Jefferson School of Population Health

AMSA – AHRQ - JSPH

PSQS

"A Call to Action"

September 8 2012

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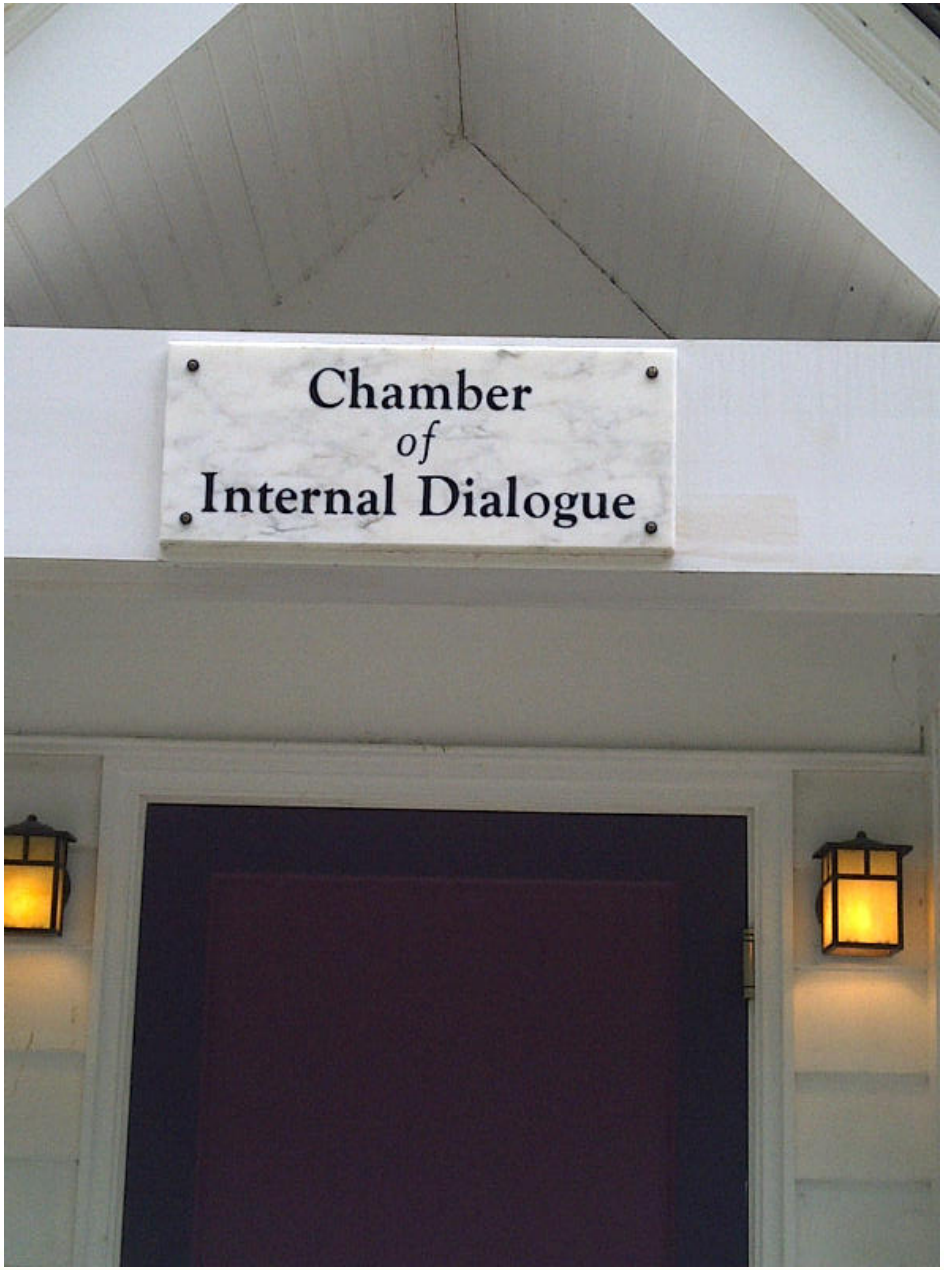
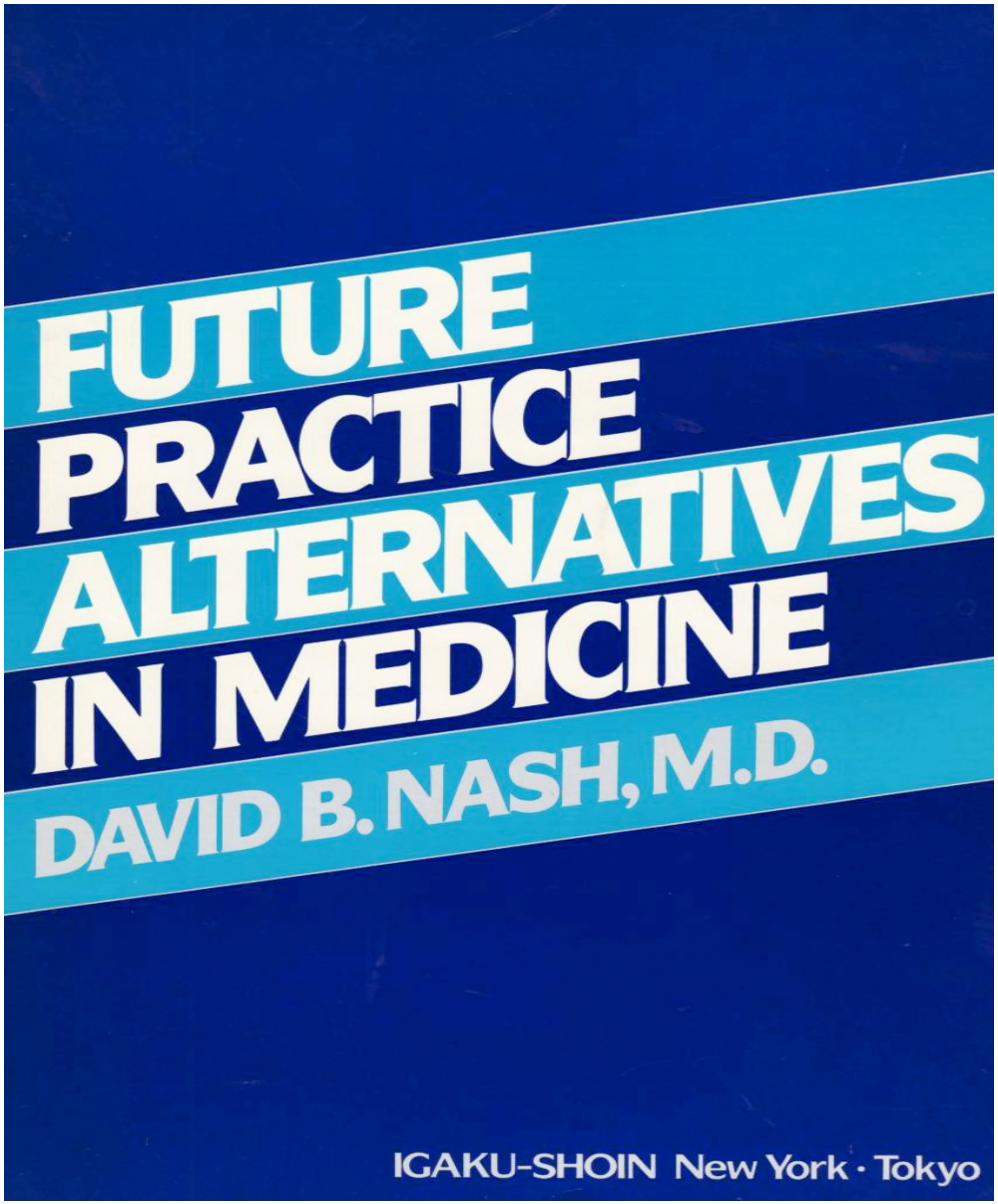
http://jefferson.edu/population_health/

http://nashhealthpolicy.blogspot.com/

Tobacco Smoke Enema (1750s-1810s)
The tobacco enema was used to infuse tobacco smoke into a patient's rectum for various medical purposes, primarily the resuscitation of drowning victims. A rectal tube inserted into the anus was connected to a fumigator and bellows that forced the smoke towards the rectum. The warmth of the smoke was thought to promote respiration, but doubts about the credibility of tobacco enemas led to the popular phrase "blow smoke up one's ass."

This Old Tool has been reintroduced in Washington D.C. by the New Administration.
Are you starting to feel it


Chamber
of
Internal Dialogue


FUTURE
PRACTICE
ALTERNATIVES
IN MEDICINE
DAVID B. NASH, M.D.
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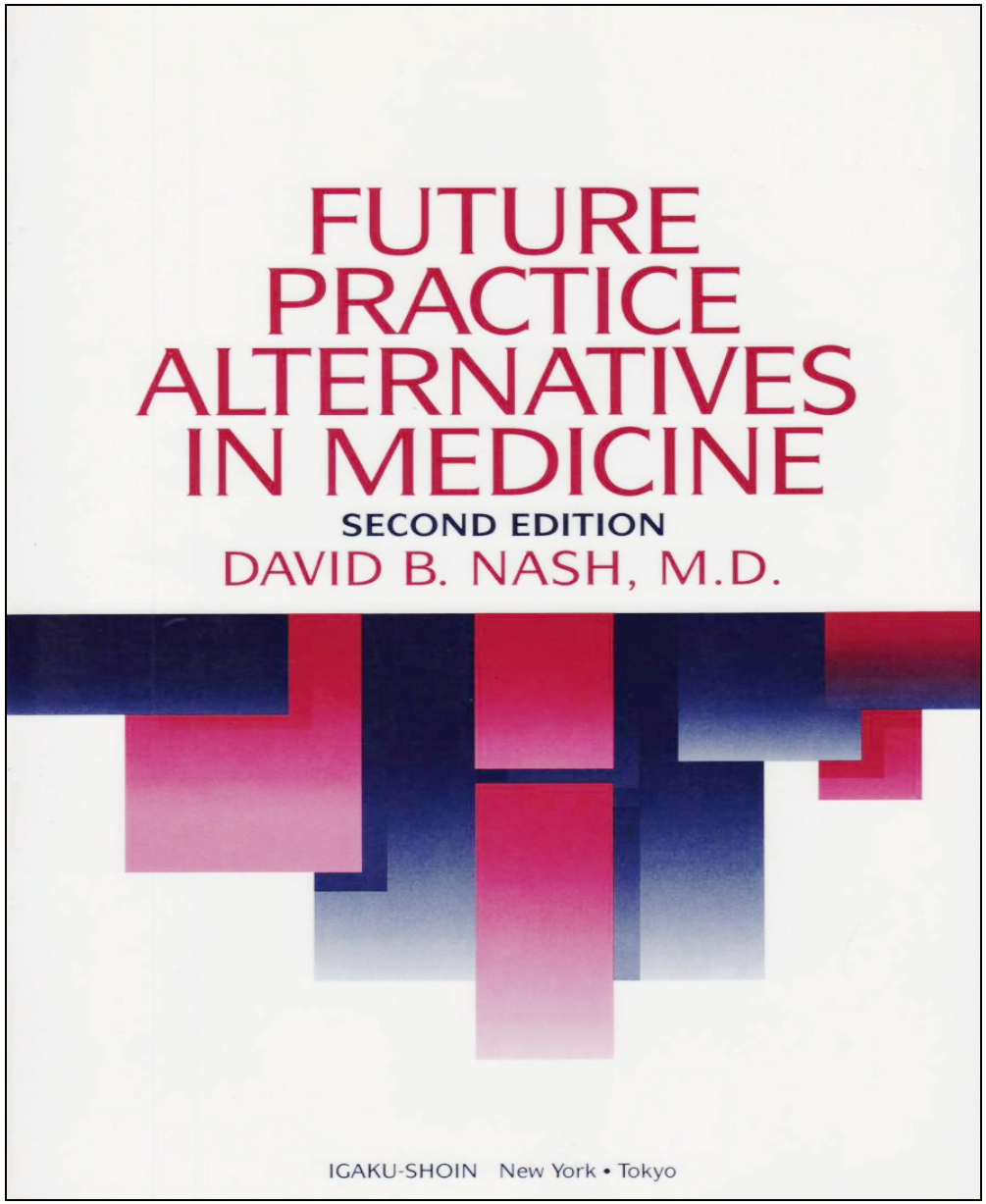
FUTURE
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IN MEDICINE
SECOND EDITION
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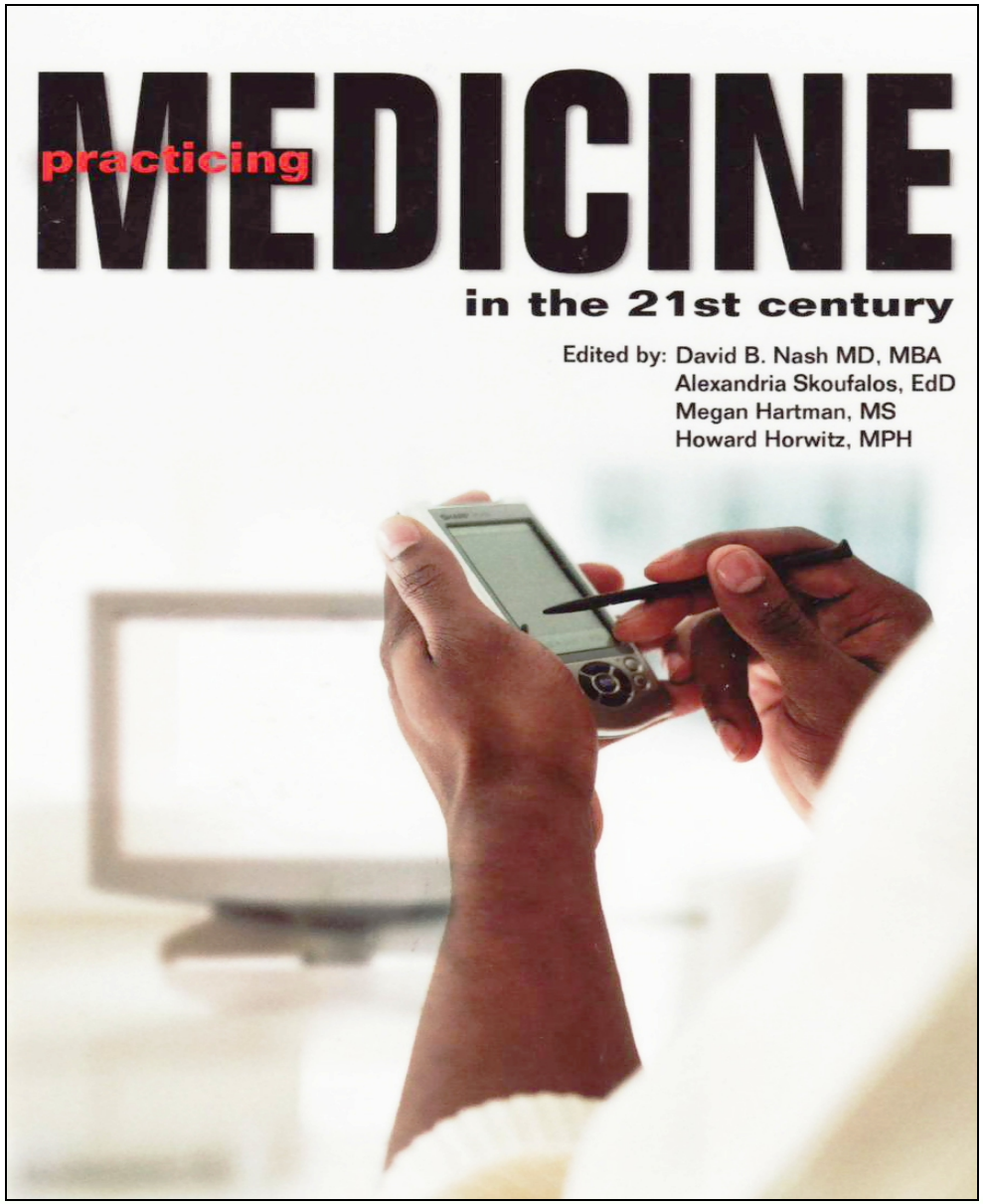
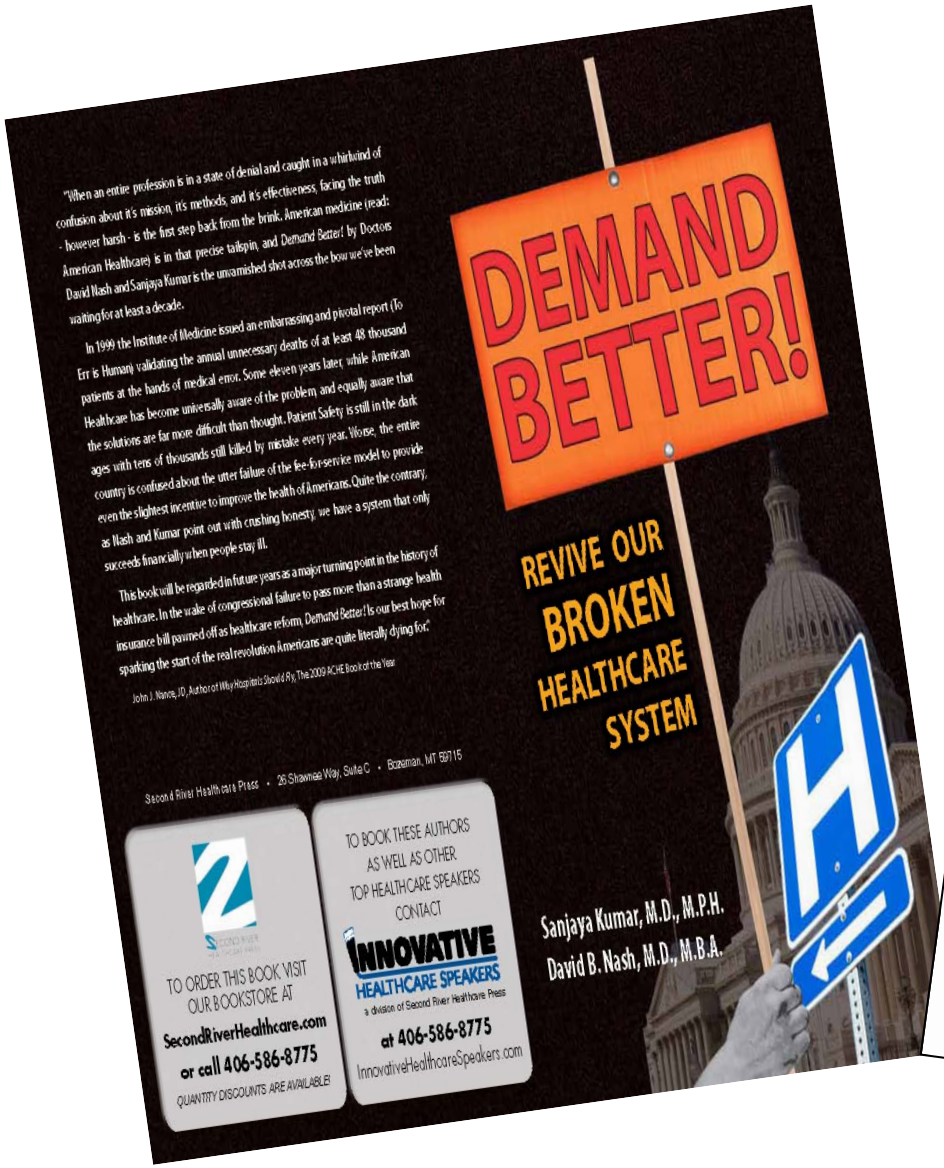

