



Central Line
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(SOUNDBITE OF MUSIC)

VOICEOVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER, HOST:

Hi, this is Adam Striker, Editor of ASA's Central Line. Today we're joined by Dr. Grant Lynde. Dr. Lynde is an expert in quality improvement, an Associate Professor in the Department of Anesthesiology and Vice-Chair of Quality Improvement for the Emory University Department of Anesthesiology. We're going to dig into the topic of quality improvement and benchmarking. Dr. Lynde, thanks for joining us today.

DR. LYNDE:

Thank you. I'm, I'm really excited to be here today.

DR. STRIKER:

Well, let's start out with, why don't you tell our audience a little bit about yourself and, uh, your current role as a Quality Leader at Emory.

DR. LYNDE:

OK, great. I've had a really fascinating career in anesthesiology. I graduated from University of Pittsburgh back in 1998 and, uh, did my anesthesiology residency through the military, at Walter Reed Army Medical Center. After that, I paid back, um, my service, uh, at Madigan Army Medical Center in Tacoma Washington, and then I transitioned to private practice ultimately ending up in Clearwater, Florida. And when the housing crisis happened in 2008 and the economy fell apart my practice had some financial difficulty and, uh, I ended up transitioning to academics at Emory in 2010 where I started as the Director of OB Anesthesiology at Grady Memorial Hospital, which is a large public health hospital here in Atlanta. And over the last 10 years, I've gained increasing administrative responsibilities and now I'm the Vice Chair of Quality for the

Department which covers anesthesia services at ten hospitals, multiple surgery centers, and is, uh, located throughout the entire state of Georgia.

DR. STRIKER:

Dr. Lynde, obviously you have a real interesting background, but in addition, you also have a Six Sigma Black Belt. You have an MBA, and I'm interested to hear how that winding path lead you to Quality Care, the role that you're fulfilling right now.

DR. LYNDE:

I think what is really interesting is, is some of it is who I am. I've always been really curious and I've always been interested in how can I do my day better? How can I take care of my patients better? But also where I first gained a lot of insight into the process of Quality Care, was actually because of the military. And if you think about it, the military has a lot of interest in performing quality improvement and ensuring that they have safety of their troops and that every day, they do things better. So they have the processes of briefing, and then debriefing, and examining in a way that is non-judgmental. How did everybody today, and how can we, uh, do tomorrow better?

And so a lot of that background has carried with me to stay where I have been interested in saying, okay, how can we approach things from a systems level, and not actually look at an individual provider and say wow, you know, you, you made the mistake, you screwed up. Uh, you know, we really need to look at things from a systems level and say to ourselves, how can we make the system, how can we make things work in a way for people to actually do the right thing every single time? Because they want to, and because is the easy thing to do. And so all these things together, uh, actually create a lot of my joy at work and that's actually how I, I've moved along in the, in my personal career, and in my own process.

DR. STRIKER:

Was there a specific "a-ha" moment that lead you to quality improvement, or, um, something specific about the topic that keeps you motivated and focused on it day after day?

DR. LYNDE:

I think it's difficult to say an "a-ha" moment, because I think that there were a lot of things always there. So for example, when I was first in private practice, you know, as you might imagine, uh, military, kind of like academia, some of the cases may take a little bit longer, or some of the metrics for throughput are, are not necessarily as

forefront as they are in private practice. And so I realized that in order to, quite honestly, be one of the better anesthesiologists in my group, I needed to treat every patient, every case, as, how can I wake my patient up better? How can my patient get discharged from PACU faster, and, and not experience nausea and vomiting, and things like that.

And so that was, again, sort of one of those intrinsic things that existed, but really where it turned for me was during my MBA. Uh, I took a course on process Improvement and Six Sigma and that eventually led to the Black Belt. And I realized that there's language that used in the business world and a whole cannon of literature to describe a lot of ways that we physicians feel on an everyday basis. And what I realized, is that if we only learn that language and only learn the processes that apply what has been known in industry for twenty or thirty years into healthcare, we will actually be incredibly successful and we physicians can be the advocates for doing healthcare better, instead of giving that right away to the various business people and financiers that you know, frequently frustrate a lot of us in our day-to-day clinical care.

