Publishing Quality Improvement/Safety work

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Financial disclosure- None
1. Why should you publish?

2. Issues with publication
   - QI is different from clinical/research interventions
   - Writing is unfamiliar
   - Review is unfamiliar
   - Choosing the right journal

   NOTE: Not everything can be labeled QI!!!

3. Use the SQUIRE guidelines
QI versus QI Research

- deviation from established practices
- individual patients are the subjects,
- randomization or blinding is conducted
- participants are subject to additional risks
- burdens beyond the usual clinical practice to make results generalizable

- Get IRB when in doubt!
Steps necessary to conduct a QI project

1. Identify target of opportunity
2. Synthesize information about optimal practice
3. Synthesize information about current practice
4. Develop a strategy for practice improvement
5. Implement strategy
6. Assess cost-effectiveness of the solution
7. Determine whether solution should be disseminated

Nolan's Model

GoaldAim
What are we trying to accomplish?

Measurement
How will you know a change is an improvement?

Improvement Ideas
What changes can you make that will result in an improvement?

PDSA Cycle

Act
Determine what changes are to be made

Plan
State objectives
Make predictions
Develop plan to carry out cycle

Study
Summarize what was learned

Do
Carry out the test and document problems and unexpected observations

Study designs

- pre and post
- time series
- control arms
- randomized controlled trials

Types of articles

- Measurement
- Improvement
- Process redesign and Innovation
- Change management
- Culture
- Safety
- Methodology
- QI Education
- Policy, public reporting/accreditation
Clinical Value Compass

- Physical Function
- Mental Health
- Social/Role
- Other (e.g., Pain, Health Risk)

**Functional**

**Clinical**
- Mortality
- Morbidity
- Complications

**Satisfaction**
- Health Care Delivery
- Perceived Health Benefit

**Costs**
- Direct Medical
- Indirect Social

Nelson et al, Dartmouth
Explicitly describe the theory behind the chosen intervention components or an explicit logic model for why this patient safety practice should work.
Describe the patient safety practice in sufficient detail that it can be replicated, including the expected effect on staff roles.
Measure high-priority contexts in the 4 domains described in Table 2.
Detail the implementation process, the actual effects on staff roles, and how the implementation or intervention changed over time.
Assess the effect of the patient safety practice on outcomes and possible unexpected effects, including data on costs, when available.
For studies with multiple intervention sites, assess the influence of context on the effectiveness of intervention and implementation.
Table 2. High-Priority Contexts to Include in Reports of Patient Safety Research

- External factors, such as regulatory requirements, public reporting or pay-for-performance, and local sentinel events
- Organization structural characteristics, such as size, complexity, and financial status or strength
- Teamwork, leadership, and patient safety culture
- Management tools, such as training resources, internal organization incentives, audit and feedback, and quality improvement consultants
Introduction

Conceptual Framework

Literature Review

Problem Statement

Statement of Study Intent

McGaghie WC. Acad Med. 2001; 76: 923
Slide from David Cook, MD, MHPE
Methods

• Statement of study design
• Describe setting, participants
• Describe intervention
• Define outcomes, data collection
• Details of data analysis
• Ethical/IRB approval
Results

- Tell a story – natural flow, think *reader*
- Interpret the results
- Judicious tables & figures
Discussion

• Summary

• Limitations

• Integrate with prior work

• Implications for practice and future work

• (optional) Conclusions
QI/safety journals

- Jt Comm J Qu Saf
- AJMQ
- J healthcare qual
- Qual saf
- Int J of Qu in healthcare
- J of patient safety
- Qual primary care

- Others
  - Specialty journals
  - Management journals
  - Topic specific; e.g. patient education, etc
A Systems Approach for Implementing Practice-Based Learning and Improvement and Systems-Based Practice in Graduate Medical Education
Prathibha Varkey, MBBS, MPH, MD, Sudhakar Kalapudi, MBBS, Steven Rose, MD, Roger Hinton, MD, and Mark Warner, MD

Abstract
The Accreditation Council for Graduate Medical Education (ACGME) initiated its Outcome-Project to better prepare an institution-wide curriculum intended to facilitate the teaching and assessment of critical and SBI competencies in the 11% measurement competency in SBP, no change in their perceived ability to measure competence in PIB, a 15% increase.

Commentary
A Systems Approach to Teach Core Topics across Graduate Medical Education Programmes
Prathibha Varkey, MBBS, MPH, MD, Sudhakar P Kalapudi, MBBS

An Experiential Interdisciplinary Quality Improvement Education Initiative
Prathibha Varkey, MD, MPH
M. Katherine Rehrer, RN, BSN, CPHQ, CMQ/CE
Alan Smith, PhD
Julie Pinto, RN, PhD, APRN-BC, AOCN
Michael Osborn, MD

Teaching Quality Improvement: A Collaboration Project Between Medicine and Engineering
Prathibha Varkey, MBBS, MPH, MD, MPH
Sudhakar P. Kalapudi, MBBS
Kevin E. Bennett, BSChE, MBA

Introduction
Systems failures and their impact on quality and cost have fueled the need for a paradigm shift in medical education. Despite a growing interest in health care quality improvement (QI), few physicians are often caused by system failures, and the design of safer systems is essential to prevent medical errors. In a second publication on patient safety.

Educating to Improve Patient Care: Integrating Quality Improvement Into a Medical School Curriculum
Prathibha Varkey, MD, MPH
The Objective Structured Clinical Examination as an Educational Tool in Patient Safety

Prathibha Varkkey, M.D., M.P.H.
Neena Natt, M.D., M.Ed.

The milieu in which today’s medical school graduates will be practicing is changing rapidly. A curriculum focused on disease and its management

Root Cause Analysis

Developing a Tool for Assessing Competency in Root Cause Analysis

Priyanka Gupta; Prathibha Varkkey, M.B.B.S., M.P.H., M.H.P.E.

Between 1995 and September 2008, The Joint Commission recorded 5,437 sentinel events.1 Root cause analysis (RCA)

Validity Evidence for an OSCE to Assess Competency in Systems-Based Practice and Practice-Based Learning and Improvement: A Preliminary Investigation

Prathibha Varkkey, MD, MPH, MHPE, Neena Natt, MD, Timothy Lesnick, MS, Steven Crowning, PhD, and Rachel Yudkowski, MD, MHPE

Abstract

Purpose
To determine the psychometric properties and validity of an OSCE to performance in each of the stations was assessed by three faculty experts using checklists and a five-point global OSCE was realistic and capable of providing accurate assessments.

Article-at-a-Glance

An Innovative Team Collaboration Assessment Tool for a Quality Improvement Curriculum

Prathibha Varkkey, MBBS, MPH, MHPE
Priyanka Gupta, BS, BSBA
Jacqueline J. Arnold, MSN, RN
Laurence C. Toshber, MD

The success of quality improvement (QI) initiatives is significantly dependent on the effective functioning of the team responsible for the project. The aviation industry developed crew resource management programs to help teams develop nontechnical skills

An Innovative Method to Assess Negotiation Skills Necessary for Quality Improvement

Prathibha Varkkey, MBBS, MPH, MHPE
Priyanka Gupta, BS, BSBA
Kevin E. Bennet, BScE, MBA

Quality improvement (QI) initiatives require leaders who can facilitate change through negotiation. Although a few education programs teach these

Keywords: negotiation; assessment; objective structured clinical examination; quality improvement; influence