practicing
MEDICINE
in the 21st century
Edited by: David B. Nash MD, MBA
Alexandria Skoufalos, EdD
Megan Hartman, MS
Howard Horwitz, MPH



DEMAND BETTER!

REVIVE OUR BROKEN HEALTHCARE SYSTEM

Much of the healthcare debate is centered on cost – the skyrocketing cost of direct patient care, the cost to insure millions of currently uninsured people, the administrative costs that eat up a large chunk of every healthcare dollar, the cost of defensive medicine to avert malpractice lawsuits. The core driver of the cost problem, however, is a set of largely unchallenged beliefs about the safety and efficacy of our healthcare system. How can it be that we spend more than $700 billion each year on medical care that fails to improve patients' health and often harms them?

The problems are cultural. We collaborate in a collective mythology about American healthcare. We "know," for example, that modern medicine is largely backed up by solid science. We boast that our delivery system is superior because we offer access to more and newer services than any other country. We've focused a great deal on safety improvement over the past decade and we trust that our healthcare will rarely harm patients. Our physicians and hospitals are paid to deliver the right care that is expertly coordinated. Our medical schools are the envy of the world and offer the very best training of future physicians. All of this we know.

There is no easy fix to these problems, of course. But there is a best place to look: focus on quality. This is a book about debunking healthcare myths through the lens of quality: what it is and is not, why it is lacking in so much of our present system and how to reclaim it. Poor healthcare quality derives from uncertainty in clinical decision-making, from persistent unexplained variation in physician practice patterns, from still-inadequate accountability for quality and patient safety, from payment for piecework and from medical training curriculum that is decades behind the curve. Reclaiming quality by addressing each of these deficiencies will transform the economics of our healthcare system. Greater safety, effectiveness and efficiency is possible.

This is not a utopian critique. It is based on a quality revolution that is already underway and is gradually transforming the way medical care is delivered in the US. It didn't need mandates from politicians, although it will need their support to achieve fruition.

This is a pivotal moment in American healthcare delivery, marked by tremendous innovation and accelerating improvements in quality and safety. Much of that innovation is aimed directly at "busting" our counterproductive myths on several fronts: improving physician decision-making, building a better research base to compare the effectiveness of different treatments for the same medical condition, devising accountability mechanisms that work, piloting second-generation pay-for-performance models, paying greater attention to quality improvement in medical training curriculum and expanding access to quality care in non-traditional venues.

A quality and safety revolution in healthcare delivery has begun. Physicians have various tools to help them make better decisions. Hospital and physician report cards are multiplying, although they need to be redesigned to leverage the power of transparency. Comparative effectiveness research is in its infancy in the US, but has been jumpstarted by recent stimulus funding and agenda-setting. Pay-for-performance initiatives continue to evolve, but they need to be supplemented with bundled payments among physicians and hospitals to reverse perverse incentives of the fee-for-service system, to minimize error and waste and to drive superior outcomes. Today's physicians need medical training that teaches them how to close their quality feedback loops and practice collaborative, patient-centered care.

Even the reader who thinks he or she knows all about some of the topics in this book will appreciate the manner in which DEMAND BETTER! integrates these topics into a cohesive appraisal of core problems and cutting-edge solutions that are of great interest to them. DEMAND BETTER! synthesizes for the healthcare executive the many trends, initiatives, reports, organizations and policies that look beyond our healthcare myths and stand on the front lines of the quality and safety revolution.

About the Authors

Sanjaya Kumar, M.D., M.P.H.

Sanjaya Kumar, M.D., M.P.H. is President, CEO and Chief Medical Officer of Quantros, Inc, a leader in web-based healthcare quality, data management and patient safety applications. Quantros products are used in one out of every three U.S. hospitals.

Dr. Kumar is driven by an agenda aimed at improving the quality of care provided to patients by today's evolving healthcare delivery systems. He has been the clinical lead on many cooperative clinical quality improvement projects.

Dr. Kumar serves on numerous quality improvement committees, task forces and working groups, both at the national level and state levels and is a frequent speaker at national healthcare conferences and meetings. Dr. Kumar has been published widely in peer reviewed medical journals and has hosted various healthcare industry conferences.

Dr. Kumar authored the book *Fatal Care: Survive in the U.S. Health System* which was published in 2008.

David B. Nash, M.D., M.B.A.

David Nash is the Founding Dean and the Dr. Raymond C. and Doris N. Grandon Professor of Health Policy at the Jefferson School of Population Health.

Dr. Nash is a board certified internist who is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement and has been repeatedly named to Modern Healthcare's list of the 100 Most Powerful Persons in Healthcare.

He is a consultant in both the public and private sectors. In December 2009, he was named to the Board of Directors for Humana Inc, one of the largest publicly traded health and supplemental benefits companies. He recently was appointed to the Board of Main Line Health – a four hospital system in suburban Philadelphia, PA. From 1998–2008, he served on the Board of Trustees of Catholic Healthcare Partners, Cincinnati, Ohio where he chaired the Board Committee on Quality and Safety.

Through publications, public appearances, his blog and an online column on MedPage Today he reaches more than 100,000 persons every month.

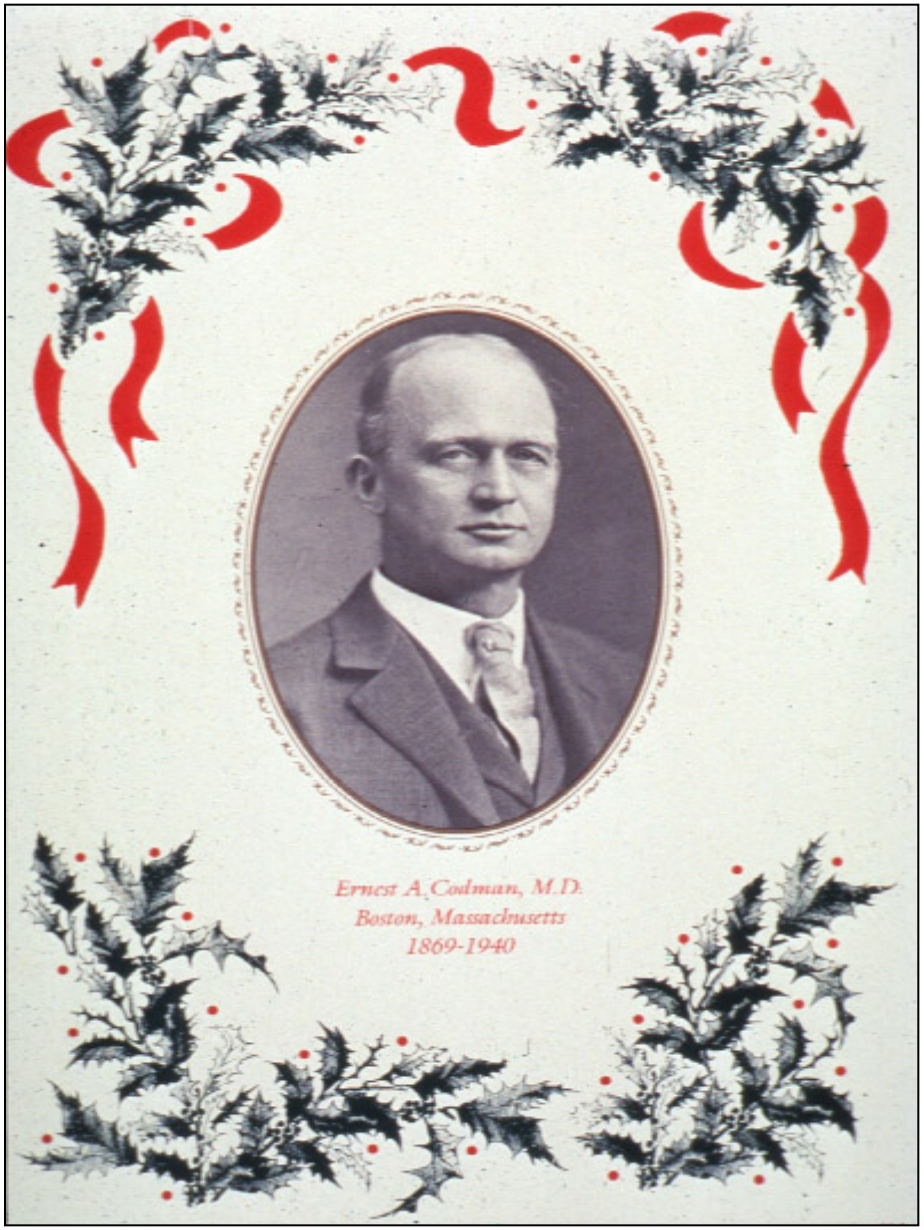
Dr. Nash received his BA in economics (Phi Beta Kappa) from Vassar College; his MD from the University of Rochester School of Medicine and his MBA in Health Administration (with honors) from the Wharton School where he was a former Robert Wood Johnson Foundation Clinical Scholar.

Jefferson School of Population Health

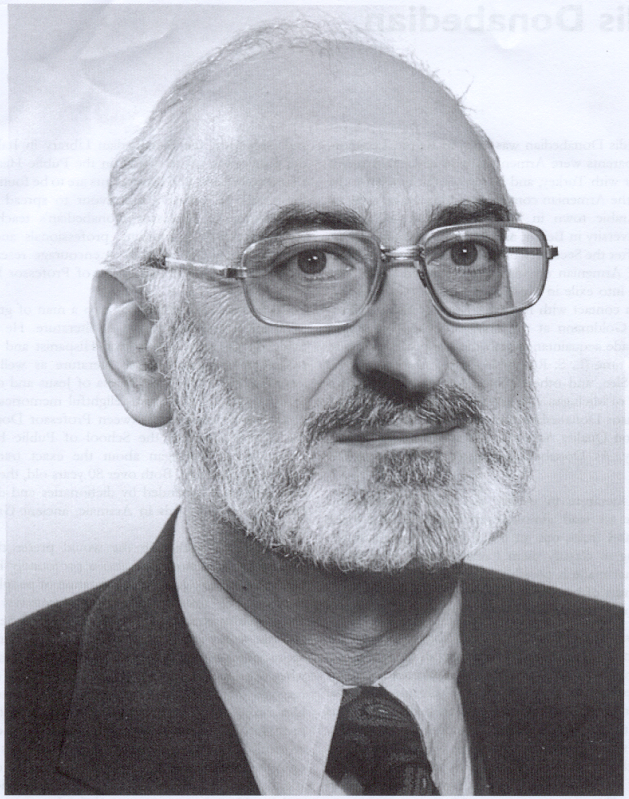
… all hospitals are accountable to the public for their degree of success…

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

1918 Am Coll Surg


Ernest A. Codman, M.D.
Boston, Massachusetts
1869-1940

International Journal for Quality in Health Care 2000; Volume 12, Number 6: pp. 451–454



Avedis Donabedian
7 January 1919–9 November 2000

The President, Executive Board, Members and Friends of The International Society for Quality in Health Care and the Editors of the Society's Journal, honour the distinguished life and acclaimed contributions of **Avedis Donabedian**, primary architect of the field of quality in health care and a life Member of ISQua, who died peacefully at his home in Ann Arbor, Michigan, USA on 9 November 2000.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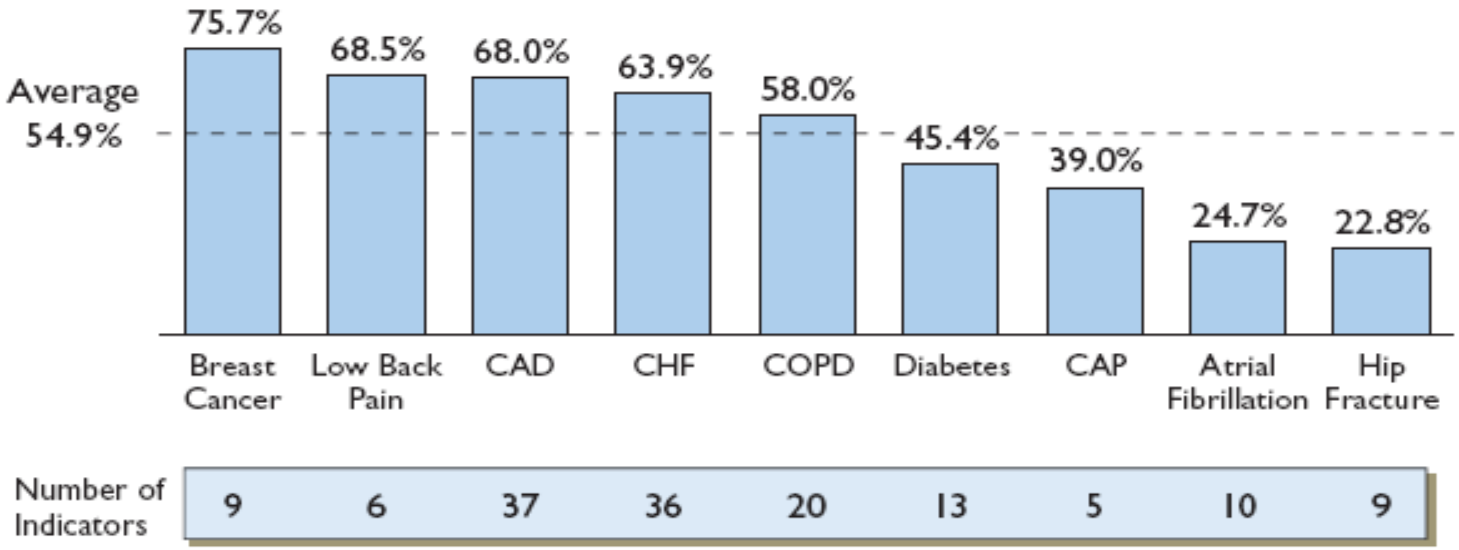
Medical Guesswork
From heart surgery to prostate care, the medical industry knows little about which treatments really work
BY JOHN CAREY (P. 72)
DRUGS
PSYCHIATRY
CHIROPRACTIC
ASPIRIN
REST
WATCH & WAIT
YOGA
SURGERY