DR. STRIKER:

Well, you know, there's a couple things I want to delve into. Number one, about the military background, I, I find quite fascinating. You know, when we as a group of some years ago had a talk about quality improvement, and one of the prime examples given by the speaker was, uh, aircraft carriers and the landing of planes, and dropping the rate of accidents upon landing, which certainly resonated and made a lot of sense. But the more some of us thought about it, and I imagine this thought is out there, I think on the surface it's obvious that quality improvement is important, and, it's, I think to a lot of us, the idea of systematically looking at what we do is important. But when you think about something like that military example, patients are, are different. And I wonder what your thoughts are on applying these principles in general to patient care where every individual has their own set of medical illnesses and backgrounds and histories as opposed to an assembly line, or a rote procedure that's repeated exactly, time after time.

DR. LYNDE:

I think what you're asking about is something really challenging and also really fascinating, which is this idea of being a craftsman on one hand where you individualize patient care so tightly, I think physicians, we look at this and we really identify with that as our role in healthcare. To look at that patient as an individual and prescribe them the perfectly tailored medication or therapy or plan.

And the opposite end of that is essentially what you're talking about, which is this mass production model and everybody's the same. So, you know, in the anesthesia sense,

it's, it's the patient comes in and you push your propofol and maybe you're, you're fentanyl, and I'm now placing my LMA, and I pull the LMA out, and you're out the door. And I think a challenge is that we do have to have some degree of mass care, protocolized care, for everybody. Uh, on things that make a lot of sense, that it's proven on.

So, you know, we don't ask the question of, uh, should propofol for example, be used as the induction agent for the vast majority of our cases? Uh, we, we think that's a, a great drug, with, uh, good side effect profile, and especially for an outpatient setting. However, you know, there are times where you have to look at that and say wow, you know, my patient's got heart failure, and you know, I, I'm concerned about the afterload reduction with propofol and, and the other cardiovascular effects of it. So you, I'm going to use (sic) or ketamine today. And that's really where physician anesthesiologists step in, and my opinion is, understanding when you can apply this, this assembly line process, and when you can, when it's essential, to individualize the care for your patients.

This is actually why I think it's important when we benchmark, uh, how we do our care, that we choose metrics that are, are truly meaningful to physicians in their practices and not just approach it from a, a centralized forum and say under no circumstances should you use, you know, pick one drug over another drug, um, because that, that may not be true one hundred percent of the time.

DR. STRIKER:

Would you say then, in general, that it's probably worthwhile for us to have a hybrid approach. You have some systemic analysis, or systematic analysis, and some tailoring of (sic) care of being able to take advantage of both of those systems together to optimize what we do on a global scale?

DR. LYNDE:

Absolutely, I think ultimately we do need to have a hybrid approach because, you know, any time you do something dogmatically and say absolutely one or the other and be an absolutist, you're not going to get the best results you're looking for. So, you know, in the quality improvement realm, uh, frequently people talk about Lean, and they talk about Lean Six Sigma and Six Sigma and when you actually come down to it, Six Sigma and Lean are diametric opposites. Lean is all about removing excess processes to make things more simple and more straightforward. On the other hand, Six Sigma is all about protocolizing what you're trying to do so that you are getting the exact same product a hundred percent of the time. And so, when you really think about it, philosophically, they're opposites. And, I think in order to be successful, you actually

need to understand both and apply both and have that agility. So turning back around to patient care, having that agility to understand when protocols are great and when they're important, but also being able to individualize care is also crucial and, and that's quite frankly, I think, what makes a well-trained, physician anesthesiologist, and what makes, what drives our value as clinicians.

