Putting Culture on Trial

A Class Action Suit

crico

Ambulatory Care

Expert Witness:
Gordon Schiff, MD
Brigham & Women's Hospital

"Culture isn't something you can see or touch—so how can we get our arms around it?"

#CRICO15

Primary Care – Culture on Trial

Gordon Schiff MD

Associate Professor of Medicine
Harvard Medical School

Associate Director Center for Patient Safety Research and Practice
Brigham & Women's Hospital

Safety Director Harvard Center for Primary Care
Academic Improvement Collaborative

- What do we mean by putting “culture on trial”
- 5 stories illustrating problematic culture
- Major challenges facing PCPs
- Looking for truths in the holes and the whole

Culture on Trial?

- What do we mean by “Culture”?
  - Conditions under which people to work?
  - Ways people behaving; how responding to those conditions?
  - Set of relationships among team?
  - Organizational memory ?
    - Where coming from, realistically where at, where going; vision
  - Tone set by leadership?
    - Set of signals of what is supported/resourced, tolerated, ignored, priorities
  - Attitudes about safety?
    - How safe to report, speak-up; how proactive, confident staff is in learning and improving
  - Global vs. local?
- “On Trial”?
  - Adversary process
    - Charging, defending; getting even, punishing
    - Withholding evidence to help your side win
    - Nondisclosure agreements to conceal evidence after case is settled

“The question that drives safety work in a just culture is not *who* is responsible for failure, rather, it asks *what* is responsible for things going wrong. What is the set of engineered and organized circumstances that is responsible for putting people in a position where they end up doing things that go wrong?”

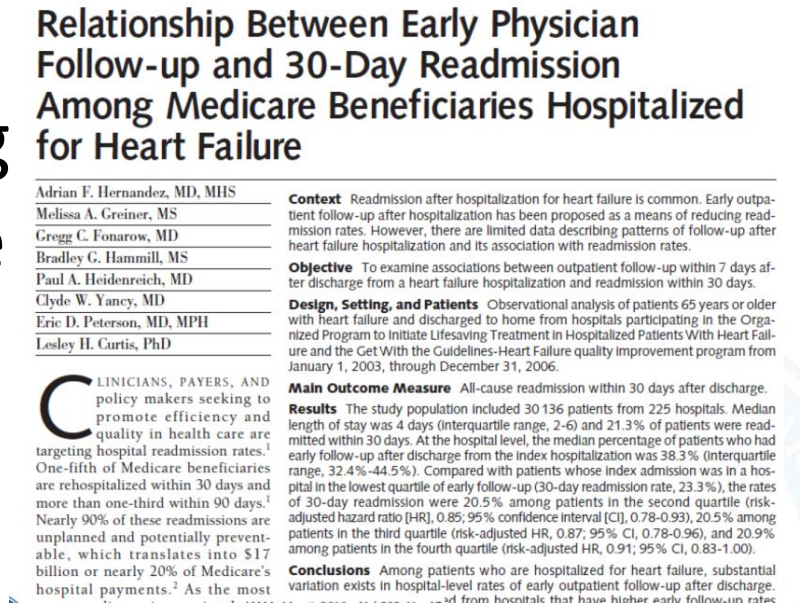
— *Sidney Dekker, Just Culture*

5 Stories

- My patients in Urgent Care - 7 days post d/c
  - Misguided P4P
- Feedback on EMR→ reported for harassment
- Last Thursday-was finally gonna get out on time
  - Spanish pt w/ “nothing wrong” ...1 hr later still in room
- Pharmacy dispensing drugs d/c’ed in EMR for ADE
  - Failure to implement Surescripts CancelRX function
- Reprimanded for “crossing boundaries” to care for pts

1. P4P at Expense of Continuity

- Regular weekly PCP session
- Stumble upon my most complex patient(s) seeing colleagues in Urgent Care
- Post discharge – patients being sent to meet 7 day f/up performance metric



Relationship Between Early Physician Follow-up and 30-Day Readmission Among Medicare Beneficiaries Hospitalized for Heart Failure

Adrian F. Hernandez, MD, MHS
Melissa A. Greiner, MS
Gregg C. Fonarow, MD
Bradley G. Hammill, MS
Paul A. Heidenreich, MD
Clyde W. Yancy, MD
Eric D. Peterson, MD, MPH
Lesley H. Curtis, PhD

Context Readmission after hospitalization for heart failure is common. Early outpatient follow-up after hospitalization has been proposed as a means of reducing readmission rates. However, there are limited data describing patterns of follow-up after heart failure hospitalization and its association with readmission rates.

Objective To examine associations between outpatient follow-up within 7 days after discharge from a heart failure hospitalization and readmission within 30 days.

Design, Setting, and Patients Observational analysis of patients 65 years or older with heart failure and discharged to home from hospitals participating in the Organized Program to Initiate Lifesaving Treatment in Hospitalized Patients With Heart Failure and the Get With the Guidelines-Heart Failure quality improvement program from January 1, 2003, through December 31, 2006.

Main Outcome Measure All-cause readmission within 30 days after discharge.

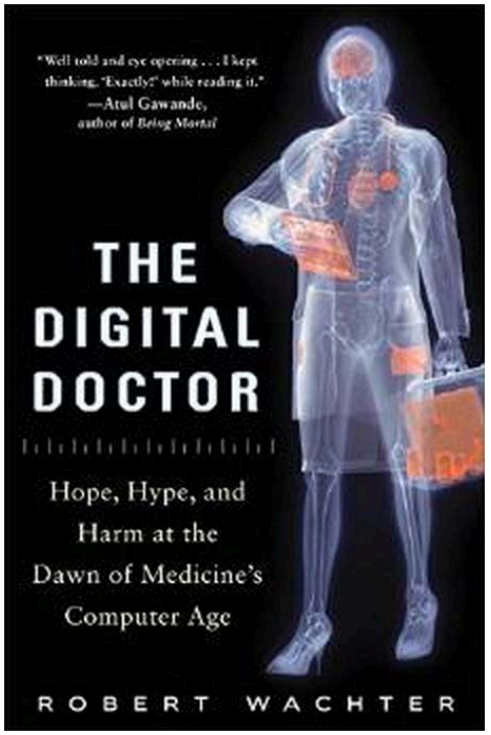
Results The study population included 30 136 patients from 225 hospitals. Median length of stay was 4 days (interquartile range, 2-6) and 21.3% of patients were readmitted within 30 days. At the hospital level, the median percentage of patients who had early follow-up after discharge from the index hospitalization was 38.3% (interquartile range, 32.4%-44.5%). Compared with patients whose index admission was in a hospital in the lowest quartile of early follow-up (30-day readmission rate, 23.3%), the rates of 30-day readmission were 20.5% among patients in the second quartile (risk-adjusted hazard ratio [HR], 0.85; 95% confidence interval [CI], 0.78-0.93), 20.5% among patients in the third quartile (risk-adjusted HR, 0.87; 95% CI, 0.78-0.96), and 20.9% among patients in the fourth quartile (risk-adjusted HR, 0.91; 95% CI, 0.83-1.00).

Conclusions Among patients who are hospitalized for heart failure, substantial variation exists in hospital-level rates of early outpatient follow-up after discharge.

CLINICIANS, PAYERS, AND policy makers seeking to promote efficiency and quality in health care are targeting hospital readmission rates.[1] One-fifth of Medicare beneficiaries are rehospitalized within 30 days and more than one-third within 90 days.[1] Nearly 90% of these readmissions are unplanned and potentially preventable, which translates into $17 billion or nearly 20% of Medicare's hospital payments.[2] As the most

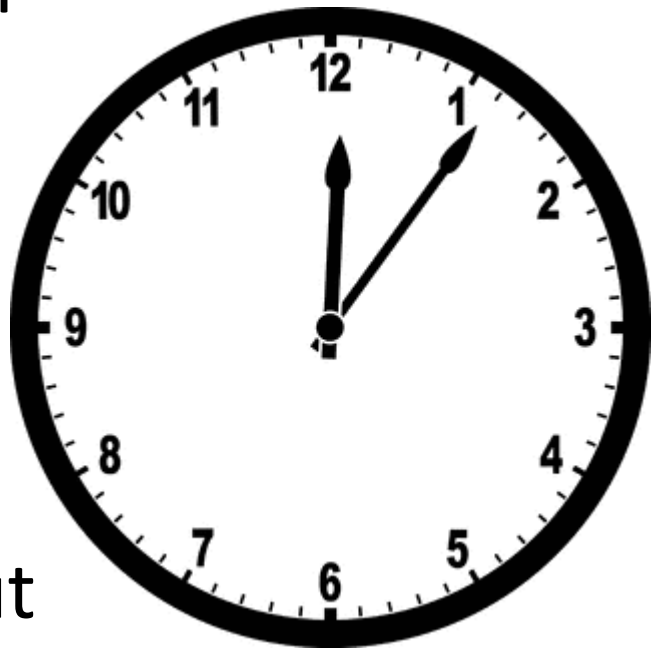
2. Helping or Bothering Help Desk

- Newly working as PCP in Boston
- Excited to be connecting to world class EMR
- Eagerly struggling to learn, calling for help, as well as pass on frustrations, learning
- Contacted my director to say that I was harassing help desk
- Genuinely thought was helping
- Epic – déjà vu all over again this week!



