Christiana Care
Value: Medicine’s New Frontier

“Educating the Healthcare Workforce of the Future: The Quality & Safety Agenda”
April 30, 2012
David B. Nash, MD, MBA
Dean
Jefferson School of Population Health
1015 Walnut Street, Curtis 115
Philadelphia, PA 19107
215-955-6969 O 215-923-7583 – F

david.nash@jefferson.edu http://jefferson.edu/population_health/
http://nashhealthpolicy.blogspot.com/
PAY FOR RESULTS
WellPoint, Highmark, and HealthPartners move beyond process measurement
Page 24
Outline of our time together:

1. Overview and context
2. “Quality and Safety” meet Health Reform
3. The “National Movement” toward educational reform
4. Tackling Unmet Needs
5. Future Challenges
Reforming health care

This is going to hurt
Regional Variation in Rates of Spine Surgery

Total Spine Surgery
There was substantial regional variation in overall spine surgery rates among Medicare enrollees in 2002-03 (Figure 3). Rates varied by a factor of almost six, from 1.6 per 1,000 enrollees to 9.4. Among the hospital referral regions where rates of spine surgery were highest were Casper, Wyoming (9.4); Mason City, Iowa (9.0); Bend, Oregon (8.7); Boise, Idaho (8.2); and Billings, Montana (8.0). Regions with rates lower than the national average of 4.0 spine surgery procedures per 1,000 enrollees included Honolulu (1.6); Newark, New Jersey (1.7); Paterson, New Jersey (1.8); Manhattan (1.8); and East Long Island, New York (1.8).

Spine surgery per 1,000 Medicare enrollees (2002-03)
Each point represents the rate in one of the 306 HRRs in the United States.

Figure 3. Rates of Spine Surgery Among Hospital Referral Regions, 2002-03

Map 1. Spine Surgery
In 71 hospital referral regions, rates of spine surgery were at least 30% higher than the United States average of 4.0 per 1,000 Medicare enrollees. In 52 hospital referral regions, rates were more than 25% lower than the national average.
... all hospitals are accountable to the public for their degree of success...

If the initiative is not taken by the medical profession, it will be taken by the lay public.

1918 Am Coll Surg
Medical Guesswork
From heart surgery to prostate care, the medical industry knows little about which treatments really work
BY JOHN CAREY (P. 72)
A World of Hurt

Exhibit ES-1. Overall Ranking

<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00–2.33</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>2.34–4.66</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>4.67–7.00</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

OVERALL RANKING (2010)

- Quality Care
  - Effective Care: AUS 4, CAN 7, GER 5, NETH 2, NZ 1, UK 3, US 6
  - Safe Care: AUS 6, CAN 5, GER 3, NETH 1, NZ 4, UK 2, US 7
  - Coordinated Care: AUS 4, CAN 5, GER 7, NETH 2, NZ 1, UK 3, US 6
  - Patient-Centered Care: AUS 2, CAN 5, GER 3, NETH 6, NZ 1, UK 7, US 4

- Cost-Related Problem: AUS 6, CAN 3.5, GER 3.5, NETH 2, NZ 5, UK 1, US 7
- Timeliness of Care: AUS 6, CAN 7, GER 2, NETH 1, NZ 3, UK 4, US 5

- Efficiency: AUS 2, CAN 6, GER 5, NETH 3, NZ 4, UK 1, US 7
- Equity: AUS 4, CAN 5, GER 3, NETH 1, NZ 6, UK 2, US 7
- Long, Healthy, Productive Lives: AUS 1, CAN 2, GER 3, NETH 4, NZ 5, UK 6, US 7
- Health Expenditures/Per Capita, 2007: $3,357, $3,895, $3,588, $3,837*, $2,454, $2,992, $7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).
Uneven Adherence to the Evidence

Percentage of Recommended Care Received, by Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>75.7%</td>
</tr>
<tr>
<td>Low Back Pain</td>
<td>68.5%</td>
</tr>
<tr>
<td>CAD</td>
<td>68.0%</td>
</tr>
<tr>
<td>CHF</td>
<td>63.9%</td>
</tr>
<tr>
<td>COPD</td>
<td>58.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>45.4%</td>
</tr>
<tr>
<td>CAP</td>
<td>39.0%</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>24.7%</td>
</tr>
<tr>
<td>Hip Fracture</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