DR. STRIKER:

The other item you mentioned in your background was the idea that there's a separate language in business culture that physicians really should be taking advantage of. Is it a matter of physicians learning the language so they can better articulate what it is we are already doing? Or is it more, is it deeper than that? Is it that the principles business are using are something that we need to apply more broadly in our practices?

DR. LYNDE:

I think both are absolutely true. I think that it's important to understand the language and the processes, but also to give you a, a great example, uh, Grady Memorial Hospital was renovating their labor and delivery unit a few years ago and all the artwork had been donated by, um, an organization that was from the rich part of town, which also happens to be white, and there were not a single piece of artwork that reflected the patients in the hospital and their, their ethnicity, and their backgrounds. And this is part of me having an MBA, and I was in this meeting and one of the nursing managers, uh, at the end of meeting where I suggested that we reach out to the community and try to find local artists that we could bring in to the hospital, and, and get them to donate some artwork, and maybe we could even give them publicity, and she turned to me and said, you know, Dr. Lynde, why don't you worry about your doctor stuff, and let the MBA's do the management-type stuff. And intrinsically, I knew what she was saying was absolutely wrong. You know, our environment needed to reflect our patients, and, and make them feel at home, and make them feel comfortable. And by having the artwork that we did, it was extremely alienating to those patients. And it was only after, after learning the, the tools, and learning the language of marketing and learning the language of voice of consumer that I actually understood, and could actually communicate that to hospital leadership in an effective manner.

DR. STRIKER:

I understand you're a big believer in benchmarking. Can you talk a bit about that, and why you think it's important?

DR. LYNDE:

Absolutely, so benchmarking, ultimately, it allows you to understand how your practice is affecting patient outcomes, and it allows, it provides you the ability to know truly, how does your patient care compare to somebody else's or some other group's patient care? And at the end of the day, it provides us an opportunity, at best, it provides us an opportunity to look at it and reflect and say wow, you know, what is it about my practice that patients are requiring more opioid than somebody else? Or more of my patients are getting admitted to the hospital after surgery than somebody else, and it allow us to reflect on that any say, wow, you know, how can we do better?

Similarly, I think that it offers groups an opportunity to have competitive advantage when they're in negotiations with hospitals to be able to say look, you know, my group here, we, we are really the premier company in the area and we deserve to provide services for your facility. And if you go with somebody else, they're not going to be as good as we are. Uh, and so because it provides a dispassionate view as well, uh, benchmarking is ultimately the way that any individual, uh, or group, is able to demonstrate their value.

DR. STRIKER:

Well, like many anesthesiologists, I'm sure you're emotionally invested in patient care and patient safety is certainly paramount when it comes to anesthesiology care. Let's connect some dots. How is patient safety advanced because of benchmarking?

DR. LYNDE:

At Emory Healthcare, one of the things that we do, is we subscribe to the National Surgical Quality Improvement Project, which is a quality initiative that is run out of the American College of Surgeons, and the NSQIP database actually allows us to benchmark ourselves against, uh, hundreds of other practices around the country for surgical care in certain types of cases. And they use a lot of preoperative variables, somewhere around forty or so variables, that then will give you a degree of predicted outcome after surgery. So using this database, we have discovered that our rate of deep vein thrombosis is higher than our national average. And that has actually caused us to look at our own processes and understand why. And through this, we've been able to develop a, a multi-disciplinary group, from surgeons and anesthesiologists and pharmacists to actually identify where are are gaps in prophylaxis of our patients. Uh, and I am really excited about that because, you know, as you said, I love direct patient care, but quite frankly being involved in this project has actually allowed me that, to affect more patients at one time, than, than I would otherwise be able to do.

DR. STRIKER:

Do you think benchmarking is becoming more important and if so, why is that?

