |
| CLABSI | 2018Q1 | 8 | 17.37 | 0.46 | 0.015 | | Statistically Significant! |
| | 2018Q2 | 9 | 16.50 | 0.545 | 0.050 | | Statistically Significant! |
| C-Diff, Hospital Onset | 2018Q1 | 15 | 22.83 | 0.657 | 0.089 | | |
| | 2018Q2 | 13 | 22.14 | 0.587 | 0.040 | | Statistically Significant! |
| MRSA Bacteremia, Hospital Onset | 2018Q1 | 4 | 5.24 | 0.764 | 0.634 | | |
| | 2018Q2 | 3 | 3.46 | 0.868 | 0.875 | | |
| PVAP | 2018Q1 | 5 | 12.07 | 0.414 | 0.027 | | Statistically Significant! |
| (Infection Related Vent-Assoc. Conditions) | 2018Q2 | 7 | 11.99 | 0.584 | 0.136 | | Data is adult only and does not include VAP surveillance for NICU and PICU. |
| Surgical Site Infection (SSI)<br>Surgery Category | | Infections Observed | Infections Predicted | SIR* | | | Interpretation / Analysis / Comments<br>Data includes all inpatients >/= 18 years of age.<br>Excludes all superficical ( SIS) & deep incisional secondary ( DIS) |
| All Procedures | 2017Q4 | 27 | 24.56 | 1.100 | 0.606 | | |
| | 2018Q1 | 26 | 23.99 | 1.084 | 0.662 | | |

