Disclosure

Drs. Tess and Myers are co-directors of the Quality and Safety Educators Academy® sponsored by the Alliance for Academic Internal Medicine and the Society of Hospital Medicine
SES 085 – Building Bridges: Developing Institutional Infrastructure and a Strategic Plan to Integrate the Quality and Safety Mission of Teaching Hospitals and their Graduate Medical Education Programs

Anjala V. Tess MD
Jennifer S. Myers MD
ACGME Annual Meeting
February 28, 2015
Learning Objectives

• Describe the foundational elements for integrating GME and residents into the quality and safety infrastructure of your health system

• Identify your organization’s strengths and weaknesses as you prepare for ACGME CLER in order to identify improvement opportunities

• Compare organizational strategies from two institutions that are developing infrastructure to align GME with their health system quality goals
Learning Objectives (in other words)

• Present a framework for thinking about what it takes to align and integrate GME into hospital quality and safety efforts

• Hear about what other institutions are doing

• Leave with concrete strategies and a to-do list
CLER Program

• Six Key Focus Areas:
  1. Quality Improvement
  2. Patient Safety
  3. Handoffs & Transitions
  4. Supervision
  5. Professionalism
  6. Duty Hours/Fatigue Mgmt

• Five Key Questions for the site visit
  – How integrated is the GME leadership and faculty in the hospital/medical center efforts across the six focus areas?
  – Who and what form the hospital/medical center’s infrastructure designed to address the six focus areas?
  – How engaged are the residents and fellows?
  – How does the hospital/medical center determine the success of its efforts to integrate GME into the six focus areas?
  – What are the areas the hospital/medical center has identified for improvement?
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How Will We Get There?
Sound Familiar?

“The curricula in quality and safety at my institution are under-developed and we have a lot of variability. We have some really innovative programs in our clinical simulation center but nothing else consistent at the GME level. There are some core programs that give residents no exposure to this field.”

- Designated Institutional Official
- GME Program Administrators
Sound Familiar?

“We cannot get a departmental QI project off the ground because we can’t get the baseline data, let alone set up a process for ongoing measurement and evaluation.”

- Associate Program Director
Sound Familiar?

We just had our CLER visit and they commented on the fact that most of our faculty and housestaff could not articulate what our quality and safety goals and initiatives are.

- Chief Quality & Safety Officer
“We have an incident reporting system, but I am pretty sure the nurses are the only ones who use it. The residents don’t know who reads them so are scared to report. We also don’t see the faculty reporting so why would we bother? We are busy enough.”

- Resident
Building Bridges Between GME and the Hospital: Easy or Hard?
Sometimes it feels like we are working at odds...
CLER – 6 Focus Areas

- Patient Safety
- Healthcare Quality
- Care Transitions
- Professionalism
- Supervision
- Duty Hours/Fatigue Mgmt
Conceptual Framework

- Resident & Fellow Engagement in Quality & Safety
- Culture
- Health System-GME Alignment
- Educational Resources
- Faculty Development
- Inter-Professional Collaboration
- Infrastructure

Patient Safety
Health Care Quality
Supervision
Professionalism
Duty Hours/Fatigue
Care Transitions
CLER Properties in Quality & Safety and the 6 Elements

• Culture
  – “Residents/fellows/faculty perceive that the clinical site provides a supportive culture for reporting patient safety events.” (PS-3)

• Infrastructure
  – “Access to data is essential to prioritizing activities ...and evaluating success of QI efforts” (HQ-3)

• Alignment
  – “Residents/fellows participate as team members in clinical site sponsored patient safety investigations” (PS-4)

• Faculty Development
  – “Faculty members report that they are proficient in clinical QI.” (HQ -1)

• Educational Resources
  – “Residents/fellows receive patient safety education that includes information specific to the clinical site.” (PS-2)

• Interprofessional Collaboration
  – “Residents/fellows are actively involved in the QI activities at the clinical site...involved in interprofessional teams” (HQ-2)
Our Framework for Today

The Ideal

Organizational characteristics

Strategy
Institutional Culture

The ideal

The culture of the organization prioritizes quality and safety, is transparent, willing to address mistakes, and values the trainee in the continuous improvement process.

