Announcer:

Welcome to Optimal neuro|spine podcast, a podcast about optimizing our brain and spine in health and disease. Each episode, leading neuroscientists, neurosurgeons, educators, patients, spine care, and quality improvement experts discuss their research, experience, emerging science, surgical advances, and insights about how to optimize neurological and spine care. Now, here's your host, Dr. Max Boakye.

Max Boakye:

Welcome to the Optimal neuro|spine podcast. This is episode 14, and we'll be speaking with Dr. Jordan Peck today. This is all things quality improvement. Dr. Peck is currently vice president of practice operations at Southern Maine Healthcare. He leads a multi-specialty network with an overall revenue of 100 million across 21 different practice sites, including over 140 providers and 400 team members. He's a leadership fellow of the Advisory Board and diplomate of the Society for Health Systems.

Max Boakye:

Dr. Peck is a nationally-recognized leader in healthcare, performance improvement, and management engineering. He has a PhD in engineering systems from MIT with a focus in healthcare systems engineering and Lean Enterprise Transformation. He's a well-regarded teacher and presenter and is currently a standing faculty at numerous institutions, including the Harvard School of Public Health. He previously won a teaching excellence award as an adjunct clinical professor of healthcare operations management at the Boston University School of Public Health. He clearly has impressive credentials in the field of operations management and quality improvement. We are delighted to speak with him today about quality improvement in healthcare. Dr. Peck, welcome.

Dr. Jordan Peck:

Thanks. Thanks for having me.

Max Boakye:

Did I miss anything in your background history and current job?

Dr. Jordan Peck:

No, that covers it, pretty comprehensive.

Max Boakye:

Awesome.

Dr. Jordan Peck:

You missed that I'm a delightful human being.

Max Boakye:

That was our little kept secret. So what is quality improvement in healthcare, and how are we doing in healthcare quality improvement? Can you talk about the good, the bad, and the ugly, and how do we compare to other industries like aviation?

Dr. Jordan Peck:

Yeah. It's interesting, right? I mean, when you say, "What is quality improvement," my first reaction is, "Shouldn't that be obvious?" But it's not, and what's interesting about it, sometimes we define things not based on what they are but what they aren't. When people say quality improvement, a lot of healthcare professionals, whether they're clinicians or administrators, often jump to what I would actually call quality management. Quality management is this idea of all these measures and preparing for visits from the joint commission or other regulatory bodies and meeting all of these random requirements and things like that. That's quality management.

Dr. Jordan Peck:

What we then do to really make sure that we are the best we can be, providing the best care we possibly can for the lowest price, that value proposition... A lot of people talk to quality over cost. When I think about quality improvement, it's the efforts we're making on a day-to-day basis through our projects, through our conversations amongst providers and provider groups, all of these different efforts that go on across the hospital or any outset system to move us towards that final outcome that we want to achieve, become a better healthcare organization and not about checking boxes. So when I think about quality improvement, it's much more about that pursuit of something great and less about meeting joint commission standards.

Dr. Jordan Peck:

So given that lofty goal of quality improvement, how are we doing compared to other organizations? In many ways, much better. As I think about a lot of other organizations, their quality is not publicly known. Sometimes, you'll walk down the street, and if you see a sign on the window of a restaurant that has a B on it, you go, "Man, should I eat there? They just got this grade from the health inspectors or whatever." I have no sense of actually whether a B is okay or not. I'd like think that whatever restaurant I go to is going to get an A. But it's not very well-known. In contrast, in healthcare, we really are in many ways exposed to the public. All of our good, bad, ugly all gets out there. It gets out there in the news, more so with the VA, where everything is public.

Dr. Jordan Peck:

So, in many ways, the first step towards quality improvement is creating that tension, that creative tension, which I like to refer to, it's from The Fifth Discipline, a book called The Fifth Discipline, this idea of just wanting to be better than what you are. I think, unlike any other industry, healthcare is amazing at wanting to be better than it is. In other industries and without making any political commentaries, you look at a lot of what's gone on with law enforcement right now. A lot of people have referred to any question of the quality of law enforcement as a question on the people in law enforcement and their intentions. Yet healthcare has this mindset that we can have great people and you can question our quality without questioning our intention, and so it creates this constant on quality.