Average: 54.9%

Number of Indicators: 9 6 37 36 20 13 5 10 9

<table>
<thead>
<tr>
<th>No harm from care (procedural competence, experience, medical knowledge, evidence based medicine)</th>
<th>No delays in acute care (pathology, process mapping, team function, information systems, procedural competence)</th>
<th>Curative of acute illness (basic science, vocabulary, key concepts integrated around biologic homeostasis, pathology, resilience, evidence based medicine)</th>
<th>Cost-benefit analysis (epidemiology, economics, statistics)</th>
<th>Justice (philosophy, public health, business, sociology)</th>
<th>Cultural beliefs (anthropology)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No errors (anatomy, physiology, pathology, etc., systems engineering, information systems, cognitive psychology)</td>
<td>Access chronic care (information systems, communications)</td>
<td>Prevention (epidemiology, evidence based medicine)</td>
<td>Reduction of waste (process engineering)</td>
<td>Finance (economics, business, international health)</td>
<td>Ethical values (philosophy, religion)</td>
</tr>
<tr>
<td>Ongoing preventive care (epidemiology, surveillance)</td>
<td></td>
<td>Reduce suffering (psychology, religion, procedural competence)</td>
<td></td>
<td></td>
<td>Communications (psychology, Spanish language skills, humanities)</td>
</tr>
</tbody>
</table>

| Safe | Timely | Effective | Efficient | Equitable | Patient-Centered |

**Objectives of Quality Medical Care**

*Figure 1* Attributes of the Institute of Medicine quality objectives with related curriculum areas.
Health Reform Builds on the Current Quality Infrastructure

- National Quality Improvement Strategy
- Quality Measure Development
- Value-Based Purchasing
- Prevention and Wellness
- New Entities and Authorities

Improved Quality of Care & Lower Overall Costs
Report to Congress

National Strategy for Quality Improvement in Health Care

March 2011
## The Four Underlying Concepts of Cost Containment Through Payment Reform

<table>
<thead>
<tr>
<th>Tying payment to evidence and outcomes rather than per unit of service</th>
<th>“Bundling” payments for physician and hospital services by episode or condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement for the coordination of care in a medical home</td>
<td>Accountability for results - patient management across care settings</td>
</tr>
</tbody>
</table>
The Four Actions Framework Builds the Foundation for Accountable Care

<table>
<thead>
<tr>
<th>Eliminate</th>
<th>Raise</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unnecessary and redundant testing</td>
<td>• Chronic disease management</td>
</tr>
<tr>
<td>• Avoidable hospital readmissions</td>
<td>• Patient engagement in their care</td>
</tr>
<tr>
<td>• Use of paper documentation</td>
<td>• Home monitoring and follow-up</td>
</tr>
<tr>
<td>• Hospital-acquired infections</td>
<td>• Health promotion</td>
</tr>
<tr>
<td></td>
<td>• Screenings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reduce</th>
<th>Create</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fragmented approach to care</td>
<td>• Integrated networks</td>
</tr>
<tr>
<td>• Overall hospital admissions</td>
<td>• Patient care teams</td>
</tr>
<tr>
<td>• One-on-one and face-to-face provider visits</td>
<td>• Patient registries</td>
</tr>
<tr>
<td>• Poor health maintenance</td>
<td>• Patient portals</td>
</tr>
<tr>
<td>• Use of phone and fax</td>
<td>• Virtual visits</td>
</tr>
<tr>
<td></td>
<td>• Multiple access points</td>
</tr>
</tbody>
</table>

Driving value up and creating new demand

National Movement

• Vision (Leape, Berwick and Clancy)
  We envision a culture that is open, transparent supportive and committed to learning; where doctors, nurses and all health workers treat each other and their patients competently and with respect; where the patient’s interest is always paramount; and where patients and families are fully engaged in their care.