Uneven Adherence to the Evidence

Percentage of Recommended Care Received, by Condition[1]



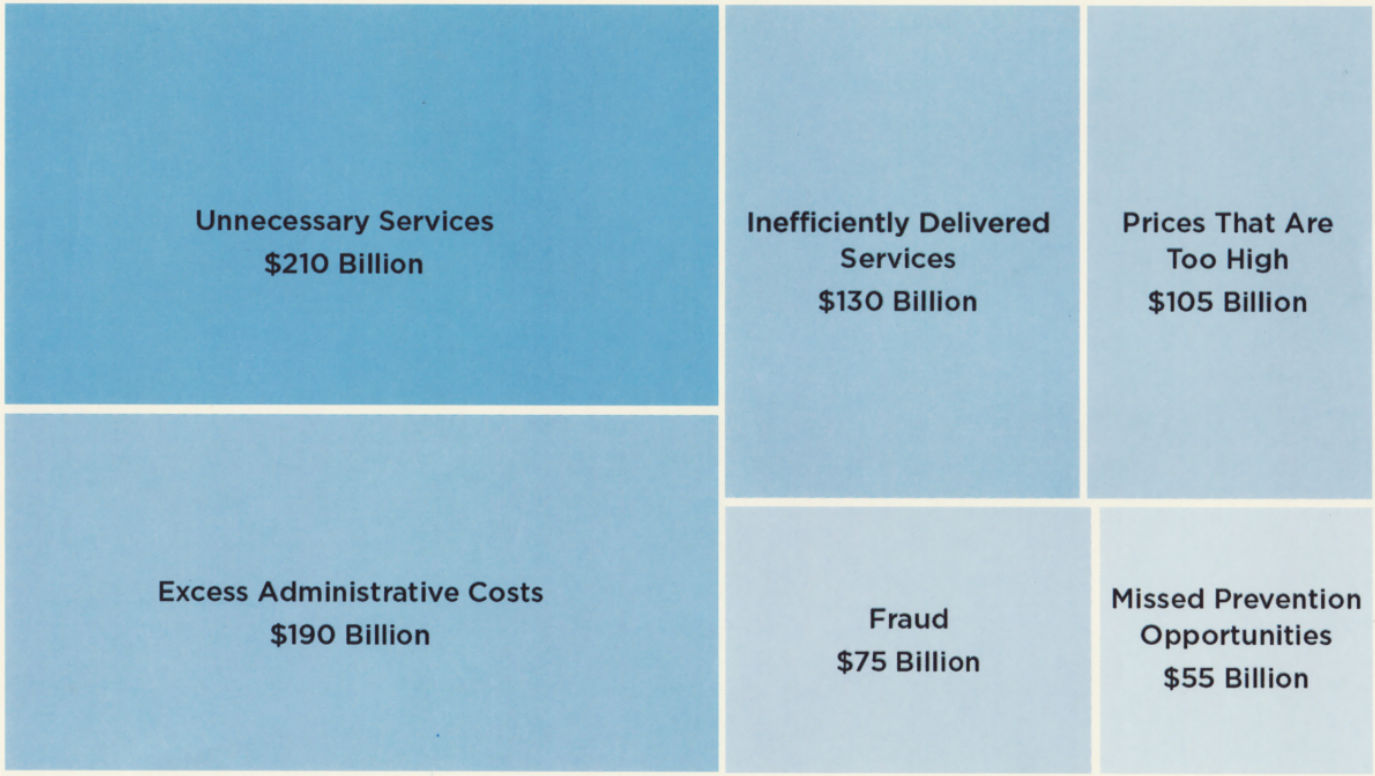
Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*. June 26, 2003: 2635–2645.

It is possible to improve care

and dramatically lower costs.

Berwick Annals 2/98

Domains of Excess Costs



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Advising the nation / Improving health

Getting to 10%

CARE-RELATED COSTS

- Prevent medical errors
- Prevent avoidable hospital admissions
- Prevent avoidable hospital readmissions
- Improve hospital efficiency
- Decrease costs of episodes of care
- Improve targeting of costly services
- Increase shared decision-making

ADMINISTRATIVE COSTS

- Use common billing and claims forms

RELATED REFORMS

- Medical Liability Reform
- Prevent Fraud and Abuse

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Shortell Stages of Integration

- Functional
  - bring partners together
- Physician - System Integration
  - bring together doctor groups
- Clinical integration

What will clinical integration require?

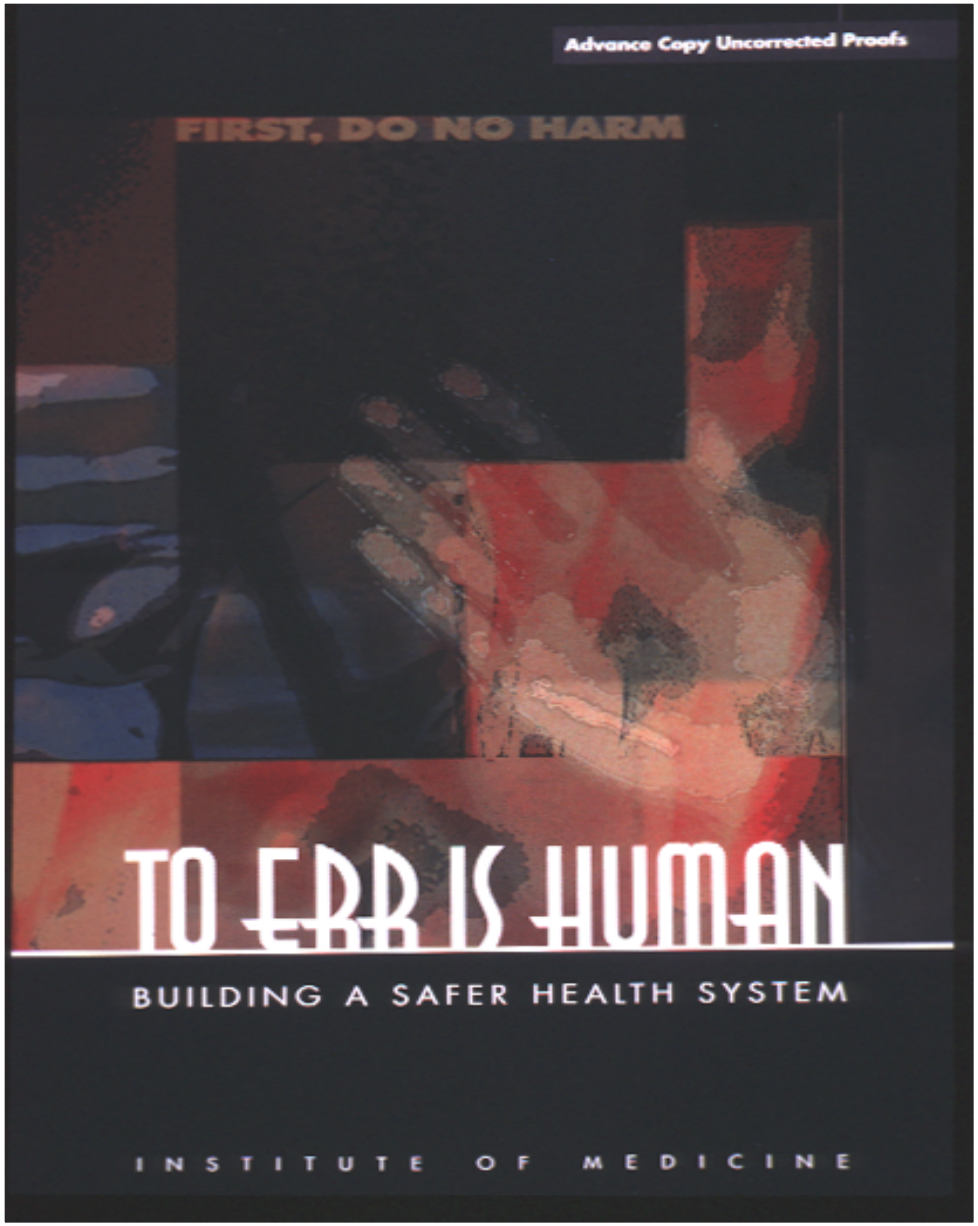
- Centralization of process
- Evidence based medical practice
- Commitment to self evaluation

Cultural Barriers to Integration
(and Industrialization)

- **Autonomous decision making**
- **Socialization**
- **Uneven evidence about outcomes**
- **Fear of performance assessment**

Definition of Quality
Institute of Medicine

"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."


Advance Copy Uncorrected Proofs
FIRST, DO NO HARM
TO ERR IS HUMAN
BUILDING A SAFER HEALTH SYSTEM
INSTITUTE OF MEDICINE

PHYSICAL EXAMINATION

Name: ____________ MR # ____________ Date: ____________

General
Apparent Age
Condition
Appearance
Race, sex, etc.

Weight______ Blood Pressure______ Pulse______ Temp______ Respirations______

WDWN w ♀

Head: NCAT

EENT:

Neck: supple

Breasts: s̄ masses

Chest & Lungs: clear

Heart and Vascular:

Abdomen: AV AF mobile

Rectal: no masses

Pelvic:

– Hyspic Myomects

Musculoskeletal:

Neurological:

Impressions:

Reviewed by Physician
No change
Treatment Still indicated
________________ M.D.
Attending Physician
Date/Time: ____________

Performed by: ____________________ M.D.
Physician (Intern or Resident)

Section I. Surgical or invasive procedure is scheduled (with right or left specified when laterality is involved), and Pre-Admission Testing sheet is consistent with documentation on current medical record and patient's verbal verification.

Site verified as (circle one): Right Left Bilateral No Laterality

PAT RN Signature

Section II. Surgical or invasive procedure is verified and site has been marked by the physician and is consistent with the patient's current medical record, which must include the H&P and consent.

Site verified as (circle one): Right (Left) Bilateral No Laterality

Site verified and marked by Surgeon

Staff Nurse Signature

Patient Identification and Site Verification Immediately Prior to the Procedure

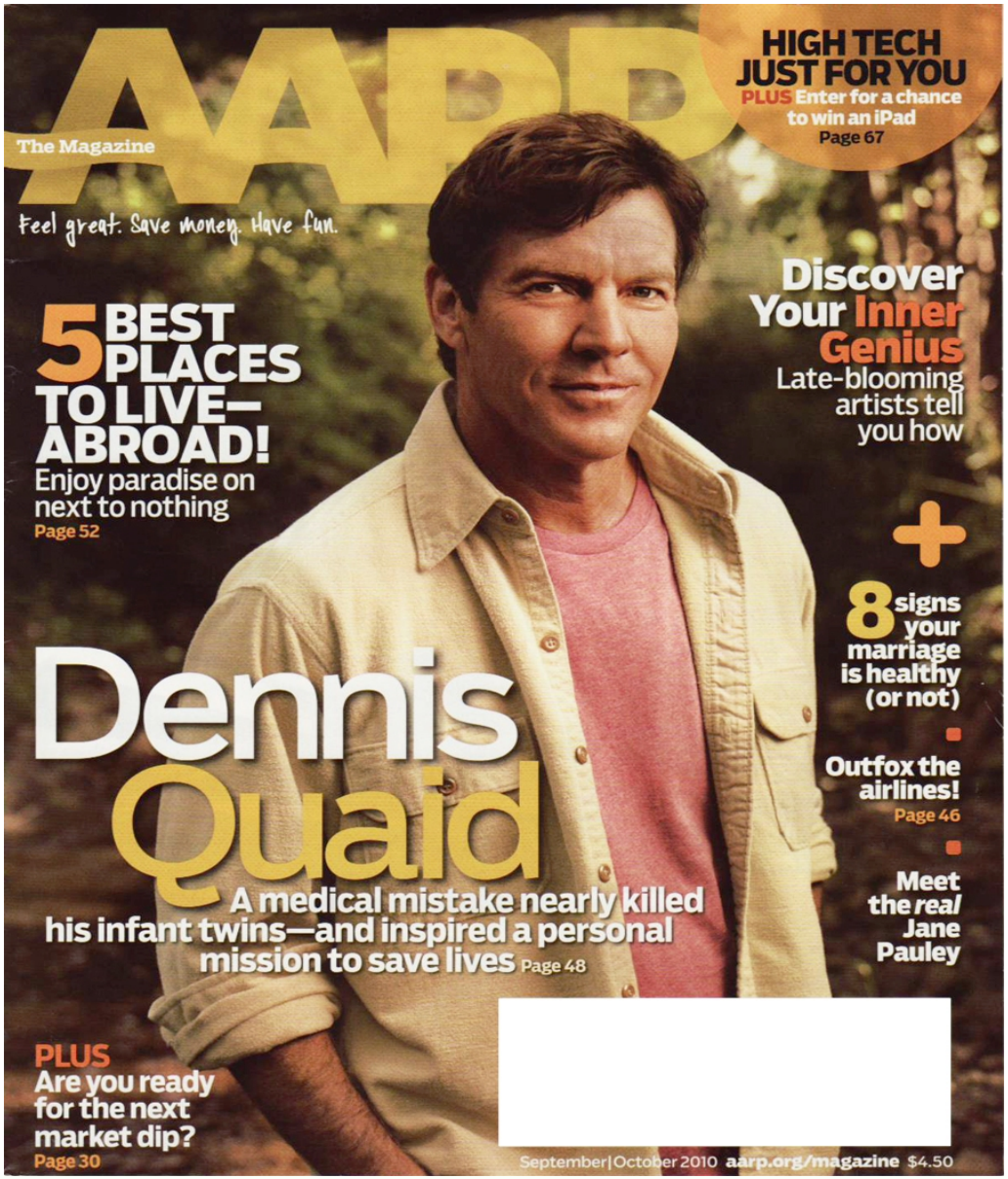
(Procedure Physician Signature below indicates that the surgeon identified the patient immediately prior to surgery with the patient on the OR/Procedure table.)

	Provider(s) Present	Procedure	Side
Circulating/ Assisting Nurse/Personnel		(Right) heel ulcer debridement with Oasis graft & wound VAC	~~Left~~ Bilateral ~~Right~~ N/A
Procedure Physician			
Anesthesia Provider			

(Circulating/Assisting Nurse to list name of anesthesia provider, if present. If no anesthesia provider is involved in the procedure, document N/A for Not Applicable. Anesthesia Provider signature, procedure and site will be documented by the Anesthesia Provider on the Anesthesia Record.)

The surgical/procedure team (Surgeon/Procedure Physician, Anesthesiologist, and Circulating/Assisting Nurse/personnel) as listed above has paused to verify the correct patient, procedure and site, and availability of correct implants/special equipment as indicated, by active communication immediately prior to the procedure with the patient on the procedure table. If x-ray films are present, the procedure physician has verified the proper orientation of the films.

