“The unexamined life is not worth living.”

-- Socrates, *Apology* 38a

Anesthesia Quality Institute

Quality of Care in Anesthesia Departments

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Anesthesia Quality Institute

The AQI

- A non-profit 501(c)3 corporation
- Vision: To become the primary source for quality improvement in the clinical practice of anesthesiology
- Mission: To establish and maintain the National Anesthesia Clinical Outcomes Registry

Questions

- How many have a QM Officer?
- How many have a QM Committee?
- How many have a QM report?
- How many have an M&M Conference?
- How many have multidisciplinary QM Conferences?

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Why Have Quality Management?

- To improve patient outcomes
- To improve business efficiency
- To meet regulatory requirements

The Challenge

The government wants to know that Ma and Pa are getting the healthcare they deserve … and that our taxes pay for.

Part One: Data

We live in the Information Age…

"Your data is going to be collected. Do you want it to be gathered by your friends or by your enemies?"

*

-- Keith Ruskin, MD

* Goofy picture of Keith obtained in 5.4 seconds of internet search.

The Data "Genie" has left the Bottle

- By understanding your own data, you can see yourself as others will see you
- By making legitimate use of your data you pre-empt illegitimate or uninformed use

Basic QM Philosophy

- The more you know, the better you do

- Quality management data
  = research data
  = business data

- Every patient encounter is a data point

“Knowledge is Power”

-- Sir Francis Bacon, 1597

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What to Collect?

- Billing data
- Hospital EHR data
- AIMS data
- QM data

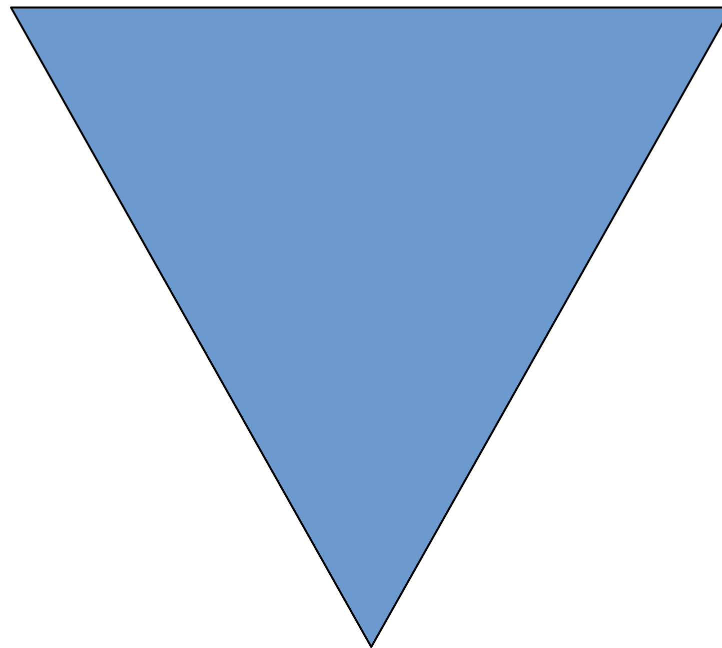
First ARS Question ….

“We have lots of information technology, we just don’t have any information”

