Using Root Cause Analyses to Kickstart QI

Jonathan Flug MD/MBA
Associate Professor of Radiology
Chair, Radiology Quality Oversight Committee
Mayo Clinic Arizona
Objectives

- Describe my journey into quality and safety
- Highlight the mistakes and challenges along the way
- Describe how RCA’s can kickstart a career in QI
My Journey – Summer 2005
Residency

- ABR Requires PQI Projects – Part IV MOC
- ACR Quality and Safety Meeting
- E. Stephen Amis Fellowship in Quality and Safety
- RSNA Quality Improvement Committee
Faculty Experience

- No formal opportunity for local involvement initially
- Failed to build a team
- Peer review replaced need for PQI projects
- Quality as an avenue for academic advancement
- Benefit of network with ACR and radiology colleagues - RSCAN
Second Position

- Formal title and team
  - Extensive institutional know-how
- Proactive institutional risk department
- Concurrent leadership training/coaching
Root Cause Analyses

- Tool used to evaluate sentinel events and other serious patient safety events
- Requires a moderator and “safe space”
  - Physicians, allied health staff, managers, risk, etc
- Generate action items
  - Build the quality team
- Create a culture of pro-active event reviews
Lessons Learned, Opportunities

- Quality Community
- Organic, bottom-up approach
- ACR Resources
- Long term proposition
Flug.Jonathan@Mayo.edu