Outcomes and Quality Improvement Initiatives for Dermatology Training Programs / Report from the AAD Committee on Patient Safety and Quality

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Biases

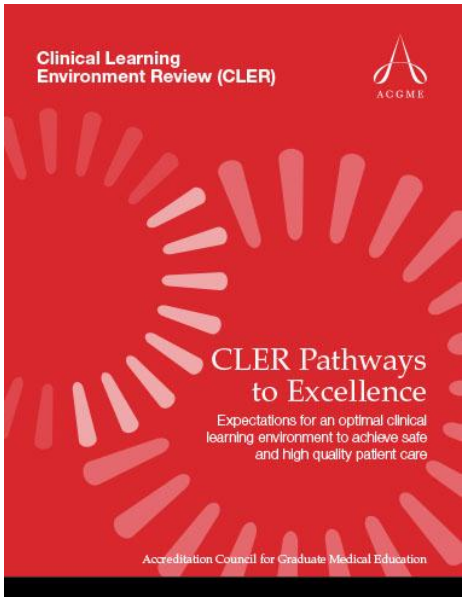
- My last APD presentation! Nov 8, 1979: AAMC/APD Washington, DC “Federal Initiatives in Occupational Skin Disorders”
- Chair / Co-Chair (Hanke / Taylor Initiative)
  - AAD Committee on Patient Safety and Quality
  - AAD Outcomes Work Group
  - AAD AHTF Data Collection and Registries
- Quality Improvement Officer- Dermatology Plastic Surgery Institute Cleveland Clinic

Outline

- QI initiatives in Residency Programs
- Outcomes
- AAD Patient Safety Activities
  - Adverse Events
  - Outcomes
  - Performance Measures
  - ERG PSO's
  - Data Base and Registries
- Culture of Patient Safety

Bringing Resident Education into the Age of Patient Safety (ACGME)

- Milestone Project: Resident QI project required
- CLER: Clinical Learning Environment Review *provides frequent on-site sampling of the learning environment that will:*
- increase the educational emphasis on patient safety demanded by the public; and,
- provide opportunity for sponsoring institutions to demonstrate leadership in patient safety, quality improvement, and reduction in health care disparities (later reporting of aggregated de-identified national data)



CLER (part of ACGME NAS)

- **Patient Safety**: Are there opportunities for residents to report errors, unsafe conditions and near misses and to participate in inter-professional teams to promote/enhance safe care?
- **Quality Improvement**: Are residents engaged in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes?

Beware of the young doctor and the old barber

Benjamin Franklin

Practice Gaps in Patient Safety Among Dermatology Residents and Their Teachers
A Survey Study of Dermatology Residents

- A survey-based study, performed at a national medical dermatology meeting in Itasca, Illinois, in 2012, included 142 dermatology residents from 44 residency programs in the United States and Canada.
- Results:
  - 45% failed to report sharps injuries
  - 83% reported cutting and pasting EMR notes without checking validity
  - 97% reported left - right mis-labelling
  - 29% did not take clinical photograph of biopsied lesions
  - 20% always do a time out
  - 58% intimidated by an attending
  - 78% witnessed willful disregard of safety steps
- Our data reinforce the need for **modified curricula, systems, and teacher development** to reduce injuries, improve communication with patients and between physicians, residents, and other members of the health care team, and create an environment free of intimidation.

Jillian Havey Swary, MD; Erik J. Stratman, MD *JAMA Dermatol*. 2014;150(7):738-742.

SERS-Safety Event Reporting System: Defining a Patient & Employee Event

- A patient event is “**any happening that is not consistent with the routine care of a patient** or any happening that is not consistent with the normal operations of your office”
- An **employee event is a work-related** injury or illness that occurs within the course and scope of employment
- An **event can involve a patient, visitor, employee or the physical environment** within your facility. It is associated with actual or potential harm, loss, or damage
- An event may involve an error, but the **term "event" is not synonymous with "error"**

28 SRE's in 6 Categories will now apply to Inpatient and Outpatient (most cases) settings

1. **Surgical**- wrong: site, person, or procedure; retained foreign object; perioperative death of healthy patient;
2. **Product or Device-** death or disability from malfunctioning device or contaminated drugs, devices or biologics
3. **Patient Protection-** patient disappearance, suicide, etc
4. **Care Management-** death or disability from medication errors; wrong: drug, dose, patient, time, preparation, or route of administration
5. **Environmental**- death or disability from electric shock, burns, falls, or wrong gas administered in O2 line
6. **Criminal**- assault; impersonation; abduction

Source: National Quality Forum (NQF)

Patient Severity Scale / RCA Root Cause Analysis Threshold

1: Near-Miss

A: Circumstances or events that have the capacity to cause an error

B: Event occurred, but did not reach the patient/person

2: No Harm

C: Reached the patient/person but did not cause harm

D: Reached patient/person; required monitoring/intervention to confirm no patient harm

3: Temporary Harm (Mild or Moderate)

E: Temporary harm to patient/person and required intervention

F: Temporary harm to patient/person and required initial or prolonged hospitalization

4: Significant Harm

G: Permanent patient/person harm

H: Intervention required to sustain life

5: Death

I: Death

Employee Event Types

- **Needlestick/Sharp**
- **Bloodborne Pathogen/Body Fluid Exposure**
- **Slip/Trip/Fall**
- Patient: Lifting/Moving/Transferring
- Patient: Struck/Injured By
- Equipment/Object: Struck By, Against, Caught Between
- Equipment/Object: Lifting, Moving (Non-Patient)
- Exposure: Communicable Disease
- Exposure: Environment/Chemical/Flame/Smoke/Spark
- Motor Vehicle Related
- Other (Please Specify)

Reporter Responsibility

- Duty of every caregiver
- Non-punitive philosophy-reporting safety events without fear of retribution
- Report within 24 hours of discovery
  - Events that cause significant harm should be reported immediately to your supervisor
  - Electronic reporting ideal; may be anonymous

Importance of Reporting (usually to Risk Management Office)

