Program Directors Meeting

February 9, 2017
Agenda

- Uber
- Leave of Absence Policy
- CAP Profiles
- Program Evaluations
- ACGME Survey
- Quality Improvement (QI Electives)
  - Anesthesia QI Elective, Presented by Ruth Fanning, MD
  - Internal Medicine QI Elective, Presented by Lisa Shieh, MD, PhD
  - Pediatrics QI Elective, Presented by Lauren Destino, MD and Nita Srinivas, MD
• December/January
• 128 rides
• Cost
  – $567.65 December
  – $1,127.55 January
  – Most frequent users (8) spent $698.26 (40% of total)
Update on SHC Leave of Absence Policy and Processes

February 9, 2017
Current Leave of Absence Policy – Maternity Leave

- In accordance with California law, a female resident must be granted an unpaid Pregnancy Disability Leave of up to four (4) months if the employee is incapable of performing her job duties because of medical disability resulting from pregnancy, delivery, or post-childbirth recovery, as verified by a physician. In addition,

- Under the California Family Rights Act (CFRA), eligible employees have a right to unpaid family care/baby bonding leave of up to 12 weeks in the 12 month period following the birth, adoption or foster care placement of a child.

- With the consent of the resident, SHC will offset unpaid time and/or applicable state disability benefits with any unused personal time off (up to 3 weeks) and/or any unused sick days (up to 20 days).

- Eligible house staff are entitled to up to 12 weeks of unpaid leave for a qualifying reason during a 12-month period. The criteria for eligibility are one year of service, and 1250 hours during the 12 months preceding the leave and that the leave entitlement has not been used within the last year.
Current Leave of Absence Policy

- State disability usually covers 6-8 weeks for the delivery of a child.

- California State Disability Insurance (SDI). California SDI pays approximately 55% of the weekly salary up to a maximum weekly benefit amount of $1,104 in 2015.
  - For more information, visit the California Employment Development Department at http://www.edd.ca.gov/Disability/.

- Failure to file for SDI benefits or ineligibility for California SDI benefits will not result in STANFORD HEALTH CARE paying the equivalent of the disability benefit available from the State of California.
Current Leave of Absence Policy

- Residents are advised that absences of longer than four (4) weeks per year may require additional training in order to comply with board regulations.

- In cases where a leave of absence has been approved by the Department Chair and the Director of GME, residents will be paid in full during the additional weeks of residency required to be board eligible if the GME Office is notified.

- If the GME Office is NOT notified of the leave, continuation of pay during any required make-up time is at the discretion and cost of the residency program.
Leave of Absence Process

- Resident/fellow notifies MATRIX (Human Resources vendor handling all SHC leaves)
  - If resident/fellow contacts GME - will be referred to MATRIX
  - MATRIX coordinates leave with GME and resident/fellow

The program is responsible for ensuring that GME is notified of the leave of absence (anything longer than 3 days)

The program is also responsible for entering the leave of absence into MedHub (and coding it as a LOA).
Every year GME sends out Annual Program Evaluations

- You choose February or May
  - Please email your choice to Thi: tdinhla@stanford.edu by February 17.
    - Default is February
  - To be used in your Annual Program valuations (APEs)
  - These evaluations by Residents/Fellows and Faculty are confidential and anonymous
    - All evaluations are aggregated by GME (14 days after distribution)
    - Aggregated reports are posted on MedHub
  - If they haven’t already, let your Coordinators know please set-up Faculty Groups by Feb 17th. Instructions were sent to Coordinators.
    - Default is all Faculty listed in your program in MedHub
ACGME Resident and Faculty Surveys

• ACGME generates reports for
  – Resident Survey Reports – 70% of residents/fellows. If program is fewer than 4 residents/fellows, reports are aggregated.
  – Faculty Survey Reports – 60% of faculty. If at least 3 have responded, a report will be generated.