# Opioid Strategies  Across the Spectrum of Health




**What you Can Do:**

Multi-modal pain control

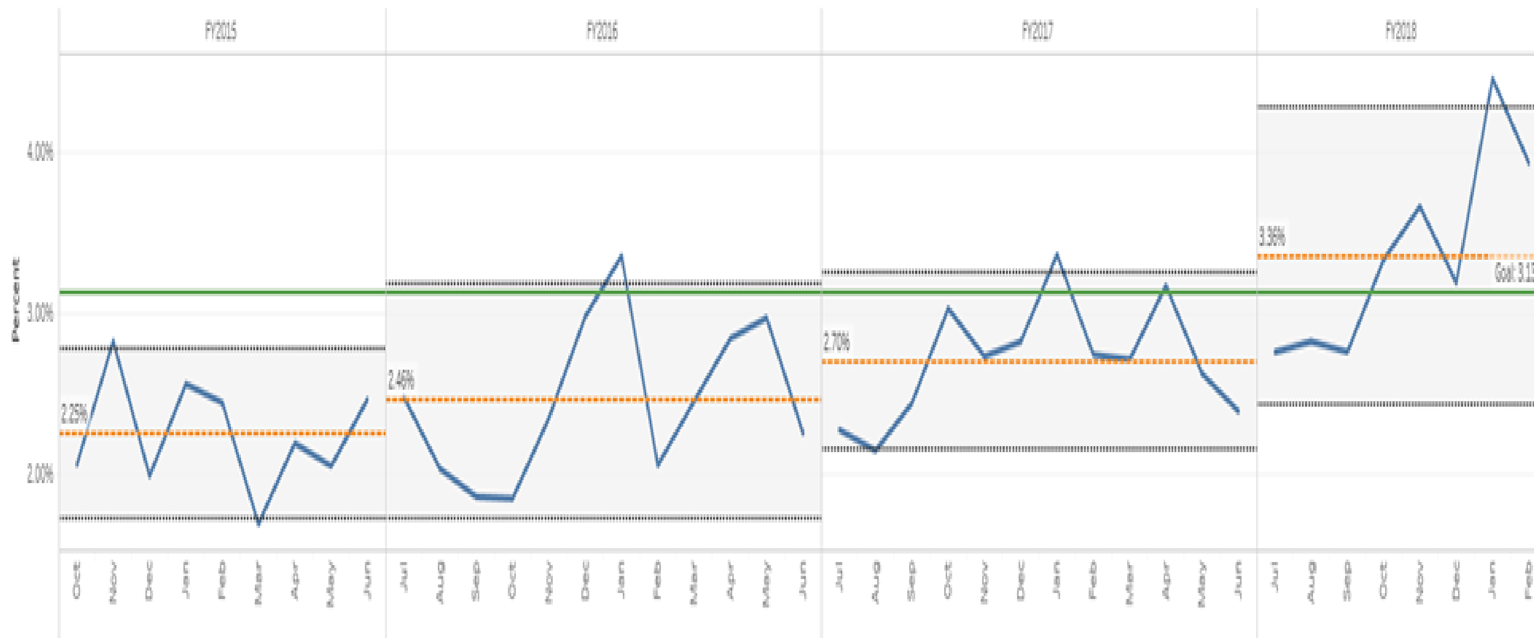
Care pathways

Prescribe shorter courses of opioids at DC

Help with standardized order sets and monitoring

Beneficial bonus: less urinary retention, Foleys come out sooner!

# Increasing number of patients seen by Palliative Care Services




**What you can do:**

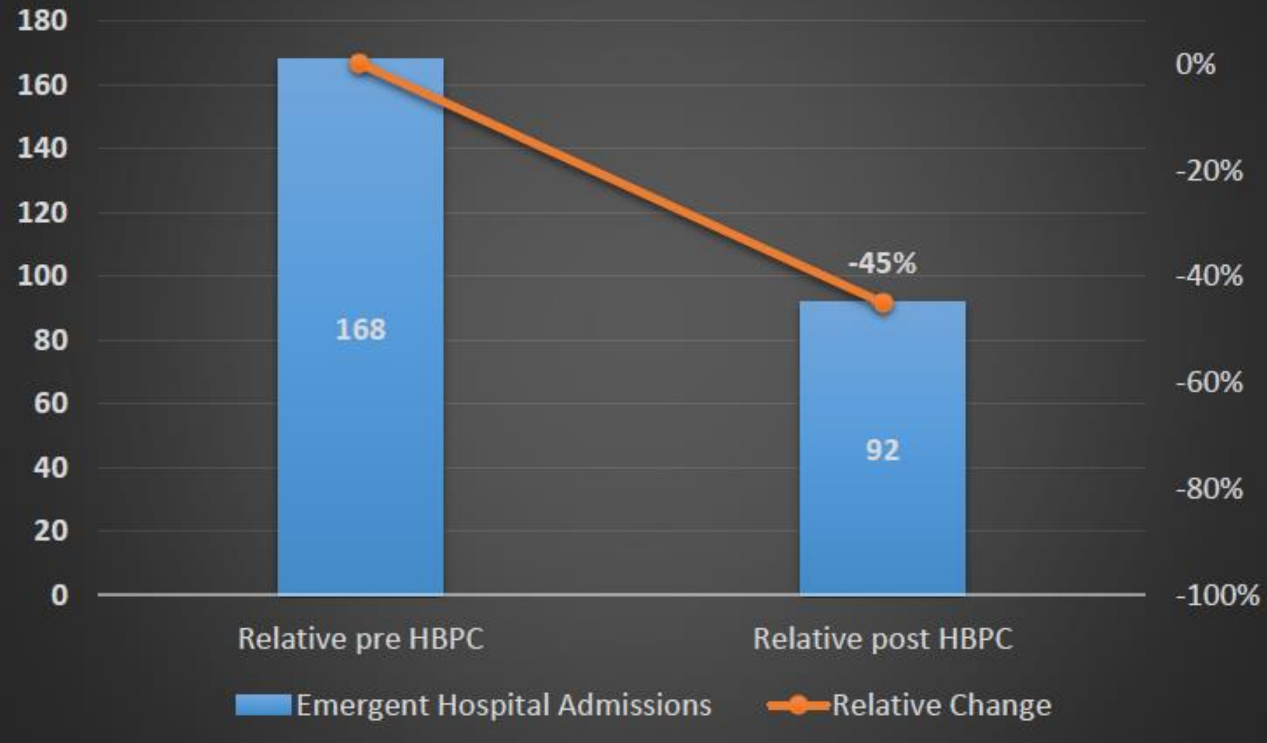
Understand what Palliative Care is (and what it isn't)