- Patient Safety is our top priority
- Opportunity to identify & learn about system failures, hazards and risks
- Drill down to where processes are breaking down
- Reduce likelihood of recurrence
- **Don’t overlook near misses**
- Improve quality and outcomes

Potential Topics for Patient Safety and Quality Improvement Projects by Residents

1. Patient Misidentification

Has resulted in:

- Medication errors
- Lab processing errors
- Wrong person procedures
- Discharge of infants to wrong family

Solution: <u>Use at least two patient identifiers for every step in health care delivery (I prefer three identifiers)</u>

- Individual's names / Identifier #
- Telephone # / Other person-specific identifier
- Standardize ID band markings or implement biometric technology
- Check schedule for same named patients

2. “Wrong-site surgery” still occurs and is significantly under-reported

- “Never” event by NQF
- **AAOS** –1998 task force estimated a 25% risk of wrong-site surgery during a 35-y career- especially
  - Wrong –knee arthroscopies and
  - Wrong-level spine surgery
- **Joint Commission Universal Protocol** July 2004
  1. Pre-procedure verification and surgical site marking
  2. “Time out” just before procedure
  3. Sign out post procedure

Biopsy site identification

- Wrong site surgery responsible for 14% of professional liability cases against Mohs surgeons
- Several studies have demonstrated the difficulty in identifying correct biopsy site by both patient and MDs
  - Dermatol Surg 36: 194, 2010
  - Dermatol Surg 36: 198, 2010
  - J Amer Acad Dermatol 65: 807-10, 2011
  - BJD 167: 1186, 2012

References

- JAMA Dermatology: Consensus Statement May 01, 2014; Alam, M et al
  - **A Multistep Approach to Improving Biopsy Site Identification in Dermatology: Physician, Staff, and Patient Roles Based on a Delphi Consensus**
- JAMA Dermatology May 2014 Volume 150, Number 5, p 558. Wrong-site surgery in dermatology. (commentary)

Biopsy Site Documentation

- Anatomic description
  - Needs to be specific
- Diagram
  - Needs to be detailed
  - Measures from landmarks
- Photography
  - Distant view
  - Close up view

3. Errors in Pathology Specimen Processing

- Most common mistake:
  - **No patient label on specimen container**
  - Corrected by walking label to surgical pathology

- Another frequent mistake:
  - **Wrong anatomic site**
  - Left vs. Right >> wrong body site

- **Failure to notify patients of biopsy results**

Amended pathology reports

- Another way to look for potential errors
- Dermatology more than other specialties
- Examples:
  - Specimen change: site, laterality
  - Procedure change; shave vs. punch

Standardized patient identification and specimen labeling: A retrospective analysis on improving patient safety

Julie K. Kim, MD,[a] Bert Dotson, MBA, HTL(ASCP),[b] Sean Thomas, MD,[a,c] and Kelly C. Nelson, MD[a]
Durham, North Carolina and San Antonio, Texas

Background: There is an increased risk of specimen labeling errors with the generation of a high volume of pathology specimens. Measuring specimen labeling accuracy has been suggested as a possible measure for patient safety.

Objective: We sought to identify operational areas for improvement around specimen handling with the institution of a standardized specimen labeling protocol in the Duke University Medical Center Department of Dermatology. The average rates of specimen labeling events before and after implementation of this protocol were analyzed to determine the efficacy of this systematic approach.

Methods: We collected the monthly aggregated rates of specimen labeling events occurring with skin specimens processed through the Duke University Medical Center Department of Pathology from December 2008 through June 2011. The average monthly rates of events per 1000 cases for the time periods from December 2008 through March 2010 and June 2010 through September 2011 were compared.

Results: The data collected showed a statistically significant decline in the average monthly rate of specimen labeling errors after institution of the protocol. Before implementation, specimen labeling events occurred at a rate of 5.79 events per 1000 with a decrease to 3.53 events per 1000 after integration of this system ($P = .028$).

Limitations: Limitations of this study include possible sampling error and regression toward the mean.

Conclusions: Low-cost, process-driven interventions are effective in the reduction of specimen handling errors. (J Am Acad Dermatol 10.1016/j.jaad.2012.06.017.)

Key words: labeling errors; pathology specimens; patient safety; safety protocol; specimen identification; specimen labeling errors.