The Quality Triangle

Risk Factors

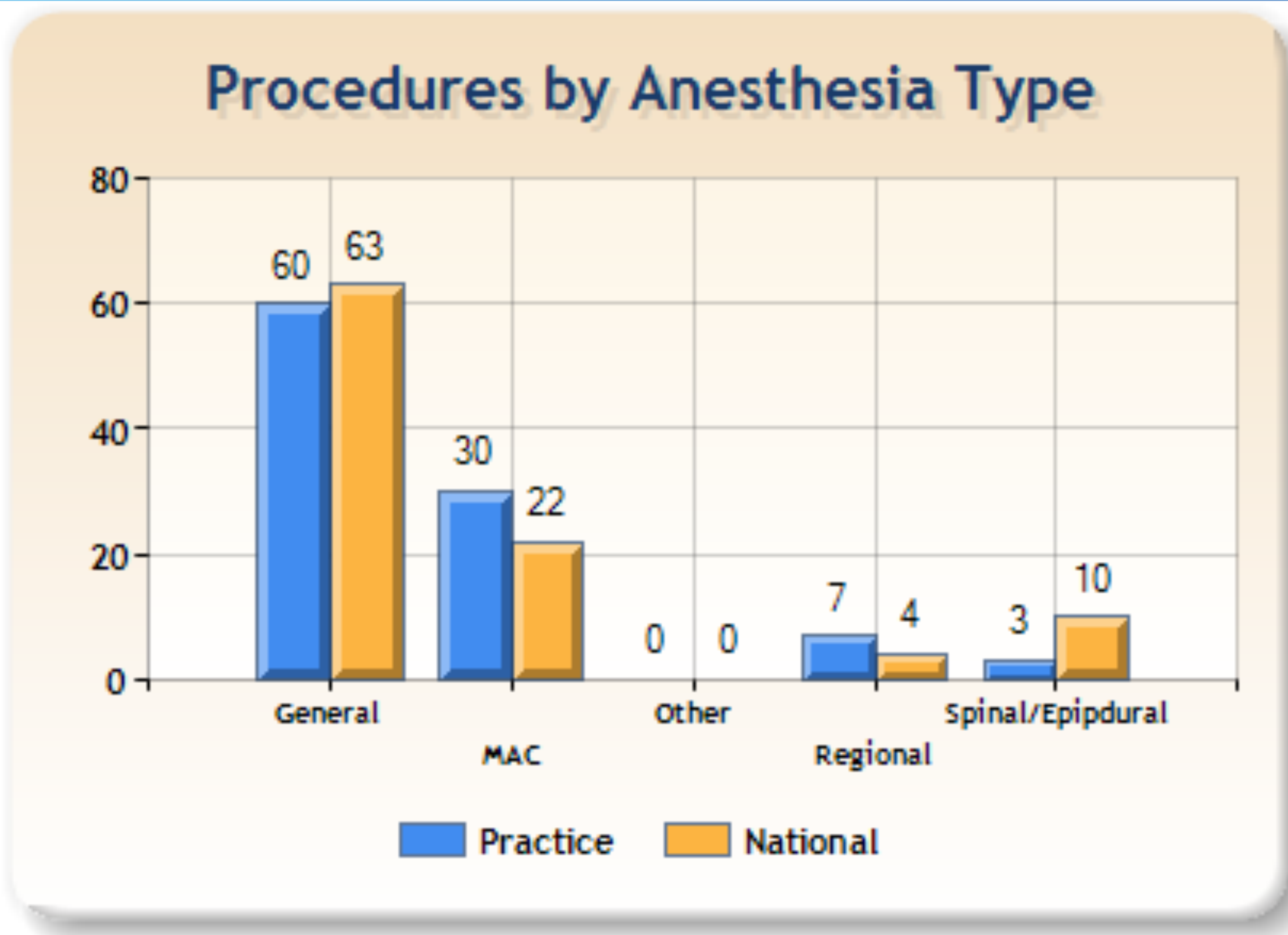
Process



Outcomes

Second ARS Question ….