• Five transforming concepts
  – Transparency
  – Integrated care platform
  – Consumer engagement
  – Joy and meaning in work
  – Medical education reform

Original viewpoint
Transforming healthcare: a safety imperative
L Leape,1 D Berwick,1,2 C Clancy,3 J Conway,2 P Gluck,4 J Guest,5 D Lawrence,6 J Morath,7 D O’Leary,8 P O’Neill,9 D Pinakiewicz,8 T Isaac,10 for the Lucian Leape Institute at the National Patient Safety Foundation
National Movement

• “Health care professionals in training are expected to gain competency in quality and safety to provide leadership in improving health care in conjunction with learning the traditional skills of their specific discipline”

• Unmet Needs
  – Set of 12 recommendations set forth by members of the Lucian Leape Institute and Expert Roundtable on Reforming Medical Education
  – 3 overarching strategies
    • Setting the right organization context to equip learners with the skills, attitudes, knowledge and behavior to advance patient safety
    • Strategies for teaching patient safety and integrating these concepts into curricula and practice
    • Leveraging change through accreditation and monitoring standards
The Pew Research Center's in-depth survey of a new generation of 18- to 29-year-olds finds them confident, self-expressive, upbeat and open to change. By Tom Ferrick Jr.
TIME FOR 'DR. NEXT'? 
What kind of healthcare can we expect from life-balancing, tech-oriented, younger doctors? 

Prepare for the Cancer Boom p 33
Reform and the Bottom Line p 38
Employees as Cost-Cutters p 43
Disturbing Realities

1. Doctors are well prepared in the science-base of medicine
2. Doctors are well prepared in the skills necessary to care for individual patients
3. Few are qualified or trained with the skills to improve care and improve patient safety
What are some of those skills?

1. Work effectively in teams
2. Understand work as a process
3. Skill in collecting, analyzing and displaying data on the outcomes of care
4. Work collaboratively with managers and patients
5. Ability and willingness to learn from mistakes
“Systemness” of Practice

Need for Cooperation

1. Modern systems theory highlights cooperation.
2. Applications of research findings on cooperation led to Crew Resource Management.
3. Break down barriers to communication especially “against the authority gradient.”
4. Key Tools for Cooperation
   1. Develop a shared purpose
   2. Create an open and safe environment
   3. Encourage diverse viewpoints
   4. Learn how to negotiate agreement
   5. Insist on equity in applying the rules
See One
Do One
Teach One

But, is it being done right the first time?
Culture at Work in Aviation and Medicine

National, Organizational and Professional Influences
Why Hospitals Should FLY
The Ultimate Flight Plan to Patient Safety and Quality Care

John J. Nance, JD

Foreword by David B. Nash, MD, MBA
Introduction by Lucian L. Leape, MD
Part 4. Tackling Unmet Needs

1. AAMC – IQ Meetings
2. Quality and Safety Educators Academy
   Tempe AZ
3. Telluride Experience
4. Veteran Administration
   1. VA National Center for Patient Safety
   2. VA National Quality Scholars
   3. Chief Resident in Quality and Patient Safety
5. NPSF Curriculum
6. IHI Open School
7. Degree Granting Programs
QUALITY AND SAFETY EDUCATORS ACADEMY (QSEA)

FEBRUARY 23-25, 2012
TEMPE MISSION PALMS
TEMPE, AZ

www.hospitalmedicine.org/qsea
Building a Q&S Skill Set

- Essential elements for a successful and sustainable quality and safety education program
  - QI role models and champions
  - Strong academic-practice partnerships
  - A variety of educational modalities
  - Supportive learning environment

- 3 schools offer programs that provide learners with a quality and safety skill set
  - Northwestern University
  - University of Illinois
  - Jefferson School of Population Health
Northwestern University
Feinberg School of Medicine

- Master of Science in Healthcare Quality and Patient Safety (MS)
- Students: medical students, clinicians and working healthcare professionals (with at least 3 years healthcare work experience)
- Part-time online program consisting of 9 courses can be completed within 2 years
  - Certificate can be completed in 12 months
- Graduates are prepared to serve as quality and safety specialists, design and implement quality and safety initiatives across health care plans, hospitals, state and federal agencies, and voluntary organizations
University of Illinois College of Medicine

- Master of Science in Patient Safety Leadership (MS-PSL)
- Students: clinical and non-clinical healthcare professionals
- Part-time online program consisting of 36 credits can be completed in 18 months
  - Certificate in Patient Safety, Error Science and Full Disclosure can be completed in 6 months
- Graduates will have the skills to design, implement, and lead a broad range of patient safety activities, including global transformation of the current error-ridden culture of health care.
Jefferson School of Population Health