DR. LYNDE:

Absolutely benchmarking is essential, and it's essential because, of just you know, I think it's difficult to be a physician anesthesiologist or any medical professional and say the way I have always done healthcare is the way I'm going to be. I'm going to be static and never change. So, I think benchmarking is going to be important to help you and, and help us understand. What are the things that you need to focus on? You know, does it, do you need to focus on deep vein thrombosis, or do you need to focus on nausea and vomiting? What is it? And benchmarking helps you do that.

It's essential also because the hospitals and our peers are using benchmark data in order to evaluate the value that you are bringing into the healthcare ecosystem. And ultimately, our payers, our patients, our surgeons, are going to demand that we all are benchmarking and, and doing top-notch care.

DR. STRIKER:

Are you finding that some of your physician colleagues are accepting or resistant to that philosophy? The idea that administrators are benchmarking them and their value is determined on the basis of how these discrete variables fall, rather than, I'm a physician, I bring value, and I shouldn't be measured in that fashion.

DR. LYNDE:

Absolutely. I think that there are certainly people in my practice and there's several hundred anesthesiologists and anesthesiologists that work for Emory Healthcare, and I certainly catch, uh, some resistance from folks who feel that the benchmarks are unfair, or the definitions don't quite fit with what they think good medical practice is, and what have you. And ultimately, there are a couple of principles that I've followed on, on benchmarking, uh, to reduce some of that resistance, but also to actually convert some of the people who really didn't believe it into people who have actually started walking around saying, wow, you know, this is really important.

Those principles are, number one is, I actually am a firm believer that for someone who's boots on the ground in the trenches, that you need to focus on process metrics and not outcomes metrics. For example, did your patient about the surgical site infection is, as an outcome, I'm sure it matters to all us because we care about our patient outcomes, but, you know, as an anesthesiologist, you could say there are a lot of other factors. The surgeon could have operated fast, or the room could have been warmer, perhaps the dressings could have been changed differently. You know, a lot of other things, but if I ask the process metric of, did you give the right antibiotic prophylaxis drugs selection, the right dose, the right time, and the right re-doses, then suddenly it's

something that's well within your control, and it suddenly becomes more difficult to dispute that as a specific metric.

And where I've really turned a corner with a lot of people, is connecting that right drug, right dose, right time, right re-dose, along with the patient outcomes. And so I'm able to show folks within my department, look, as our compliance rates have gone up on these various areas, look patient outcomes for us as a whole have also improved. And, so I think now that people seeing and sort of tying together, that they are a lot more accepting of what it was originally. But I also have to say, that every time a new one roles out, I'm always going to get grumpy people who really are curmudgeons and don't really want to see another metric coming their way.

DR. STRIKER:

In that vein, it's uh, I imagine that it's important to figure out how to sustain these processes. And how, what would you suggest are possible keys to sustain change?

DR. LYNDE:

I think there are a couple of factors in creating sustainability for creating metrics and and quality improvement. Number one is you need to have high quality data. If you don't have high quality data that is also automated and that can provide dashboards that are easy to understand and tell a story, uh, it, it becomes very difficult. And you also need people who are invested in the project. I personally can't be the cheerleader for absolutely everything because quite frankly, at some point, uh, people are going to get sick of hearing me and seeing me. Uh, and so at the end of the day, it's important for me to engage my peers, and engage our residents, and our anesthesiologists, our surgeons, and a lot of other people into a project and get them excited about it, allowing them to have the opportunity to, you know, to have impact.

So, beyond data, and beyond people, uh, the other key is building a team. And I think that that is something that a lot of folks don't necessarily, uh, pay attention to. What the reality is, I'm more of a coach for a team of people that do the work and are cheerleaders and make sure it happens, and make sure happened successfully. And none of these projects are about Grant Lynde. These projects are always about the patients and their outcomes and it's also about the team and I make sure that the team receives the credit, uh, and that I always put the team in front of myself.

DR. STRIKER:

Well, let's talk a little bit about Emory. What kind of quality initiative programs is Emory involved in?