• For more information, go to ACGME: http://www.acgme.org/Data-Collection-Systems/Resident-Fellow-and-Faculty-Surveys
Compliance % Reached (as of 02/06/2017)

- Adult cardiothoracic anesthesiology
- Child neurology
- Clinical neurophysiology
- Critical Care Medicine
- Dermatology
- Epilepsy
- Gynecologic oncology

- Hospice & Palliative Care
- Medical genetics and genomics
- Neuromuscular medicine
- Neurotology
- Nuclear medicine
- Pediatric Anesthesia
- Plastic Hand surgery
ACGME Resident and Faculty Surveys – ACGME SURVEY LIVE NOW: First Group from January 16 – February 19, 2017

Compliance NOT % Reached (as of 02/06/2017)

- Allergy and immunology
- Anesthesiology
- Critical care medicine
- Dermatopathology
- Emergency medicine
- Hospice and palliative medicine
- Medical genetics and genomics
- Molecular genetic pathology
- Neurology

- Neurology
- Obstetric anesthesiology
- Obstetrics and gynecology
- Otolaryngology
- Pediatric anesthesiology
- Pediatric otolaryngology
- Plastic Surgery - Integrated
- Vascular neurology
ACGME Resident and Faculty Surveys – ACGME SURVEY LIVE NOW:
Second Group from February 13 – March 19, 2017

- Adolescent medicine
- Blood banking/transfusion medicine
- Child and adolescent psychiatry
- Clinical informatics
- Cytopathology
- Developmental- behavioral pediatrics
- Female pelvic medicine and reconstructive surgery
- Geriatric psychiatry
- Hematology
- Medical microbiology
- Neonatal-perinatal medicine
- Neuropathology
- Orthopedic Hand surgery
- Orthopedic sports medicine
- Orthopedic surgery
- Pathology- anatomic and clinical
- Pediatric cardiology
- Pediatric critical care medicine
- Pediatric endocrinology
- Pediatric gastroenterology
- Pediatric hematology/oncology
- Pediatric infectious diseases
- Pediatric nephrology
- Pediatric pulmonology
- Pediatric rheumatology
- Pediatric surgery
- Pediatric urology
- Pediatrics
- Physical medicine and rehabilitation
- Psychiatry
- Psychosomatic medicine
- Selective pathology
- Spinal cord injury medicine
- Sports medicine
- Surgery
- Surgical critical care
- Thoracic surgery
- Thoracic surgery - integrated
- Urology
- Vascular surgery
- Vascular surgery - integrated
ACGME Resident and Faculty Surveys – ACGME SURVEY LIVE NOW: Third Group from March 13 – April 16, 2017

- Adult congenital heart disease
- Advanced heart failure and transplant cardiology
- Cardiovascular disease
- Clinical cardiac electrophysiology
- Critical care medicine
- Endocrinology, diabetes, and metabolism
- Gastroenterology
- Geriatric medicine
- Hematology
- Infectious disease
- Internal medicine
- Internal medicine/Anesthesiology (components individually accredited)
- Interventional cardiology
- Medical oncology

- Nephrology
- Neurological surgery
- Neuroradiology
- Ophthalmology
- Pain medicine
- Pediatric radiology
- Pediatrics/Anesthesiology (components individually accredited)
- Pulmonary disease and critical care medicine
- Radiation oncology
- Radiology- diagnostic
- Rheumatology
- Sleep medicine
- Vascular and interventional radiology
Anesthesia
Quality Improvement and Patient Safety Program Update
February 2017

Ruth Fanning
Clinical Associate Professor
Department of Anesthesiology, Perioperative and Pain Medicine.
1) ECO2 ICU

2) AIRWAY MODULE ICU Fellows/HOSPITAL WIDE

3) STREAMLINE POST OP PROCESS

4) INTEROP OR ENVIRONMENT IMPROVEMENT

5) SLOW PATIENT HAND OFF/TRANSPORT IMPROVEMENT

6) ZERO WASTE BUCKET — AIM IS WASTE

7) SIGN OUT SHEETS: IMPROVE HANDOFFS

8) PAPER RECORD: EPIC

PROBLEM / AIM:

(HELISSA)
Louise Wen, MD, CA-3, mentored by Steven Howard, MD, (Palo Alto VA), and Ruth Fanning, MD, (Stanford), was recognized by the Anesthesia Patient Safety Foundation (APSF) for her quality improvement work on sharps safety for anesthesia residents. After a contaminated needle stick injury at the end of her CA-1 year, Louise became very interested in this subject. In March 2015, she surveyed her class when they were halfway through their anesthesia training (middle of CA-2 year) and found that 68% of her class had suffered from contaminated sharps injuries. Three residents had completed antiretroviral prophylaxis for HIV exposure and 2 residents had been exposed to patients with Hepatitis C. Stanford occupational health data showed that anesthesia residents were exposed to contaminated sharps injuries at a higher rate than any other residency department at Stanford Hospital. Using these findings, Louise developed a simulation-based sharps training...
Francis Picabia

Our Heads Are Round so Our Thoughts Can Change Direction
Internal Medicine
Highlights of the Elective in
Quality Improvement, Patient
Safety, and Organizational Change

Lisa Shieh, MD, PhD
Clinical Professor of Medicine
Director of Quality, Department of Medicine
Stanford School of Medicine

Kambria H. Evans, MEd, MA
Director of Education and Quality Improvement
Stanford School of Medicine

February 9, 2017
Purpose

- Nationally, hospitals are working to improve their institutions’ patient safety culture, requiring a *culture change*
  - reaching from leadership to the trenches
  - through informal and formal processes

- Despite increasing recognition of the importance of quality improvement (QI) and patient safety (PS), the physician role in QI is often not defined or role modeled to physicians in training
  - In 2012, ACGME starts CLER (Clinical Learning Environment Review)
    - Assesses the integration of residents/fellows along with demonstration of impact in PS and QI programs
Background

- **2008** Resident QI rotation created
  - Experiential learning through immersion in QI meetings and completion of QI project
  - Perceive QI as part of professional role; be valuable participants in QI at the institution level
  - Emphasize scholarship: encourage publications and presentations at national meetings

- **2009** Addition of clerkship for Stanford and visiting medical students

- **2013** Collaborations with Palliative care fellowship, Stanford Internal Medicine Clinic, and Stanford Healthcare Consulting Group

- With 15-20 learners/year, ~150 students and residents have gone through the QI rotation to date

- Resident and student self-assessments (2008-2012) show significant increases in all rotation objectives
In 2015, Medicine residents rated the QI Elective #6 out of 50 rotations
4-week QI curriculum

- Review and synthesize literature on quality, patient safety, and organizational improvement
- Online curriculum: SafetyQuest and Stanford RITE videos
- Opportunity to audit CELT (Clinical Effectiveness Leadership Training)
- Participate in QI/PS activities, such as Department Quality Council meetings and hospital-level quality committees
- Educate peers about QI project and methodology by teaching at QI noon conference
  - Increase awareness about QI and increased likelihood of culture change.
- Develop relationship with a “QI Champion,” a physician or staff member with a leadership role in QI and who serves as a role model, mentor and educator
- Complete a quality/patient safety project aligned with hospital initiatives
Need to find innovative ways to teach

Students retain approximately **39%** of factual information immediately after a lecture and only **3%** less than 1 month later.

Recall is greatest about 10 minutes after a presentation. Twenty-four hours later **80%** is forgotten.

McLeish, 1968; Ludwig, 1968; D’Eon, 2006
Gamification:

Process of applying gaming principles (competition, rewards, enjoyment) to a nongame endeavor

The Stanford Games

**Septris:** Sepsis + Tetris

SICKO: Surgery decision making

SonoDoc: Ultrasound

Newest game...