Organizational Characteristics

- Improvement ideas are welcomed from all providers, including trainees
- Reporting of safety events is valued and encouraged by leadership
- Quality and safety data are widely available and used for clinical and educational purposes
Institutional Culture

Strategies

• Review process for errors or unanticipated events uses an approach that balances system fixes with individual responsibility

• Trainees are supported in reporting and error disclosure

• Trainee QI activities are aligned with institutional data and priorities
Health System and GME Leadership Alignment

The ideal

Health system leaders and academic leaders recognize value of each other and collaborate on safety, quality, and educational initiatives

Organizational Characteristics

• Program directors and chairs supportive of institutional and department quality and safety efforts
• Health system leaders interested in engaging trainees in quality and safety efforts
• Regular opportunities for conversations between these two leadership groups
• Health system and GME leaders incorporate QI/PS integration into their strategic plans and hold leaders accountable for the results
Health System and GME Leadership Alignment

Strategy

• Quality and safety committees have representation from training programs and program directors support attendance

• Health system leaders sit on GME committees

• Health system and GME create definitive outcome measures for success in GME QI/PS integration

• Utilize housestaff councils to support alignment
Infrastructure

The ideal

The health system and GME infrastructure provide the necessary systems, processes, and roles to support the quality and safety educational mission.

Organizational Characteristics

• Data systems exist to collect and share quality and safety data
• Systems and processes exist to support creation and sharing of educational programming and content
Infrastructure

Strategy

• Error reporting system accessible
• Mechanism for training programs to access quality data
• Repository for curricular sharing
• Liaison roles between healthcare quality and education
Educational Resources

The ideal

Educational programs in quality improvement and patient safety are well developed, resourced, implemented, and span the institution.

Organizational Characteristics

- Institutional standardization of safety and quality vocabulary and tools, allowing for variation in education that is customized to different clinical specialties
Educational Resources

Strategy

• GME office and hospital partners come to agreement on standards for educational programs in safety

• GME office offers centralized training resources for use with residents and fellows
Faculty Development

The ideal

Faculty development programs in quality improvement and patient safety aim to train both frontline faculty and medical educators across the institution.

Organizational Characteristics

- All faculty are competent and comfortable role modeling behaviors that promote QI and PS
- A critical mass of expert faculty educators in QI/PS exist*
Faculty Development

Strategy

• Create, sponsor, and promote faculty development opportunities for all teaching faculty to become proficient in QI/PS

• Create, sponsor, and promote faculty development to develop some faculty as QI/PS educators
Interprofessional Collaboration

The ideal GME education in quality and safety involve other healthcare professionals and some is developed collaboratively.

Organizational Characteristics

- Regular discussions between health system, GME, and nursing leaders related to QI/PS initiatives and educational programs.
Interprofessional Collaboration

Strategy

• Nursing and other allied health leadership serve on GME committees

• Opportunities for interprofessional educational activities are offered to GME community
Breakout 1: Organizational Self-Assessment

• Review the grid
• Jot down your strength, weaknesses, improvement opportunities
• Share with a neighbor
Case Study 1:
University of Pennsylvania Health System

Jennifer S. Myers, MD
Associate DIO for Quality and Safety
Department of Graduate Medical Education
Perelman School of Medicine
University of Pennsylvania Health System
University of Pennsylvania Health System

- Tertiary care health system in Philadelphia (3 hospitals)
- 789 beds at our primary academic teaching hospital
- 78 accredited GME programs – 1147 housestaff
- Department of Clinical Effectiveness & Quality Improvement (CEQI)
- National reputation for quality and safety

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PJ Brennan MD; CMO
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Ilene Rosen MD; Assoc DIO
Pat Sullivan PhD; VP QI/PS
Neha Patel MD MS
Lisa Bellini MD; Vice-Dean Faculty Affairs
Penn’s Blueprint for Quality & Patient Safety

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### Penn Medicine Blueprint for Quality and Patient Safety

*Penn Medicine will eliminate preventable deaths and preventable 30-day readmissions by July 1, 2014*

<table>
<thead>
<tr>
<th>Imperatives</th>
<th>Priority Actions</th>
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</thead>
<tbody>
<tr>
<td>Accountability For Perfect Care</td>
<td>- “Always” events - strive to provide perfect care&lt;br&gt;- Implement clear lines of accountability that span inpatient and ambulatory environments</td>
</tr>
<tr>
<td>Patient And Family Centered Care</td>
<td>- Provide consistent and thorough communication regarding plan of care&lt;br&gt;- Increase patient and family involvement in UPHS forums and integrate patient feedback into clinical and service improvement efforts</td>
</tr>
<tr>
<td>Transitions In Care/Coordination Of Care</td>
<td>- Redesign clinical processes to ensure that patients and their information are safely transitioned from one setting of care to another</td>
</tr>
<tr>
<td>Reducing Unnecessary Variations In Care</td>
<td>- Eliminate variations in care processes where evidence exists&lt;br&gt;- Balance conformity in practice with needs for personalized care&lt;br&gt;- Improve the value of our health care processes and outcomes</td>
</tr>
<tr>
<td>Provider Engagement, Leadership, And Advocacy</td>
<td>- Strengthen organizational capacity and capability for continuous improvement&lt;br&gt;- Increase involvement of housestaff in quality, safety and service excellence efforts</td>
</tr>
</tbody>
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*Increase involvement of house staff in quality, safety and service excellence efforts*
We Started with the “Innovators” & “Early Adopter” Residents
Residents as Leaders and Change Agents for Healthcare Improvement