Benchmarks



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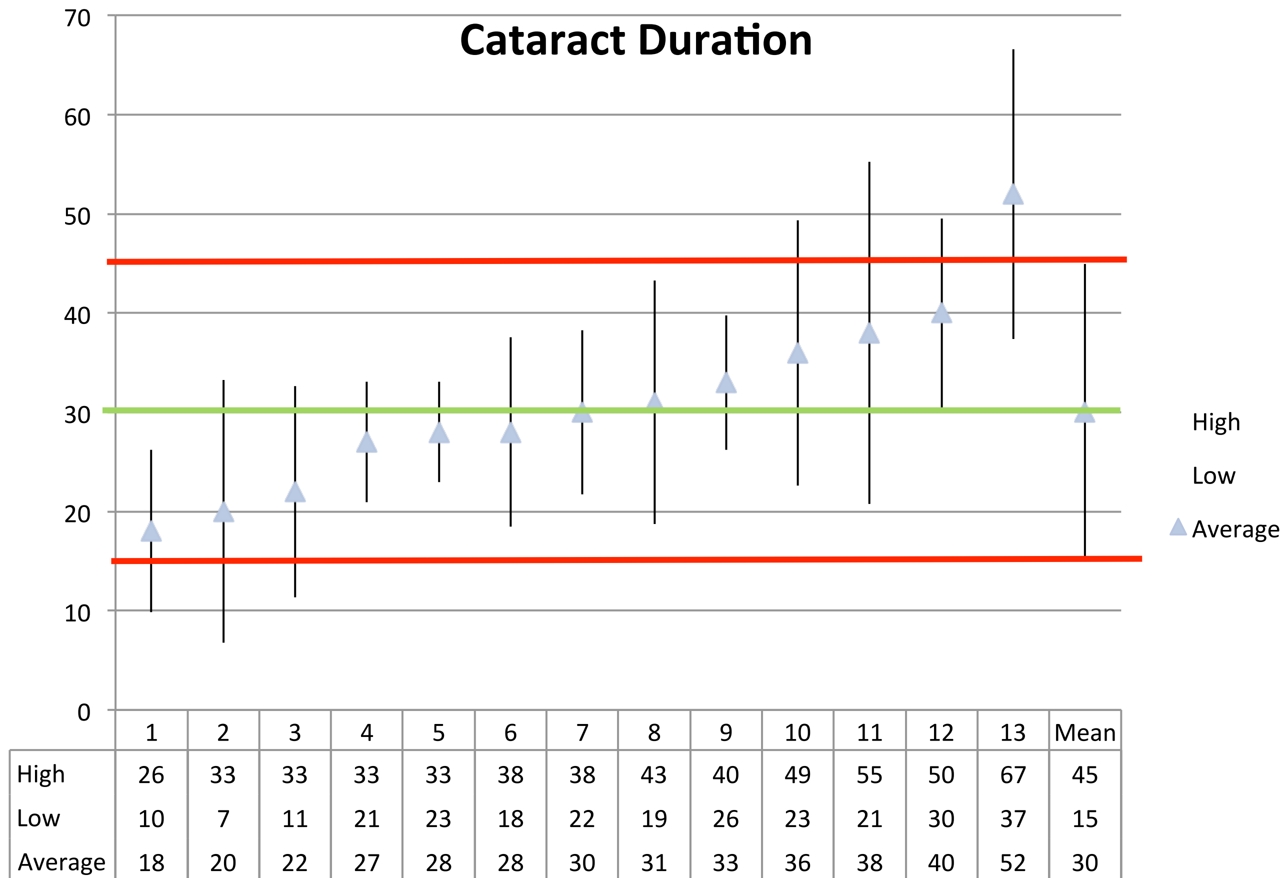
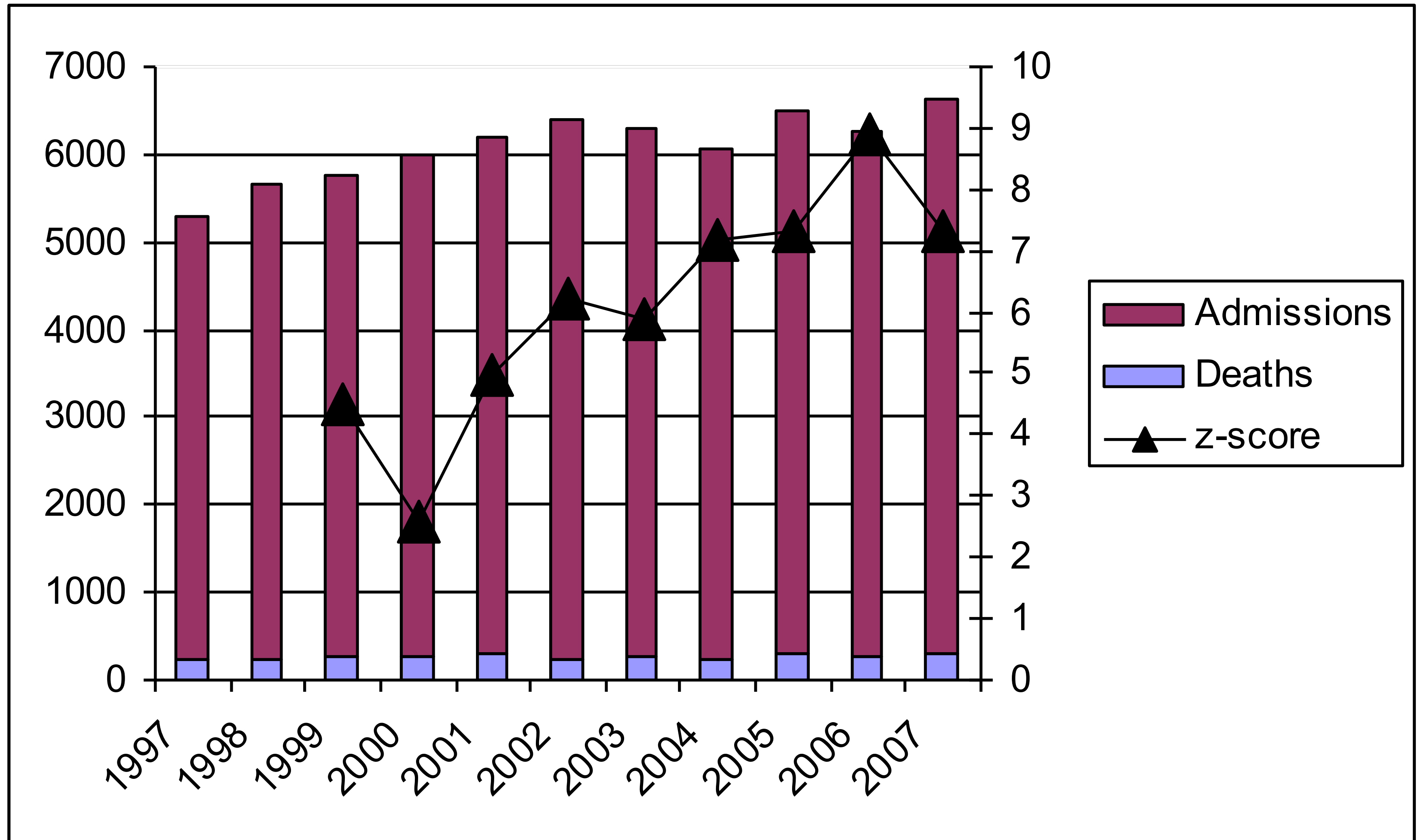
NACOR: Duration of surgery