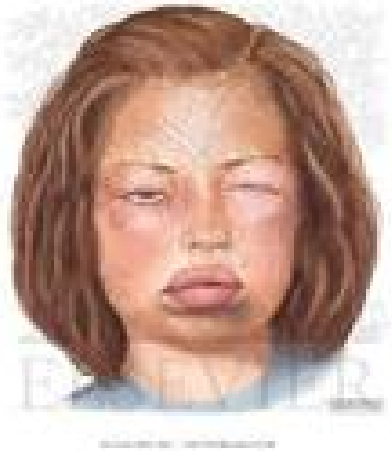
3. Out on Time (not)

- Monthly P&T meeting at noon
  - Cancelled 2o Epic prep
- Easy, Spanish sp patient
  - Simple, nonspecific back pain
  - Dismissed interpreter early
    - But offered to stay
- As about to d/c, story spills out
  - Marital problems, tears, ~suicidal, never before told anyone

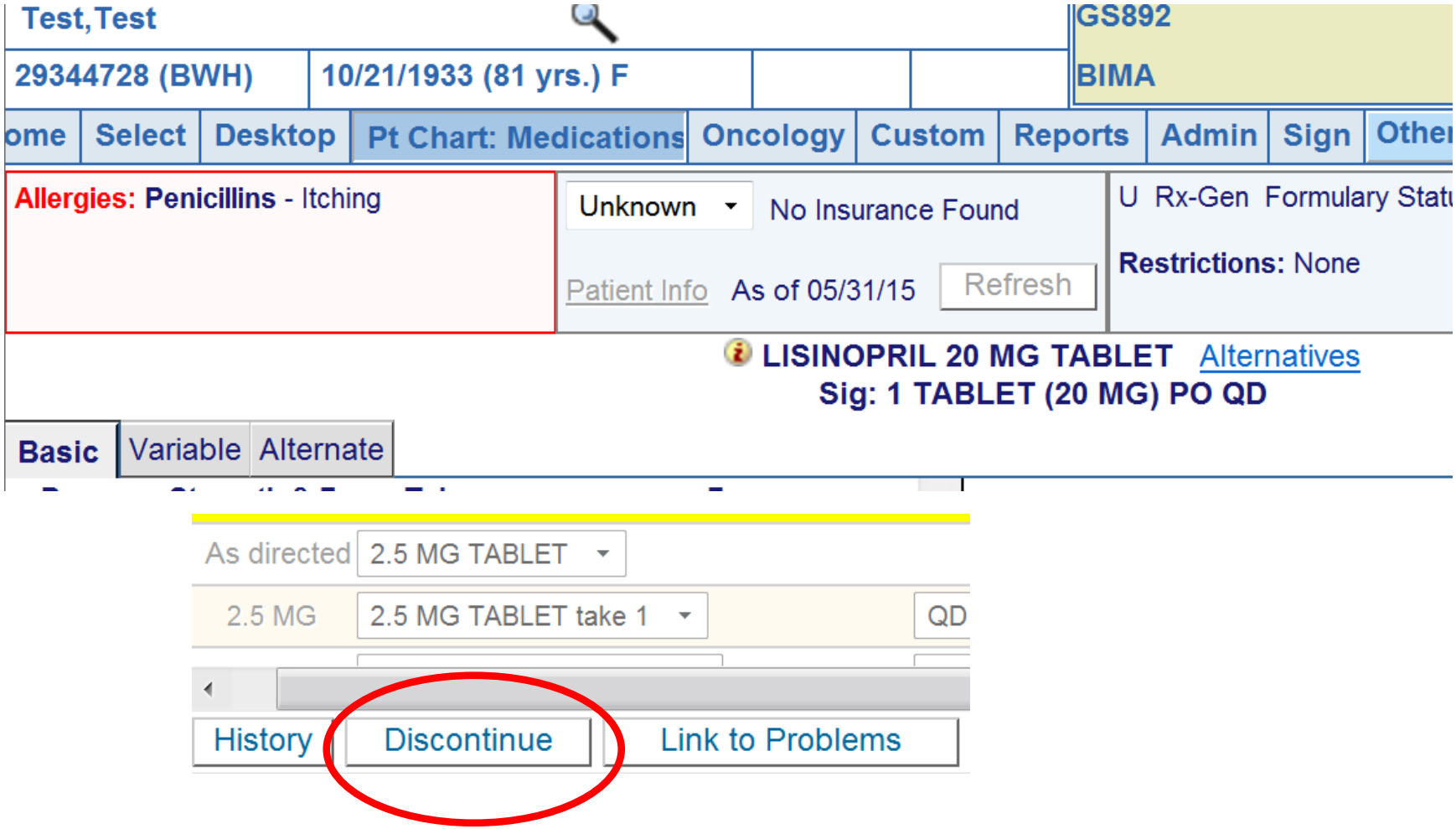


4. Continuing Discontinued Drugs

- 81 F developed angiodema to newly started ACE-Inhibitor rx
- Recognized, stopped, d/c'd
- Pharmacy calls her next month to pick up refill