Dr. Jordan Peck:

I think a lot of times we don't think we're doing a good job because we're so focused on how to improve, but I don't know of too many other industries that are so focused on quality. That said, there are plenty of examples, and, as a Lean person, we could talk about Toyota and other industries that are preoccupied with quality. In healthcare, we've started to talk about something called a high reliability organization, where we want zero defects and no mistake is acceptable. That didn't come from healthcare. That started from other industries. Often, we talk about the military and nuclear submarines as an example where you cannot make a mistake. So there's a lot of industries that do well at it, and

there's a lot that do much worse. One thing any healthcare organization will resonate with is we just have so much we can focus on, so many different processes, so many different customers, so many different outcomes, that our journey towards quality improvement is essentially infinite. That's part of what makes me excited to be part of it.

Max Boakye:

So one of the things for a patient seeking care is how good is the hospital that I'm going to be getting my care at? How does one assess the quality of their institutions? That includes physicians and patients alike. If I'm part of a hospital system, how do I assess how good they are? How do I know if my organization is above average? There are a lot of different ratings in quality out there. How do I know what to trust?

Dr. Jordan Peck:

Yeah. It's really hard. It's a funny story. My son is four now. When he was born, it was obvious that we would have him at Maine Medical Center up here, which was the hospital I was working for. My wife once said to me... When we were planning this, she says, "Well, are they actually really good?" I was in the quality department, and I didn't know how to answer her. I was like, "I should know this, but I don't. I don't actually know whether"... There are quality measures, how many C-sections they have weighted by the complexity of the patients, how many episiotomies, and patient experience scores, and I didn't know any of it. It was not easy to immediately get my hands on and let alone to try to compare it to the other community hospitals in the area.

Dr. Jordan Peck:

So it is hard. We advertise a lot. You can look at... US News and World Report tends to be more about reputations, but there's things like Leapfrog, and there's Joint Commission and CMS stars. Each one of those things, many of which are public, each one measures the hospital based on different things, so you might look at any one of them and not actually get a good sense of whether a hospital's any good or not. I have found that there are a few that do well on everything, high patient experience, high patient safety scores, strong reputation, Becker's Top 100. If you find an organization, a hospital, is scoring well on a lot of them, that is a sign that they didn't just focus on one thing. A lot of us working in healthcare are probably used to having a hospital that says, 'Okay, this year, we're going to focus on surgical site infections," and so we work really hard on surgical site infections, and we get it down, and we might get some award or some accreditation for it, but maybe we blew it in somewhere else.

Dr. Jordan Peck:

An organization that does well on all of these different quality measures, chances are it means they have some integrated daily management system that allows them to continuously work on performance improvement and maintain that quality as they pivot to their next focus. So, end of the day, we shouldn't be looking at any one score, but looking across multiple is useful. That said, if you are going for a specific thing, having a baby, having neurosurgery, if you're going in for neurosurgery, you probably don't care how many C-sections they have. In contrast, if you're going in for a C-section, you're probably not all that interested in the quality of the neurosurgery program. So we can look at hospitals as a whole or we can look at them at a programmatic level, and both is a good way to assess the quality of an organization for your own needs.

Max Boakye:

Very interesting. There was a famous researcher. I believe his name was Donabedian, and he basically said to look at quality, you can either look at the structure of an institution or the processes or outcomes. In this current day-to-day, what is the current thinking on the best way to improve quality? Which of those should you focus on?

Dr. Jordan Peck:

I mean, Donabedian is still a benchmark and comes up all the time in the quality discussions. It's still the way to think about it. Basically, what he's saying is he's talking about the process of care or quality, but you might think about quality improvement as a process itself, right, and thinking about not just how we've structured our organization. Anyone who's working in healthcare knows that these structures are changing daily, who's reporting to who now and all of that. So a structure is in flux, processes are in flux, as we know, as we get new best practice published, as we get new people who have learned things elsewhere that they bring with them, and then outcomes, of course, are moving.