	1	2	3	4	5	6	7	8	9	10	11	12	13	Mean
High	26	33	33	33	33	38	38	43	40	49	55	50	67	45
Low	10	7	11	21	23	18	22	19	26	23	21	30	37	15
Average	18	20	22	27	28	28	30	31	33	36	38	40	52	30

Where is the Improvement?



Mortality

Easy to define

Easy to count

Should be a good way to define effectiveness …

…right?

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Part Two: Events

More Questions

- How many cases last year?
- How many deaths?
  - Anesthesia related?
  - Preventable?
- How many got antibiotics?
- How much nausea and vomiting?
- Satisfaction with pain management?

Third ARS Question ….

Anesthesia Safety

- **Generic Patient Safety Events**
  - Wrong site/side surgery
  - Medication errors
  - Etc.
- **CPOM defined outcome measures**
  - Significant bad events
  - Low frequency
  - Require MILLIONS of cases to establish rates and benchmarks
- **Undefined events will still occur!**

Here's one …

A 79 yo female presents for re-do total hip replacement (following peri-prosthetic fracture).

Following induction of GETA, a left subclavian central line is placed, uneventfully.

The patient becomes progressively hypotensive.

Management BY Anecdote

- Over-reaction to isolated events
- Layered bureaucracy
- Failure to discover root causes
- Failure to assess both benefits and risks

- Frequent disposal of both baby and bathwater!

Management OF Anecdotes

- **Have a process for addressing sentinel events**
  - Discovery
  - Reporting
  - Disclosure
  - Fact finding: who?
  - Analysis
  - Discussion and System Changes

Baby

Bath Water

Next Steps for Your Practice

- **Take good care of your patients**
- **Gather your data**
  - Use standard definitions
  - Follow-up
  - Link your records
- **Examine your events**
- **Sign up with the AQI!**

Contact Us!

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