Signature – Circulating/Assisting Nurse/Personnel 2/23/09 Date 1526 Time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Feel great. Save money. Have fun.
HIGH TECH JUST FOR YOU
PLUS Enter for a chance to win an iPad
Page 67
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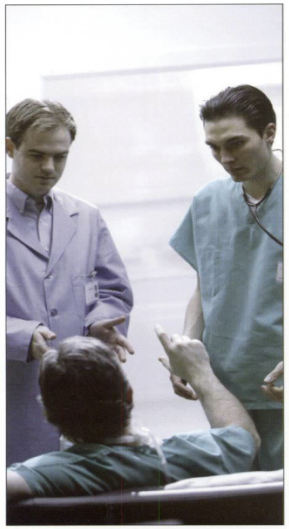
Enjoy paradise on next to nothing
Page 52
Discover Your Inner Genius
Late-blooming artists tell you how
+
8 signs your marriage is healthy (or not)
Outfox the airlines!
Page 46
Meet the real Jane Pauley
Dennis Quaid
A medical mistake nearly killed his infant twins—and inspired a personal mission to save lives Page 48
PLUS
Are you ready for the next market dip?
Page 30
September|October 2010 aarp.org/magazine $4.50

The Joint Commission
Journal on Quality and Patient Safety
Improvement from Front Office to Front Line
August 2007
Volume 33 Number 8



Joint Commission Resources

How Medical Errors Affect Physicians

Features

Reporting Systems

- The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada

5 Million Lives Campaign

- Miles to Go: An Introduction to the 5 Million Lives Campaign

Teamwork and Communication

- The Continuing Problem of Missed Test Results in an Integrated Health System with an Advanced Electronic Medical Record

Health Professions Education

- Housestaff and Medical Student Attitudes Toward Medical Errors and Adverse Events

Methods, Tools, and Strategies

- Awareness and Use of a Cognitive Aid for Anesthesiology

Department

Rapid Response Systems: The Stories

- Improving Rapid Response Systems: Progress, Issues, and Future Directions

www.jcrinc.com

Only 77% wash hands after using the toilet

Advocates are pushing for more frequent scrubbings in health care and non-health care settings.

VICTORIA STAGG ELLIOTT
AMNEWS STAFF

How clean are your hands? How about the person who just shook yours?

Several presentations at last month's Interscience Conference on Antimicrobial Agents and Chemotherapy in Chicago suggested that people not only wash their hands less often than they say they do, but the number who really do appears to be decreasing. Also, improving hand hygiene in the health care setting saves money.

"Hands are great distributors of disease, but hand washing is a great intervention," said Judy Daly, PhD, spokeswoman for the American Society for Microbiology, which organizes this meeting. She is also director of the microbiology laboratory at Primary Children's Medical Center in Salt Lake City.

According to data from observational and telephone surveys by Harris Interactive, which were commissioned by the society as well as the Soap and Detergent Assn. and released at the meeting, 92% of adults say they always wash their hands after using a public restroom. When observed in places such as train stations and sports stadiums, only 77% actually do. This represented a decline from the 83% observed in the 2005 version of this survey.

Significant gender differences also were seen, with only 66% of men soaping up compared with 88% of women. Similar gaps between men and women also were found by other studies that examined the behavior of doctors and health care professionals.

"Very clearly, guys need to step up to the sink," said Brian Sansoni, vice president of communication for the soap association.

This issue has long concerned medical societies, patient safety organizations and public health agencies. The American Medical Association urges everyone to view hand washing as important. Experts suggest, however, that while this activity is important across the board, more payoff may be gained from programs that focus on health care settings.

"The message about improving hand hygiene is a good message to support, but we will naturally see the greatest result in the places where the sickest people are," said Dr. M. Lindsay Grayson, vice chair of Austin Hospital/Austin Health in Melbourne, Australia.

In these venues, the benefit of hand hygiene is increasingly being quantified. For instance, a paper presented by Dr. Grayson found that hand hygiene education for health care professionals along with ensuring that alcohol hand rubs were available significantly reduced the number of methicillin-resistant *Staphylococcus aureus* infections. In turn, this result saved his state's health system more than a million dollars.

"We need a culture change," Dr. Grayson said. "Those who provide care should feel funny walking up to a patient having not used an alcohol-based hand rub. And the patient should feel pretty funny, too."

An Argentinean study also found that upping compliance with hand hygiene recommendations in the intensive care unit reduced the device-associated infection rate from nearly 20% to just shy of 5%. But although researchers say these efforts can pay for themselves, improving hand hygiene comes with significant challenges. In Dr. Grayson's study, the urban institutions did not do as well as the rural ones because of high staff turnover.

The factors that motivate health care professionals to wash more often also might not be the most obvious ones. A study out of the University of Geneva Hospitals in Switzerland found that the opportunity to reduce nosocomial infections did not increase hand washing, but peer pressure and easy access to hand-washing facilities did. ◆

PHOTO BY TED GRUDZINSKI
Judy Daly, PhD, presented the hygiene findings at the Chicago conference.


MAY 1, 2006
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INSIDE THE WHITE HOUSE SHAKE-UP
PREVIEW: HOT SUMMER MOVIES
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DR. PETERSEN
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An insider's view of what can go wrong—and how you can improve your odds of getting the right treatment
BY NANCY GIBBS & AMANDA BOWER
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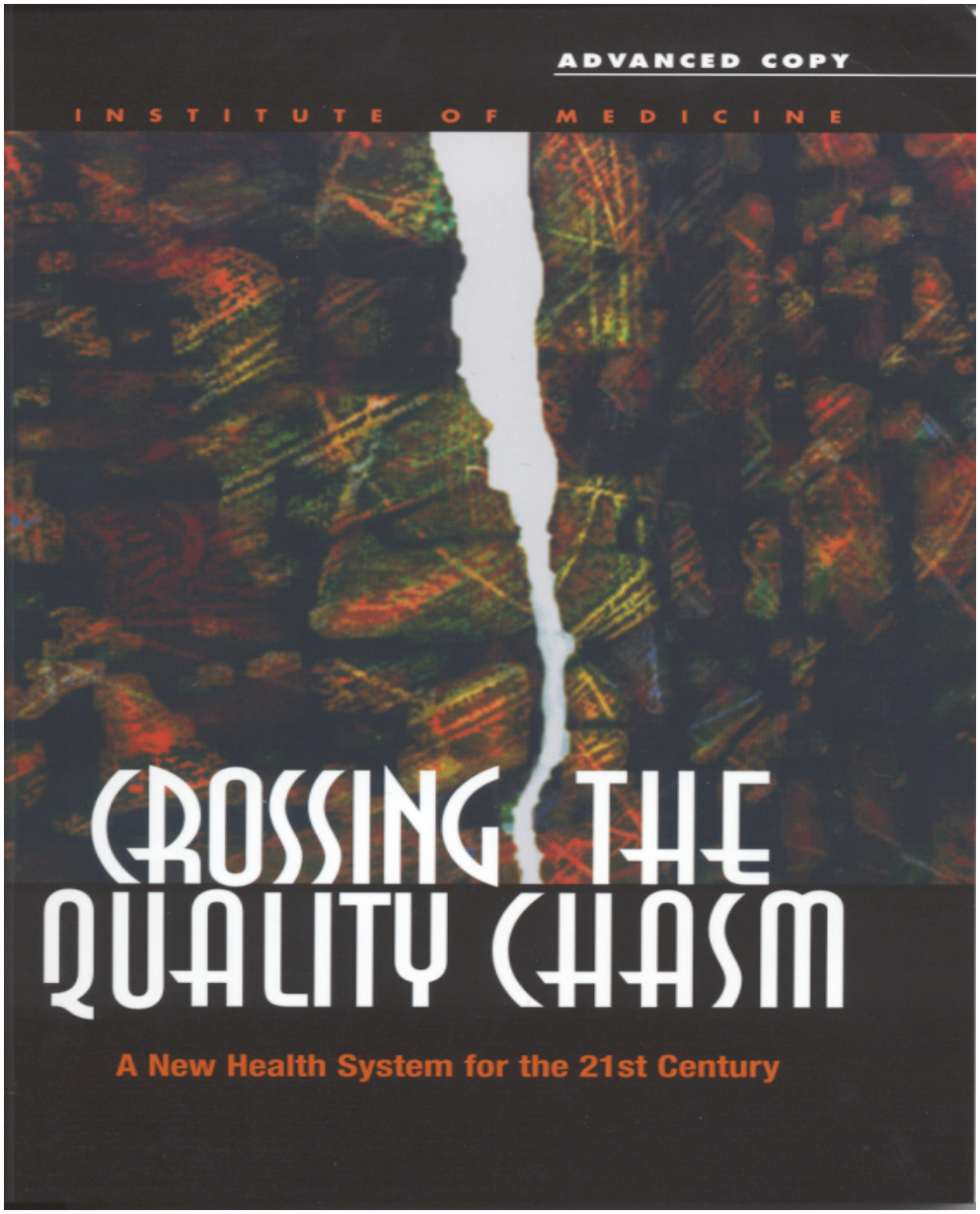
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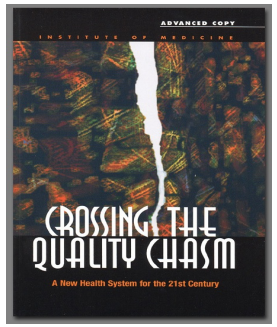
INSTITUTE OF MEDICINE
CROSSING THE QUALITY CHASM
A New Health System for the 21st Century

Institute of Medicine Report 2001



Outlines Key Dimensions of the Healthcare Delivery System:

Safe: **avoiding injuries to patients from the care that is intended to help them.**

Effective: **providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).**

Patient-centered: **providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.**

Timely: **reducing waits and sometimes harmful delays for both those who receive and those who give care.**

Equitable: **providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.**

Efficient: **avoiding waste, including waste of equipment, supplies, ideas, and energy.**

Source: Institute of Medicine 2001; 5-6

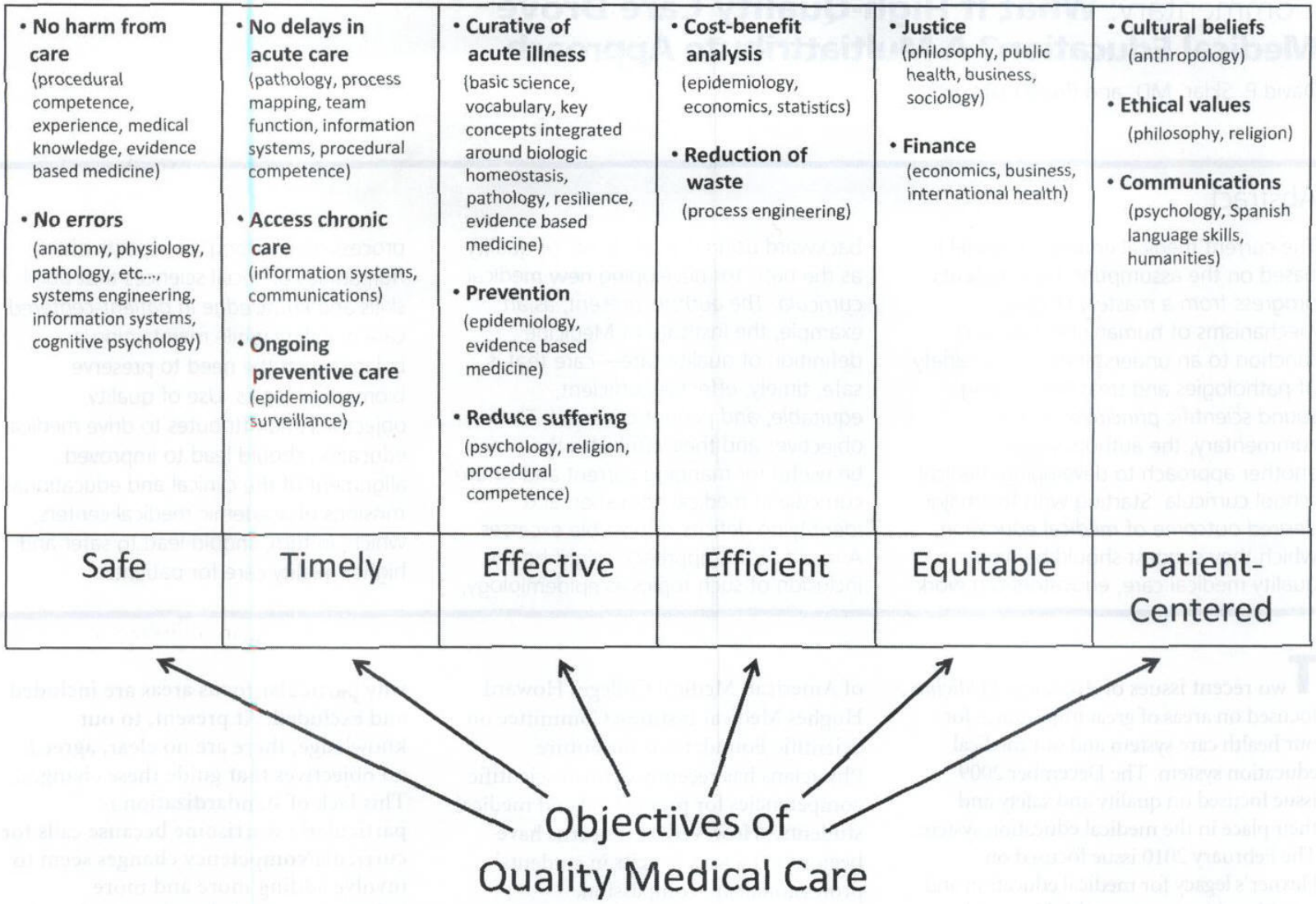
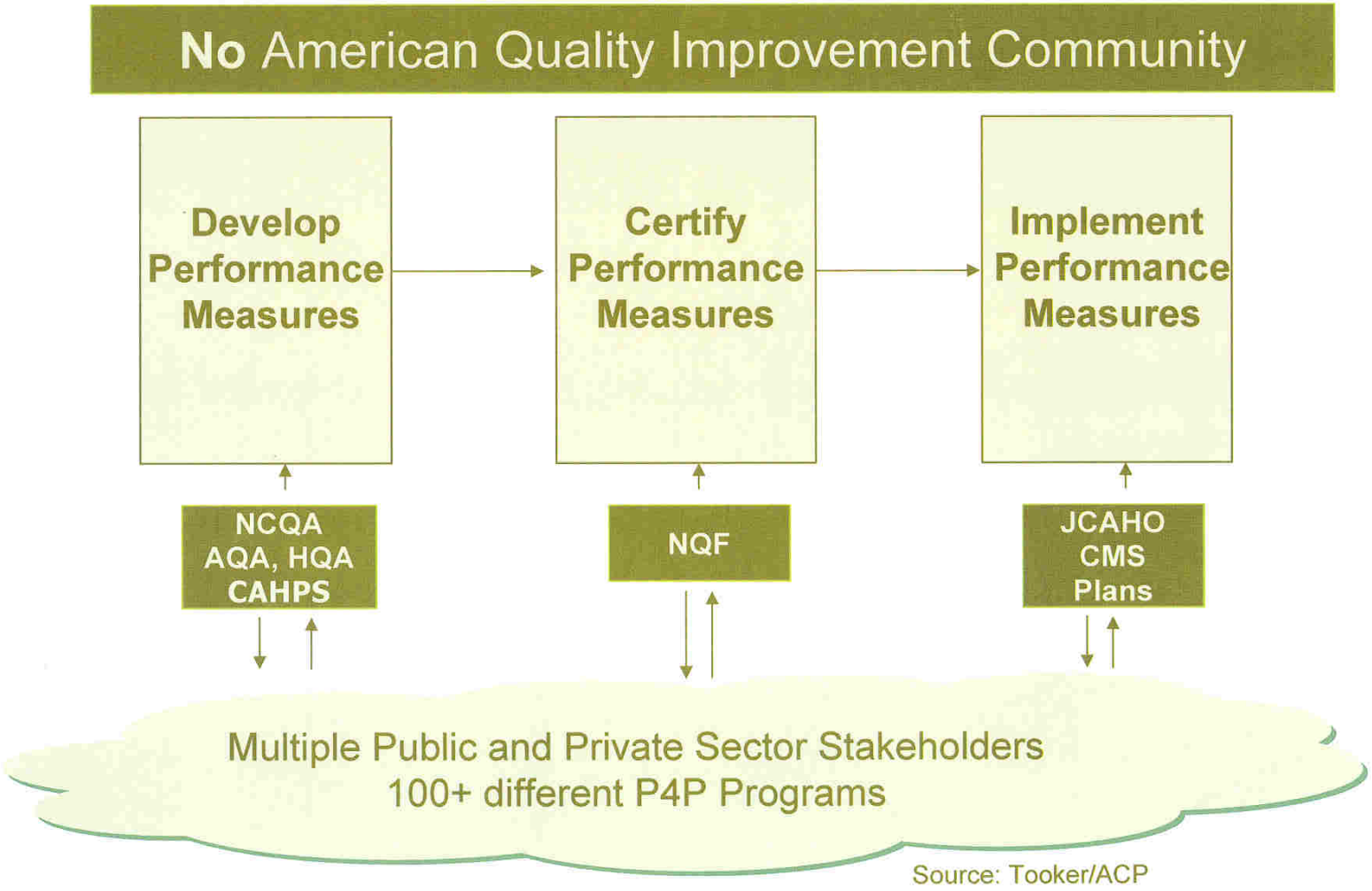


Figure 1 Attributes of the Institute of Medicine quality objectives with related curriculum areas.