- Advanced Training
- Career Development Pathway
- Pipeline...
- Healthcare Leadership in Quality Track
- Housestaff & Advanced Practitioner Quality Council
- Connect health system QI goals with resident ideas
- Group Project aligned with institution
- Problem-solving with residents from diverse depts
How to Reach the Majority?
Where Are We Starting From?
GME-Wide Needs Assessment Survey

Penn

- Patient Safety
- Quality Improvement
- Inpatient Handoffs
- Discharge Transitions
- Value/Cost Conscious Care
- QIP Participation by All Residents?

n = 18 core residency programs at Penn; self-reported data
# Penn’s GME Quality/Safety Efforts

## Culture
- Patient Safety Event Reporting Campaign

## Educational Resources
- Quality & Safety Toolkit on GME website
- Develop customized Penn-specific tools:
  1. Orientation module in Penn QI/PS
  2. Explainer videos for our RCA process
  3. Housestaff Guide for Event Reports

## Faculty Development
- Faculty Development for Quality and Safety Educators: GME Symposium in “Teaching & Mentoring Residents in QI”
- Grand Rounds for all Departments for frontline faculty & housestaff

## Infrastructure
- Quality data accessible to programs and trainees.
- Hstaff Quality/Safety Leadership Council
- Healthcare Leadership in Quality Track
- Associate DIO for QI/PS
- FOCLE Walk Rounds

## Health System – GME Alignment
- Identification of faculty members responsible for QI/PS education/engage
- Outcome measures to track progress

## Interprofessional Collaboration
- RN/NP involvement in HS Council
- Partnering with Nurses for svc orientation
Educational Methods:
- Videos that illustrate both good and bad safety behaviors (Penn Medicine Academy & First Generation© Film)
- Narration to emphasize key points from video examples
- Brief executive and faculty narratives
- 5-item quiz emphasizing key points
Housestaff Barriers to PSN Reporting

- Don't have time: 169 votes
- No Feedback: 96 votes
- No incentive: 64 votes
- Not sure what to report: 60 votes
- Hard to find the site: 57 votes
- Confusing System: 46 votes
- Hard to find a work station: 35 votes
- Other: 33 votes
- Not important: 6 votes

Total votes: 313
Penn Safety Net Reporting among MDs (HUP, CPUP, PPMC)

- Median = 53 PSN/month
- 20% increase among housestaff and 40% increase in reporting among faculty in CY2014 compared with CY 2013
Focusing On Excellence in the Clinical Learning Environment at Penn

- Monthly “Walk Rounds” focused on 1 or 2 CLE Topics
- Attendees: GME Leader, Program Leader, Hstaff
- Goals
  - Increase awareness of current practice within the CLE focus areas
  - Foster collaboration between GME, UPHS, and residency program leadership around CLER
  - Identify best practice and opportunities for improvement; identify an improvement plans
# Housestaff & Advanced Practitioners

Penn Medicine will improve the health of our patients and assure safe care.

## Blueprint for Quality & Patient Safety

### Engagement

- **If You See Something, Say Something**
  - Use Penn Safety Net to report safety concerns
- **If You Are Unsure, Ask...**
  - Speak up when something seems wrong
- **Collaborate & Communicate**
  - Communicate daily care plan every day with patient, nurse, and other providers

### Continuity

- **Transition Patients Safely**
  - Identify & communicate with the next provider of care at discharge

### Value

- **Provide High Value Care**
  - Think before you order and choose wisely: reduce unnecessary labs or imaging tests
Case Study 2:
Beth Israel Deaconess Medical Center

Anjala V. Tess MD
Director of QI and Safety for GME
Office of GME
BIDMC
Beth Israel Deaconess Medical Center