Dr. Jordan Peck:

So when I think about quality improvement now and the focus around organizations, you look at the history and you look at Total Quality Management, which was how do you create a culture that's continuously focused on quality, Six Sigma, which was then more focused on the outcome, how reliable is our outcome, and then Lean with this... What most people associate with Lean is process improvement, this idea of how do we reduce waste in our processes to maximize the value we're providing to our stakeholders. I think that the focus these days, the conversations that I have found particularly interesting, I'm seeing it coming from a lot of different sources. IHI talks about it a little bit with their high-performing health systems model. The Lean Enterprise Institute is now talking about this and Catalysis, which sprang from the ThedaCare Healthcare Value Network. They're all focusing now on this idea of daily management. How do you structure your organization, not in terms of who reports to who but the daily process of identifying problems, talking about them, resolving them, empowering the frontline?

Dr. Jordan Peck:

So, now, we want to think about systems, not about how good is their quality department and how many Lean experts do they have so that they can do X number of projects a year and more how effective is the organization at creating time for the frontline to have conversations, empowering frontline team members to make improvements, to make suggestions, to speak out when they see something wrong. Going back to Donabedian, the structure that we're talking about here is not the organizational structure but instead the quality improvement infrastructure that we've created because our healthcare organizations are organisms, that they're evolving and they're changing constantly. So how well we've developed them so that they can respond to this constant change is really a measure of how we look at a successful quality and proven infrastructure.

Max Boakye:

For the audience that are either new to this field, can you explain maybe the main approaches used for quality improvement and perhaps use the example of two or three institutions and how they approach it, for example, the Virginia Mason or the Mayo Clinic or Cleveland Clinic, to highlight the differences in the different approaches? For example, Lean, Six Sigma, and the other systems, IHI. What are the key similarities and differences, and which ones are these institutions using?

Dr. Jordan Peck:

First of all, one of the things that's really hard about studying quality improvement is this idea that it's a grounded theory science. As a scientist, we tend to think about normative theory science, where we have a hypothesis that we then experiment with and we get a result and you want to have a control group and a test group and you want to use statistics to see whether one performs better than the other and so on. That's normative science. The way we're looking at, really, anything around organizational behavior, organizational change, a lot of business school type science, and this also applies to quality improvement in healthcare, is instead we use this grounded theory approach, where we look at organizations that have emerged and they've found ways to characterize their system and we say, "Okay, here's a organization that's performing well. Let's study them and understand their processes, their tools, and then try to apply them elsewhere and see if we can get a similar outcome."

Dr. Jordan Peck:

The other difficult thing about it, of course, is that every hospital is different. Every healthcare organization is different. So something that works at one may work at 10 out of 20 others or 15 out of 20 others, but you're still going to find those five that it just didn't work for cultural reasons, for leadership issues, or other underlying things. There's no hard and fast rule to say, "Here's what works, and here's what doesn't." But what we are seeing emerge from places like Virginia Mason, from Mayo Clinic, from Cleveland clinic, from ThedaCare that started to advertise this a lot, and other organizations that have done really well with quality and haven't yet written their books, places like UMass Memorial and, I believe, in Maine Health, where I work and where I think we're doing some great work, some consistent features are appearing.

Dr. Jordan Peck:

That is these huddles structures, training the frontline to do performance improvement, having these huddles where you have visual data. You have continuous improvement being done by the frontline. You have this ability to escalate up. Many of these organizations have what they call cascading huddles, where the frontline will be doing some improvement work. But if something is coming up in all of them, it might come up to the next level where all the practice managers or floor managers meet and discuss with their director and then all the directors meet and discuss with their VPs and so on. So you have this ability to escalate problems rapidly, and these are through daily or at least weekly huddles. So all the organizations that I have seen that are doing this well have some level of daily management, some level of huddles going on.