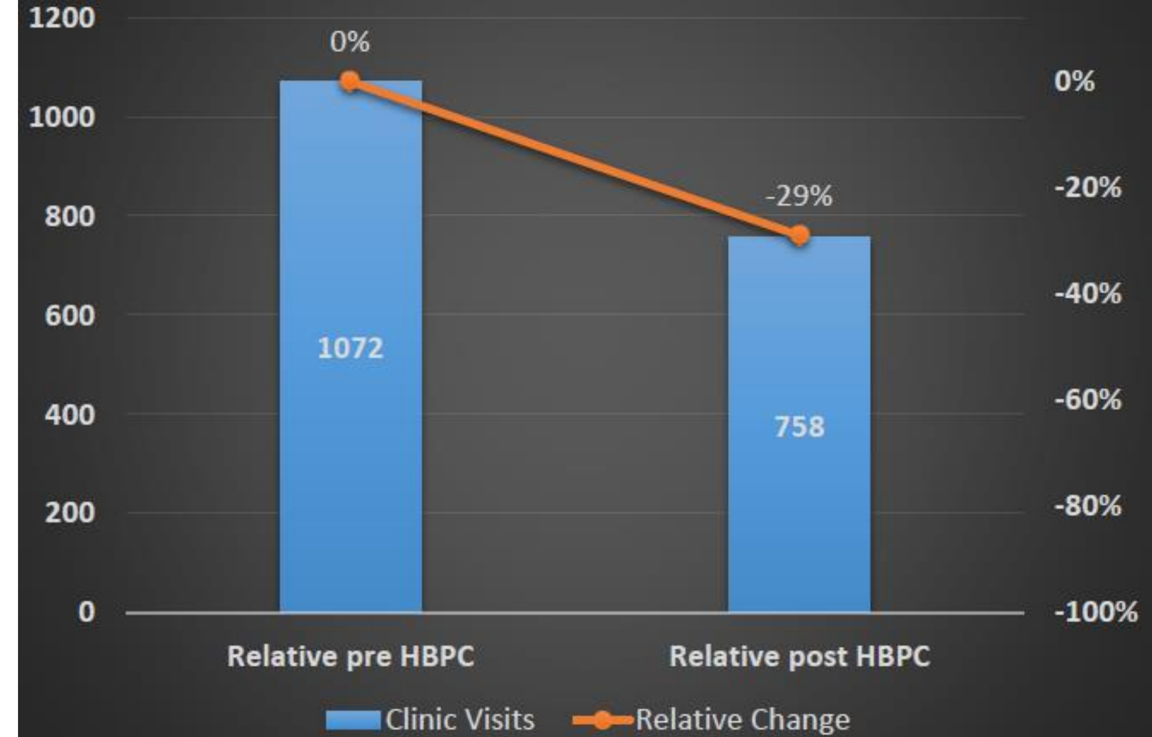
End of life discussions

Integrate consideration of Palliative care into routine

Help standardize documentation re: EOL

Refer early, rather than late


Hospital Admission
180
160
140
120
100
80
60
40
20
0
0%
-20%
-40%
-60%
-80%
-100%
168
92
-45%
Relative pre HBPC
Relative post HBPC
Emergent Hospital Admissions
Relative Change


Number of Clinic Visits
1200
1000
800
600
400
200
0
0%
-20%
-40%
-60%
-80%
-100%
0%
1072
-29%
758
Relative pre HBPC
Relative post HBPC
Clinic Visits
Relative Change