SafetyQuest: QI & safety
SafetyQuest

Online game: QI/PS curriculum

Faculty: Lisa Shieh, Kambria Evans, Anu Phadke, Laura Mazer, Nita Srinivas, Larry Katznelson

- Available for CME
- 20 cases: 10 general medicine, 5 pediatrics, 5 surgery
- Interactive with immediate feedback
- Patients falling to harm
  - Safety actions to increase patient’s safety level
- Game points = future lives saved
- Dr. QI and Safety teach throughout
- Earn QI problem solving tools (e.g. PDCA, A3, RCA, etc.) and medals
- Interns improve QI knowledge after play

http://sm.stanford.edu/archive/safetyquest/
## Case examples

<table>
<thead>
<tr>
<th>Case 1: Discharge</th>
<th>Case 2: Wrong pt</th>
<th>Case 3: Adverse Event</th>
<th>Case etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topic</strong></td>
<td><strong>Best Practices</strong></td>
<td><strong>QI Tool</strong></td>
<td><strong>QI Tool</strong></td>
</tr>
<tr>
<td>Discharge -&gt; Readmission</td>
<td>Medication Reconciliation Follow Up with Patients Post-Discharge Involving Patients, Families, and Caretakers Identifying High-Readmission Risk Patients</td>
<td>Process Mapping</td>
<td>Root Cause Analysis/ Fishbone</td>
</tr>
<tr>
<td><strong>Case 2: Wrong pt</strong></td>
<td>Identify error as adverse event or near miss Describe Swiss cheese model of error Describe communications w/ pt and providers</td>
<td>Root Cause Analysis/ Fishbone</td>
<td>A3</td>
</tr>
<tr>
<td><strong>Case 3: Adverse Event</strong></td>
<td>Best practices re hospital-acquired infections and Foley indications Recognize adverse event Use order sets and checklists</td>
<td>A3</td>
<td>A3</td>
</tr>
</tbody>
</table>

### 4 Steps of A3 Thinking

1. **What is the problem or gap? (What are we trying to improve?)**
2. **What causes are preventing us from meeting our target(s)? What are the “root” causes?**
3. **Based on data, what are the causes in order of importance?**
4. **Which actions will address the most important causes?**

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Confidential – For Discussion Purposes Only
**Level 1**
- CASE 1: Qi Tool: Swiss Cheese
  - Wrong Patient
- CASE 3: Qi Tool: Critical Language
  - Missing Code Status
- CASE 4: Qi Tool: PDCA
  - Catheter Associated UTI
  - High Score: 15885
- CASE 7: Qi Tool: Time-Out
  - Wrong Side
- CASE 11: Qi Tool: High Reliability
  - Unclean Hands

**Level 2**
- CASE 2: Qi Tool: Pareto
  - Adverse Event
- CASE 8: Qi Tool: Process Map
  - Best Practice Discharge
- CASE 9: Qi Tool: Fishbone
  - Wrong Medication
- CASE 12: Qi Tool: Systems Engineering
  - Wrong Formulation
- CASE 13: Qi Tool: TeamSTEPPS
  - Missing Antibiotics

**Level 3**
- CASE 5: Qi Tool: FMEA
  - CLABSI
- CASE 14: Qi Tool: A3
  - Breast Milk Mix-up
- CASE 16: Qi Tool: Universal Protocol
  - Wrong Site Surgery
- CASE 17: Qi Tool: TeamSTEPPS
  - Retained Guidewire
- CASE 20: Qi Tool: Sustainability
  - Retained Sponge

**Bonus Level**
- CASE 6: Qi Tool: High Value Care
  - Readmission
- CASE 10: Qi Tool: 5S
  - What's the Plan?
- CASE 13: Qi Tool: SPC
  - Delayed Diagnosis
  - High Score: 3535
- CASE 14: Qi Tool: SMART Goals
  - Missing Medications
- CASE 15: Qi Tool: High Value Medications

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**Q:** What is a root cause?