Dr. Jordan Peck:

In terms of what tools they use, it's actually varied. When you look at Six Sigma, a lot of that focused on precision. A lot of that is focused on making sure that we're six standard deviations from average in terms of performance. But, in the end, the major focus on Six Sigma is DMAIC, define measure, implement or improve, and control. DMAIC, analyze, improve, control, sorry. That's exactly the same structure as PDSA, Plan-Do-Study-Act, which tends to be associated with Lean, although that was also part of Total Quality Management. Basically, all these tools are saying, "Find something that's wrong and apply the scientific method." It all goes back to Frederick Taylor and scientific management, use applying the scientific method towards improvement, coming up with your hypothesis, doing some data analysis to see if you can prove your hypothesis, and then publishing it or making something from it.

Dr. Jordan Peck:

So all of them use this continuous improvement model. It's almost irrelevant which one you end up choosing. One thing I have seen that does lead to consistent success is picking one and sticking with it. So if you are a DMAIC organization, fine, make sure that everyone gets trained in DMAIC and that they have the tools and consistent templates. If you're a Lean organization and you're using A3s, which are a poster... A3 is a metric size, it's about 11 by 17 inches, and it's just too small to be an official poster but big enough to put a lot on it, and it's big enough to put up on a wall, and it uses the PDSA methodology to do improvement. Whichever one you use, as long as you have a consistent framework that's shared and leveraged across the organization to facilitate conversation and feedback, that's the key to success.

Max Boakye:

Interesting. That is really one of the best explanations on the differences between the different systems. Can you speak a little bit about the relationship between patient safety and quality and also the trend to move away from the culture of blame in recent times and trying to make hospitals as patient care much safer?

Dr. Jordan Peck:

I tend to mention this in my classes. One of the things I love about working with physicians is they bring this mission with them. It's inherent to who they are, and it's about taking care of human beings. It's about first do no harm. For a while there, as we started to focus more on quality management, as I noted, we started associating quality in general with quality management. If you get this accreditation, you're a good organization. If you pass your joint commission survey, you're a good organization, you have high quality. In reality, I think a lot of people came to realize that that's not always true. You can get one of these certifications, you can get one of these accreditations, and it doesn't always mean you're a great organization.

Dr. Jordan Peck:

Patient safety is a great way of getting back to the original mission. First, do no harm. First, we have to make sure that if we are providing great care... No matter how good our surgeons are, if in the recovery rooms we have patient falls, that's not acceptable. No matter how good our primary care providers are, if we don't resource them enough that they can catch a abnormal lab when it comes through or connect with a patient to help them deal with an acute crisis, then we're creating safety issues despite the fact that we might have very high point of care quality with a strong provider with a strong care team. So, again, this is where gets down to quality improvement focuses on everything with the goal of really improving our outcomes versus quality management is about. I don't mean to be disparaging of quality management. It is correlated with the quality of the organization but tends to be about that checking box.

Max Boakye:

What is the role of physicians? Well, it's clear that physicians are extremely critical to any QI effort, but what has been the main barriers to more effective participation and leadership from physicians?

Dr. Jordan Peck:

So the barriers are many. The first barrier I think I'd be remiss without mentioning is time, and as administrator I'm well aware of the dual instructions I give to a provider to say, "Hey, I really need you to keep on seeing these patients and create access in the community. Oh, but also why don't you come

spend four hours in a Kaizen event with me?" So it's a bit hypocritical, and I know a lot of administrators who do it, and it's hard, right? So how do we create that time?

Dr. Jordan Peck:

I think the other thing we've lost in healthcare, it's still present looking up at the doctors, but I don't think they always feel it, is this sense of a physician or even of any provider as a leader in their own right. When the physicians were running their own practices or were contractors at the hospital or whatever, they felt like leaders. They were running their own business. In many ways, with employed physicians, that's gone away, and many of them feel very well-compensated average employees. I don't think that's true. I've been in many performance improvement initiatives where physicians don't realize the power of their words. They don't realize their ability to inspire their frontline team, their nurses, their MAs, their CNAs, their unit secretaries, whatever it is, to inspire them to action, to inspire them towards improving outcomes, or, the opposite, to disparage them. I think that's one thing we've lost, is empowering our physicians to feel like leaders again and letting them know that role that they have.