DR. LYNDE:

Our department is really fortunate. Over the last several years, we've built some very strong relationships with the departments of surgery and nursing, to the point where although the system sees nursing and surgeons as separate, uh, we all have basically from the ground-up, created ourselves a service line. And so as a result, we collectively look at different areas, identify areas where we have high impact, but also areas where there's a lot of interested in, in improvement. So right now, our focus is on surgical site infections, you know, clearly because it's a CMS hack that, that they focus a lot on. Uh, deep vein thrombosis and hyperglycemia management is the other one that we're really focusing on right now.

DR. STRIKER:

And can you tell us a little bit about how you collect the data, how you use it, specifically for your improvement initiatives? And, um, maybe a little bit about how it's stored, who has access to it?

DR. LYNDE:

So, to not get too far deep in the weeds, uh, we've got data that comes from a lot of different directions. Number one is the electronic medical record and Emory Healthcare, all of our electronic medical records across the healthcare system are uploaded into a clinical data warehouse where absolutely every piece of electronic data that is collected on a patient sits. Unfortunately, we don't have electronic medical records, believe it or not on labor and delivery. We don't have it on a lot of our off-site care for, uh, anesthesia services. And so that's still on paper and so there's a little bit of black box where those exist.

Independent of this we have, uh, quality-improvement (sic) sheets. They're, uh, performed on every single patient across the system. And, for a variety of reasons, uh, they're all on paper, and they're bubble sheets. But these bubble sheets all get scanned, and, and they go through optical character recognition software, also uploaded into the same clinical data warehouse. And so, through some absolute magic, that computer geniuses who work for me have done, uh, these sheets, the patient care records, and our benchmarking data sets that include Vizient, NSQIP, NHSN, uh, and other (sic) databases are all merged into one giant dataset. And so, uh to use a technical term, we have a data lake, all focused on perioperative anesthesia care. Uh, we then create stories with the data. And we take the data, and, uh, create visualizations around it to help tell the story for how to deliver better care.

And, uh, who has access to it? It, it's pretty open-access, believe it or not. Uh, so people's individual, uh, outcomes and processes are given to them, uh, on a monthly basis and in terms of higher level data, uh, anyone wanting to do a quality project or a research project has access to it. And we also are actually the source of data for the healthcare system for perioperative services. So, uh, it's really exciting. It's a great opportunity.

DR. STRIKER:

Are the downsides to collecting too much data?

DR. LYNDE:

That's a tough question. I don't think the collection of the data has a downside as long as you don't have any manual intervention related to it, but where I think you end up with a lot of challenges, is when we get data requests. So, uh one of our ongoing jokes, we had t-shirts made to move a team project where it says, you know, every anesthesia data analytics, and then on the back in binary, it says "all the data". And, you know, one of our challenges is you, you will get a data request where someone says, I want all the data related to anesthesia services on, on this, on this type of patient and they don't really know what all the data is. And then I think it also leads downstream to you know, some bad research where people go P hunting and uh, don't really have a fully formed hypothesis other than I want to see how this relates to this. So it's a association, and not necessarily even looking for, uh, story behind causality, and so those are analysis and analytics things, independent of the collection, but I think our great collection sometimes runs the risk of feeding that.

DR. STRIKER:

Yeah, I've always wondered if you know, if you, if you have a question the data can be helpful, but that if you are always processing data or always analyzing data, might you end up drawing conclusions that you, you may wish you hadn't, um, just because you have the data? And I don't know how often that might occur, um, if that's more theoretical?

DR. LYNDE:

Yeah, absolutely. I think, I think you're bringing up a great point about, you know, the data side and, and drawing wrong conclusions, because the thing is, it's so easy to connect things that don't necessarily belong together. So, you know, taking two somewhat relatable things and putting together, like sunshine and a warm day, and you know, actually saying okay, um, if it's a sunny day out then it's going to be hot, but then

the reality is, it's not necessarily, it has a lot of other factors of whether or not it's going to be hot.