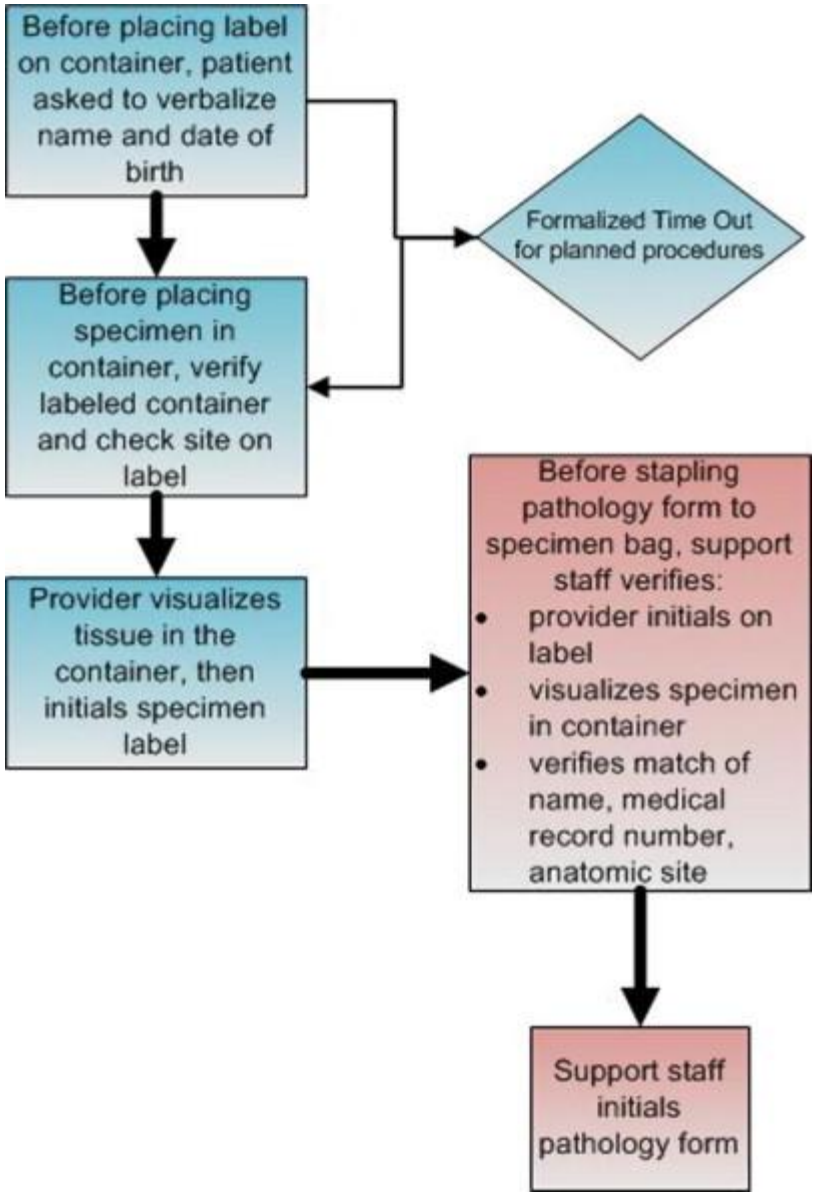


Fig 1: Essential specimen handling steps. Blue items are physician-specific responsibilities; pink items are nursing staff–specific responsibilities. JAAD

Other Post-analytical errors

- Errors worse in send-out or esoteric tests
  - Long time lag
  - Wrong test may have been ordered
  - Scanned results are displayed in different place and form
- Formatting issues with EMR
  - Truncated reports, missing data, arrows confused with numbers, key results buried in body of report and missed.
  - Patients are “innumerate” and prefer graphs

Adapted from SIDM Sept 2013

Other Post-analytical errors

- We are awash in data
- More likely to have ***communication without collaboration*** with pathology
- More data residing outside our systems
- Patients come to our offices with tests that we did not order—genetic, allergy, toxicology

Adapted from SIDM Sept 2013

4. Medication Errors

Medication Errors Reporting Program

Operated by the
United States Pharmacopeia in cooperation
with the
Institute for Safe Medication Practices

Report medication errors in confidence:
1 800 23 ERROR
www.ismp.org/www.usp.org

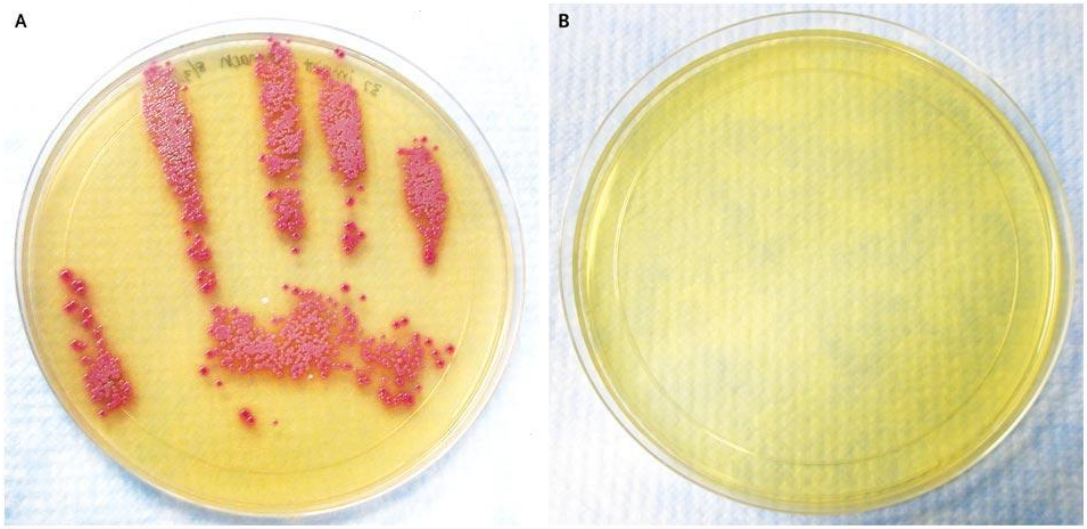
(USP and ISMP are FDA MEDWATCH partners)

5. Hand Hygiene: 1980 vs 2014

- Hand hygiene is mandatory
- “Foam in and Foam out”
- “Ask me if I have washed my hands”
- Anonymous observers

Hand Hygiene

- Monitor Adherence- goal 100%
- **Focus on sustaining the effort**
- Still need new converts
- Novel strategies



6. Sharps Injuries and Reporting Practices of US Dermatologists

- "Sharps injuries are common. Underreporting is common & places providers and patients at risk of blood-borne illnesses."
- 336 Dermatologists / Trainees
  - 85% Sharps injury ever (40% past year)
  - Sources: Surgery > Biopsy > Injections
  - Perceived causes: Sense of being rushed / awkward posture
  - Percent Reporting Injuries: Trainees (63%) > Derm. Surgeons (38%) > Medical Derms (27%)
    - Why not reported?: perceived low risk / time

Donnelly et al *Dermatol Surg* 2013

Preventive Strategies

- **Visually inspect** the field and all waste material for presence of sharps before disposal
- Establish **SOP** in the office for **preventing and reporting** sharps injuries
- Educate all personnel and new hires and periodically review safe practices
- Lead by example in your office
- It takes a team to eliminate sharps injuries…
- http://www.cdc.gov/niosh/topics/bbp/#prevent
- AAD ERG for Dermatology Patient Safety Officers

Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program

A workbook designed for:

Infection Control & Occupational Health Personnel •
Healthcare Administrators •
Sharps Injury Prevention Committees •

CDC

Occupational (Your) Health: Dangers in Dermatologic Surgery: Protect your hands (Dermatol Surg 2004;30:1210-13) and feet (Dermatol Surg 2004;30:1495-97)