Dr. Jordan Peck:

The last thing that I think has prevented us from really making the most of having physicians in the room and being part of quality improvement is really training for it. We would say, 'They don't really have time, so let's just bring them into the room for the project but, otherwise, let them go." I think they're hungry to learn more, too, or at least some of them, and learn some of the tools that they need to do this improvement. So it's always a pleasure meeting providers like yourself, who have had the time to get this training and to learn it. It brings so much rich content to any quality improvement initiative that it's really valuable.

Max Boakye:

So for hospitals that are looking to get started or improve their quality, how do they go about choosing problems to work on and what should they be doing? Should they be joining... You know about the VA NSQIP system, the American College of Surgeon NSQIP? Should they be joining such registries? Can you talk about some of the strategies that institutions can use to really begin to build the equality efforts and the hierarchy of controls that it can use to advance that?

Dr. Jordan Peck:

Yeah. So I think there's a lot of different ways to do it, and I'd say one of the frameworks that's out there right now is called the learning healthcare organization, and that's the idea of a healthcare organization that has this outward-looking view, where it looks for best practice. It looks for issues in the organization and tries to pull best practice in, applies it, learns from it, and then shares it back out again. Frameworks are fantastic, but they are really only useful when we then turn around and create some structured purpose around it. So much like what I was saying with the performance improvement initiatives, pick a method and stick with it, say, "This is our model for how we identify problems." Whether it's we join things like NSQIP or other registries, it makes a lot of sense. They're out there. They're great for benchmarking. They're a great way to know are we above average, are we not above average?

Dr. Jordan Peck:

The other thing I'd say is really important is engaging with the frontline. We always want to have these lofty strategic plans. We put out the strategic plans every year that I don't know how many employees end up just throwing out this pamphlet that they get in the mail or whatever. We put out there what

sounds good, what we're really excited about as administration. Many organizations don't do a great job of talking to their frontline, to their physicians, to their staff, to anyone about, "What are you passionate about? What really excites you?" There's so many different directions we can take quality improvement any given time that picking something that really engages the frontline and providers is going to set you up for the most success.

Dr. Jordan Peck:

So things like NSQIP, things like registries, they're great. They're great for benchmarking. They're great for validating. Maybe someone says, "Hey, we've got a real problem here," and you look at the data and you go, "Actually, it's saying we're not, but let's maybe dig into it some more." But having that conversation and using the data to inform the conversation as opposed to using the data instead of the conversation is the real key, that you want to pull this data to do this scan of your environment but really engage with your frontline staff and providers to understand where they see issues and start to engage in those. They'll be more excited about participating, and you'll get better outcomes. Then, as people get into it and they develop the habits of quality improvement doing the things they care about, then maybe they'll be more engaged in doing some quality improvement issues that they're less excited about.

Max Boakye:

Looking at it philosophically, and I don't know if philosophical is the right word, but the quality improvement movement and the patient safety movement didn't really start till the '90s or '80s or '90s. Why didn't it just happen? Why did it take so long, and why is it so hard for us to learn from failures? I imagine these failures had been happening in the '50s, '60s, '70s. Why has it been so hard for good-intentioned physicians and administrators to learn from failures and take so long before this movement gets started?

Dr. Jordan Peck:

Well, that is a long conversation itself, and I don't know that there's any clear answer to it. A lot of times, as we're talking about performance improvement, we talk about the automobile industry, and we compare to Toyota and others. Back in the '50s, '60s, you had the pioneers, Deming and Juran, the pioneers of performance improvement methodologies, creating Six Sigma, creating Total Quality Management, and they didn't get much traction in American manufacturing. They went to Ford and they went to Chevy and they said, "Hey, you got to improve your quality." Back then, there's the examples of finding beer bottles in the doors of cars and things like that. They were sort of left out of the room. No one cared because US manufacturing was on top. We were still coming out of World War II having won the war and feeling really strong, and people were buying American, and people thought status came from owning an American car and things like that.