A need for unified governance



Source: Tooker/ACP

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

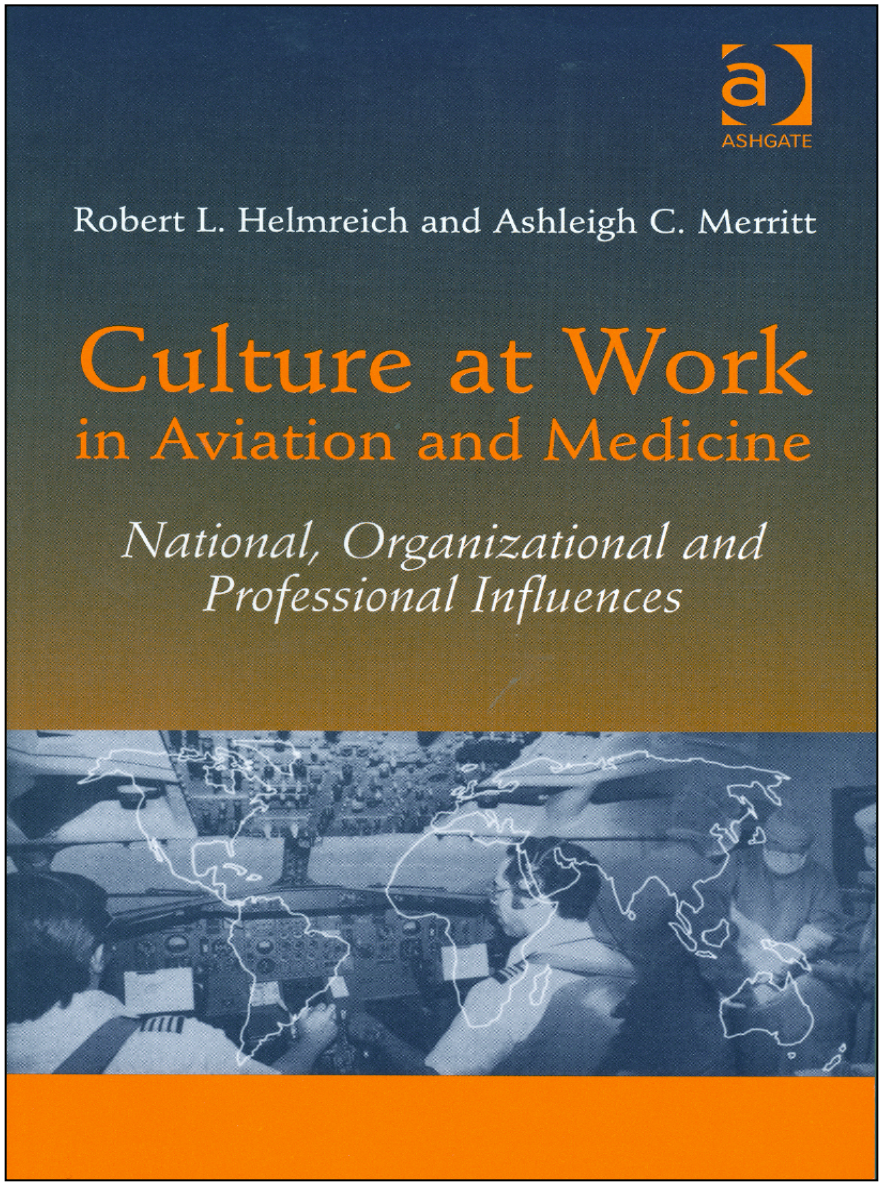
"A set of interdependent elements interacting to achieve a common aim."

1. Non-linear
2. Defy simple cause and effect notions
3. Prediction is difficult
4. Test changes on a small scale because of the interdependencies
5. Traditional discipline specific improvement *ignores* systemness i.e., to make doctors better at doctoring, to replace one drug with another one

"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 view points
    4. Learn how to negotiate agreement
    5. Insist on equity in applying the rules


ASHGATE
Robert L. Helmreich and Ashleigh C. Merritt
Culture at Work
in Aviation and Medicine
National, Organizational and
Professional Influences

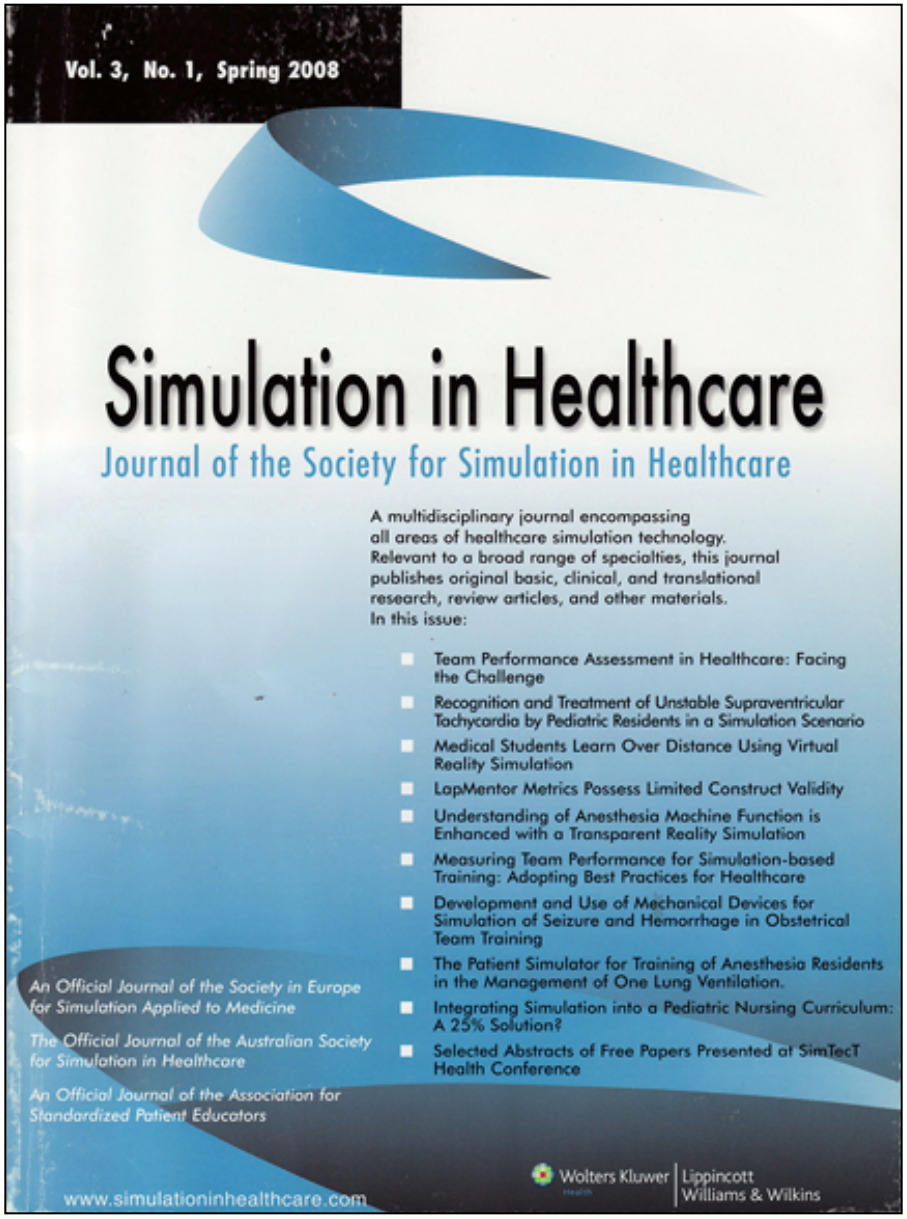
Why Are Isolated Gains Not More Widespread?

- No NASA – Ames Research Center
- No cultural support to review near misses
- Standardization and simplification

vs.

Autonomy and Customization

(Personal Accountability and Blame)


Vol. 3, No. 1, Spring 2008
Simulation in Healthcare
Journal of the Society for Simulation in Healthcare
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Recognition and Treatment of Unstable Supraventricular Tachycardia by Pediatric Residents in a Simulation Scenario
Medical Students Learn Over Distance Using Virtual Reality Simulation
LapMentor Metrics Possess Limited Construct Validity
Understanding of Anesthesia Machine Function is Enhanced with a Transparent Reality Simulation
Measuring Team Performance for Simulation-based Training: Adopting Best Practices for Healthcare
Development and Use of Mechanical Devices for Simulation of Seizure and Hemorrhage in Obstetrical Team Training
The Patient Simulator for Training of Anesthesia Residents in the Management of One Lung Ventilation.
Integrating Simulation into a Pediatric Nursing Curriculum: A 25% Solution?
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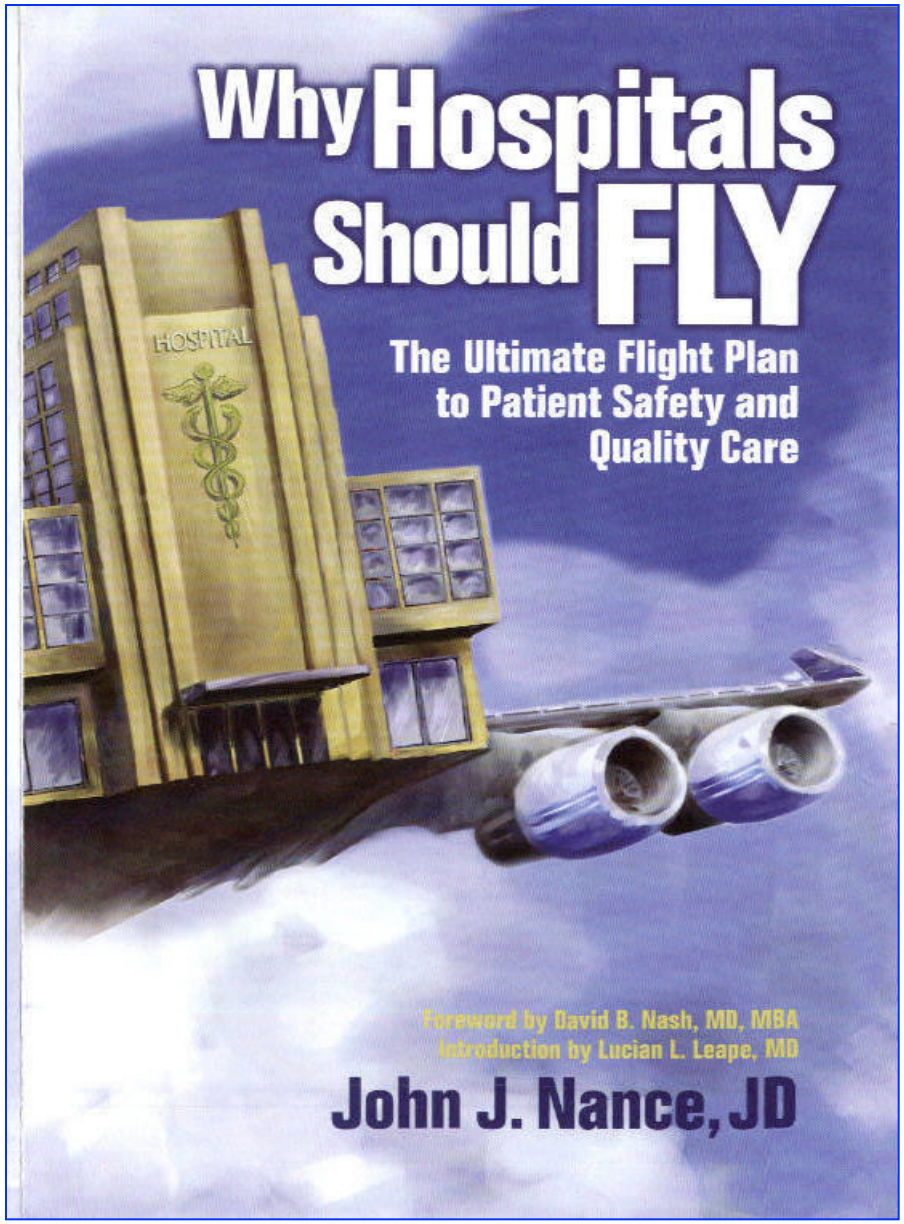
Why Hospitals Should FLY
The Ultimate Flight Plan to Patient Safety and Quality Care
HOSPITAL
Foreword by David B. Nash, MD, MBA
Introduction by Lucian L. Leape, MD
John J. Nance, JD


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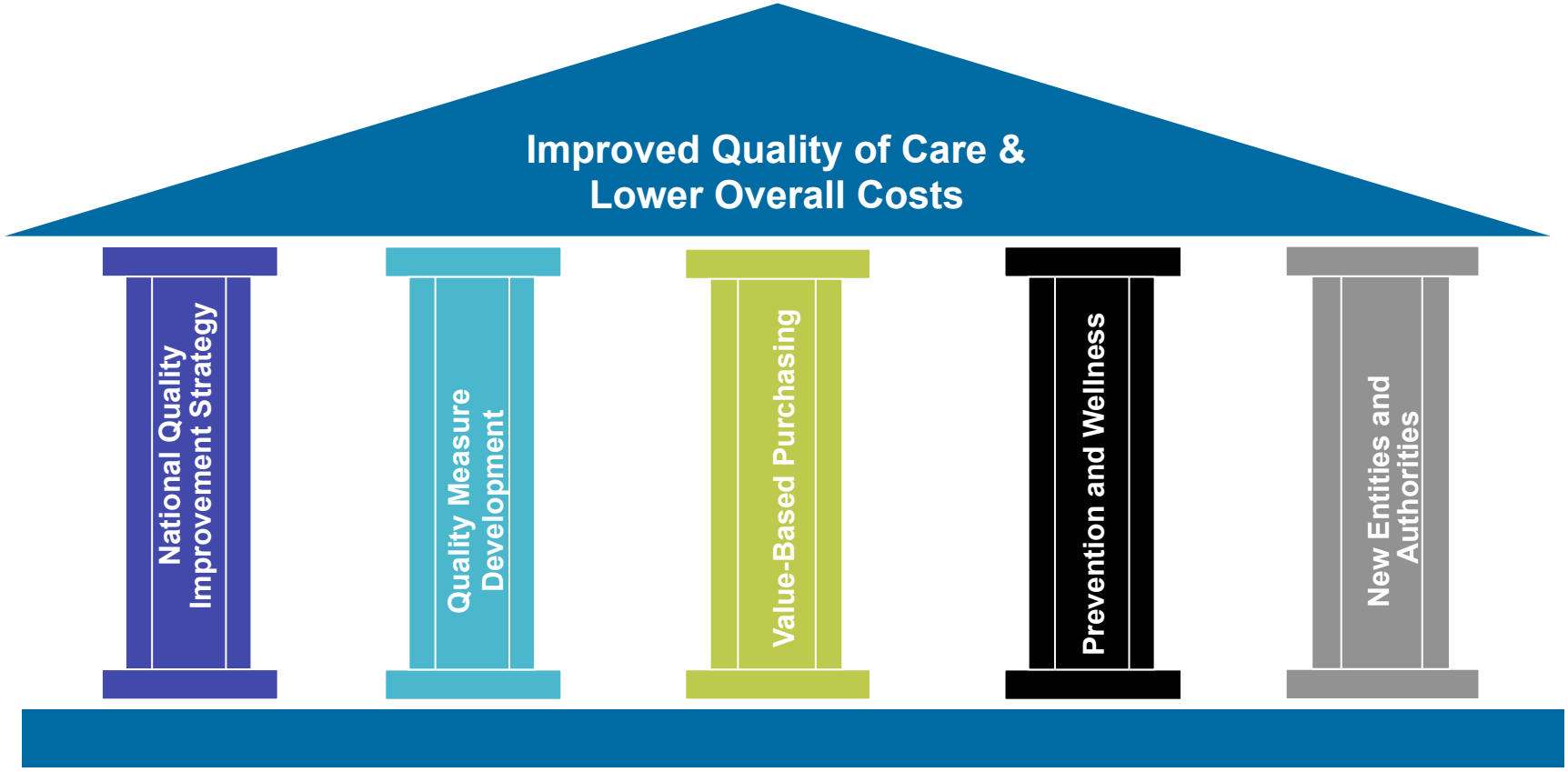