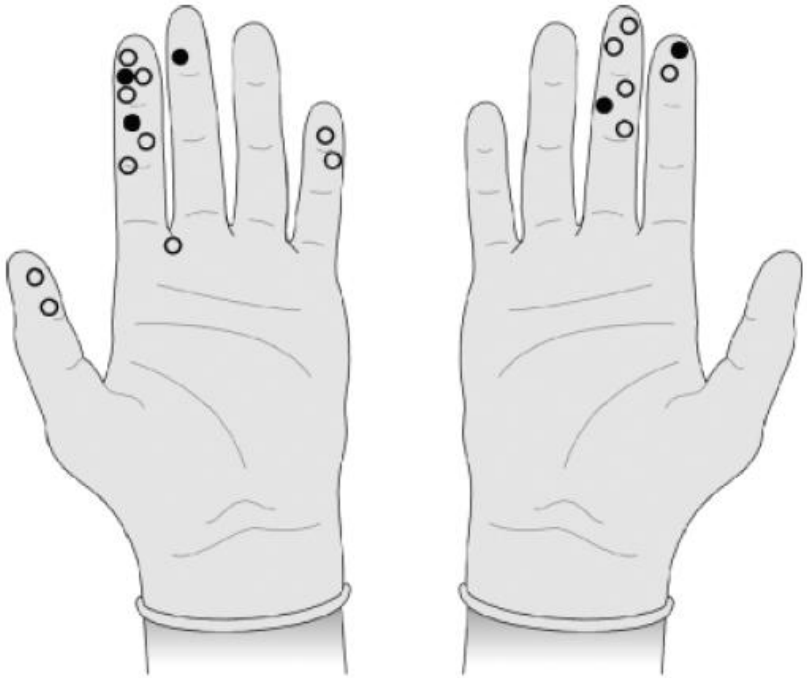


Figure 1. (Open circles) Perforations unnoticed by the wearer; (solid circles) perforations noticed by the wearer.

Figure 3. Falling scalpel not able to penetrate through the new rubber shoe.

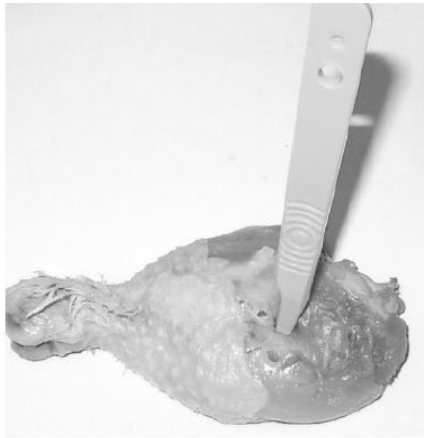


Figure 2. Plastic scalpel penetrating into the meat of the control.

7. Other Patient safety quality improvement projects suitable for dermatology

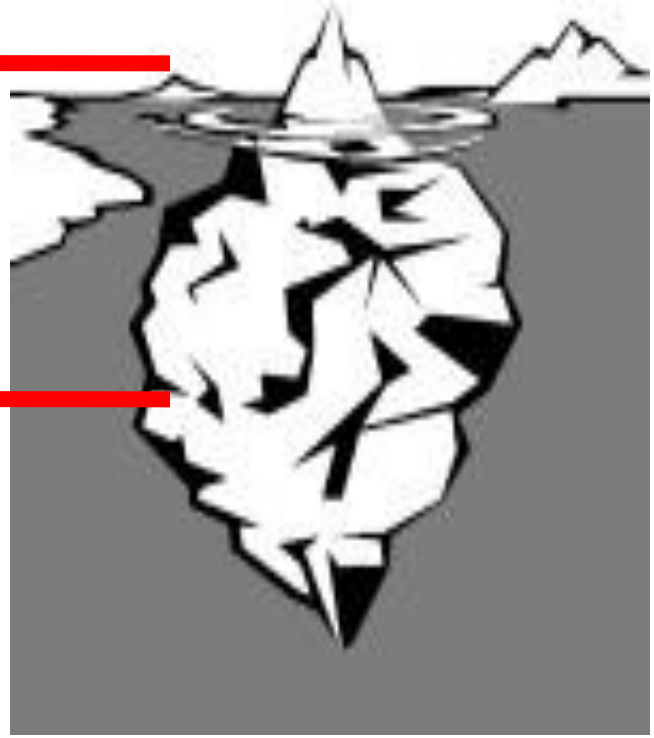
- Supervision and competency assessment of ancillary staff
- Surgical infection rates
- Management of cardiac arrest and syncopal episodes
- Appropriate timing of tuberculosis screening in patients on immunosuppressive therapy
- Early osteoporosis risk assessment and intervention for patients on chronic corticosteroid therapy
- Responsible use of antibiotics (perioperative, acne, and chronic wounds)

Patient safety quality improvement projects suitable for dermatology

- Continuity of care for patients with high-risk tumors
- Continuity of care for patients on high-risk medications
- Appropriate screening for skin cancer risk, connective tissue disease, and photosensitizing medications before ultraviolet therapy
- Appropriate monitoring of the light source and phototherapy visits
- Documentation of high-risk tumor attributes in dermatopathology reports to guide management
- Timely and appropriate reporting of adverse drug reactions

Patient Safety
Impact of Trigger Tools:
Identifying Adverse Events: Background

Voluntary Event Reporting – "Tip of the Iceberg"



Trigger Tools

- IHI Global Trigger Tools
- Pediatric Trigger Tools
- Focused Medication Trigger Tools
  - Naloxone / Narcotic
  - Vitamin K / Warfarin

Safety alert triggers suitable for dermatologic practice

- Transfer to a higher level of care (including emergency room visit or hospital admission) related to a medication or surgery
- Mislabeling of pathology forms
- Discrepant pathologic diagnosis suggesting a mislabeled specimen
- Postoperative infection
- Prolonged operative time
- Falls in the office
- Adverse medication reaction or abrupt discontinuation of a medication

Safety alert triggers suitable for dermatologic practice

- Unplanned procedure
- Return to operating room
- Change in procedure
- Change of anesthetic
- Inter- or postoperative radiograph
- Use of an antihistamine or epinephrine in the office
- Cardiac arrest or stroke
- Positive *Clostridium difficile* culture
- Use of blood products or colony-stimulating factors