- D/C order does not flow to pharmacy
  - Surescripts CancelRx function/field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Alternatives
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2.5 MG TABLET take 1
QD
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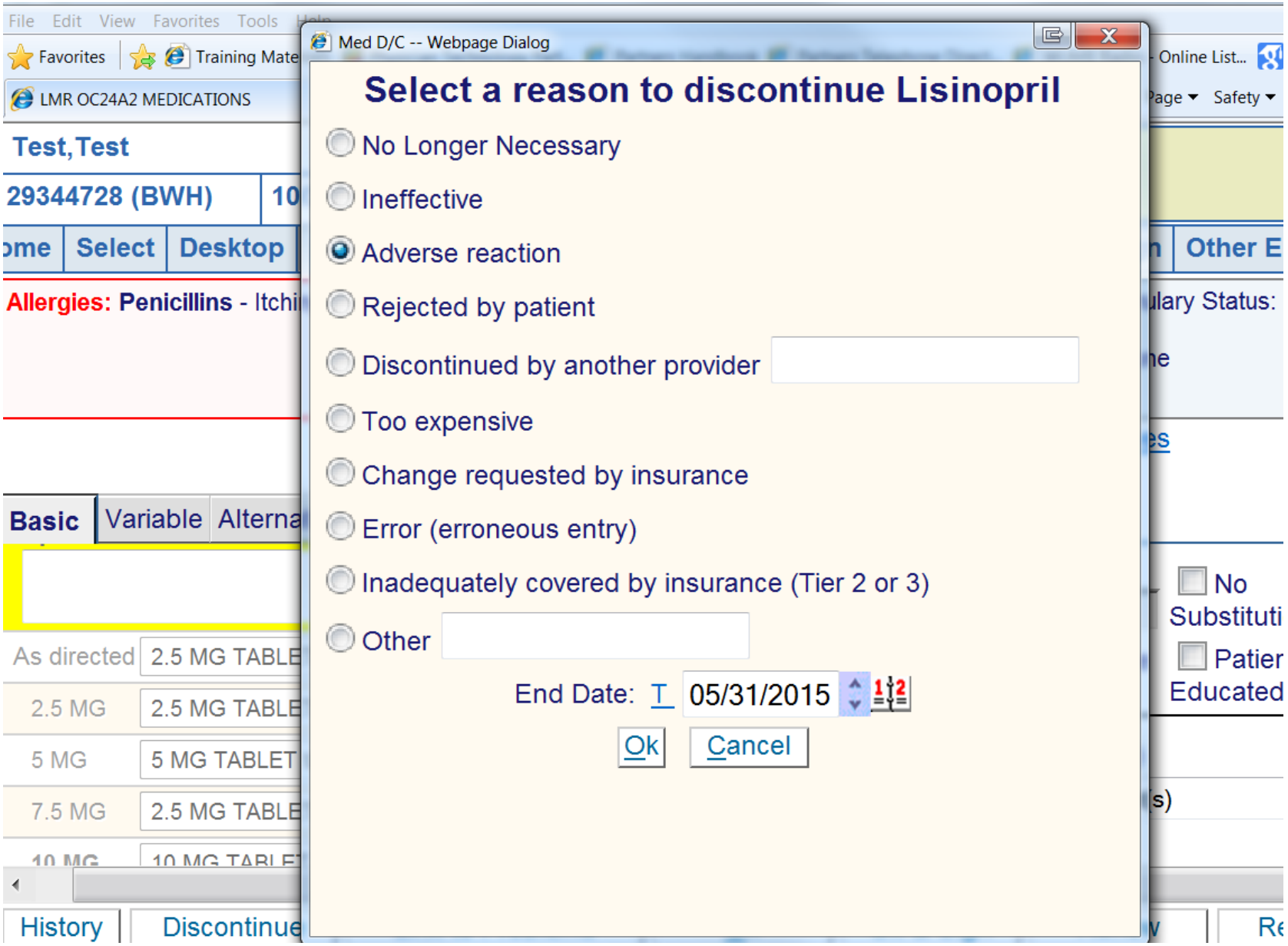
Link to Problems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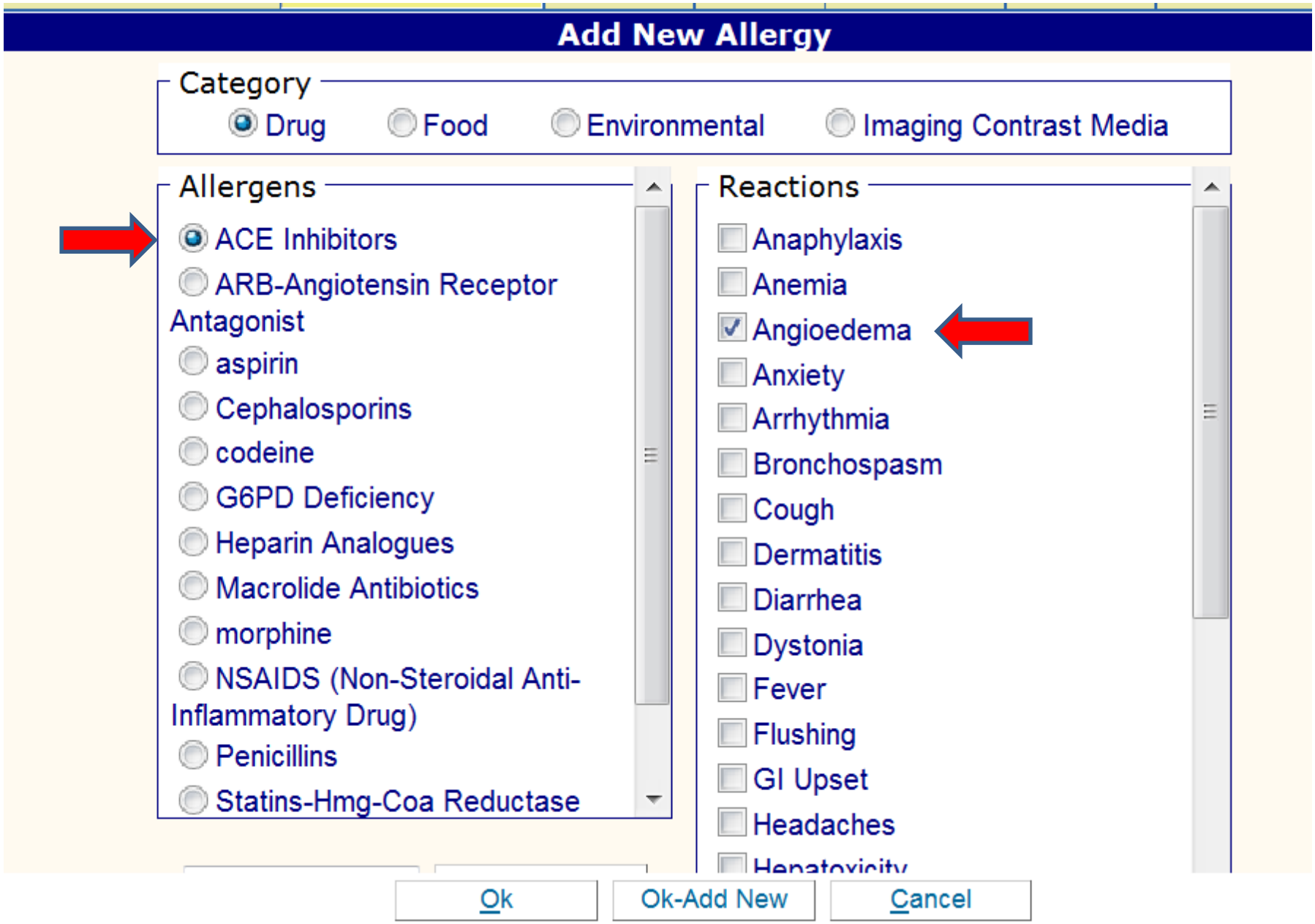
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Cephalosporins
codeine
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Macrolide Antibiotics
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Penicillins
Statins-Hmg-Coa Reductase
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Anemia
Angioedema
Anxiety
Arrhythmia
Bronchospasm
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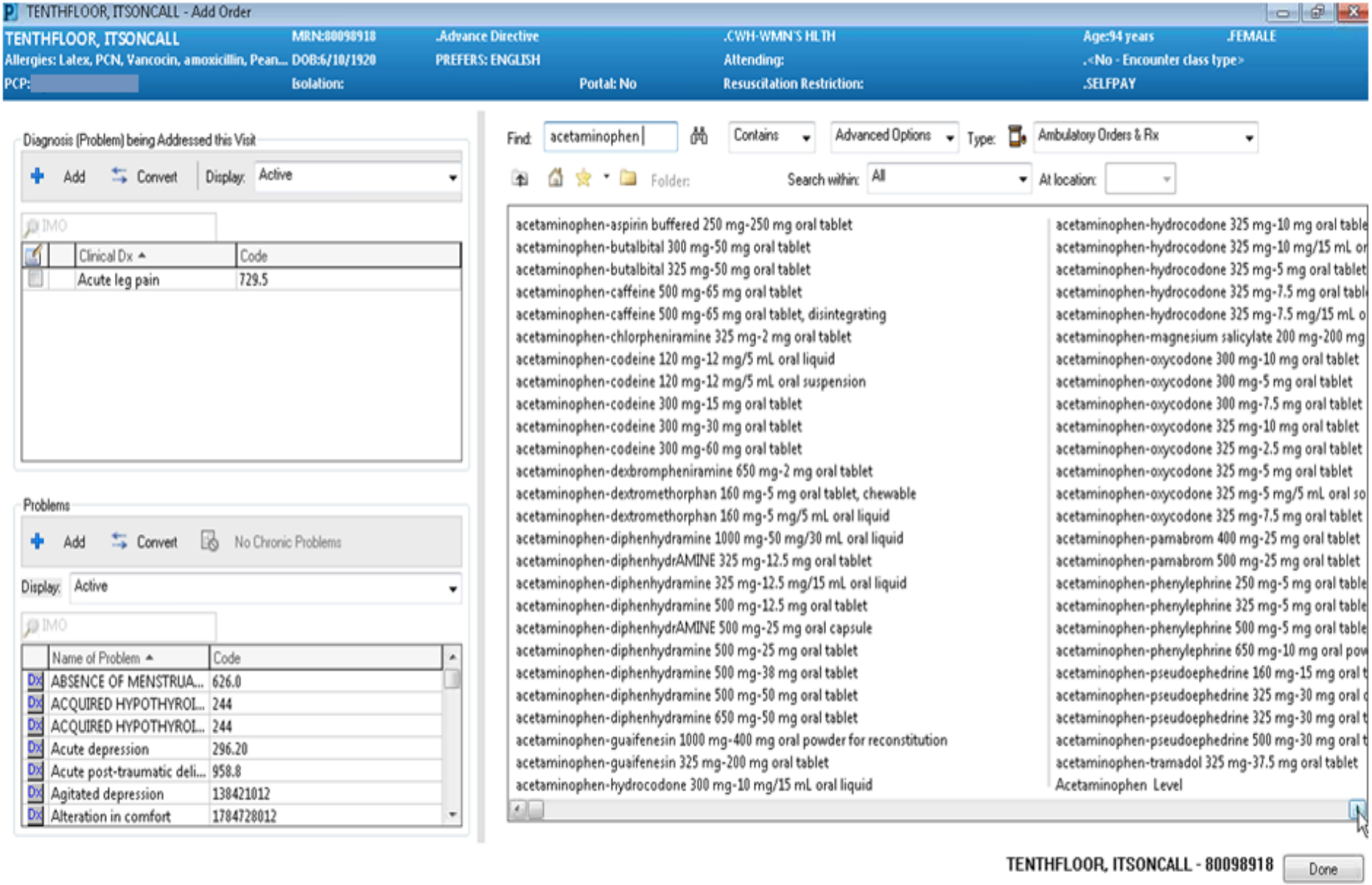
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Allergies: Latex, PCN, Vancocin, amoxicillin, Pean...
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acetaminophen-guaifenesin 1000 mg-400 mg oral powder for reconstitution
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We wouldn’t think of asking the lawyer to create the legal proceedings of the courtroom at the same time they are doing their job.