Um, so I think that before you engage in any sort of data analysis, whether it's for a research project, whether it's for a business plan, you need to have a plausible explanation for how those associations uh, came into existence. And then you also have to have, in addition, looking for evidence that your theory is true. You also need to look for evidence and, and be open to the idea that your theory isn't true, and look for that evidence showing that your theory isn't true.

DR. STRIKER:

Well, I understand Emory has reviewed preoperative antibiotics as you mentioned, you mentioned timing, administration and the impact on surgical site infection. How did you zoom in on that specific challenge? Was it that you mention that because of CMS made sense, but I didn't know if there was more to it than that, or, um, if it was simply because CMS looks at that. That's how you, the surgery division, the nursing division, and anesthesiology department all agreed to go about that.

DR. LYNDE:

This is actually kind of cool story about accidentally ending up in the, in the place, the right place at the right time. Uh, so through NHSN data that the, uh, hospital judges their hospital required surgical conditions on for surgical site infection, it showed a bump in our surgical site infections and simultaneously through NSQIP data the results were showing a bump in our surgical site infections. And so, I was aware of the NSQIP data, but I wasn't aware of the NHSN data, and so at the time where I was starting to look at developing a project and realizing that I needed a lot of resources around programming, uh, reminder algorithms, dashboards, things like that, the healthcare system said wow, you know we really need to fix these surgical site infections and we don't really know why they're happening.

And so, um, that actually created the resources for me to be able to uh, create the algorithms and the reminders and the protocols to go back and, and address this. That's how it all came about. The nurses were all actually interested, because, you know, in usual fashion, they, they had ideas of what they thought was affecting it. And of course, the surgeons had their ideas of what was affecting it but what was interesting is, as we gained increasing access, and visibility of the data, it became clear that it, for us, antibiotics was, uh, by far the number one reason that surgical site infection rate was above the benchmark rate.

DR. STRIKER:

Can you talk a little bit more about the deep vein thrombosis project? I'm interested to hear how that's going and how that started. Delve into that a little bit for our listeners.

DR. LYNDE:

With our deep vein thrombosis, what we discovered is that our observed to expected ratio was higher than one, meaning that more patients were having deep vein thrombosis than what you would normally expect. And so when we originally started the project we came from the point of view of even asking the questions of are we doing the right things, to prophylax? And so, there are two common scores that are talked about, the Caprini score, which a lot of our surgeons will talk about and then there's a Padua score.

The Padua score hasn't been, uh, validated in surgical populations, it's more of a medical population, uh, that they looked at, and we fortunately had a medical student who is interested in doing surgery, and we actually went through a chart review of every deep vein thrombosis, created the Caprini score, created the Padua score, looked at what we did, and we created a control group around this, and we discovered that we were really good at putting a SEDs on patient, but quite frankly were awful at chemoprophylaxis in our higher risk patients.

From this basic information, we then moved on to a question of why aren't people doing chemoprophylaxis? I mean, I've worked with a lot of great doctors and a lot of really cool people, and everyone works hard. And so the question becomes, you know, it's not, if no one is doing it. It's not any one provider who was just like eh, forget it. There's got to be systemic issue. And part of the problem, it turns out is Caprini score has way too many variables. It's not like calculating a nausea vomiting score or any of the other, you know, simple four or five letter acronyms that we're all used to. It literally has dozens of variables and a point system and you have to sit there with a piece of paper and ask a lot of questions. So it's time intensive, it's thought intensive, and it's not an easy thing to remember. And so, and the end of the day, people choose to not do it because it's just cumbersome.

So the third step of this was then to actually do a giant uh, database pull, where we looked at all of our deep vein thromboses. And we looked at, uh, what were the common factors with the hope of identifying the top four or five things that lead to deep vein thrombosis in our surgical patient population. So it's older age, it's, uh, morbid obesity, patients who have a history of cancer. So either, they're coming in for cancer surgery, or they've had a cancer history, prior, uh, DVT, and there may be a role for racial disparities, as well. And so after looking at this and validating it, prior the COVID crisis, we were starting to implement a, uh, automated and reminder system for patients who were at higher risk for developing DVT.