Other Quality Improvement Topics

- CAHPS surveys– *consumer assessment of health care providers and systems;* payment related to scores
- Survey of employee engagement in patient safety (SOPS)
- Caregiver conduct / physician disruptive behavior

Outcomes

Dermatology & Plastic Surgery Institute

Cleveland Clinic

2013
Outcomes

Dermatology Outcome / Process Measures 2013

- Melafind study
- Face Transplant
- Alopecia
- Contact Dermatitis
- Dermatopathology
- Hyperhidrosis
- Infantile Hemangiomas

Measuring Performance & Quality

Process Measures

Description	Example	Strengths	Weaknesses
Assess performance at different levels of care pathway	*Wait time for appt. for pts with pigmented lesions * % of patients told to do self skin exam	*Impact patient experience directly *Short time course *Easy to identify remedial actions	*May be manipulated *May correlate poorly with patient outcome *May lead to quick fixes *May become outdated with new technology

Measuring Performance and Quality

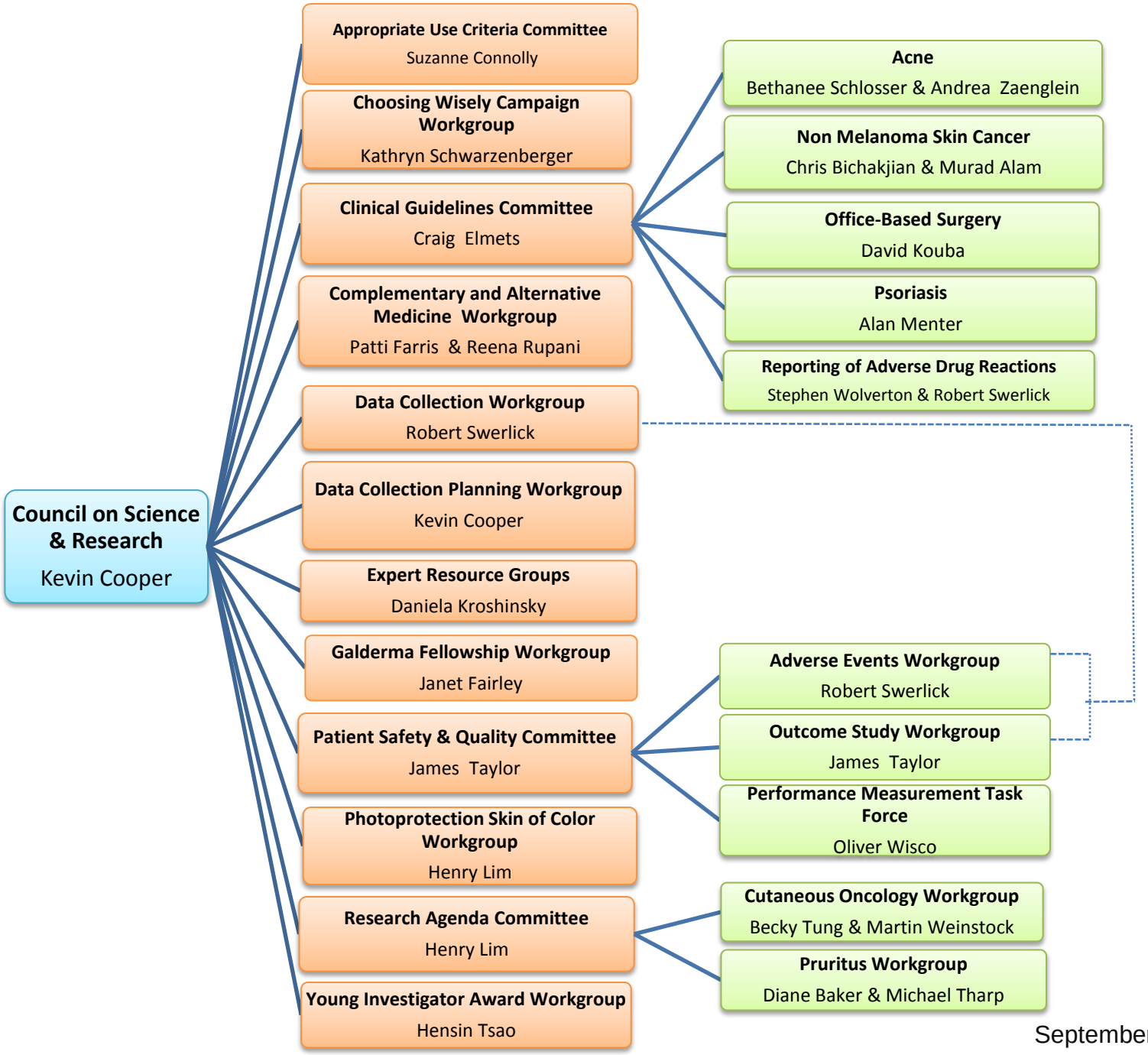
Outcome Measures

Description	Example	Strengths	Weaknesses
Measures the end results of care	*5 year survival in melanoma patients *Surgical infection rate in out patient procedures *QOL in psoriasis	*Ultimate end product of clinical care *Hard to manipulate *Promotes innovation on how to get there	*Often thought to not be under MD control *Multi-factorial *Prone to create perverse incentive *Long-term horizon *May be hard to define / capture

Report from AAD Patient Safety and Quality Committee

- Mission: *The Committee is responsible for Academy activities related to creating a culture of patient safety and continuous measurement and improvement in dermatology.*
- The PSQC activities include:
  - Participation in relevant patient safety conferences and quality related physician groups- NQF, A4HI, SIDM, IHI
  - Assess needs for and develop pertinent resources
  - Oversee relevant workgroups such as adverse events and outcomes in dermatology

CoSR Organizational Chart



September 22, 2014

Medical error in dermatology practice: Development of a classification system to drive priority setting in patient safety efforts

Alice J. Watson, MD, MPH,[a] Kelley Redbord, MD,[b,c,d] James S. Taylor, MD,[c] Alison Shippy, MPH,[f] James Kostecki, MS,[f] and Robert Swerlick, MD[g]