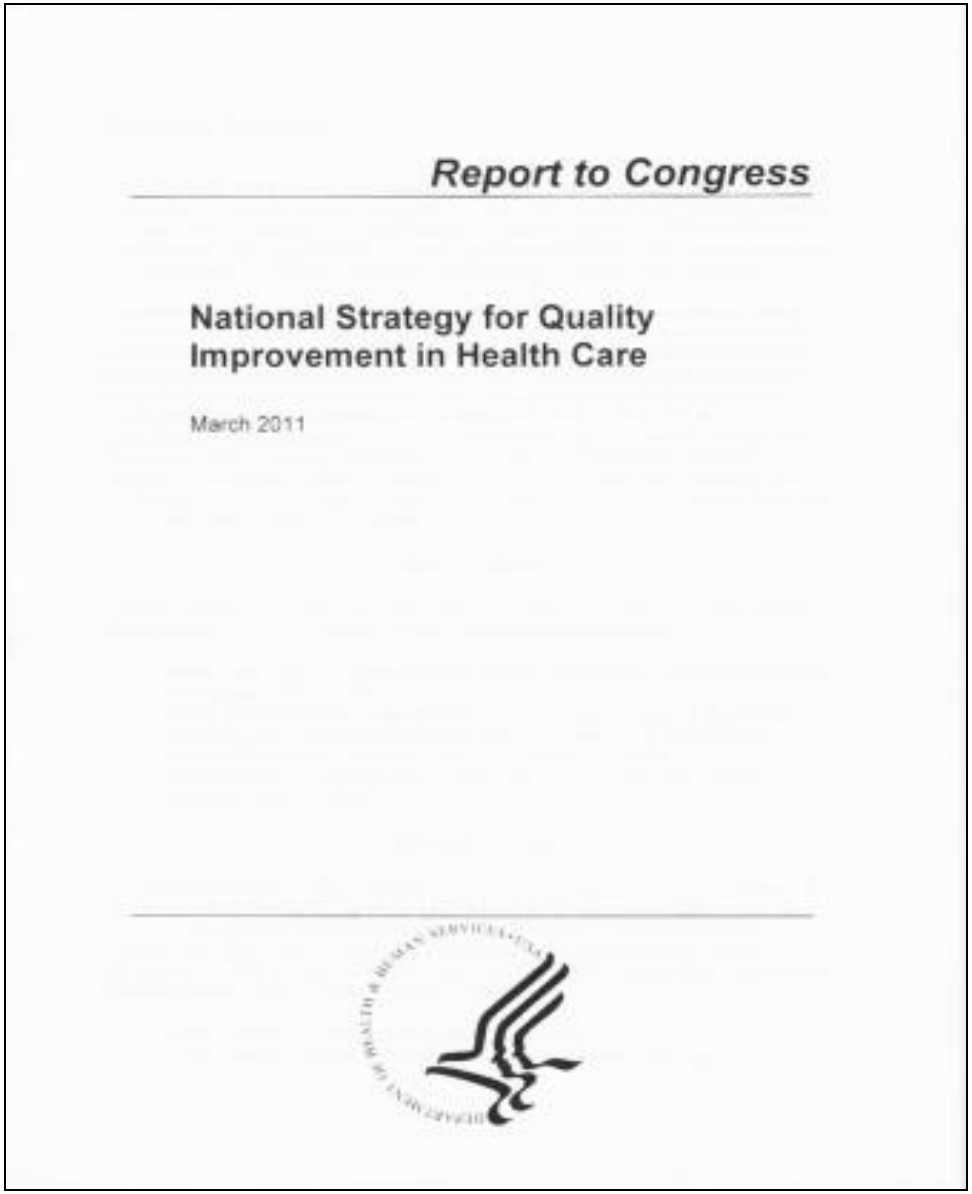
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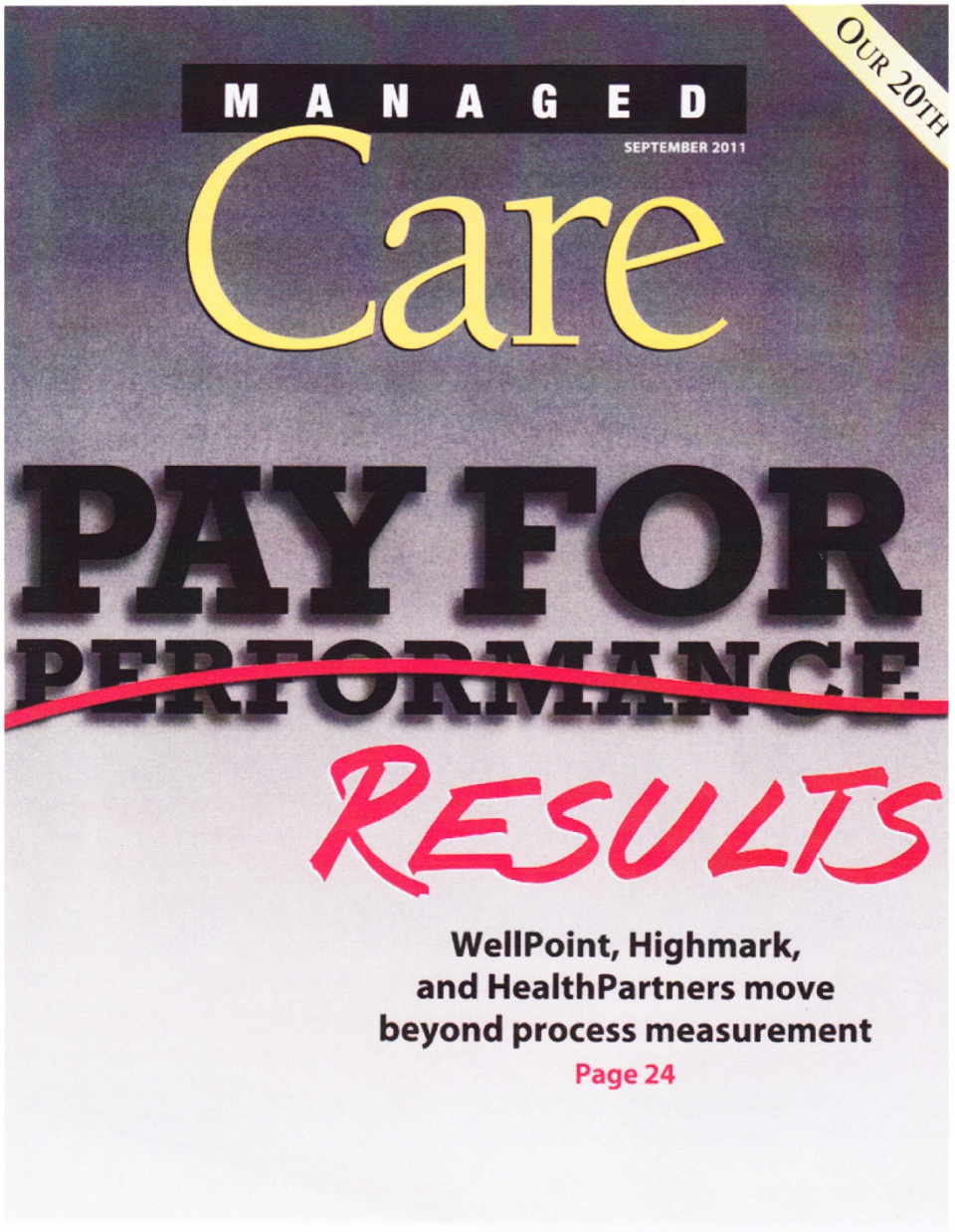
Reimbursement for the **coordination of care** in a medical home	**Accountability for results -** patient management across care settings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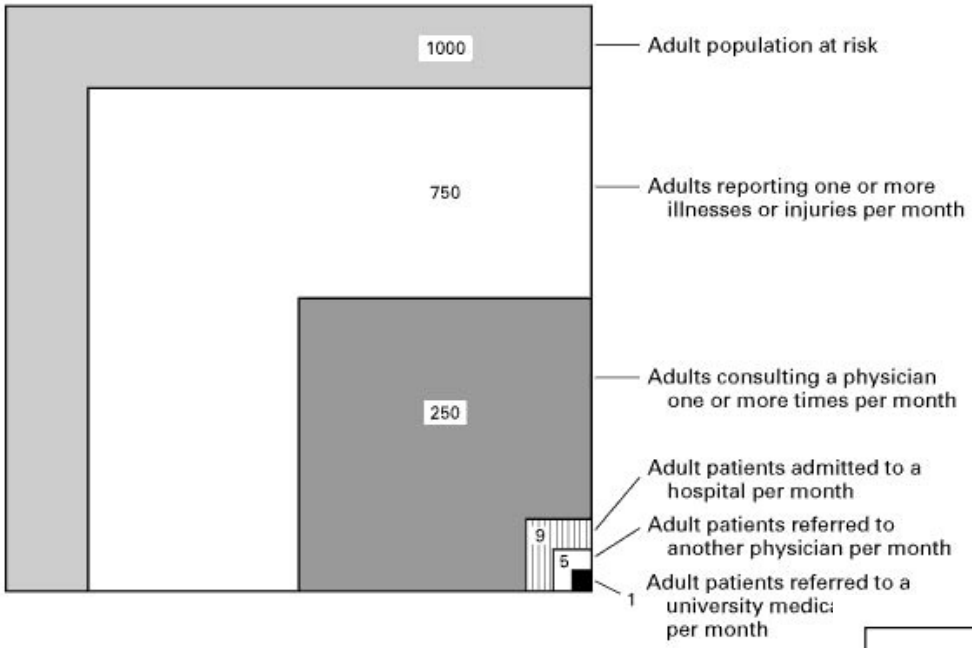

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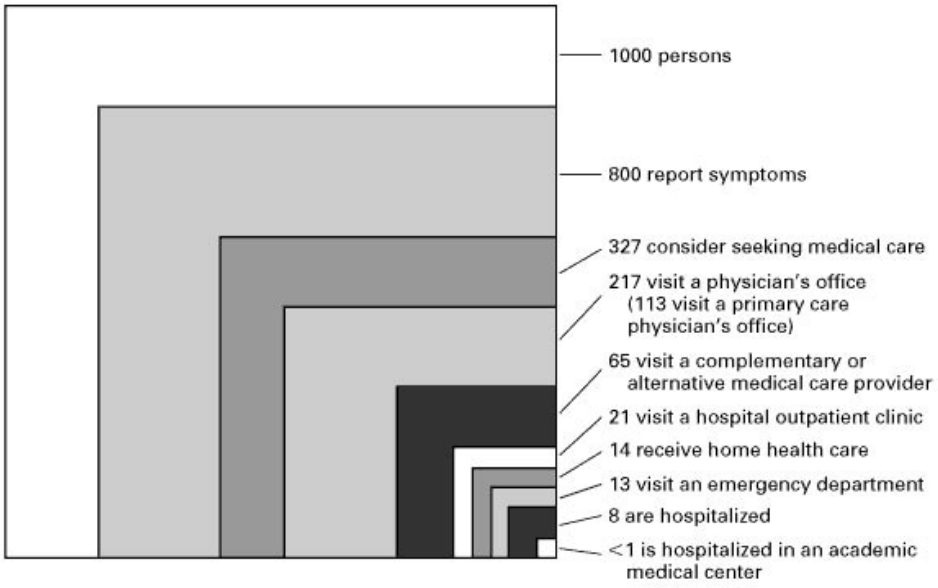

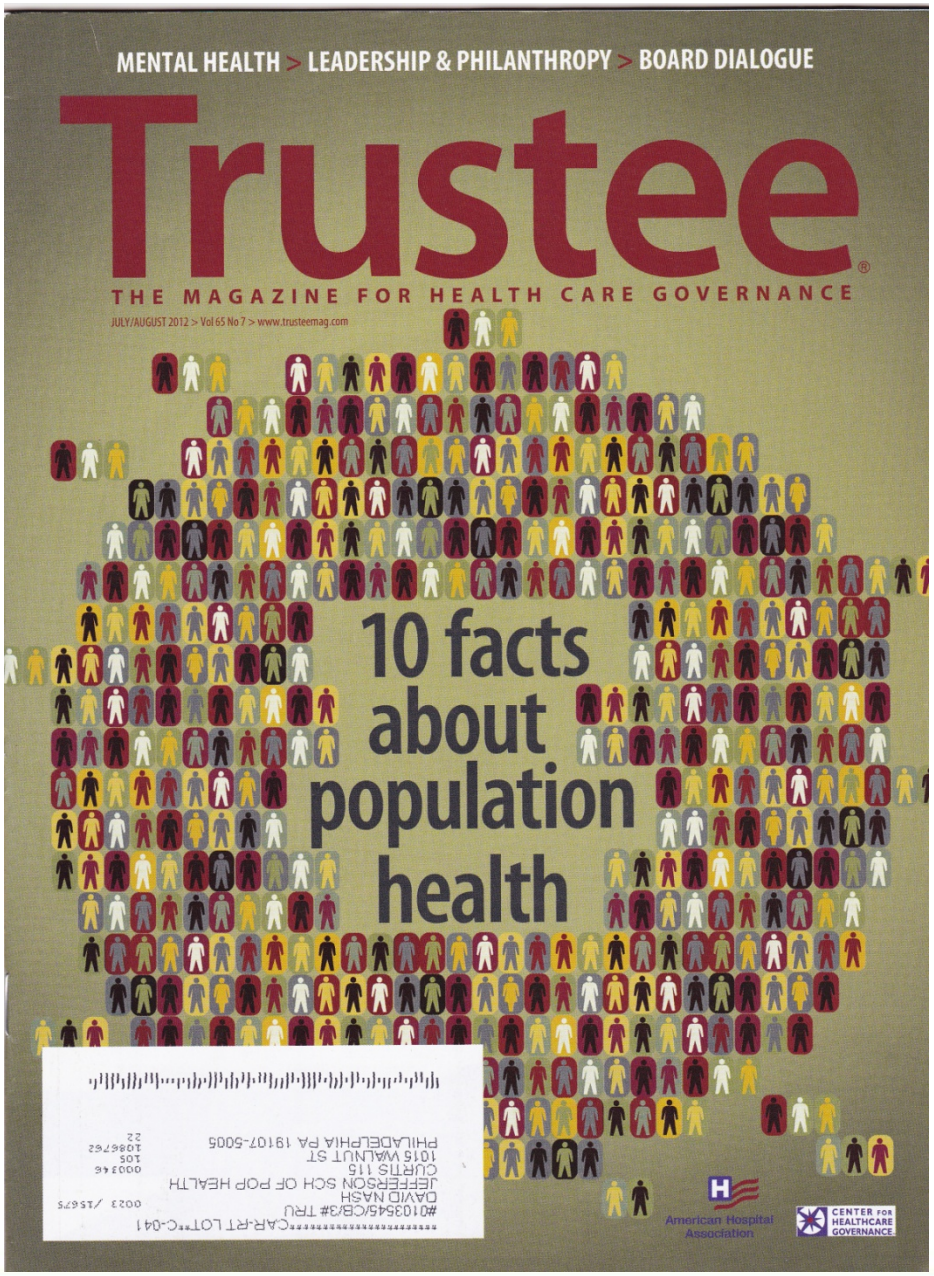
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ACADEMIC MEDICINE

Journal of the Association of American Medical Colleges

December 2009
Volume 84
Number 12

Quality and Safety in Medicine

www.academicmedicine.org

VOL. 78, NO. 6
NOVEMBER/DECEMBER 2011

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A Journal of Translational and Personalized Medicine

Issue Theme
Patient Safety: Issues and Advances

Theme Editor
Erin DuPree, MD
Ira Nash, MD

Improving Quality in Healthcare, Starting with the Patient
Effective Teamwork and Communication in Delivering Safe, High-Quality Care
Integrated e-Prescribing Systems: Effect on Medication Errors and Adverse Events
Teaching Healthcare Quality and Safety to Medical Students and Physicians Patient Safety Training Simulations Based on ACGME Competency Criteria
Errors in Transfusion Medicine: Have We Learned Our Lesson?
Prevention of Retained Surgical Items

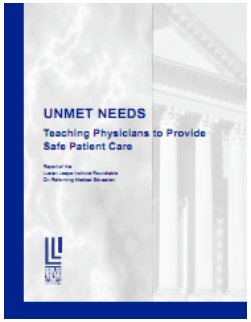
Special Features

Mitochondrial Pathology in Parkinson's Disease
Use of In Vivo Real-Time Optical Imaging for Esophageal Neoplasia
Image Analysis of Small Pulmonary Nodules Identified by Computed Tomography

WILEY-BLACKWELL

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



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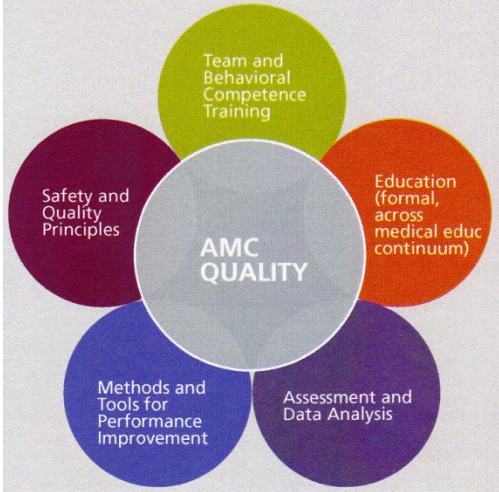

The IQ mission is to assist AAMC members in enhancing the culture of quality in their organizations by providing resources and activities for sharing strategies that build coordinated approaches to quality, patient safety, and performance improvement across the continuum of clinical care and medical education in academic medical centers.