Dr. Jordan Peck:

So quality was going down the tubes there, and they didn't do anything about it either. Toyota was in shambles. I mean, the Japanese economy was a mess. They went from having this little empire with all the resources that comes with it to being trapped back on the Japanese islands with limited natural resources. So, now, you have this car company that had to figure out a way to compete. They had to figure out, "How do we compete with these American car companies," and they said, "We're going to compete on quality." It was out of necessity that they started to study quality improvement and deducing cost because that was all they had. That was their only option to get an edge. Then it was in

the '80s that the car company, that Toyota, after a very slow and steady ascent, finally overtook the American car companies in the market. Although it was happening consistently, it seemed to catch them by surprise, and they started asking for studies to find out what's going on in Japan that we didn't do here, and that's when all the quality stuff came out.

Dr. Jordan Peck:

So there's a similar mindset in American medicine or in medicine in general of the physician as God in a way, as the physician is well-versed and studied. We still had this mentality of this person who comes with the black bag to your side table and gives you comfort and knows everything you need them to know. There's still a generational divide there of many older people who really struggle with questioning their doctor. I was actually talking to a patient recently who was upset that their doctor asked them what they wanted. He had a health problem, and the doctor said, "So here's a couple"... The primary care doc said, "Here's a couple of options. What do you want to do?" The person was just flabbergasted. The patient was, "What do you mean? What do I want to do? Tell me what to do." Meanwhile, this patient is complaining to me, and I'm thinking to myself, "I love it when my doctors ask me what I want to do. I love being engaged in my care." But we were a different generation.

Dr. Jordan Peck:

So there's this mindset of capability. It's so ingrained in healthcare that we're then teaching it to even new people coming out as well, that expressing that you're hurting, expressing that you've done something wrong, expressing that there's a problem is really frowned upon. First of all, you don't want to tattle on one of your colleagues. You don't want to acknowledge when you've made a mistake. That really hinders our focus on improvement. So that's hindered to this day, the culture of improvement. It stops us from trying to solve the big problems because we get a lot of satisfaction from solving what's in front of us today.

Dr. Jordan Peck:

There's an article I love called Why Hospitals Don't Learn from Failure, and it talks all about how we get this charge from fixing the problem today. "We ran out of linens in the room. Oh, well, I fixed it. I ran and grabbed linens from the other unit." Then they move on, and whoever did that felt really good at the end of the day. "Look, I fixed this problem. I got through the day. I helped this patient." They don't stop and turn around and say, "Why did we run out of linens in the first place? What do we have to do to make sure this doesn't happen again?" How do they approach it in a way that doesn't look like it's just blaming the linen department or EDS or whatever? That's where these structures come into doing it right. So we didn't have the structures in place that we've talked about already to overcome this idea of solving your own problems, fixing your own issue in the moment, and getting satisfaction out of it.

Dr. Jordan Peck:

So what happened in the late '80s and into '90s is we started focusing on quality improvement because payment changed. We started paying more based on quality. We started saying, "Hey, if you make a mistake, we're not going to pay you as well," and you had the HMOs and now accountable care organizations. There's something from the top that's forcing quality, and so we're starting to look at quality because of that, but we actually still haven't tapped into that inherent creative tension around how do we improve our day-to-day because we just believe it's the right thing to do. That's something that organizations like Toyota have ingrained in them, that they've learned that their quality is their edge, and so they're focused on quality and improving and pushing things further, not because

regulatory agencies are making them do it, but because of who they are. I think we're getting there in healthcare. We're seeing more and more of it, but we're still not there.

Max Boakye:

I once took some lessons trying to learn how to fly, and even though that went nowhere, it struck me how many checklists you had to do before you got into the air. A Harvard surgeon, Atul Gawande, wrote a book on checklists in healthcare. What is the current thinking on checklists, and are they a cure for everything? Do they have limitations?