**a.** The deeper underlying reason why the problem happened.  
+50. Correct!

**b.** The impression most commonly held as to why a problem happened.

**c.** The explanation your supervisor provides you for the error.

**d.** The active error that you are trying to solve.

The root cause is NOT the obvious or most commonly believed reason why a problem occurred. Rather, it can only be determined by careful analysis.
Dr. Qi says, “Let’s go back to the A3. The Root Cause Analysis comes in between setting a goal and developing solutions. It is a way of understanding your problem so that you can develop targeted solutions to test during the Countermeasures step.”

<table>
<thead>
<tr>
<th>PLAN</th>
<th>DO</th>
<th>CHECK</th>
<th>ACT</th>
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</thead>
<tbody>
<tr>
<td>A3 PDCA</td>
<td><strong>COUNTERMEASURES</strong></td>
<td><strong>EFFECT CONFIRMATION</strong></td>
<td>FOLLOW-UP ACTIONS</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>CURRENT STATE</td>
<td>FUTURE STATE/GOAL</td>
<td><strong>ROOT CAUSE ANALYSIS</strong></td>
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</tbody>
</table>

**QI MODE to teach problem-solving tools**

Dr. Qi: "Ok, now let's review the easiest way to do a root cause analysis, a tool called the 5 whys. In the 5 whys, you start with the proximate cause and keep on asking why until you get to a root cause. To understanding it further, will you please help me order the “whys” below?"

**The Error:**
You ordered a medication for Mrs. Park that should not have been ordered.

<table>
<thead>
<tr>
<th>Why 1</th>
<th>Why 2</th>
<th>Why 3</th>
<th>Why 4</th>
<th>Why 5</th>
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</thead>
<tbody>
<tr>
<td>Proximate cause</td>
<td></td>
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<td>Root cause</td>
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</table>

- Why 1: You ordered a medication for Mrs. Park and you had to admit all the patients.
- Why 2: Your team incorrectly scheduled your team-mate in clinic on an admiring day.
- Why 3: You did not do medication reconciliation with the patient.
- Why 4: Your had four other patients to admit.
- Why 5: You did not have enough time to do medication reconciliation.

**Fishbone**

- People
- Process/Policy
- Equipment/Supplies
- Environment

- The patient was altered and was unable to reconcile medications
- You could not verify recently filled meds because the patient's pharmacy is closed
- You reconciled medications in a busy ER
- On admission you order a medication to which patient has had a previous adverse reaction.
- It is your first week at the University hospital
- The medication was incorrectly listed as active in the EMR
- The pharm techs who help with med recs were not working when the patient was admitted
Case 13: Delayed diagnosis of septic shock leading to RRT

Safety actions:
- Call for help early
- Use order sets and checklist
- Use critical communication
- Debrief

QI tool: SPC chart

Take home point

Case complete! +3000!

Improve quality by reducing variation. By understanding SPC charts, you are able to better interpret data from your QI processes. Do not make adjustments in response to common cause variation.
High value care - bonus round

Drag and drop the medication into the correct cost range.

Acetaminophen 1000 mg

What is the reimbursed cost (Medicare, 2015) for a two view chest xray?

+100! The actual price is $28

When your answer is within 10% of perfect, you get double points.

$20

Prices that your colleagues guessed

- $250.00
- $1.00
- $100.00

Fellow
Resident
Medical Student

Case complete! +3000!
You can improve value in medical care and the system by switching from IV to oral equivalent medications when appropriate (e.g., the patient is able to take, eat, and absorb medications) or using the hospital formulary.

This improves value not only to the patient (as some IV medications are painful during infusion), but to nursing and pharmacy staff as well (IV medications are more labor intensive to administer).