- Master of Science in Healthcare Quality & Safety (MS-HQS)
- Students
- Part-time online program consisting of 39 credits can be completed within 2 years
  - Certificate in Healthcare Quality & Safety consists of 18 credits to be completed at your own pace
- Graduates will have the skills to analyze U.S. healthcare benefits and systems for delivering healthcare services; design, conduct, and evaluate improvement; develop and analyze policies, care guidelines, and regulations; evaluate information systems and technology to support decision-making; lead, manage, and develop approaches to address healthcare quality and patient safety
## Choose the University That's Right For You

Decide which master's degree you wish to pursue and apply to that university.

ACPE has partnered with four top universities that recognize ACPE prerequisites and extend tuition savings to ACPE students.

<table>
<thead>
<tr>
<th>University</th>
<th>MBA</th>
<th>MMM</th>
<th>MMM</th>
<th>MS-HQSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Massachusetts Amherst</td>
<td>University of Carnegie Mellon University</td>
<td>University of Carnegie Mellon University</td>
<td>University of Southern California</td>
<td>Thomas Jefferson University</td>
</tr>
<tr>
<td>Online Part-Time MBA with a Focus in Medical Management</td>
<td>Carnegiemellon University</td>
<td>Heinz College</td>
<td>USC Marshall School of Business</td>
<td>Master of Science in Healthcare Quality and Safety Management</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>• Practical business knowledge</td>
<td>• Leadership</td>
<td>• Physician executive as a leader</td>
<td>• Health care quality</td>
</tr>
<tr>
<td></td>
<td>• Emphasis on best practices</td>
<td>• Strategy development</td>
<td>• Entrepreneurship — internal and external</td>
<td>• Patient safety</td>
</tr>
<tr>
<td></td>
<td>• Easily applied to health care</td>
<td>• Information technology</td>
<td>• Fully implementable business plans</td>
<td>• Tools, methods and applications</td>
</tr>
<tr>
<td><strong>Programs Begin</strong></td>
<td>January, May, and September</td>
<td>September</td>
<td>March (pre-work is mailed late January)</td>
<td>January and September</td>
</tr>
<tr>
<td><strong>Format</strong></td>
<td>11 courses, 100% online, asynchronous</td>
<td>Four 1/2-day on-campus sessions over 18 months plus distance education</td>
<td>Four 7-day sessions over one year plus distance education</td>
<td>9 online courses plus Capstone project. 18 months (5 terms) to complete (2 courses per term), but pacing is flexible</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>9-11 hours per week, per class</td>
<td>10-15 hours per week</td>
<td>10-15 hours per week</td>
<td>8-12 hours per week, per course</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>$22,550 (pay as you go at $675 per credit, plus registration fees and books)</td>
<td>$31,200 (includes books and miscellaneous fees)</td>
<td>$33,380 (includes fees, books and most meals)</td>
<td>$28,350</td>
</tr>
</tbody>
</table>

Visit [acpe.org/MyFuture4](http://acpe.org/MyFuture4) to access each university's website for more details.
Changing The Culture In Medical Education To Teach Patient Safety

By Darrell G. Kirch and Philip G. Boyesen

ABSTRACT In 1999 a seminal Institute of Medicine report estimated that preventable medical errors accounted for 44,000–98,000 patient deaths annually in U.S. hospitals. In response to this problem, the nation’s medical schools, teaching hospitals, and health systems recognized that achieving greater patient safety requires more than a brief course in an already crowded medical school curriculum. It requires a fundamental culture change across all phases of medical education. This includes graduate medical education, which is already teaching the next generation of physicians to approach patient safety in a new way. In this paper the authors explore five factors critical to transforming the culture for patient safety and reflect on one real-world example at the University of North Carolina School of Medicine.

When a report on medical errors comes out, the response often is the question: “Why aren’t they teaching this in medical school?” As noted by the Institute of Medicine (IOM) a decade ago in To Err Is Human, one’s first reaction to a medical error is to blame someone. The report noted, however, that blame may be misplaced, because the conditions of the current health care delivery system can contribute to errors. Therefore, the IOM stated, a multilayered approach—ones that addresses systems errors as well as human ones—must be taken to prevent medical errors. There is no “magic bullet” to fix this problem. Advancing patient safety requires a fundamental culture change in health care.