So why do we expect doctors to multi-task and be distracted from both doing a good job interacting with their patients was well as simultaneously documenting.

Christine Sinsky
PCP Dubuque IA
AMA VP for Profl Satisfaction

5. Crossing Boundaries-Violation or Obligation

- Reprimanded for helping patients
  - Money for medicines
  - Help getting job
  - Too personal caring relationships
- Touched raw nerve
  - JAMA Piece of my Mind
    - >250 emails, 2 NYT articles

The New York Times

HARD CASES

When Healers Get Too Friendly

By ABIGAIL ZUGER, M.D. NOVEMBER 11, 2013 4:54 PM

It takes only a moment to step over the line, especially when no one knows exactly where the line is. In my case, it started with a visit from my old friend the activist.

The activist became my patient back in the mid-1990s, when H.I.V. was slowly morphing into a treatable disease. He was young then, with a mop of dark curls — excitable, suspicious and

JAMA The Journal of the American Medical Association

A PIECE OF MY MIND

Crossing Boundaries—Violation or Obligation?

Gordon D. Schiff, MD
Center for Patient Safety Research and Practice, Division of General Internal Medicine, Brigham and Women's Hospital; and Harvard Medical School, Boston, Massachusetts.

It is 5 PM on Friday afternoon. After 2 hours on the telephone trying (and failing) to get her insurance plan to pay for her medication refill, I reached into my pocket and handed the patient $30 so she could fill the prescription. It seemed both kinder and more honest than sending her away saying, "I'm sorry I can't help you." While I hardly expected a commendation for such a simple act of kindness, I was completely surprised to find myself being reprimanded for my "unprofessional boundary-crossing behavior" after the resident I was supervising shared this incident with the clinic directors. This allegation of an ethics violation was not only personally painful; it also raised important, controversial, and timely questions about appropriate professional roles.

After more than three decades as a general internist at a Midwest public hospital, I joined the staff of an academic medical center in Boston. While the public hospitals' patients were predominantly poor and uninsured, the academic center had both a different patient-mix and, to my surprise, a different culture and different norms related to "professional-patient boundaries." Actions my public hospital colleagues and I regularly took to help needy patients were questioned as inappropriate and unprofessional. Indeed, informal polls I've recently conducted at conferences

relationships?[2] And will such bounded thinking serve to rationalize abdication of our professional and personal responsibilities to humanely respond to patient suffering and underlying injustices?

While I had rarely paid for a patient's medication as I did on that Friday afternoon (medications had been free at the public hospital clinic), in this situation it seemed reasonable and appropriate. Various ethics and conflict of interest rules prohibiting physicians from having "financial relationships" with patients may be appropriate when it comes to physicians *taking* or *soliciting* money from patients. But what about the propriety of *giving* money to a needy patient in this particular situation? While other alternatives such as using a special fund might be preferable, when I found that no such fund existed at my hospital (and the drug insurance plan denied coverage due to a technical glitch in the patient's enrollment), was it wrong to personally help a patient in such a moment of need?

Everything we do in medicine has risks. Whether prescribing a medication or performing surgery, we, in consultation with the patient and family, must weigh potential benefits and risks. When considering reaching out to help patients in need, possible adverse effects should be weighed against the benefits in that particular con-

The New York Times

HARD CASES

When Healers Get Too Friendly

By ABIGAIL ZUGER, M.D. NOVEMBER 11, 2013 4:54 PM 103 Comments

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The activist became my patient back in the mid-1990s, when H.I.V. was slowly morphing into a treatable disease. He was young then, with a mop of dark curls — excitable, suspicious and

DOCTORS

When Doctors Give Patients Money

By DANIELLE OFRI, M.D. JANUARY 30, 2014 11:07 AM 131 Comments

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Recently a few of my colleagues were sitting together and one asked if any of us had ever given money to a patient. There was an awkward pause, and then the stories starting coming out — a few dollars for a co-pay, or to help a frail patient take a cab instead of a bus; a bag of food or an extra meal. “How could I not,” one doctor said, “when my patient’s immediate need could be solved by the small change in my coat pocket?”

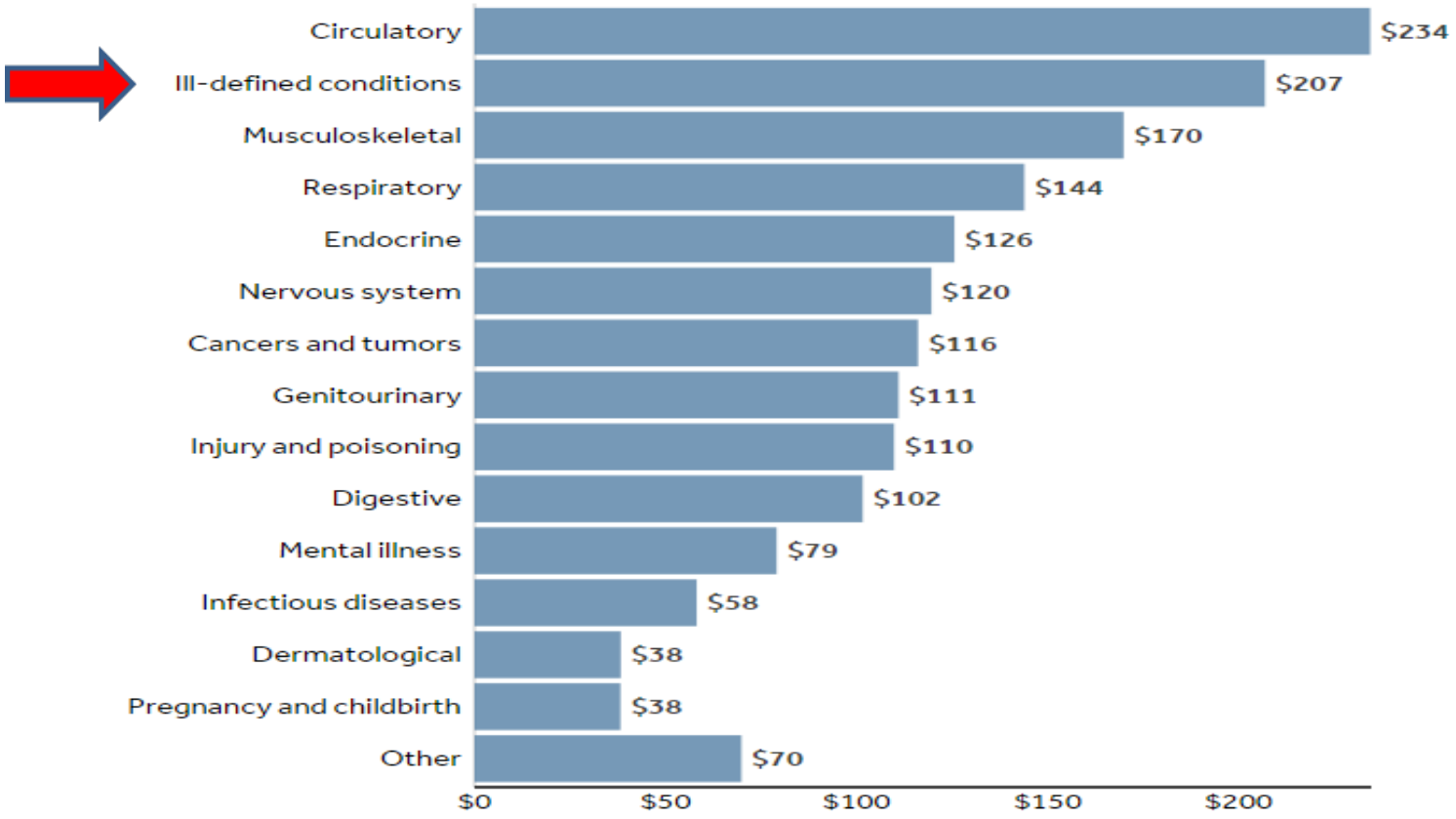
A physician recently wrote in JAMA about giving a patient $30 to help pay for a medication after a two-hour phone battle with the insurance company came to naught. He was cited by his institution