# Transitions of Care

- Risk Assessment
- Expedited phone / office follow up
- Improved medication reconciliation / medication management
- Collaborative Care Model: following patients into SNFs;
- Community / SNF / FQHC / Mental Health networking
- Following high-risk patients until they are ‘caught’ by next provider; and
- Transition efficiency network – streamline prior authorization
- Focus on Multi-Visit Patients (MVPs)

# Targeting Multi-Visit Patients (MVPs)
# 3.4% of patients account for 49% of readmissions

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**Frequent Inpatients**
4+ Inpatient Encounters within Previous 12 Months

Report Index

| Frequent Patient | Total Patients | % of Total Patients. | Total Encounters | % of Total Encounters. | 30-Day Readmit | % of Total 30-Day Readmit. | Avg. LOS |
|---|---|---|---|---|---|---|---|
| No | 23,799 | 96.60% | 28,750 | 85.97% | 1,934 | 50.96% | 5.87 |
| Yes | 838 | 3.40% | 4,693 | 14.03% | 1,861 | 49.04% | 7.47 |

Age Class
- ☑ Adult
- ☑ Pediatric

UCD Patient
- ☑ No
- ☑ Yes

Discharge Department: (All)

Discharge Division: (All)

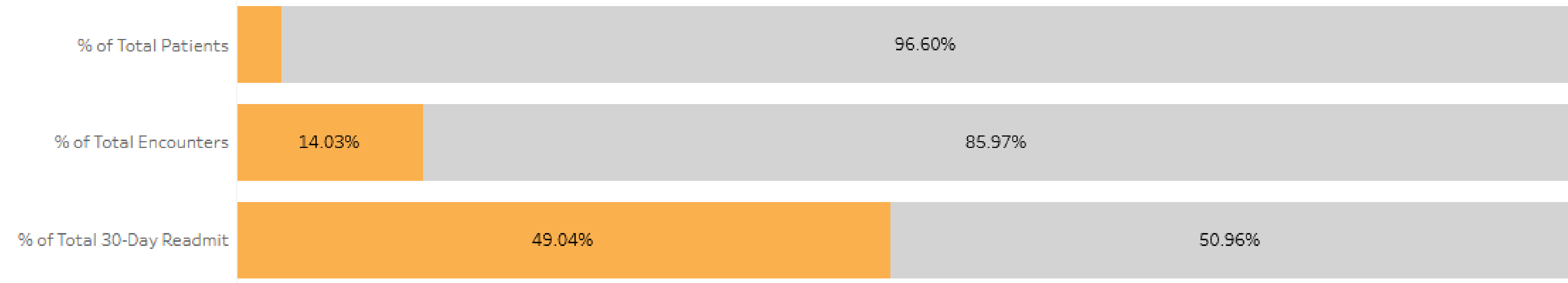
Discharge Service: (All)

Discharge Unit Type: (All)

Discharge Unit Name: (All)

Payor Group Description: (All)

Hospitalization Usage: Frequently Hospitalized Patients vs Non-Frequently Hospitalized Patients




Frequent Patients. (hover for associated diagnoses)