Boston, Massachusetts; Rockville, Maryland; Vienna, Virginia; Washington, District of Columbia; Cleveland, Ohio; and Atlanta, Georgia

J Amer Acad Dermatol 10.1016/j.jaad.2012.10.058. *Available online 26 January 2013*

- Survey of 150 dermatologists
- Classes of errors:
  - **Assessment**: Biopsy pathway: 49 (34%) of most recent errors and 23 (21%) of most serious errors
  - **Intervention**:
    - Medication management
    - Wrong site surgery: 5 (3%) of most recent errors and 21 (19%) of most serious errors

AAD Outcome Study Workgroup

- Identification of need to assess outcomes which are feasible and meaningful in everyday practice.
- Workgroup is planning pilot data collection to define 1) patient reported outcomes, 2) physician reported outcomes, and 3) the intersect of physician and patient outcome interests within the context of two silos of a pilot (A. Inflammatory skin diseases and B. Non-melanoma and melanoma skin cancer).

AAD Performance Measurement Task Force

- Mission: To **identify gaps in care, recommend topics for evidence-based clinical guidelines** for areas where measures are needed, **develop quality performance measures for dermatology**, promote their implementation in various internal and external programs, and evaluate their effectiveness in improving care.
- The PMTF activities include:
  - Review of relevant topics/issues for comment
  - Oversee workgroups for specific metric development.

AAD PQRS Registry - QRS

- Over 8,600 participants and with over 396,000 patient encounters to date.
- In 2012, dermatology was in the top ten specialties for reporting via registry with over 80% of dermatologists submitting via AAD's QRS.
- One of the highest success rates (~98% via registry submission) for earning reporting incentives.
- In 2013, over 3300 users submitted 160,000 patient encounters

AAD Patient Safety & Quality Committee (PSQC) Updates

- The PSQC has been working on a patient safety focused edition of *Dialogues in Dermatology*, which was recorded at the AAD Annual 2014 and has been made available for free to AAD members. It can be accessed at this website:

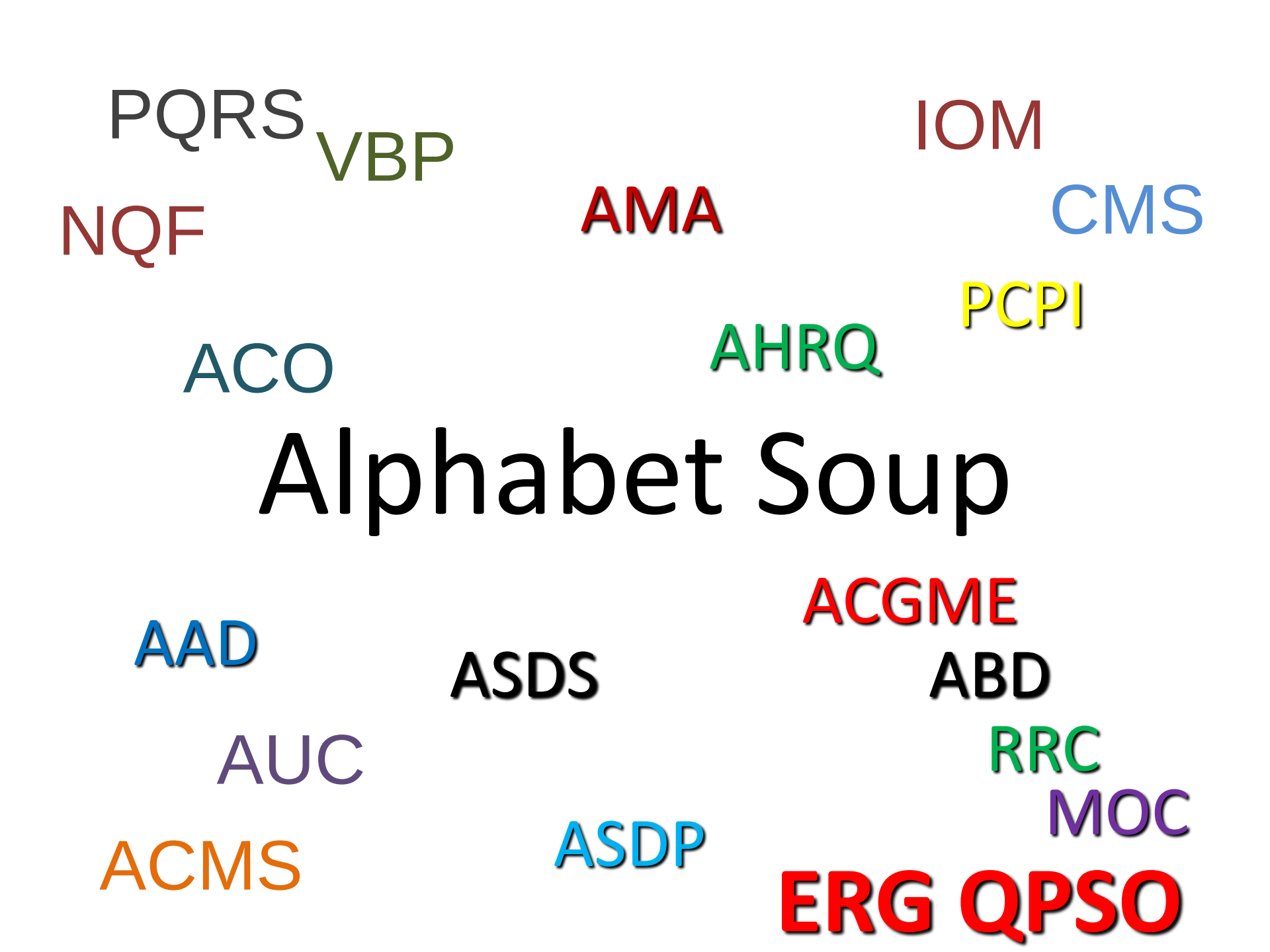
http://www.aad.org/education/aad-professional-education/dialogues-in-dermatology