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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.

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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

2 Choose the University That's Right For You

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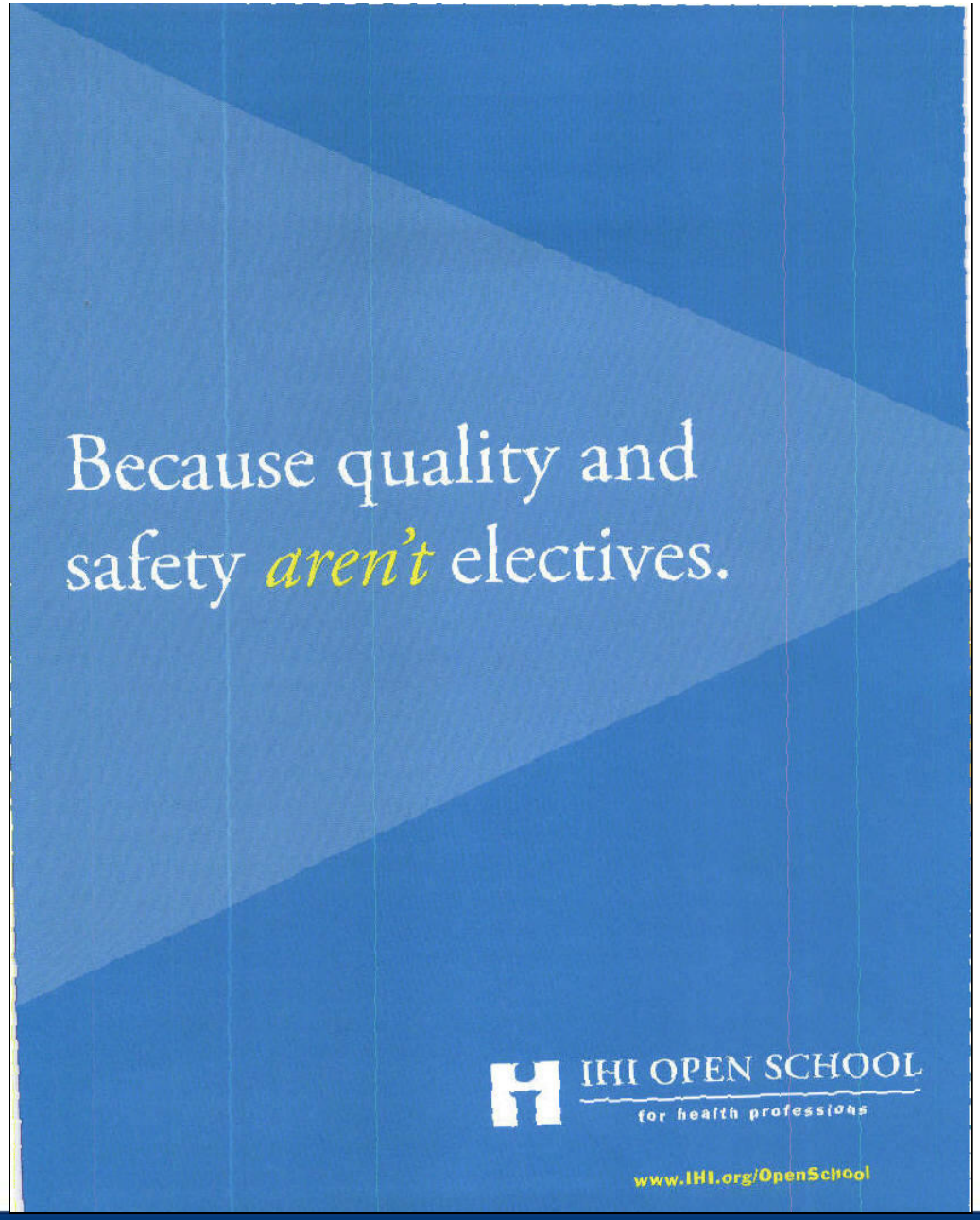
University	**University of Massachusetts Amherst** Online Part-Time MBA with a Focus in Medical Management	**Carnegie Mellon University** Master of Medical Management	**University of Southern California** Master of Medical Management	**Thomas Jefferson University** Master of Science in Healthcare Quality and Safety Management
Content	• Practical business knowledge • Emphasis on best practices • Easily applied to health care	• Leadership • Strategy development • Information technology	• Physician executive as a leader • Entrepreneurship — internal and external • Fully implementable business plans	• Health care quality • Patient safety • Tools, methods and applications • Medical management
Programs Begin	January, May, and September	September	March (pre-work is mailed late January)	January and September
Format	11 courses, 100% online, asynchronous Available 11 months/year (not August) Admission throughout the year	Four 4½-day on-campus sessions over 18 months plus distance education	Four 7-day sessions over one year plus distance education	9 online courses plus Capstone project. 18 months (5 terms) to complete (2 courses per term), but pacing is flexible
Time	9-11 hours per week, per class	10-15 hours per week	10-15 hours per week	8-12 hours per week, per course
Cost	**$22,950** (pay as you go at $675 per credit, plus registration fees and books)	**$31,200** (includes books and misc fees)	**$33,880** (includes fees, books and most meals)	**$28,350**

Visit **acpe.org/MyFuture4** to access each university's website for more details.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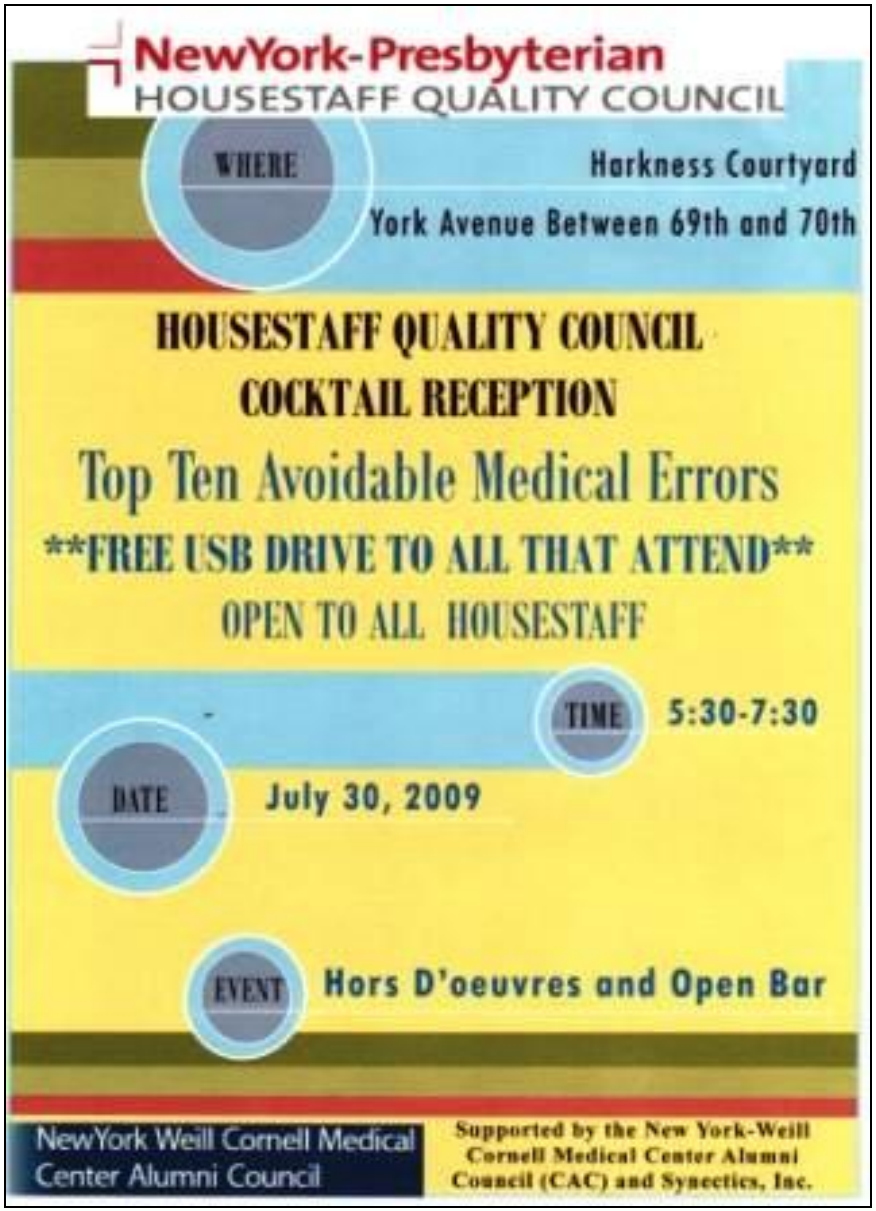
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Jefferson
School of Population Health

By Darrell G. Kirch and Philip G. Boysen

DOI: 10.1377/hlthaff.2010.0776
HEALTH AFFAIRS 29,
NO. 9 (2010): 1600–1604

Changing The Culture In Medical Education To Teach Patient Safety

Darrell G. Kirch (dgkirch@aamc.org) is president and chief executive officer of the Association of American Medical Colleges, in Washington, D.C.

Philip G. Boysen is executive associate dean of graduate medical education and a professor of anesthesia and medicine at the School of Medicine, University of North Carolina at Chapel Hill.

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*,[1] 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—one 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

Evaluating Obstetrical Residency Programs Using Patient Outcomes

David A. Asch, MD, MBA
Sean Nicholson, PhD
Sindhu Srinivas, MD, MSCE
Jeph 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 nonclinical measures.

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

Design, Setting, and Patients A retrospective analysis of all Florida and New York obstetrical hospital discharges between 1992 and 2007, representing 4 906 169 deliveries performed by 4124 obstetricians from 107 US residency programs.

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

Many physicians and nonphysicians 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.[1] 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 clinician volume when selecting a surgeon and a hospital.[2] 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,[3] 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 mea-

Author Affiliations: Center for Health Equity Research and Promotion, Philadelphia Veterans Affairs Medical Center, Philadelphia, Pennsylvania (Dr Asch); Leonard Davis Institute of Health Economics (Drs Asch, Nicholson, Srinivas, and Epstein) and Department of Obstetrics and Gynecology (Dr Srinivas), University of Pennsylvania, Philadelphia; Cornell University, Ithaca, New York (Dr Nicholson); and Yale University, New Haven, Connecticut (Drs Herrin and Epstein).
Corresponding Author: David A. Asch, MD, MBA, Leonard Davis Institute of Health Economics, University of Pennsylvania, 3641 Locust Walk, Philadelphia, PA 19104-6218 (asch@wharton.upenn.edu).

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APM Perspectives

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For the latest information about departments of internal medicine, please visit APM's website at www.im.org/APM.

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 Levinson, MD,[c] William J. Bremner, MD, PhD[a]

[a]Department of Medicine, [b]Department of Health Services, University of Washington, Seattle; [c]Department of Medicine, University of Toronto, ON, Canada.

Academic health centers (AHCs) are devoting substantial and increasing 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.[1,5-11] Many AHCs face challenges in enlisting faculty to participate in these activities.[1,12]

Academic infrastructures are currently geared towards physician-scientists 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] In response to the changing needs of academic medicine over the past 2 decades, excellence in teaching, clinical care, and medical education have been integrated into the promotions process at many institutions within clinician-educator pathways.[10,11,14] 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

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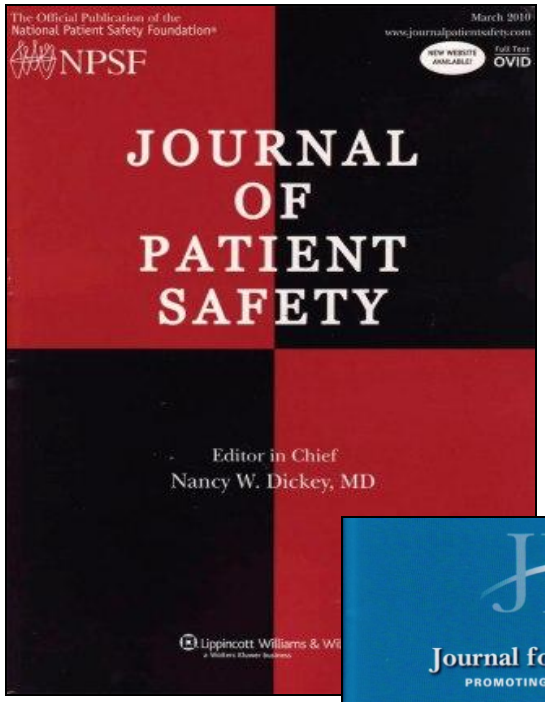
Conflict of Interest: No authors have any affiliations with organizations with a financial interest in this subject matter or any other conflicts of interest to disclose.

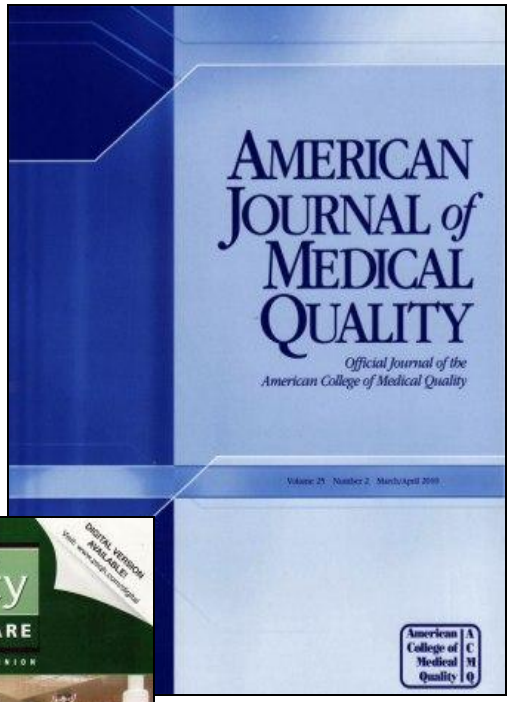
Authorship: All authors had access to the data and played a role in writing this manuscript.