Future lives saved

3380

You have earned the following QI Tool:

High Value Medications

Problem Solving Toolkit

High Value Care

Confidential – For Discussion Purposes Only
Scholarship from QI elective

- Winner of national American College of Physicians (ACP) QI/Patient Safety Poster Competition for trainee in April 2015 (Mala Mandyam)

- 9 resident posters/abstracts at national Society of Hospital Medicine in RIV (research innovation vignette) competition in San Diego March 2016
  - Winner of RIV competition in research for trainee (Lance Downing)
  - 3 out of 40 finalists out of >600 accepted abstracts (Josh Rolnick, Justin Lotfi)

- Winner of regional ACP research and QI in Nov 2016 (Eric Mou, Silvia McClandish, Kathleen Jia)

- Mini QI grant program started 2015
Scholarship from QI elective


Scholarship from QI elective

- **M. Kantor, K. Evans, L. Shieh**, “Pending studies at hospital discharge: A pre-post analysis of an electronic medical record tool to improve communication at hospital discharge”, J Gen Intern Med. 30(3): 312-8, Mar 2015


Value-based Care curriculum

- Partnership with Internal Medicine Residency to create curriculum and study design
  - 100 interns participated over 2 academic years
  - Material rated as highly useful on a five-point Likert scale (M=4.4, SD=0.6)
  - Significant improvement reported in self-rated knowledge, skills and attitudes after the six seminars (mean improvement 1.6 points, SD 0.4 [95% CI: 1.5-1.7]; p<0.001)
  - Outcomes: Decreased inappropriate hypercoagulable workup
  - Accepted as finalist poster presentation at national ACP (Henry Kwang & Eric Mou)

- Other projects:
  - Transparency of lab and pharmacy costs during order entry

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<thead>
<tr>
<th>Educational Intervention</th>
<th>Percent Inappropriate</th>
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<td>Intern Group 1</td>
<td>Pre-Intervention</td>
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<td>Post-Intervention</td>
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<td>Intern Group 2</td>
<td>Pre-Intervention</td>
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<td>Post-Intervention</td>
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<td>27.78</td>
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<td>Total</td>
<td>Pre-Intervention</td>
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<td>Post-Intervention</td>
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Summary

QI elective:

- Engaged over 150 residents/medical students in QI/PS
- Produced scholarly work in peer-reviewed publications and presentations at national conferences

Next Steps:

- Partnership with Larry Katznelson /GME office to study SafetyQuest
  - Expand curriculum vertically and horizontally to residents and fellows in all departments
- Increase scholarship with more collaborations
  - Establish longitudinal resident teams for QI projects
  - Working with Paul Heidenreich, Abraham Verghese
  - Partner with medical students in creating QI interest group
  - Open to collaboration with other Stanford departments
Pediatrics
Quality and Process Improvement
Scholarly Concentration and Elective
Lauren Destino, MD and Nita Srinivas, MD
February 9, 2017
Improvement: We know what to do we just don’t do it!

• Elective Deliveries <39 weeks in normal pregnancies result in increased NICU admits

• Elective deliveries prior to 39 weeks at Intermountain Healthcare:

  Decrease in 1 min APGAR <5, C-section due to fetal distress, meconium aspiration
Improvement: Other times we just need to be better
Quality and Performance Improvement
Scholarly Concentration

Nita Srinivas, MD
Lauren Destino, MD
Terry Platchek, MD
Quality and Performance Improvement: Concentration

Scholarly Pursuit is chosen in area of Quality and Performance Improvement

2.5 year experience:

- Research Retreats that are class specific
  - Learn basics of research (ex. asking a good question, methods, basic statistics, IRB, literature search, abstract and manuscript writing)
  - Breakout sessions with concentration – focus on QI/PI projects with A3 thinking
- Quarterly Dinners
  - Discuss projects
  - Discuss general topics relevant to QI
- Elective Block
- Completion of IHI Basic Curriculum
- Completion of Scholarly Project
  - Abstract
  - Oral Presentation
Quality and Performance Improvement: Elective

Course for residents and fellows interested in pursuing quality and performance improvement projects and/or careers

Goal is for residents/fellows to:

- Gain fundamental knowledge of QI/PI in healthcare
- Gain practical experience in QI/PI methods
- Be able to plan and implement your own improvement project
- Learn about careers in QI/PI

4 week rotation (Fall):