** Use slidebar filter in menu bar at right to adjust total visits within 12 months.*

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# Readmissions

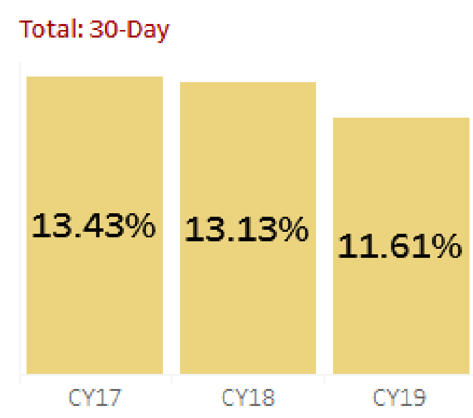
## All Cause Readmissions

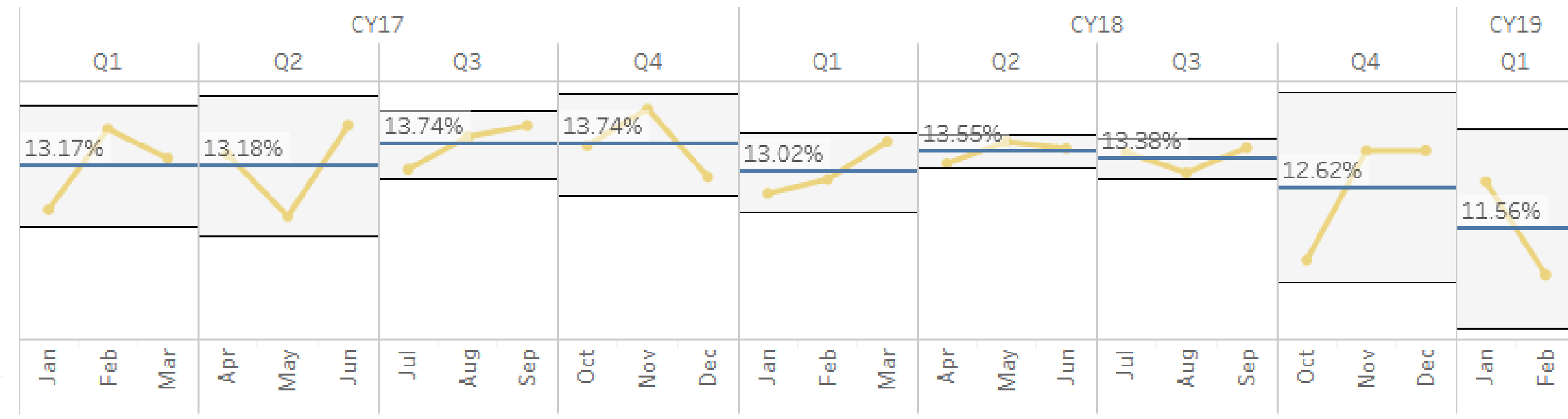
Report Index

Date Range

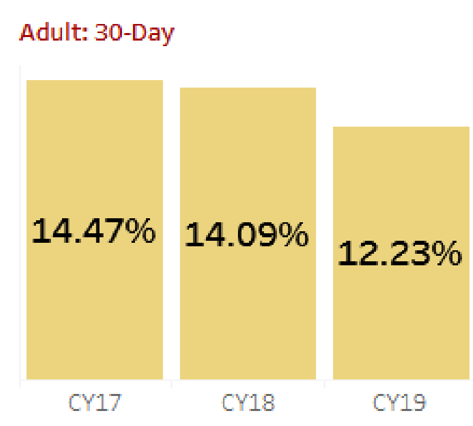
2016-01 to 2019-02

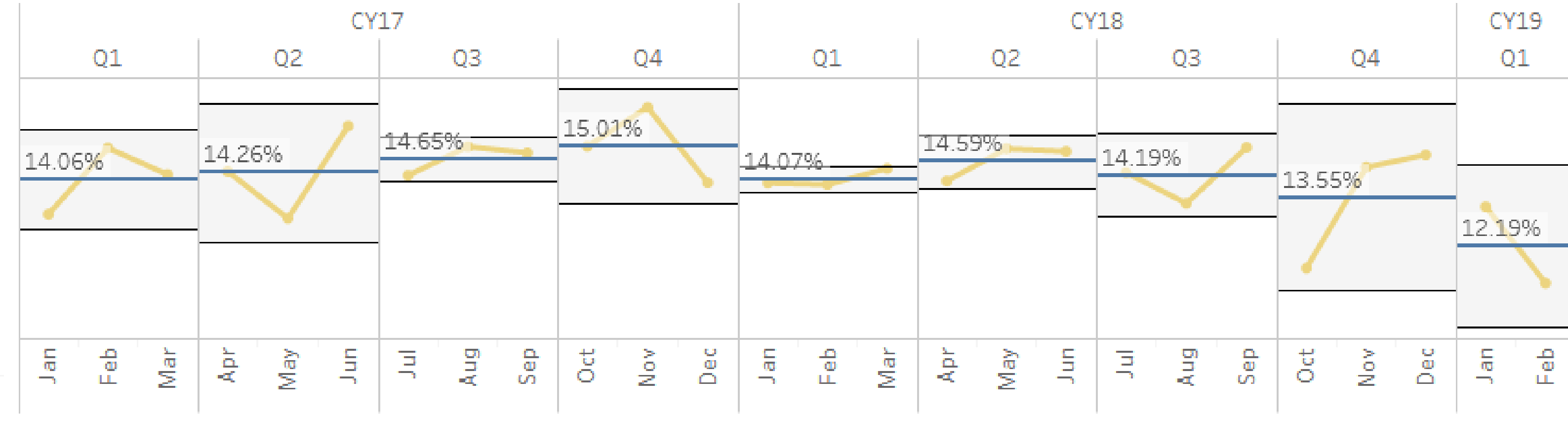
### Total: 30-Day



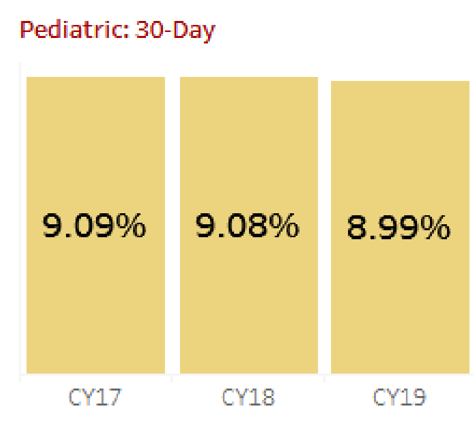



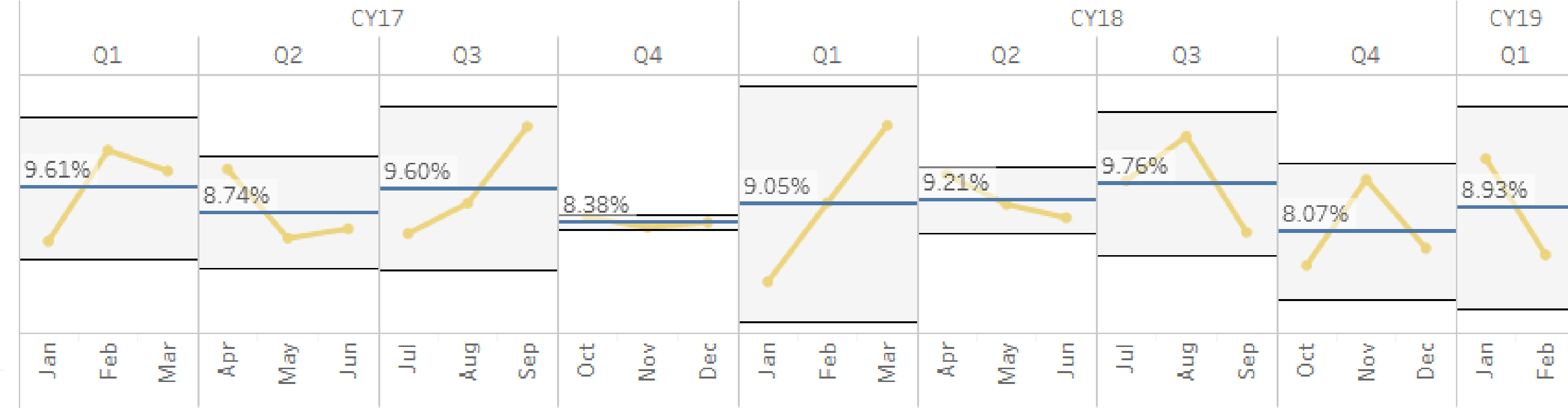

### Adult: 30-Day




### Pediatric: 30-Day




Discharge Date Range

*Click date(s) to change range.*

2016-01 2019-02

Calendar Type

Calendar Year

Frequent Patient

- [x] No
- [x] Yes

UCD Patient

- [x] No
- [x] Yes

Days to Readmit

30

Primary Diagnosis Name (group)