Medical education alone cannot accomplish this shift. However, critical elements of the change are evolving in the nation’s teaching hospitals and medical schools—collectively referred to as “academic medicine.” These institutions recognize that although they produce the best clinicians and scientific experts in the world and provide them with a great body of knowledge, today’s challenge lies in getting these experts to work well together in the clinical environment. Both individually and collectively as the academic medicine community, these institutions are changing their overall culture to bring about an environment more conducive to patient safety. They are putting processes in place to ensure that clinicians deliver care in optimal ways and, in doing so, are fostering the learning environment needed for resident physicians to become the central change agents for patient safety.

This paper provides an overview of this cultural change, identifies five factors critical to that change, and offers examples of how those factors are being implemented at the University of North Carolina (UNC) School of Medicine, one of the nation’s academic medical centers. Along with many other academic medical centers, the school is participating in the Agency for Healthcare Research and Quality (AHRQ) patient safety initiative called TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety). TeamSTEPPS is a set of tools used to assess an institution’s readiness for change. The program offers patient safety training for health care staff.
Because quality and safety *aren't* electives.
Figure. Systems View of Professionalism

Expressions of professionalism

Physician-patient interactions

Interactions with care team

Practice settings

Training environment

External environment

Payment

Regulation

Socioeconomic determinants of health

Influences on professionalism

Strategies to strengthen professionalism

- Develop individual competencies
- Promote physician leadership and supportive organizational culture
- Encourage physician advocacy and engagement in system reform
Evaluating Obstetrical Residency Programs Using Patient Outcomes

David A. Ach, MD, MBA
Sean Nicholson, PhD
Sindhu Srivats, MD, MSCE
Joph Herrin, PhD
Andrew J. Epstein, PhD, MPP

Context Patient outcomes have been used to assess the performance of hospitals and physicians; in contrast, residency programs have been compared based on non-clinical measures.

Objective To assess whether obstetrics and gynecology residency programs can be evaluated by the quality of care their alumni deliver.


Main Outcome Measures Nine measures of maternal complications from vaginal and cesarean births reflecting laceration, hemorrhage, and all other complications after vaginal delivery, hemorrhage, infection, and all other complications after cesarean delivery, and composites for vaginal and cesarean deliveries and for all deliveries regardless of mode.

Results Obstetricians’ residency program was associated with substantial variation in maternal complication rates. Women treated by obstetricians trained in residency programs in the bottom quintile for risk-standardized major maternal complication rates had an adjusted complication rate of 13.6%, approximately one-third higher than the 10.3% adjusted rate for women treated by obstetricians from programs in the top quintile (absolute difference, 3.3%; 95% confidence interval, 2.8%-3.8%). The rankings of residency programs based on each of the 9 measures were similar. Adjustment for medical licensure examination scores did not substantially alter the program ranking.

Conclusions Obstetrics and gynecology training programs can be ranked by the maternal complication rates of their graduates’ patients. These rankings are stable across individual types of complications and are not associated with residents’ licensing examination scores.

JAMA. 2009;302(12):1277-1283

www.jama.com

Any physicians and non-physicians likely assume that some residency programs tend to produce better physicians than others—either because those residency programs train physicians better or because those residency programs can recruit more capable trainees. Although plausible, these intuitions have not been empirically tested. This information could be useful in at least 2 different ways. First, identifying which training programs produce better physicians and separating out the effects that are due to the ability to attract better trainees might indicate what makes better programs better. Some of these factors might be exportable to other programs, raising the quality of medical education more broadly. Second, by identifying which training programs produce better physicians, patients could use this information when selecting a physician, much as patients in some surgical settings use information on clinical volume when selecting a surgeon and a hospital. Some patients might already be preferentially seeking physicians who have graduated from programs they believe to be elite, but without the evidence to support their intuition.