Dr. Jordan Peck:

Yeah. It's interesting. I love Gawande's quote in his book where he says, "If I offered you a device that would improve your quality by," I forget the percentage, 30% or something, "you'd pay me three million dollars for it. But if I offer you a free checklist, which has the same outcome, you yell at me and say, 'I don't do textbook medicine,' and throw me out the door." We're so interested in these sexy new tools to get the outcomes we want, and yet something as simple as a checklist we don't want to do. But the difference here, of course, is the checklist requires a lot of discipline to create. It requires getting the group together, buy-in to say, "Yes, these are the necessary steps. This is how you do it."

Dr. Jordan Peck:

I think airline pilots have been trained to be used to having... They learn in school the idea that they're going to follow a checklist and that the airplane companies helped develop this and that science has helped develop it. We don't really teach that as much. I think it's changing now from talking to new graduates and from medical school, but we still emphasize that independence of the doc. There's this mindset that using something like a checklist is contrary to being independent. What performance improvement methodologies tend to emphasize is that standardization is the first step towards improvement. Standardize first so that everybody's doing it the same way, and then engage these really smart, capable people to say, "Now, how do we do it better," and find that thing that's better and then standardize that.

Dr. Jordan Peck:

I think one of the things that's caused checklists to be unpopular is we spend all this time developing a checklist and then it's seen as done. We've done it. Now, it's the word of God, and that's it. We can't change the checklist. Then people just ignore it or don't want to deal with it because it's not perfect. It's not great. It was supposed to just be the start. So the key is to focus, again, on DMAIC or PDSA and say, "Everything we do to standardize is just the first step. We then have to keep the team together evaluating is this working for us? Is it not? How do we keep it fresh so that it doesn't just collect dust?" Whether it's a checklist or other kind of performance improvement, we tend to finish this full-day meeting where we've developed a document and then never look at it again as opposed to really seeing that as just the first step. It requires more time. It requires more discipline to stick with something until we really feel like it's done.

Dr. Jordan Peck:

In my classes, I tend to share examples of quality improvement efforts, and most of the really good ones take years, and they plan to take years from the get go. "This is a five-year project that we're going to really focus on improving central line infections." In contrast, if you think about most hospitals, and many people have experienced this, we put it in the strategic plan and say, "We're going to fix this this

year." We give it a lot of intense attention and then it peters off in following years as opposed to saying, "No, we are going to focus on this for five years, and now we can create a plan that's going to take five years and really invest the resources we need over that time, knowing how long it's going to take." So a little bit of that discipline around performance improvement and that willingness to stick to it, I think, would go a long way to making more of the checklists we have as well as more of the standard procedures we create and all those other efforts that we do for quality improvement.

Max Boakye:

Reducing the central line infections probably has been one of the most successful QI projects in history. Any other projects that you think are way overdue for improvement that has not happened yet?

Dr. Jordan Peck:

Oh, boy. Well, there's a lot. Patient flow tends to come up a lot. How do we improve the flow in the hospital? I think there's a lot of work that's been... As much as that's an operational issue, it's a quality issue. You don't want people sitting in the emergency department. There's a lot of known efforts that improve that, so Litvak at Boston Medical Center, his studies that show how do you balance the surgical schedule with the admissions to improve flow. I think there's a lot of best practices out there that haven't quite been implemented, and every hospital seems to work on it on their own. I think there's still opportunity there.

Dr. Jordan Peck:

I don't know that I can think of a specific care type that needs more attention. One thing I'd like to see more quality improvement efforts focus on is engaging the patient. Another very common thing that hospitals have worked on for quality improvement is the five Ps. So when a nurse enters into an in-patient room, they're supposed to... And I don't remember what all the Ps are, but they're supposed to make sure the patient had their possessions nearby, if they have to go potty, they can go, that their position has changed, they're not in any pain, and I always forget what the fifth P is. Maybe someone listening will remember. That's a standard thing that a lot of places have worked on.