DR. STRIKER:

This is fascinating. This example, coupled with your other example, I think truly shows the power of, of these initiatives, and, uh, the data analysis and, and the effect it can have on our patients. So how important is it to connect these initiatives to organizational values and then also help practices looking to demonstrate the value of data to their stakeholders?

DR. LYNDE:

You absolutely have to tie it back to your organizational values. And that's because quite frankly that's going to be your source of, of funding for doing it. You know, and I think you also do things because it's the right thing but hopefully doing the right thing is you're, one of your organization outmeets. Um, so, you know, at the end of the day, if you, uh, for example, antibiotics. I can turn back to Emory Healthcare and say look, on an annualized basis, from where we were to where we are now, uh, you are getting an extra one point five million dollars a year as a result of our decreased SSI rate.

And so with that one point five million dollars a year, I need your help supporting a data team that's going to allow me to tackle other questions. I need your help having the right IT infrastructure and even salaries of, of some folks who can help, and spread the work and, and get it out. So that's where time together with your organizational values matter. Also again, you got to come back to the values of the people who are (sic), so, in my case anesthesia providers. And at the end of the day, all these things have to tie together to how are we doing better for our patients?

And they've got to be able to see it. First of all, what we're doing has to be simple enough and straight forward enough and, and it's got to make sense for people want to do it. But then also you have to show them how it's making patient outcomes better. Uh, because at the end of day, I think you know, all providers really just want to do a good job. They want to go home and look at look back on their day and think to themselves, you know, wow, you know what? I'm making a difference in people's lives and making it better.

DR. STRIKER:

One thing I'd like to talk about as well, is the topic of failure. Um, sometimes I think we would all admit we learn the most from things when we get them wrong rather than right, and benchmark is iterative process, and I was wondering if you could share with our listeners the role errors can play in quality improvement. Perhaps you even have an example of something that we can all potentially relate to and how you've uh, how you've learned from it.

DR. LYNDE:

Absolutely. So, you know, I tell everyone on my teams when we start out, that we will never have it perfect the first time we do it. And I think that it's important to stress to everybody that that's the case because as you look at something that you're going to take on it ended up that way because it is a complex, it's a complex process. It didn't just end up that way because someone was wrong and made a bad decision one day. It got that way because of a whole series of events. You know, with antibiotics, one piece of it is the pharmacy decided that they should have all the antibiotics locked away in the pharmacy and not give anesthesia providers can access to (sic) stuff. So, you know, so, so there's that. I think that you need to also walk into a lot of these situations, and, and acknowledge that you're not to have it perfect which allows everybody the willingness to be more open and be more honest about the role that they or their department might play in the broader ecosystem. Because if you're not coming to a table and just being incredibly honest about, about that role, uh, you're never going to get the most ideal solution.

In our case, we dropped our SSI rate because I and my leadership at the time was willing to admit that there were discrepancies between what the anesthesiologist recorded on the anesthesia record and what the pharmacy records showed as antibiotics actually being dispensed from the pharmacy. And what we discovered on a chart review of some of our infections, was that there, about 10% of the time, the anesthesia providers in the room documented that the antibiotics were given, but then there were absolutely no pharmacy records of the antibiotics ever being taken out.

And you know, that's really concerning and I think a lot of facilities, and a lot of groups would find that incredibly scary and never want to admit that. But because we were willing to admit it, we were able to change, and we were able to have a major impact on the patient care that we were providing.