This study tested the concept that residency programs matter by exploring whether obstetrics and gynecology (OB) residency programs can be evaluated according to the outcomes of the women delivered by the graduates of those programs. The advantages of using obstetrics to evaluate the connection between training and clinical outcomes include (1) more than 4 million women giving birth annually in the United States, making delivery one of the most common reasons for hospital care; (2) most women who deliver are healthy, so only limited severity adjustment is needed in evaluating clinical outcomes; and (3) in most cases vaginal deliveries are performed by a single physician and cesarean deliveries are led by a single physician. Furthermore, maternal complications of vaginal and cesarean deliveries, such as hemorrhage, infection, and laceration, occur with sufficient frequency and have enough clinical meaning to patients to serve as markers of quality in maternal care. Risk-adjusted rates of these complications were evaluated as measures of program performance.

Author Affiliations: Center for Health Equity Research and Promotion, Philadelphia Veterans Affairs Medical Center, Philadelphia, Pennsylvania (Dr Ach); Leonard Davis Institute of Health Economics (Dr Ach), University of Pennsylvania, Philadelphia, Pennsylvania, and Department of Obstetrics and Gynecology (Dr Srivats), University of Pennsylvania, Philadelphia, and Cornell University, Ithaca, New York (Dr Nicholson), and Yale University, New Haven, Connecticut (Dr Herrin and Epstein).

Corresponding Author: David A. Ach, MD, MBA, Leonard Davis Institute of Health Economics, University of Pennsylvania, 3641 Locust Walk, Philadelphia, PA 19104-4218 (dach@hkr.upenn.edu).
The Role of Quality Improvement and Patient Safety in Academic Promotion: Results of a Survey of Chairs of Departments of Internal Medicine in North America

Thomas O. Staiger, MD, a, Emily Y. Wong, MD, a, Anneliese M. Schleyer, MD, a, Diane P. Martin, PhD, b Wendy Levison, MD, a William J. Brenner, MD, PhD a

*Department of Medicine, Department of Health Services, University of Washington, Seattle, bDepartment of Medicine, University of Toronto, ON, Canada.

Academic health centers (AHCs) are devoting substantial resources to improving quality and safety.1,4 Strong physician engagement and leadership in quality improvement (QI) and patient safety (PS) are critical to the success of these efforts.1,5,6 Many AHCs face challenges in enlisting faculty to participate in these activities.3,4,7

Academic infrastructures are currently geared towards physicianscientists and clinician-teachers.11,12 Traditionally, research, peer-reviewed publications, grant funding, and regional or national reputation are required for promotion and academic success.10,11,13,14 In response to the changing needs of academic medicine over the past 20 decades, excellence in teaching, clinical care, and medical education have been integrated into the promotion process at many institutions within clinician-educator pathways.11,14,15 Similar promotion pathways for faculty leading QI/PS efforts have not yet been developed.1

To understand whether faculty are currently being promoted for QI/PS work and to identify what is needed to address the challenge of how to reward faculty for this work, we surveyed leaders of departments of internal medicine.

METHODS

In review of the literature, existing survey questions did not assess opinions about the role of QI/PS in academic promotion so we developed a brief, self-administered 16-item questionnaire. Questions were designed to ascertain the importance of recognition of QI/PS in academic promotion (4 questions) and to determine if physician faculty had been promoted based on QI/PS activities, specifying which activities chairs considered relevant for promotion (7 questions). Additional questions were developed to identify if existing promotion criteria account for QI/PS activities (1 question) and whether guidelines by which these activities could be assessed would be helpful (1 question). For questions related to opinions about the role of QI/PS in academic promotion, responses were categorized on 5-point Likert scales ranging from “not important” to “extremely important.” Responses regarding experiences with promotion were either numeric (“In the past 5 years, how
Robert O. Bonow, MD, graduated from medical school in 1973. Caitlin Schaninger will graduate in June. Despite training in different generations, they see similar gaps in quality and safety education.

Much has changed in medical education in the nearly four decades that separate their medical school experiences.

What has remained largely unchanged is the lack of education most medical school graduates receive in the science and skills of quality improvement and patient safety — how to deliver the right care to the right patient at the right time, and how to prevent a patient from being harmed.

Dr. Bonow is chief of the cardiology division at Northwestern Memorial Hospital in Chicago. He directs the Center for Cardiovascular Quality and Outcomes at Northwestern University's Feinberg School of Medicine and has served on several guideline and measure development bodies. Yet even with all his experience and expertise, Dr. Bonow felt compelled to pursue a master's degree in health care quality and patient safety.