(All)

Payor Group Description

(All)

Discharge Department

(All)

Discharge Division

(All)

Discharge Service

(All)

Discharge Unit Type

(All)

Discharge Unit Name

(All)

Discharge Facility Type

(All)

# Mortality Improving – Less than Expected

Info and Definitions | Mortality. | LOS | Readmissions | Cost | FAQ | Dept/Div/Service Map | Service Line Mapping

Quality & Safety Scorecard

Mortality

| Total Discharges | Total Patient Days |
|---|---|
| 104,947 | 595,094 |

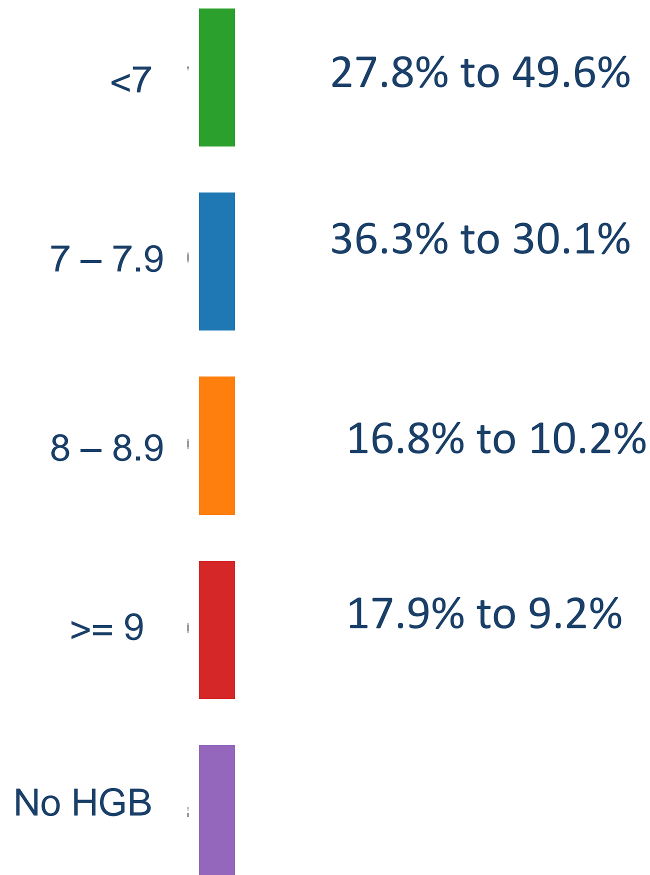
Date Range: 2016-01 to 2019-01

Mortality Index (Obs/Exp): Total, Adult, Pediatric

| Year | Mortality Index (O/E) |
|---|---|
| 2016 | 1.00 |
| 2017 | 0.95 |
| 2018 | 0.83 |
| 2019 | 0.74 |

Mortality Index (O/E): 0.00, 0.20, 0.40, 0.60, 0.80, 1.00

# Improving blood product utilization




**Institution-Wide HGB Rate Distribution**

50%
40%
30%
20%
10%
0%

2014-Q3 2014-Q4 2015-Q1 2015-Q2 2015-Q3 2015-Q4 2016-Q1 2016-Q2 2016-Q3 2016-Q4 2017-Q1 2017-Q2 2017-Q3 2017-Q4 2018-Q1

- Chief resident
- Clinician educator, associate program director for IM residency program
- Masters, Biostatistics and Clinical Research Design
- Evidence-based medicine training
- Convergence of Hospital Medicine and Quality / Safety movement
- Division Chief, Hospital Medicine: UC San Diego
- Grants, improvement guides - VTE Prevention, Glycemic, Transitions, etc.
- Collaboratives, Society of Hospital Medicine, Moore Foundation
- Chief Quality Officer – UC Davis Health

"Things just sort of fell into place, I feel lucky!"