- Lectures by local experts in QI/PI
- Packard Leader Training
- Participate in a hospital-prioritized improvement project
- Institute for Healthcare Improvement Modules
- Off-site visit to see QI/PI in action outside of healthcare
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<tr>
<th></th>
<th>DAY 1</th>
<th>DAY 2</th>
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<tr>
<td><strong>INTRODUCTION TO QUALITY AND PROCESS IMPROVEMENT</strong></td>
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<td><strong>Morning Didactics and Hands-on Improvement Activities</strong></td>
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<td>LEAN Conference</td>
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<td>780 Welch Rd, CJ330</td>
<td>9-9:30 AM Course and Scholarly Concentration Overview</td>
<td>9-10:30 AM Defining a Problem in QI/PI (Nita Srinivas, M)</td>
<td>780 Welch Rd, CJ350E</td>
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<td>9:30-10:30 AM Introductions and Project Updates</td>
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<td>10:30-12 PM Introduction to PI/LEAN (Terry Platchek, MD)</td>
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<td>Morning Didactics and Hands-on Improvement Activities</td>
<td>DAY 6</td>
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<td>8:30-9:30 AM QI Methodologies (Lauren Destino, MD)</td>
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<td>9-10 AM RPI Debrief</td>
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<td>9:30-10:30 AM Defining Measures in QI/PI (Lauren Destino, MD)</td>
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# Implementing a QI/PI Project

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<th>Date</th>
<th>Morning Didactics and Hands-on Improvement Activities</th>
<th>Midday Didactics and Hands-on Improvement Activities</th>
<th>Afternoon Didactics and Hands-on Improvement Activities</th>
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<tr>
<td>10/17/16</td>
<td>8:30-9:30 AM Publishing QI Work (Steven Asch, MD)</td>
<td>9-12 PM Individual Project Updates</td>
<td>9-10 AM Local Improvement Teams: Anesthesia (Tom Caruso, MD)</td>
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<td>9:30-10:30 AM High Reliability Design (Paul Sharek, MD)</td>
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<td>9-10 AM SQUIRE Guidelines (Nita Srinivas, MD)</td>
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<td>10:30-12 PM High Value Care (Alan Schroeder MD)</td>
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<td>10/19/16</td>
<td>780 Welch Rd, CJ350A</td>
<td>10-11 AM Clinical Effectiveness (Dan Imler, MD)</td>
<td>10-11 AM Hospital Regulations and QI (Brea Aldorfer, RN)</td>
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<td>10/20/16</td>
<td>780 Welch Rd, CJ350A</td>
<td>11-12 PM Clinical Informatics and QI (Natalie Pageler, MD)</td>
<td>11-12 PM Population Health and QI (Jason Wang, MD)</td>
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“The Daily Bulge” Group Project

**AIM:** Alleviate the hospital bed shortage at LPCH by optimizing morning rounds

**MEASURES:**
- Number of hospital discharges before 11AM
- Median discharge time

**CHANGE:** Implementation of a pre-round huddle and discharge readiness checklist on BLUE team
Some Individual Projects

• Association between implementation of a pre-anesthesia diet order and improved patient and family satisfaction

• Implementation and utilization of a pre-round huddle to improve rate of early hospital discharges

• Lean methodology to improve the quality of the after visit summary for patients

• Improving Patient flow through Packard Gardner Clinic

• Logic Based Ordersets to standardize care in the Emergency Department
Lessons Learned

• SC specific: Have a project that already has institution support

• Faculty member really owns the project (particularly if large and/or trainee is resident)

• Opportunity to engage others through MOC part 4

• If the improvement relies upon the EHR it can take a while to implement

• Yearly PDSA of the elective (lectures, modules, readings)
Next steps

• Opening course to NPs/PAs involved in improvement and continued involvement of fellows

• Two, 2 week blocks next year to allow for project development/work in between

• Continued look at lectures and readings

• No requirement to have pre-designated project/mentor though preferred

• Ensure project amenable to RPI can take place during the elective
Thank you!
nivedita@stanford.edu
Idestino@stanford.edu