"There's a knowledge gap that I think I personally have," he said. "I've been involved with a lot of quality initiatives, but have never had necessary formal training in this stuff. I've learned it by osmosis for a decade and a half."

Northwestern University's program, launched in 2006, was believed to be the first of its kind. At least four other universities now offer similar master's degree programs aimed at addressing this training gap and helping to educate the faculty who will teach medical students and residents skills such as how to analyze errors and how to measure quality performance. Many medical schools and teaching hospitals are working to integrate quality and safety into their training, but critics say the pace of change is too slow and too inconsistent.

"Unmet needs"

Schaninger is among medical students across the country looking outside the formal curriculum of medical school for quality and safety training. As a student at the University of Chicago Pritzker School of Medicine she helped found a campus chapter of the Institute for Health Improvement's Open School for Health Professions.

The Open School offers free online quality and safety training to medical, nursing and other health professions students, and boasts chapters on 204 campuses in 41 U.S. states and 26 other countries.

“The education I experienced over the last four years did not include a lot of mandatory coursework on quality improvement or patient safety,” Schaninger said. "I can't think of any dedicated time so far where everybody has been exposed to these topics. That's something we need to work on as an educational community, not just at Pritzker, but in all medical
9th Annual Interclerkship Day
IMPROVING PATIENT SAFETY

Tuesday, January 3, 2012
Thomas Jefferson University
Dorrance H. Hamilton Building, Connelly Auditorium
1001 Locust Street, Philadelphia, PA 19107

Sponsored by:
Jefferson School of Population Health
and Office of the Dean, Jefferson Medical College
ACGME’s Goals for Accreditation
Specific Aims for the Sponsor Visit Program

• **Provision of High Quality, Safe Patient Care in the Future**
  To demonstrate the outcomes of knowledge and application of that knowledge of patient safety and quality improvement principles in actual practice

• **In order to accomplish the above, we must assure:**
  Training in an Environment that provides High Quality, Safe Patient Care Today
  To demonstrate the presence and effectiveness of:
  – Supporting systems to assure both patient safety and quality of care
  – Systems of transitions in care and assurance of effective communication
  – System for institutional oversight of resident fatigue and duty hours standards compliance
The Next Accreditation System

- **Predicated on a continuous improvement and oversight model**
  - Continuous data acquisition and review by RRC
  - Measurement of trainee intermediate outcomes (Milestone achievement as a meaningful measure of program effectiveness)
  - Truthful identification of areas for improvement by residents and faculty on Resident and Faculty Surveys
  - Enhanced institutional responsibility for oversight of programs and education environment
  - Institutional Visit Program assessment of organizational commitment to quality and safety

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The Next Accreditation System

• Desired outcomes
  – Enhance ACGME’s ability to influence (In a constructive manner) the quality and safety of care rendered in the educational environment
    • Quality Improvement and Patient Safety Programs (resident engagement)
    • Transitions in Care
    • Duty Hours Compliance
  – Ability to more closely supervise and improve programs with less than desirable outcomes, unstable educational environments, or environments where less than acceptable care is rendered (quality or safety)
  – Enhanced opportunity for programs with strong outcomes and solid history to innovate
  – Ability to introduce new “competencies” through Milestones
  – Produce physicians with the “new competencies” needed/desired by the public
  – Reduce burden, and measure what is important

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Timeline for Implementation

- Institutional Visit Program – September 2012
  - Recruitment of Physician leader (SVP) – Announcement I 2012
  - Recruitment and training of Site Visitors - Spring 2012
    - Solicitation of Peer Volunteers, March 2012
  - Configuration of Evaluation Committee – Spring 2012
  - First Meeting, Evaluation Committee – June/July 2012
  - Practice Site Visits - August 2012
  - First Institutional Visits - September 2012

- Phase 1 Specialties implement “Next Accreditation Systems” July 2013

- Phase 2 Specialties implement “Next Accreditation Systems” July 2014

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Nash’s Immutable Rule

High Quality care costs less!
“The institutionalization of leadership training is one of the key attributes of good leadership.”

John P. Kotter,
Harvard Business School