Daunting PCP Challenges

- Chronic pain patients
- Opiate crisis; war on drugs
- Multiple somatic sx pts

Circulatory conditions, such as heart attacks and high blood pressure, are the largest category of spending

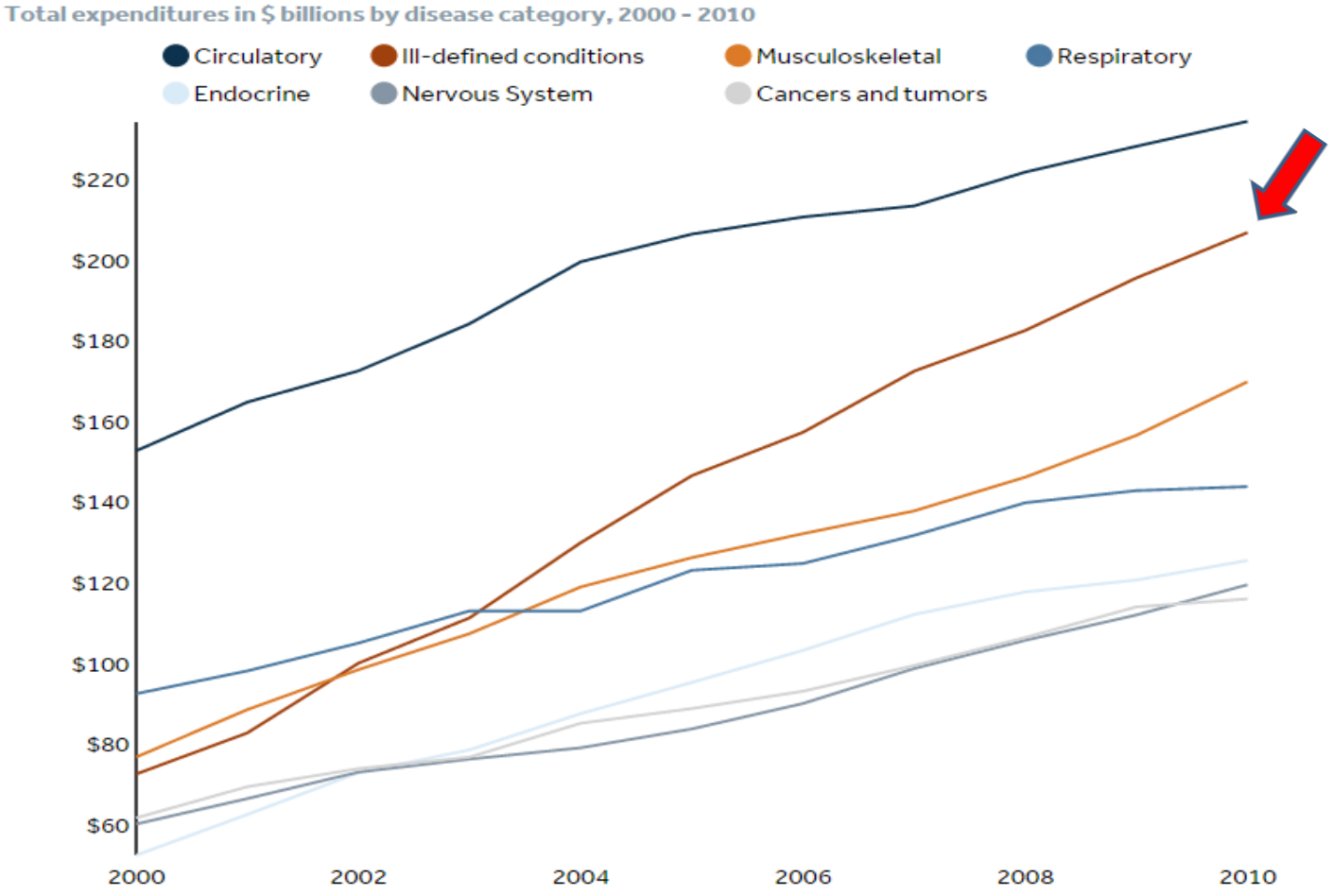
Total expenditures in $ billions by disease category, 2010



Source: Bureau of Economic Analysis Health Care Satellite Account (Blended Account) Note: Expenditures on nursing home and dental care are not included in health services spending by disease.

Peterson-Kaiser Health System Tracker

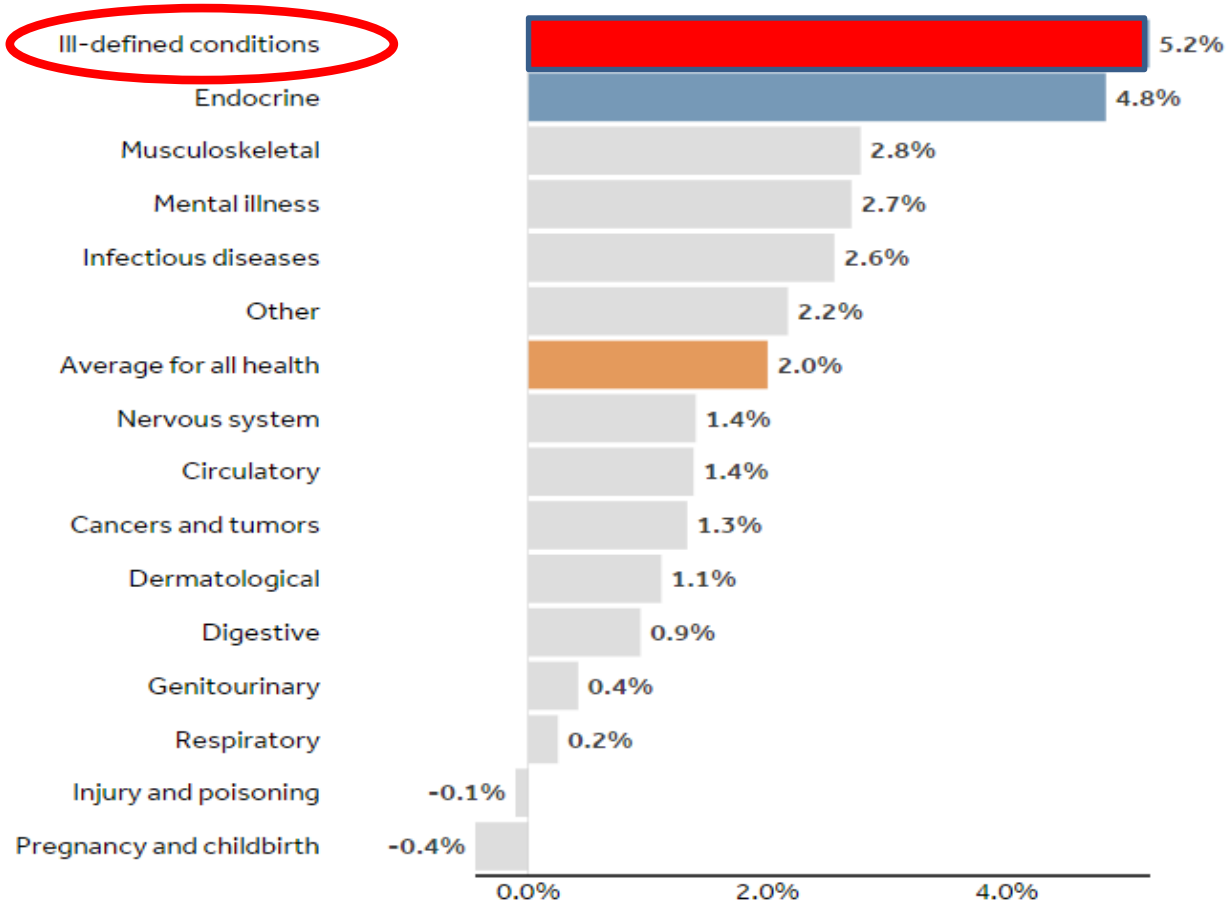
Spending on the highest cost diseases has increased at varying rates