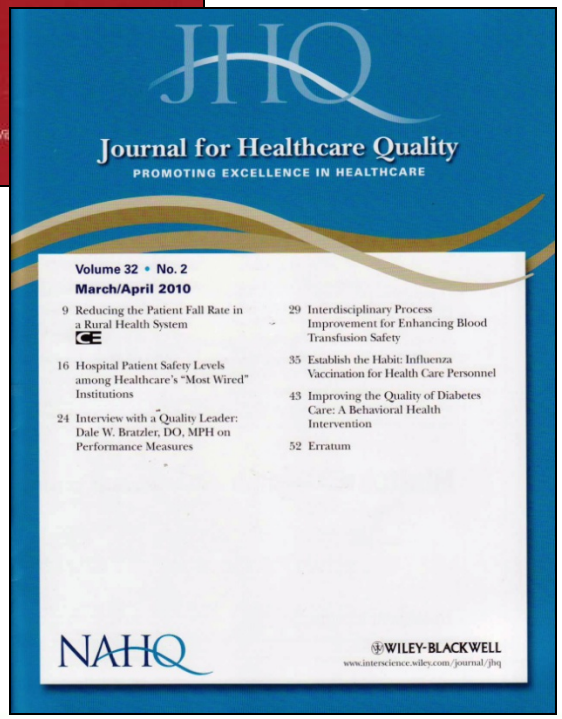
Requests for reprints should be addressed to Thomas O. Staiger, MD, Department of Medicine, University of Washington, Box 356330, Seattle, WA 98195.

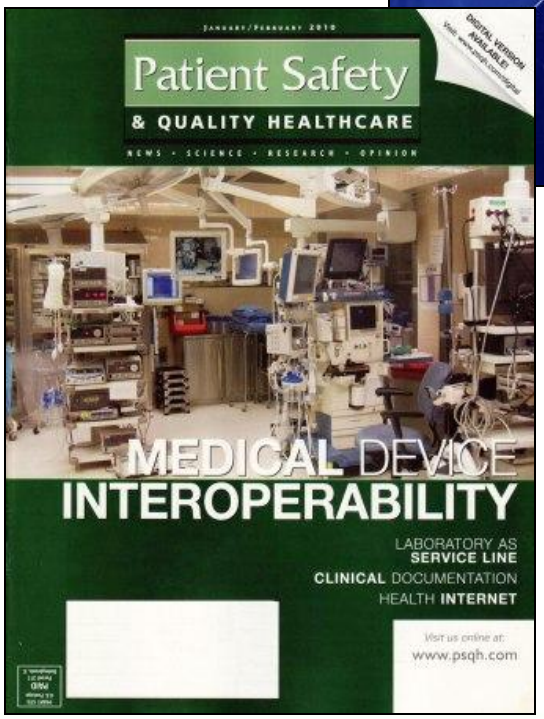
E-mail address: staiger@u.washington.edu

0002-9343/$ -see front matter
doi:10.1016/j.amjmed.2010.09.018









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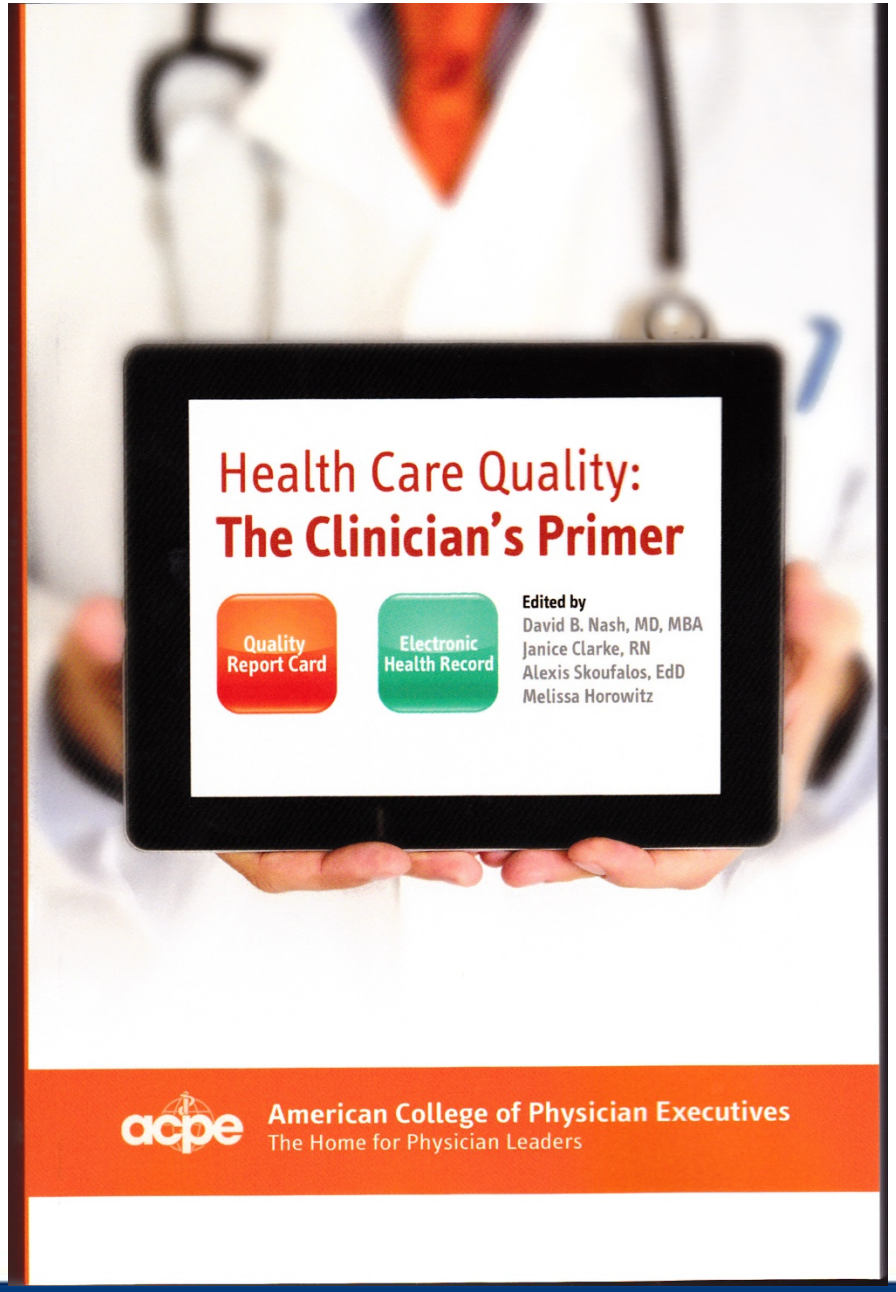
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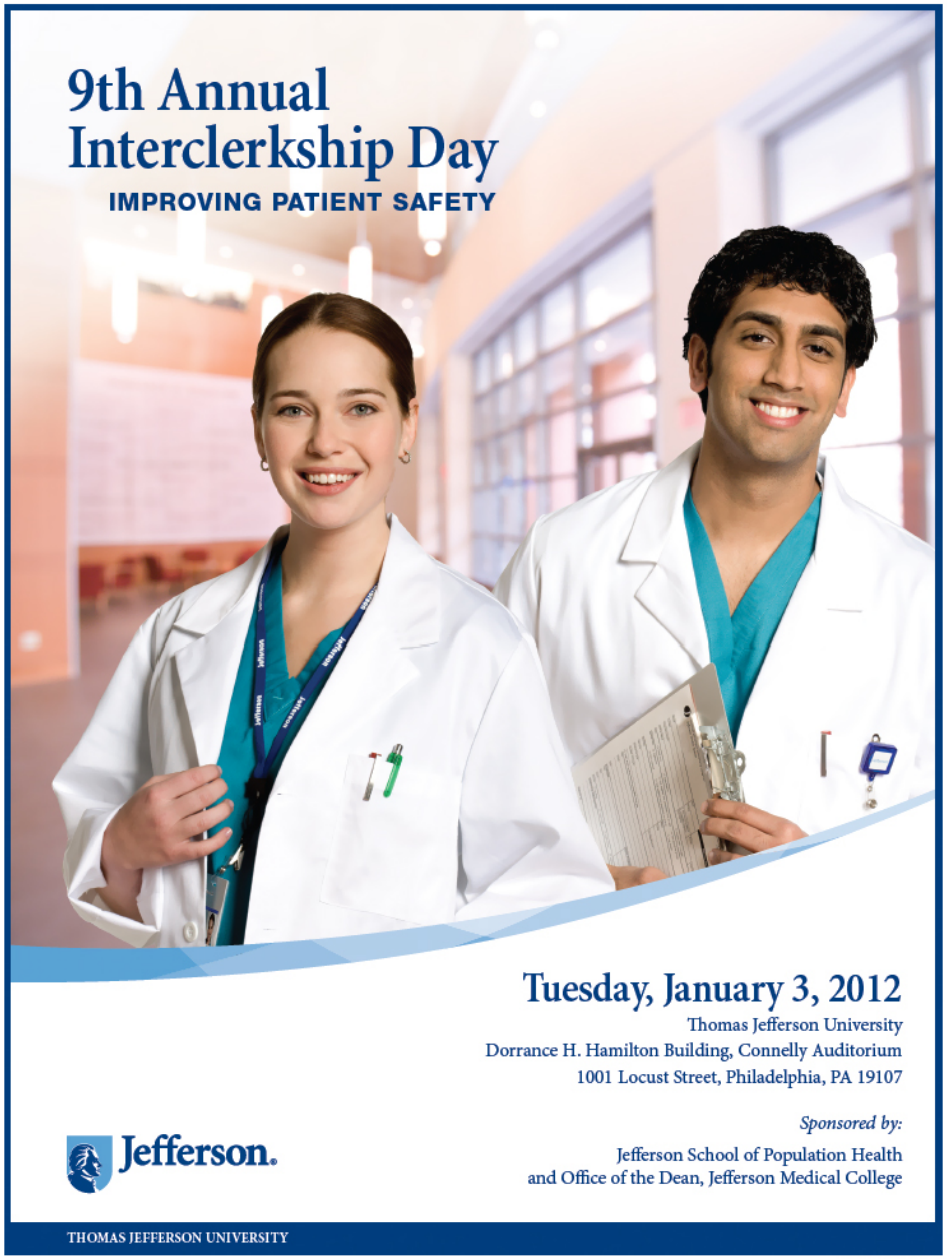
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ACGME's Goals for Accreditation Specific Aims for the Sponsor Visit Program

- 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

ACGME October 31, 2011

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 achievement0 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

ACGME October 31, 2011

The Next Accreditation System

- **Desired outcomes**
  - Enhance ACGME's ability to influence (*Ina 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

ACGME October 31, 2011

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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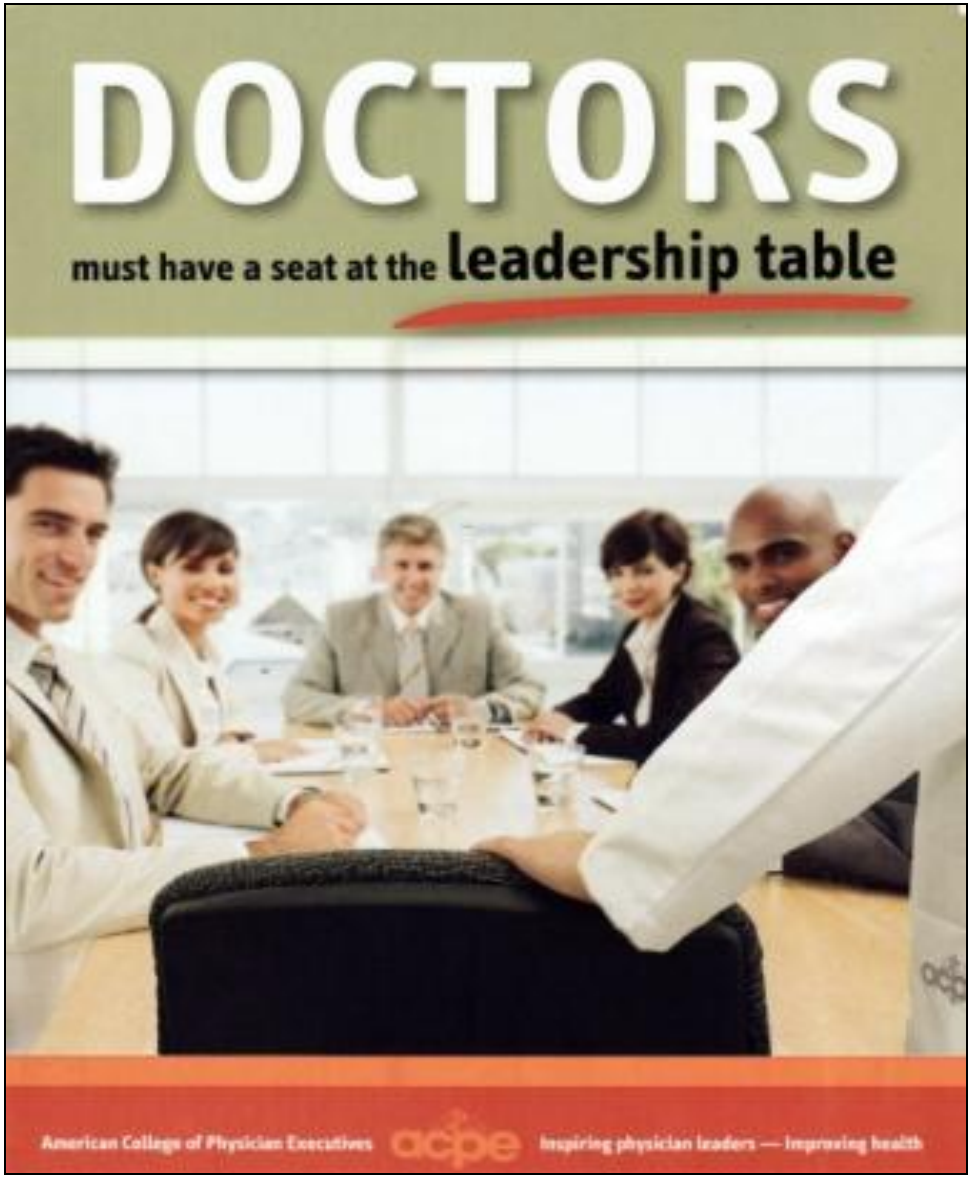
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Medical Education Program

Palm Beach Medical College is our investor-financed, private, allopathic medical school, currently in development, and is the platform of our medical education programs.

Our medical educational programs are designed based on the accreditation standards of the Liaison Committee on Medical Education (LCME), the nationally recognized accrediting authority for programs leading to the M.D. degree in the U.S. and Canada. These standards are used to ensure general professional competencies that are appropriate for entry to the next stage of medical training and as the foundation for life-long learning and proficient medical care.

We encourage you to explore the Palm Beach Medical College website and join our mailing list to stay current on our progress and development.

Palm Beach Medical College (PBMC) is not currently accepting student applications.

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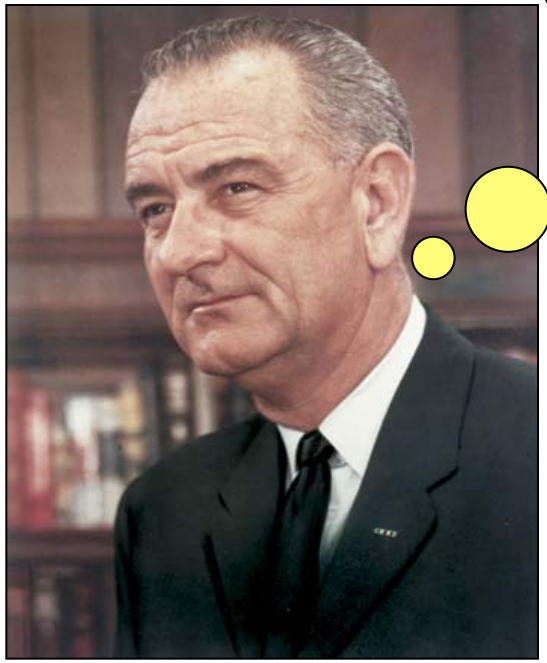
“It’s always better to have them in the tent pissing out, than outside the tent pissing in.”



President, L.B. Johnson

"The institutionalization of leadership training is one of the key attributes of good leadership."

John P. Kotter,
Harvard Business School

Sacred Cows Make the Best Hamburgers