Dr. Jordan Peck:

One time, I was working on this, and I had an idea that got shot down, and I said, "Why don't we put up a sign in the hospital room and engage the patient and say, 'Every time somebody comes into your room, they should go over these five Ps,' and empower the patient or family member or caregiver to have some control over the quality of their own care?" Every time, we miss a P, you get a free cream from the cafeteria or something like... You know? Really, to try and incentivize these patients to own their own care. I think there's a lot more opportunity there. Dialysis is a famous example where people said we'd never be able to do dialysis, and there's more and more home care agencies but also patients doing their own kind of dialysis. Really, how do we start to trust our patients more and engage them in our improvement efforts, but not just engage them in terms of get their input, but actually engage them in the solution? How is the patient part of the solution? I think there's a lot more opportunity there that we haven't leveraged.

Max Boakye:

I just looked at the five Ps. It says potty, position, possessions, pain, and peaceful environment.

Dr. Jordan Peck:

Peaceful environment. All right. Maybe I've just given up on the peaceful environment. That's why I could never remember.

Max Boakye:

One last question for you. So maybe a word about, in your opinion, what you think the future of quality improvement... I mean, what is it going to look like in 10 years? And if you had a magic wand, what would you like to see, or what would you do with it?

Dr. Jordan Peck:

Yeah. If the trend continues the way it's going, I think we will see more organizations who are committed to really integrating quality improvement into their day-to-day. As we look at government motion towards accountable care, towards pay for performance and things like that, I think the incentive to invest more time and resources in quality improvement is increasing. It's growing, and so that's great, and that's exciting. As examples, you have now health systems talking about, at least in primary care, moving from an RVU-based model to a salary-based model and then allowing primary care docs to maybe have lower panels or giving them more time to do quality improvement because we're going to get paid by that quality and not by their RVU generation. So you see more and more like that, and I expect to see a continuation of that over the next 10 years.

Dr. Jordan Peck:

If I had a magic wand... That's a great question. I think I would want to see even more of that. How do we continue to incentivize value for patients? When I say value, actually, there's a lot of different definitions. In the Lean sense, when we talk about a value-added process, a value-added process is one that moves the patient closer to their desired outcome, it's done right the first time, and it's something they're willing to pay for. So that requires moving it in their desired direction. Interestingly enough, there's a lot of things a patient is willing to pay for and is done right the first time but actually doesn't move the patient towards their final desired outcome.

Dr. Jordan Peck:

This comes up a lot, another Gawande book, Being Mortal. It comes up in the end of life conversation of not everybody... We have people who get all these procedures or get all these things done at the end of life. But, really, they just want to be comfortable, be able to go to their grandchild's wedding or whatever, and then pass peacefully. Yet, if they have a certain provider who might push them towards more procedures or push them towards more treatments that they don't actually want, but it's done right the first time and they end up paying for it. So really focusing on all three of those things, getting to know the patients and saying, "What is a desired outcome for you, and how do we make sure we're providing just the care that's right for you and that we have the proper incentives in place to do it?"

Dr. Jordan Peck:

I think if we have those right incentives and, like I said, they are moving in that direction, then my magic wand turns towards creating the structures to do it. There are best practices out there. There are a lot of consultants out there that come and they sell themselves based on projects, really looking for ways to... I would want a magic wand to move us towards longer-term planning, not saying how do we fix our hospital this year but how do we start to partner with consultants or other outside organizations or do internal work to just start building that culture of improvement which allows us to maximize those new

payment models? Just changing that mindset from quick gains to long-term investment and culture would be my magic wand target.

Max Boakye:

Yeah. Well, that brings us to the end of this conversation with Dr. Peck. Not only has he demonstrated his expert in this area, but also our secret is no longer a secret, his delightful conversation on quality improvement that I think, yeah, I hope the audience really enjoy. I certainly have enjoyed it a great deal. Dr. Peck, thank you very much.

Dr. Jordan Peck:

Thank you. Thanks for having me. It was fun.

Announcer:

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