Source: Bureau of Economic Analysis Health Care Satellite Account (Blended Account) Note: Expenditures on nursing home and dental care are not included in health services spending by disease

The number of treated cases grew fastest for ill-defined conditions and endocrine disorders

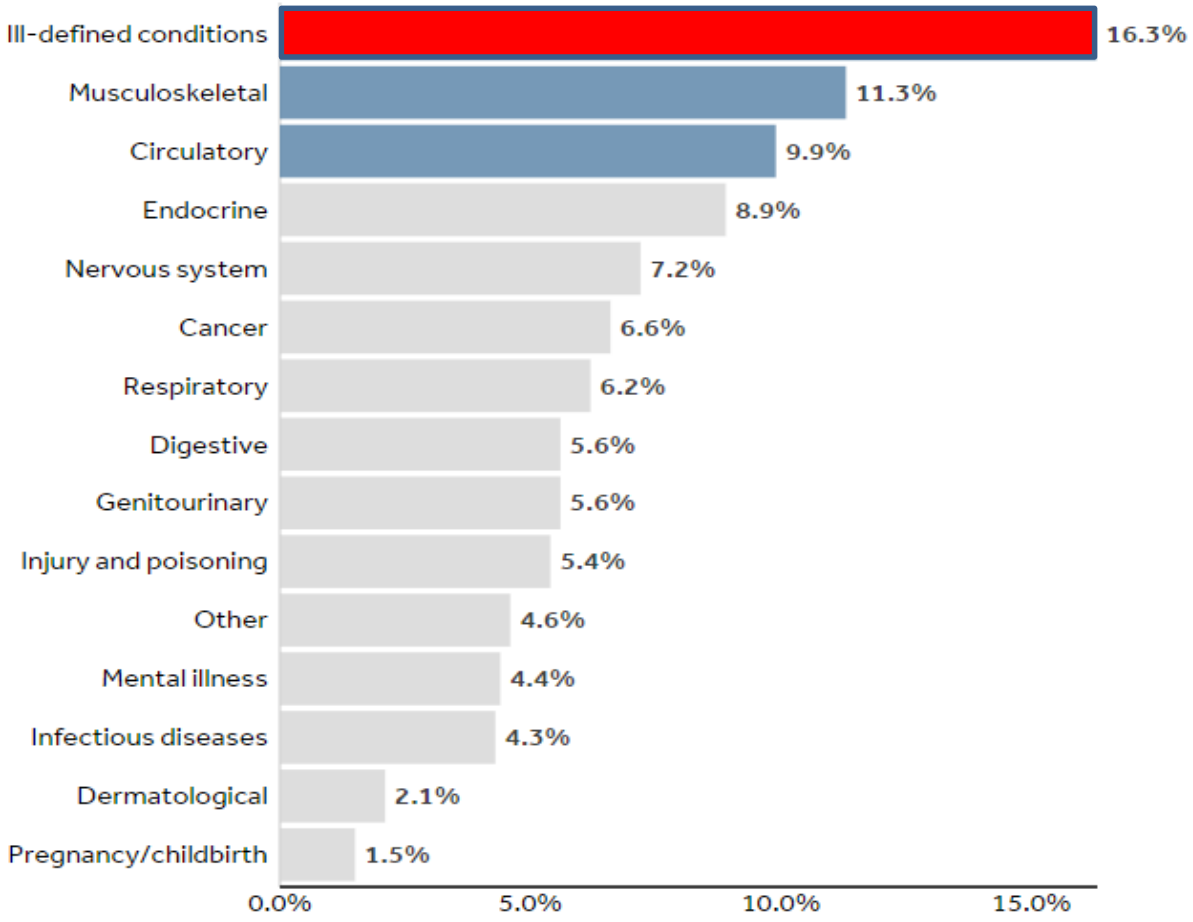
Average annual increase in real expenditures by disease category, 2000 - 2010



Source: Bureau of Economic Analysis Health Care Satellite Account (Blended Account)

About a third of medical services cost growth was from ill-defined, musculoskeletal, and circulatory conditions

Contribution to medical services expenditure growth, by disease, 2000 - 2010

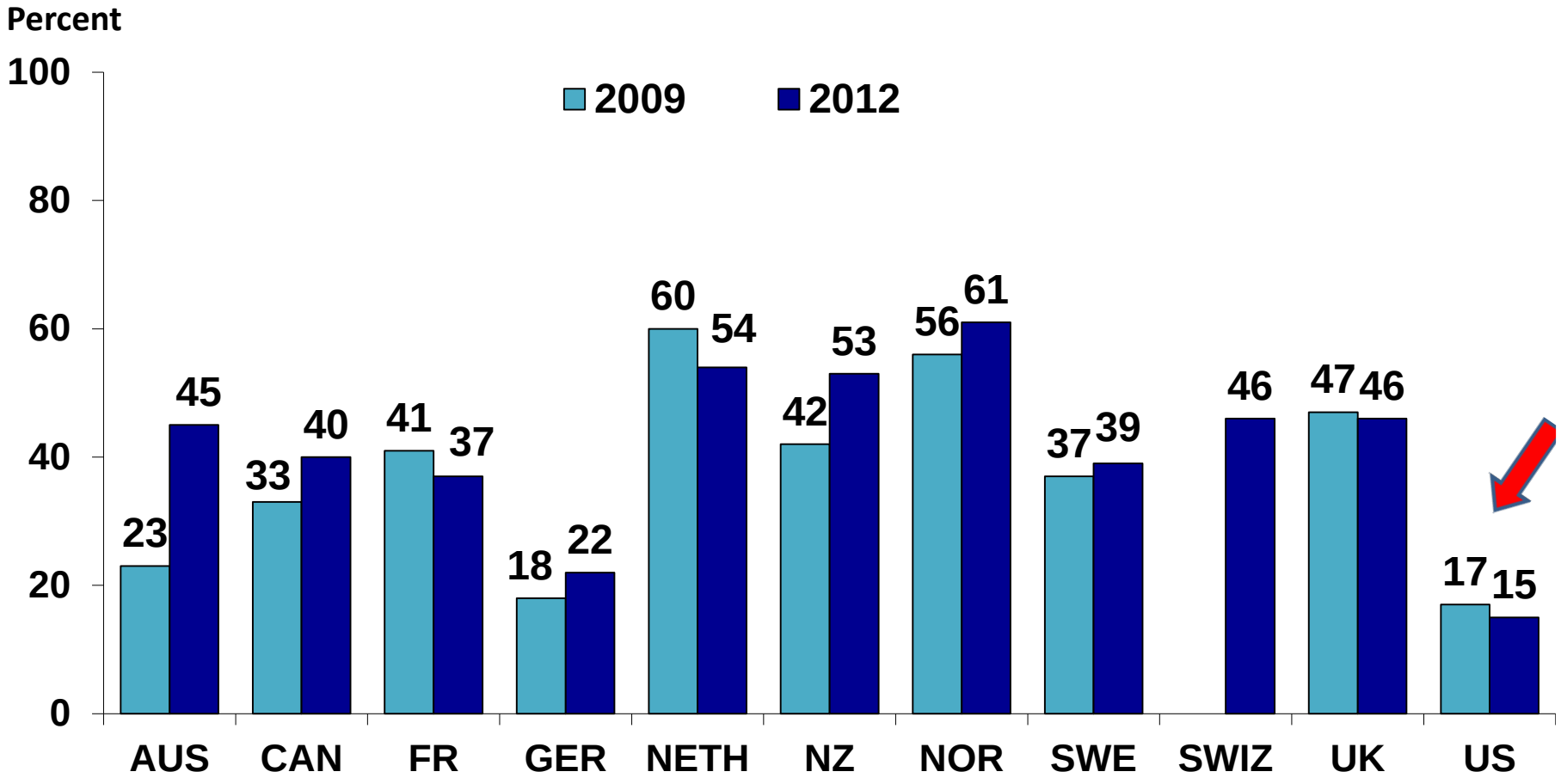


te Account (Blended Account) Note:

Daunting PCP Challenges

- Chronic pain patients
- Opiate crisis; war on drugs
- Multiple somatic sx pts
- Obesity epidemic
- Conflicting screening guidelines
- Information overload
- Malpractice, missed diagnosis
- Over-testing, overdiagnosis
- Poorly designed EMRs
- Lack of health insurance
- Huge deductable, copay plans
- Narrow, out of network issues
- Indefensible high changes
- Mind boggling drug costs
- Parking, traffic, snow, no-shows
- Poverty, homelessness

Physician Views of the Health System, 2009 and 2012: "System Works Well, Only Minor Changes Needed"



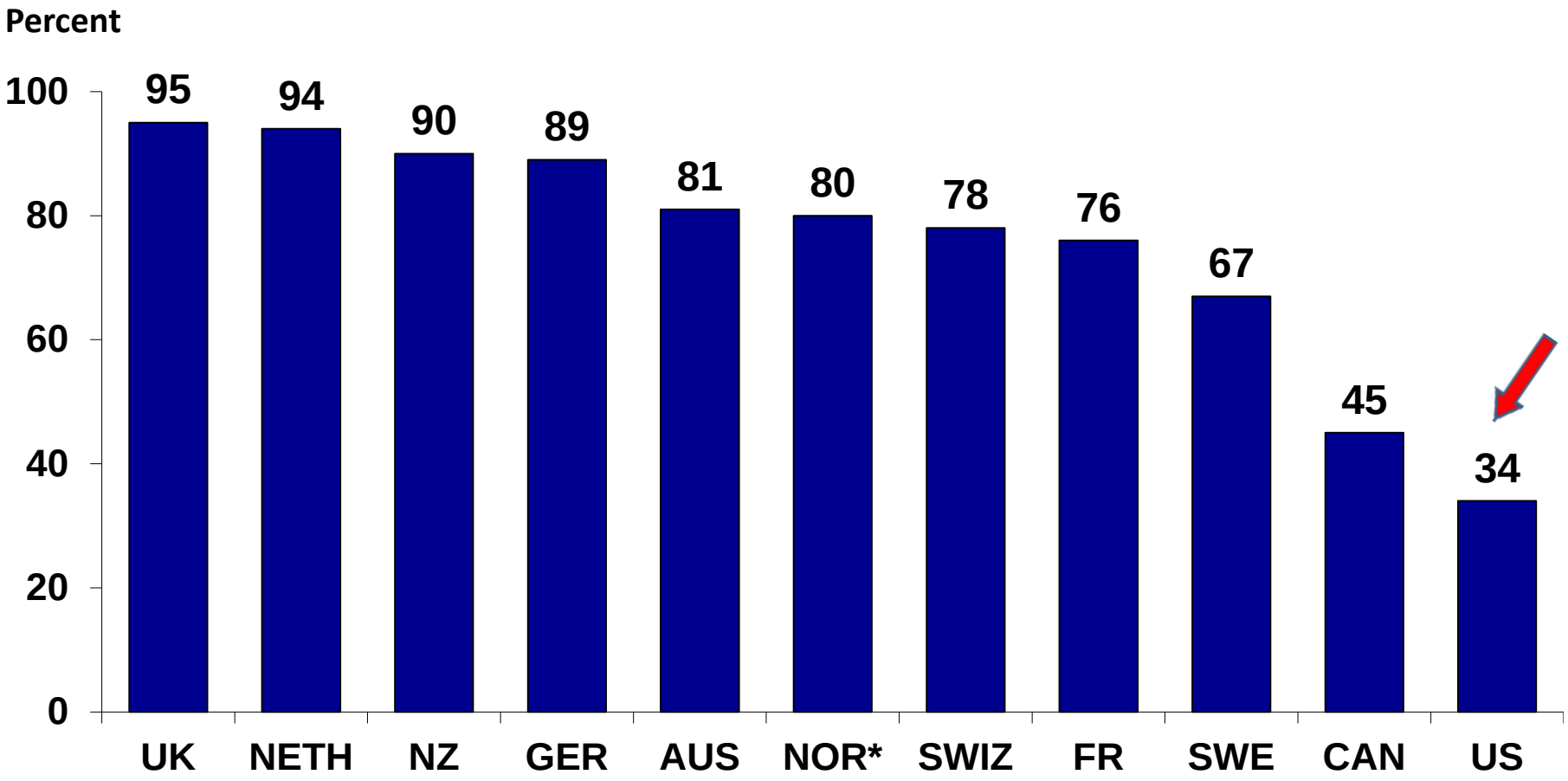
Source: 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Doctors' Perception of Patient Access Barriers

Percent reporting their patients OFTEN have:	AUS	CAN	FR	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
Difficulty paying out-of-pocket costs	25	26	29	21	42	26	4	6	16	13	59
Difficulty getting diagnostic tests	16	38	41	27	7	59	10	15	3	14	23
Long waits to see a specialist	60	73	59	68	21	75	60	49	10	28	28

Source: 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Practice Has Arrangement for Patients' After-Hours Care to See Doctor or Nurse



* In Norway, respondents were asked whether there practice has arrangements or if there are regional arrangements.
Source: 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

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How Do Medical Students View the Work Life of Primary Care and Specialty Physicians?

Dr. Julie Phillips, MD, MPH, **Dr. David Weismantel, MD, MS**, **Dr. Katherine Gold, MD, MSW, MS**, and **Dr. Thomas Schwenk, MD**
College of Human Medicine, Michigan State University (Drs Phillips and Weismantel); and Department of Family Medicine, University of Michigan Health System (Drs Gold and Schwenk)

Abstract

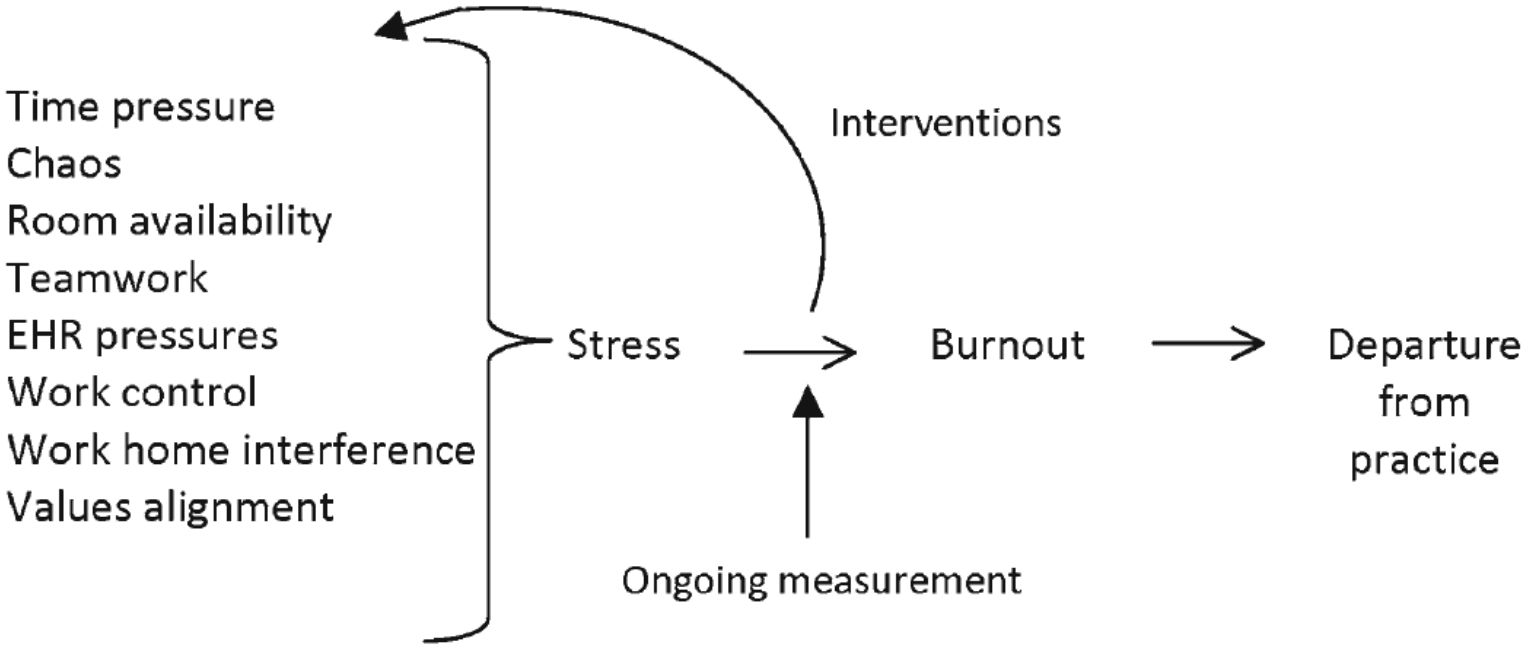
Background and Objectives—Student perceptions of day-to-day physician work life, and relationships between these perceptions and specialty choices, have not been quantitatively explored. The study's purposes were to measure student perceptions of primary care and specialist physician work life, including administrative burden, time pressures, autonomy, and relationships with patients; to determine whether senior students' perceptions vary from junior students' perceptions; and to determine whether students with primary care career plans view primary care work life differently than their peers.