AAD Expert Resource Group for Quality and Patient Safety Officers

- The ERG-QPSO will ***enhance patient care and physician education by facilitating communication and collaboration among dermatology quality officers and other interested dermatologists in non-academic and academic settings.***
- ***Residents may attend and participate***

Quality Improvement Officer

- Hospital based issues
  - Publically reported measures
    - Hospital readmission- all causes: one size does not fit all; unintended consequences? (JAMA ’14)
    - Avoiding never events RFB, WSS and WSP
    - SSI / CLABSI / CAUTI
- Ambulatory issues assuming more importance
- Regulatory Rain- Uberlevels of certification
  - Impact of documentation / External pressures
  - Surveys, Surveys, Surveys / Mock and Real
- Attend lots of meetings
- Multiple constituencies


PQRS
VBP
IOM
NQF
AMA
CMS
PCPI
ACO
AHRQ
Alphabet Soup
ACGME
AAD
ASDS
ABD
RRC
AUC
MOC
ACMS
ASDP
ERG QPSO

Challenges for Patient Safety Officers (PSO)

- Institutional Objectives – ACO
  - Access
  - Patient Satisfaction
- Peer Review
- Resident Education
- Physician Compensation Plans
- Maintenance of Certification
- Clinic Operations and Patient Safety

What We (PSO) Need

- Mechanisms to collect data
- Benchmarks
- Best practices
- Projects

After Dan Bennett MD

U WI Madison

AAD Expert Resource Group for Quality and Patient Safety Officers

- Ongoing communication via Google group and regular meetings at AAD (60+ members to date)
  - Residents and Academy members welcome!
  - Dr. Bennett (ddbennett3@wisc.edu) or Kristina Finney (kfinney@aad.org)
- Collaborative projects:
  - QI Project Templates for Residents and/or MOC, lead Dr. Alice C. Watson
  - Job Descriptions of Quality Improvement and Patient Safety Office Positions, lead Dr. Dan Bennett
  - Quality Metrics, workgroup on AHRQ measurement mining, lead Dr. Oliver Wisco

AAD Data Collection Platform

The future data platform will facilitate comprehensive data collection across the membership to help address data needs including, but not limited to:

1. Reporting requirements (e.g. PQRS, Meaningful Use).
2. Specialty advocacy (e.g. outcomes of care, value of dermatology).
3. Quality improvement. The AAD is committed to developing a data platform which integrates into the current workflow of our membership.

Professional Organizations' Role in Supporting Physicians to Improve Value in Health Care- Choosing Wisely campaign cited. JAMA 2014; 312; 231-232

AAD Data Collection Platform

To address the challenges facing Dermatology, at our recent Board meeting:

- The Board supported moving forward with planning for the development of an AAD registry.
- The Ad Hoc Task Force on Data Collection Platform and Registries is working through a Request for Proposals (RFP) and vendor selection process currently.

Data

- Data is everything
  - Science tells us what we can do
  - Guidelines what we should do &
  - Registries (Real time data bases) what we are actually doing
    - Paradigms: ACC, STS: hospital data manually submitted moving to ambulatory data electronically pulled from electronic health records
- Data scientists are a “most wanted” hire

Patient Safety Resources

- Patient Safety Courses at AAD Annual & SAM designated in program with yellow triangle
- Patient Safety MOC module by Dr. Erik Stratman replaced ABMS module
- AAD web site (www.aad.org) under Patient Safety lists multiple organization links, reference articles, and resources

Patient safety

The Academy is dedicated to improving patient safety in the clinical setting. The AAD's Patient Safety and Quality Committee leads efforts to promote patient safety education to encourage members to practice even safer and higher-quality medicine. The following resources document patient safety challenges in medicine as a whole and in dermatology specifically, and highlight opportunities to learn more about this vital topic.

Patient safety in medicine

In its landmark 1999 publication, "To Err Is Human," the Institute of Medicine defines patient safety as "freedom from accidental injury." Although the staffs of hospitals, clinics, and doctors' offices take many steps to keep their patients safe, medical errors can happen. According to the Institute for Healthcare Improvement, medical errors — also known as adverse events — occur when there is a single misstep in a chain of activities.

At the National Patient Safety Foundation, researchers have identified a number of ongoing patient safety challenges in medicine as a whole. Chief among them are:

- Wrong-site surgery.
- Medication errors.
- Health-care-acquired infections.
- Falls.
- Readmissions.
- Diagnostic failures.

Patient safety in dermatology

Malpractice data are good indicators of the most common medical errors. According to the 2009 *JAAD* article, "Patient Safety: Part I. Patient Safety and the Dermatologist," the number of closed claims against dermatologists are few. They have remained relatively constant for more than 20 years, with a range from about 86 to 123 per year. Additionally, the proportion of dermatologists facing claims is among the lowest of all specialties, according to the article, "Malpractice Risk According to Physician Specialty," in the *New England Journal of Medicine*. Some of the most common procedural errors cited in claims against dermatologists are:

- Improper performance.
- Error in diagnosis.
- Medication errors.
- Failure to supervise or monitor.
- Performed when not indicated.
- Failure to instruct or communicate with patient.
- Failure to recognize a complication of treatment.
- Improper supervision of residents or staff.

From 1985-2006, the most common diagnoses in malpractice claims against dermatologists were:

- Malignant neoplasms.
- Acne dyschromia.
- Psoriasis.
- Malignant melanoma.
- Contact dermatitis and eczema.
- Benign neoplasm.
- Viral warts.
- Disorder of the skin and subcutaneous tissue (not otherwise specified).
- Diseases of the nails.

Recommended reading

Explore the following resources to get a deeper look at patient safety in dermatology practices.