And so it's that honesty that actually built the trust in the team and, and a lot of (sic) result. You know, we dropped our SSI rate by more than 50% system-wide, uh, as a result of the work that we did. And it required everyone on the team to accept the failures and the acknowledgement that everybody else is giving, and come together as a team to improve it and not, you know, point fingers at each other and say, well surgeons do this, and anesthesiologists do this, um. And you know, we really came together said we do this, and we are going to stop and we're going to do it differently next time.

DR. STRIKER:

That's a great example. It's certainly a, a strong lesson that it's best to admit mistakes or be honest about looking at yourself, whether it's individually or as a group in the mirror and ask what you are doing wrong, how you can improve. But more importantly even acknowledge that what you're doing is wrong, and uh, you're never going to get better as a group or an organization without acknowledging some of those faults.

DR. LYNDE:

Absolutely.

DR. STRIKER:

Um, wanted to not forget about listing some resources that groups can look to, uh, when they're looking for help or information about either starting or maintaining their quality initiatives. We mentioned, we've talked about NACOR, um, NSQIP, but are there other resources or contacts that groups could look to, as other resources as well?

DR. LYNDE:

So, yeah, clearly, uh, you know, I think, you know, ASA with, uh, AQR and NACOR are great resources to look towards. Uh, NSQIP and other federal databases. There's Vizient, which a hospital or hospital system would need to subscribe to. And a lot of times, a lot of hospitals actually subscribe to it. They just don't tell you that they're doing it because they don't think that you, as an anesthesia provider, care. And just, you know, going to hospital saying, hey, we do care, will, will go a long way.

Other great resources include things like um, you know, the ABA. Because of the requirement for MOCA Part 4 to do a quality improvement initiative, have some skeleton uh, structure around it. The American Society of Quality, the ASQ, uh, also offers a great bunch of resources in terms of both how to look at a quality project, but if you're so lucky to be able to work with someone within a, a quality-improvement section your hospital, they've got this great dictionary and a great tool set to allow you to kind of secretly read up on, on some of the things they are talking about, and plow through of jargon quality improvement.

DR. STRIKER:

Great. I think that's going to be really helpful to many of our listeners. One final question before we let you go. I'd love to get some advice about quality improvement. What are some words of wisdom that you might provide to, uh, to our listeners?

DR. LYNDE:

I think this is a really great question and it's crucial, uh, to ask. I think that one thing is before I ever really engage in a project, I ask myself and ask the people I interact with, you know, what got us to this point? Or, what's it going to take to change things? And, and then finally, how are we going to say in the new state once it's changed? Um, you know, it's not very uncommon for people say, I don't like the fact that my patients are coming in to get blood drawn for type and cross before a surgery, and, and it needs to change. You know, but then when you start to dig in and you, you try to figure out why it is the way it is, suddenly you find out that there are a lot of other factors that the person making that request just are completely unaware of.

Um, and so, ultimately, if you don't have that complete understanding of why something is the way it is, I guarantee you, it's going to be right back where you started when you stop paying attention to whatever it is that you're, you're trying to change. And then just a piece of general advice, which is that all these quality improvement projects, they're a marathon, they're not a sprint. So when you walk in the door, you might suddenly say, wow, you know, I, I want to make this change. I need to make it right now and these are quick fixes. Um, but the thing to remember is, for most of these situations, it takes years for process and all the workarounds and everything to happen to make the current state what it is. And the reality is, it's going to take months or years to really reverse course and to ask yourself, okay, you know, am I getting where I need to be? So you need to have a lot of patience, you need to pace yourself and you know, you really have to realize that you're in it for the long haul. You're never going to be able to do something in a month or two months and make it sticky.

DR. STRIKER:

That's great advice. Uh, Dr. Lynde, just want to thank you for great interesting conversation on, on the topic of the quality. Thanks, Dr. Lynde.

DR. LYNDE:

OK, thank you so much. This was great. I really enjoyed myself.

DR. STRIKER:

This is Adam Striker for ASA's Central Line. I thank you and look forward to having you join us next time.

(SOUNDBITE OF MUSIC)

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