Methods—A cross-sectional anonymous survey was offered to all students at three allopathic U.S. medical schools between 2006 and 2008.

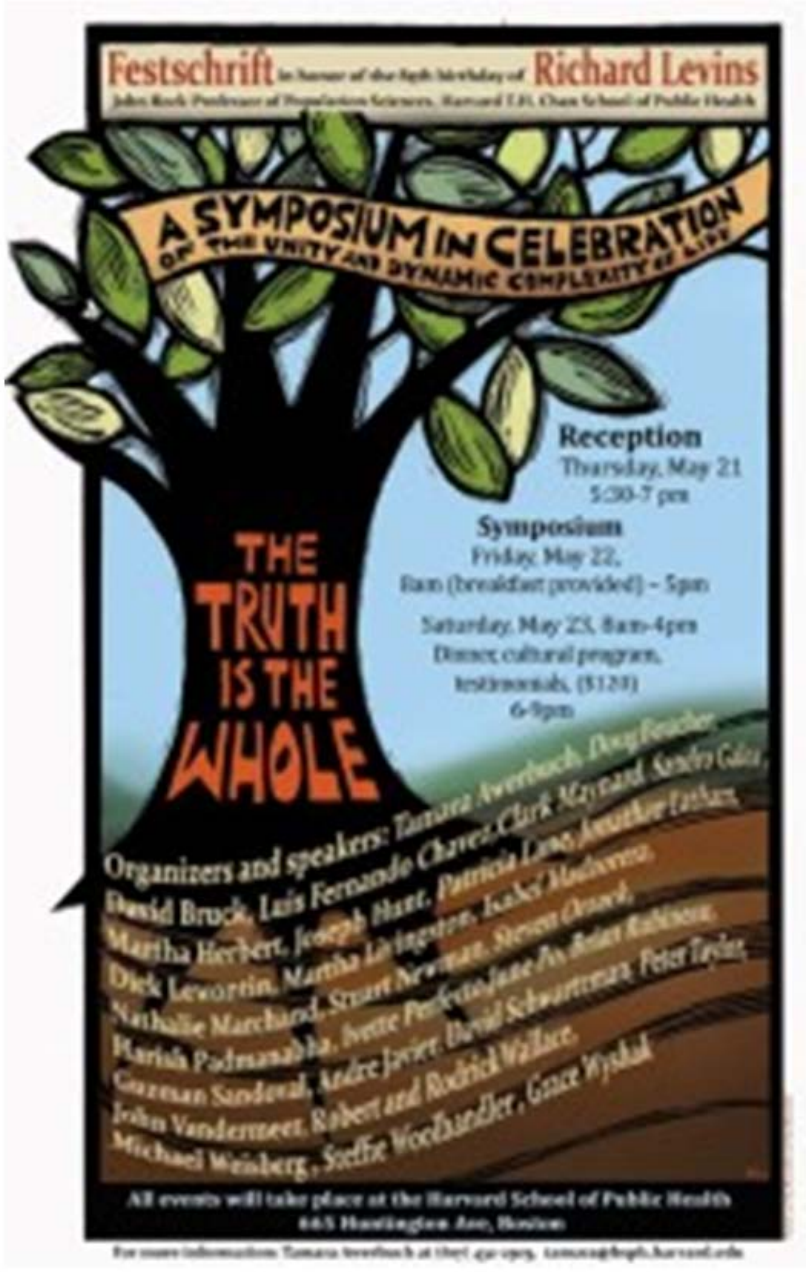
Results—Of 1533 eligible students, 983 submitted usable surveys (response rate 64.1%). Students viewed the day-to-day work life of all physicians negatively, but viewed primary care physician work life more negatively. Senior students viewed specialist work life more positively, and primary care work life more negatively, than junior students. Students planning primary care and specialist careers had similar views of primary care and specialist work life.

Conclusions—Students have negative views of the work life of all physicians, especially primary care physicians. Students planning careers in primary care share this negative view of their future work life, suggesting that their career choices are not based on different work life perceptions.

Model of QI feedback loop to prevent stress, burnout and turnover



Linzer JGIM 2014


Festschrift in honor of the 65th birthday of Richard Levins
A SYMPOSIUM IN CELEBRATION
THE TRUTH IS THE WHOLE
Reception
Thursday, May 21
5:30-7 pm
Symposium
Friday, May 22,
8am (breakfast provided) - 5pm
Saturday, May 23, 8am-4pm
Dinner, cultural program,
testimonials, ($120)
6-9pm
Organizers and speakers: Tamara Awerbuch, Doug Brucker,
Ronald Bruce, Luis Fernando Chaves, Clark Mayeard, Sandro Galea,
Martha Herbert, Joseph Hunt, Patricia Lane, Jonathan Latham,
Dick Lewontin, Martha Livingston, Isaac Maidowa,
Nathalie Marchand, Stuart Newman, Steven Osmond,
Mariah Padmanabha, Ivette Perfecto, Jane Pu, Brian Robinson,
Guzman Sandoval, Andre Javier, David Schwartzman, Peter Taylor,
John Vandermeer, Robert and Rodrick Wallace,
Michael Weinberg, Steffie Woolhandler, Grace Wyshak
All events will take place at the Harvard School of Public Health
665 Huntington Ave, Boston

Editorial

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EDITORIAL

Diagnosis and diagnostic errors: time for a new paradigm

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It looks like diagnosis triggers may be gaining traction. Building on their earlier efforts,[1 2] a team of investigators based in Houston reports on their latest effort to apply electronic screens—so called 'triggers'—to large clinical databases, to identify cases of potential diagnostic errors.[3] They searched nearly 300 000 patients' records over a 12-month period at two large health systems with comprehensive electronic health records. They sought patients who had one of four 'red flag' findings for prostate or colon cancer—elevated prostate specific antigen (PSA), positive fecal occult blood test (FOBT), rectal bleeding (haematochezia), and iron deficiency anaemia. They then used a refined electronic algorithm to cull out patients who (1) were already known to have prostate or colorectal cancer, or (2) had evidence of appropriate follow-up testing or referral. This process left roughly 1500 patients with one of the

did not. Since there is no reason to believe their findings are not broadly representative of ambulatory care in general (and the fact that both the institutions had advanced electronic systems should, in theory, put them in a better position for reliable follow-up than those lacking such capability);, the findings mean that healthcare diagnosis, as measured by this one metric at least, is a long way from *six-sigma* quality (defined as one defect per 3.4 million). This study's rate translates into roughly 13 600 defects per 3.4 million patients. While one could quibble with some of the arbitrary cut-off intervals chosen for this study—a colonoscopy 61 days after a positive FOBT was failed care, whereas, one after 59 days was not; similarly with 91 vs 89 days for follow-up of an elevated PSA—the study unquestionably highlights undesirable delays that more efficient and more reliable care should be able to avoid.


Nothing about us
without
us
is for
us
Based on slogan popularized by South African disability rights and youth activists.

Where and How to Go Forward

- Recognize changes are symptoms/reflections of large power shifts
  - PCPs in middle of crossfire, struggles; part of problem or solution
- MD wellness linked to patients' wellness
  - Alliance to co-produce and mutually support
- Congruency of our frustrations and safety risks
- EMR — need for fundamental redesign
- Time — currency of primary care (2 ways)
- Teams, teamwork, leadership to support complex pts and care complexities
- Crossing boundaries to care for pts and selves
- Bringing pride and joy back to practice of medicine
- Simplified single universal insurance system