Quality & Patient Safety in the Outpatient Setting

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Who is this Man?
Potter Stewart (1915 – 1985)

Associate Justice of the United States Supreme Court
1959 - 1981
Why do we remember him?
And the answer is...

• In a Supreme Court decision he wrote that hard-core pornography was hard to define, but that "I know it when I see it."

• Can the same be said for quality and patient safety?

NO!
Quality Definition

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Definitions

**Patient safety:** Freedom from accidental injury; The prevention and mitigation of harm caused by errors of omission or commission that are associated with healthcare, and involving the establishment of operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur.
Definitions

Patient harm: Any physical or psychological injury or damage to the health of a person
Why do we care about improving quality and patient safety?

• It is the right thing to do
• We would want the same
• If we don’t, we won’t get paid, and we won’t be here (also known as the government, payers and patients told us we must)
When it hit the fan

• 1999
• 98,000 deaths due to medical error
The cost-quality curve

Goal: Move curve to the left

A: Marked benefit
B: Marginal benefit
C: Wasteful
D: Harmful
Quality (Performance) Improvement

A Little History
Who is this Man?
Avedis Donabedian

1919 – 2000
Physician and founder of the study of quality in health care and medical outcomes research
Donabedian’s quality triangle (triad)

Structure

Process

Outcomes
Process vs. Outcome

• Good processes without good outcomes doesn’t help patients
• Good outcomes without good processes may represent luck
• Good outcomes linked to good processes are likely to be real and sustainable
Or “3 Faces of Quality”

- CQI, TQM, Re-engineering, Process Improvement
- Outcomes Management, Disease Management, Profiling
- Clinical Guidelines, Case Management, Standardization, Evidence Based Medicine
The Question:

Why do events (errors) happen?
Because humans work in healthcare
Human Performance

- **Skill-based**: Routine tasks (no thinking) (1/1000 errors)
- **Rule-based**: Conscious decision making to select the appropriate rule and apply it, (some thinking)(1/100 errors)
- **Knowledge-based**: Conscious decision making when explicit “rules” do not exist or the individual is not aware of them (extensive thinking) (1/10 errors)

*from J. Rasmussen, Information Processing and Human-Machine Interaction. (Amsterdam: North-Holland, 1986)*
Why Do Events Happen?

Event Triggers

• Human Errors,
• Equipment Failures
or
• External Events
starts a chain of events

System Barriers to Stop Event
(Policies, Training, Self Checking etc.)

Holes in our barriers don’t stop the event

How many barriers failed if there is a significant event?...How many successful barriers to prevent an event?...

Based on Dr. James Reason, Managing the Risks of Organizational Accidents, 1997.
The Question:

How Do we Improve Quality (performance)?
Quality Improvement isn’t easy

Sometimes I feel that I have the worst job in the world!

Ya...right!
Who is this Man?
William Edwards Deming

1900 –1993

statistician, professor, author, lecturer and consultant – the Deming Cycle
Plan → DO

Act ↪ Check
If you don’t like change, 
get out of healthcare!
Four Components of Patient Safety

• Reactive improvements
• Proactive improvements
• Behavioral expectations
• Error reduction strategies and tools
Reactive improvements

• After an event
• Fix a problem after something “bad” happened
Proactive improvements

• Actively looking for issues
• Takes energy, work, dedication
• There is no rest for the quality minded
Behavioral expectations

• Set, communicate, and achieve buy-in to safety, quality and performance improvement expectations
• Expect patient safety
• Expect risk/harm reduction strategies
• Expect attentiveness to potential errors
• Expect attention to detail
Paying Attention to Details??
What must you do to support good quality and safe care?

• Stay current
• Balance population and patient needs
• Don’t bash data – appreciate its limitations
• Understand performance improvement
• Remember that little things matter
• Learn informal Root Cause Analysis (RCA)
• Be humble about error
• Remember that outcomes = incomes
Some would say...

You can’t manage (or move) what you can’t measure.
8 Principles of Measurement

• Seek usefulness, not perfection
• Use a balanced set of measures
• Keep measurements simple
• Use qualitative and quantitative data
• Write down operational definitions
• Measure small representative samples
• Build measurement into the daily work
• Develop a measurement team
Your personal journey to improving quality and safety

• Quality and safety requires a commitment
  – Starts with a change of focus
  – Perpetual dissatisfaction with present state

• Quality and safety requires a set of skills
  – Content knowledge which is appropriate to your role in the organization
  – Perpetual dissatisfaction with your current knowledge and skills
Your personal journey to improving quality and safety

• Quality and safety requires prioritization of effort and the ability to change culture
• Quality and safety requires a measurement model and data system
• Quality and safety requires a team
Your personal journey to improving quality and safety

• Quality and safety requires unrelenting execution
  – having a change management strategy
  – knowing how to react to data
  – Being both strategic and tactical
  – holding myself and others accountable for outcomes
  – never being satisfied
What can you do?

• Be mindful
• Look for potential errors
• Standardize
• Measure
• Turn the cycle again
• Commit
Some Wound Center Specifics

• Venous ulcers
  –Compression

• Diabetic ulcers
  –Glucose control
  –Offloading

• Pressure ulcers
  –Offloading
  –Nutrition
Really?

- Less than 14% of venous ulcers had documentation of compression consideration
- Less than 4% of diabetic ulcers had documentation of offloading
Outpatient Quality

- Venous Ulcers- Compression
- Diabetic Ulcers- Offloading, Glucose Control
- Pressure Ulcers- Offloading/Nutritional Status
- Vascular Screening of all lower extremity ulcers
- Biopsy of all problems > 6 months duration
Learn from every patient, so that the next patient will receive better treatment.

Don Berwick, IHI