Articles/ reports | Patient safety resources | AAD patient safety materials | AAD measurement resources

- Institute of Medicine: "To Err is Human: Building a Safer Health System."
- *Journal of the American Academy of Dermatology (JAAD)*: "Patient Safety: Part I. Patient Safety and the Dermatologist." August 2009.
- *Journal of the American Academy of Dermatology (JAAD)*: "Patient Safety: Part II. Opportunities for Improvement in Patient Safety." August 2009.
- *Journal of the American Academy of Dermatology (JAAD)*: "Standardized patient identification and specimen labeling: A retrospective analysis on improving patient safety." July 2012.
- *Journal of the American Academy of Dermatology (JAAD)*: "Integrated safety analysis: Short- and long-term safety profiles of etanercept in patients with psoriasis." August 2012.
- National Quality Forum (NQF): "Serious Reportable Events (SREs)."
- *Dermatology World*: "Not to Err," "Trained for the Task," and "Patient-Centric Office Ensures Excellent Service."
- *Annals of Internal Medicine*: "Making Health Care Safer: A Critical Review of Evidence Supporting Strategies to Improve Patient Safety"
- *Health Affairs:* "Root Cause Analysis Reports Help Identify Common Factors In Delayed Diagnosis And Treatment Of Outpatients" 2013.
- *Journal of the American Academy of Dermatology (JAAD)*: "Current status of surgery in dermatology" October 2013.

Recommended reading

Explore the following resources to get a deeper look at patient safety in dermatology practices.

Articles/ reports | Patient safety resources | AAD patient safety materials | AAD measurement resources

- Agency for Healthcare Research and Quality
- American Board of Dermatology
- American Board of Medical Specialties
- American Society for Dermatologic Surgery Association
- Institute for Healthcare Improvement
- National Patient Safety Foundation
- National Quality Forum
- Surveys on Patient Safety Culture

Recommended reading

Explore the following resources to get a deeper look at patient safety in dermatology practices.

Articles/ reports | Patient safety resources | AAD patient safety materials | AAD measurement resources

- The Patient Safety in Dermatology module helps your dermatology care team develop strategies to avoid and reduce common errors.
- The practice of dermatology: Protecting and preserving patient safety and quality care position statement.
- "Who should be providing your cosmetic treatment?" FAQs and patient education video.
- Medical spa standards of practice position statement and background information.
- Truth in advertising position statement and background information.

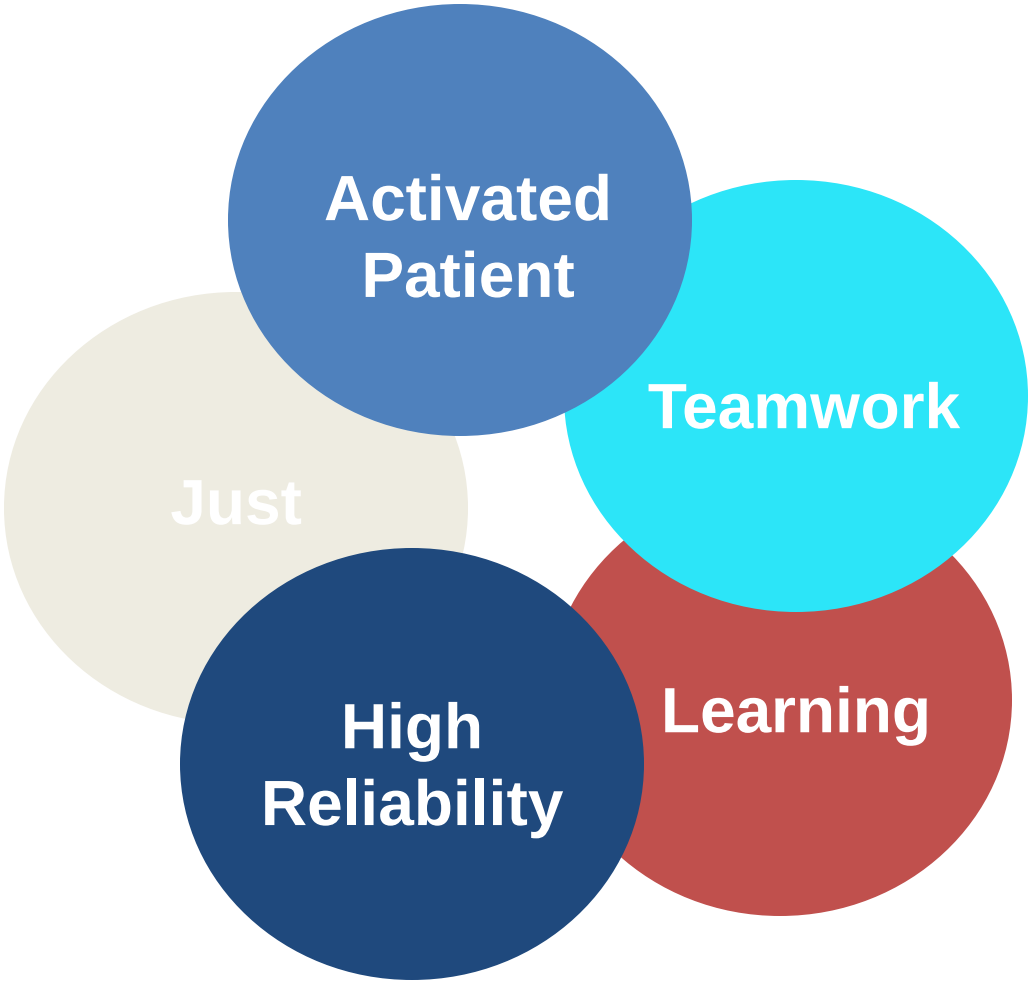
Recommended reading

Explore the following resources to get a deeper look at patient safety in dermatology practices.

Articles/ reports	Patient safety resources	AAD patient safety materials	AAD measurement resources

- Medicare Physician Quality Reporting System (PQRS)
- Maintenance of Certification (MOC)


Patient Experience
Employee Engagement
Safety Culture


Activated Patient
Teamwork
Just
Learning
High Reliability

How Do We Identify and Change Ineffective Practice Patterns

- Convince physicians that these are real and important quality issues
- Look at systems issues and overcome Murphy's law "If a thing can go wrong it will"

Changing Practice Patterns: Methods of High Reliability Organizations

- Recognize small things going wrong are early warning signs of trouble
- Treat near misses and errors as information about the health of their systems and learn from them
- Engineering is better than education
  - The system should be optimized to deliver the highest quality
  - Make the right thing to do the only option
- Lead by example in your Residency Programs

Questions

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