# So, your advice is that I should be lucky???

What the residents and faculty were really asking:

What tools and strategies will allow me to thrive in an environment of ongoing, disruptive change, that is likely only going to accelerate?

# How to be lucky in a Disruptive Environment

## Learn how your hospital / system works

- Organizational / Committee structure
- Where to go with new ideas
- Institutional goals / priorities (alignment is great)
- Politics
- Join something you find interesting

# How to be lucky in a Disruptive Environment

## Start small, but think big!

- Try things on a small scale first
- Learn how to change practice in your own group

BUT

- Think about spread / sustainability
- Changing protocols / policies etc. across an entire hospital or system can have an enormous impact
- Think about the areas that are important across multiple services
- Collaborative and research experience

# How to be lucky in a Disruptive Environment

Broaden your skills – examples

- Procedural
- Informatics / EMR
- Research
- QI
- EBM
- Public health / policy
- Business
- Leadership and advocacy
- Public speaking
- Telehealth

The combinations are endless -

# My balance: QI vs research

# How to be lucky in a Disruptive Environment

## Engage in mentor / mentee relationships

- Read a little about how to be a good mentor and mentee
- People with titles are not always the best mentors
- Mentors often benefit as much as mentee

# How to be lucky in a Disruptive Environment

## Participate in community

- Interest groups
- Professional societies
- Community health / networking
- Can lead to collaborative improvement efforts and lifelong friendships
- A safe place to gripe and be inspired

# How to be lucky in a Disruptive Environment

Avoid my past mistakes:

*(this might take a few slides)*

**Tribalism**

Those darn (insert punching bag here) make our lives miserable!

Show of hands:

Cardiologists, ED docs, Orthopedists, Oncologists, Surgeons, Nurses, Penny pinching administrators, PCPs

Sit down, face-to-face, get to know your "enemy"

Getting from "we" and "them" to "Us"

## How to be lucky in a Disruptive Environment

Avoid my past mistakes:

**Storming out of meeting with CMO / CEO, door slamming**

90% of administration leaders are human beings

# How to be lucky in a Disruptive Environment

## Avoid my past mistakes:
## **Using e-mail to resolve conflict**

That goes for Twitter, Facebook, and Snapchat too!

# How to be lucky in a Disruptive Environment

## Avoid my past mistakes:

## **Forgetting to put patients first**

- Harder than it sounds
- Gives group credibility and will serve hospitalists well in the long run
- Helps in re-designing systems in times of rapid change

# How to be lucky in a Disruptive Environment

## Know when it's time to move on

- You can grow and thrive in a variety of environments
- Don't expect perfect infrastructure, culture, or leadership
- Being part of improving the imperfection is very satisfying

BUT

Sometimes it is just not on the cards in your current environment.  The grass is not always greener, but sometimes, it is!

## How to be lucky in a Disruptive Environment

Make time for yourself, friends, family, fun, and self reflection

- Foster self-awareness of your own strengths, weaknesses, what makes you uncomfortable or insecure. Address them.
- Foster your sense of humor
- A little exercise can help tremendously
- Choose your life partner carefully! (Thanks Michelle)

# Questions and Comments?

Photographs from around my home

Sacramento can be a nice place to live!
Maybe you can visit sometime

gmaynard@ucdavis.edu
Cell 916-281-8098