- Tertiary care center in Boston
- 600+ beds
- 43 accredited programs
- Office of GME
- Department of Healthcare Quality
- Institutional reputation for quality and safety
BIDMC Paradigm : Shared Responsibility

- BIDMC
- GME Office
- Frontline Faculty
- Program Directors
- Core faculty
- Trainees
- Error reporting systems
- QI structure
- Oversight
- Centralized resources
- Integration into hospital structures

Curriculum development
Teaching

Basic principles
Daily practice enforces local safety culture

A Tess, 2015
Laying the groundwork for NAS

- Education and outreach around CLER
  - Follow up after CLER report back
- Restructuring GME oversight
  - Includes QI and Safety

https://www.acgme.org/acgmeweb/Portals/0/PDFs/NAS/NEJMfinal.pdf; accessed 1/20/2014
Inventory

- Creation of standard tool
  - Universal language
  - Curricular elements
  - Integration of trainees
- Meetings with every program director
  - QI director in core departments
SAFETY

Hands-on for everyone

Hands-on for some

No hands-on

No hands-on

Hand-on for some

Hands-on for everyone

Hands-on for everyone

Hands-on for some

No hands-on

QI
Supporting Program Development

General approach
• Build on strengths
• Serve as resource
  – Slide sets
  – Project tools
  – One on one meetings
• Offering central training for certain groups

Example: Medicine Fellowships
• 3 hour symposia
  – Reporting at BIDMC
  – Root cause analysis of real relevant cases
  – Design a QI intervention
  – Turning QI work into research
• Curricular support
• Faculty and fellow mentorship
<table>
<thead>
<tr>
<th>Domain</th>
<th>Potential Contributing Factors (RMF Reporting framework)</th>
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<tbody>
<tr>
<td>Clinical Environment</td>
<td>- Workflow or workload issues</td>
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<td></td>
<td>- Workplace physical conditions</td>
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<td></td>
<td>- Distractions/fatigue/impairment of the provider</td>
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<tr>
<td>Clinical Judgment</td>
<td>- Assessment issues: Inadequate, delay in dx or ordering, misinterpreting results</td>
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<tr>
<td></td>
<td>- Management issues: wrong/inadequate medication, wrong/inadequate medical or surgical/procedural therapeutic approach</td>
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<td></td>
<td>- Issue with patient monitoring</td>
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<td>- Delay or failure to obtain consult</td>
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<td></td>
<td>- Practicing beyond scope/expertise</td>
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<td></td>
<td>- Not questioning or following order</td>
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<td></td>
<td>- Rushed decision making</td>
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<tr>
<td>Communication</td>
<td>- Between patient/family and providers including consent and adherence issues</td>
</tr>
<tr>
<td></td>
<td>- Team issues: hierarchy problems, inadequate handoff at transitions in care, failure to communicate changes in patient status, unclear lines of responsibility, lack of consensus, supervision of trainees/nursing</td>
</tr>
<tr>
<td>Clinical Systems</td>
<td>- Lack of provider coordinating care</td>
</tr>
<tr>
<td></td>
<td>- Failure/delay in test performance or reporting results</td>
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<td></td>
<td>- Delay in performance of procedure or surgery</td>
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<td></td>
<td>- Failure/delay in patient follow up</td>
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<tr>
<td>Administrative/Other</td>
<td>- Documentation problems</td>
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<td></td>
<td>- Staff issues: access, staffing levels, training and education, turnover</td>
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<td></td>
<td>- Ethical issues including code status, confidentiality issues, discrimination</td>
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<tr>
<td></td>
<td>- Protocol/Policy related: none, not accessible, not followed</td>
</tr>
<tr>
<td></td>
<td>- Safety Culture: lack of reporting, unwillingness to seek help or speak up</td>
</tr>
<tr>
<td></td>
<td>- OTHER:______________________________________________________</td>
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</table>
Collaborating with Healthcare Quality

- GME presence at QI committees
- Meetings with healthcare quality leaders
- Housestaff QI council (HSQIC)
<table>
<thead>
<tr>
<th>Element</th>
<th>BIDMC Strategy</th>
</tr>
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</table>
| Culture                      | • Reporting system now captures trainees  
                                • QI symposium to capture resident work                                        |
| Health System and GME Alignment | • Educational outreach  
                                • QI education now formally links to Annual Operating Plan  
                                • Housestaff QI council supports alignment                                        |
| Infrastructure               | • Director of QI and PS for GME  
                                • GME presence at QI Directors and new core initiatives                        |
| Educational Resources        | • Creation of standards for curricular inventory  
                                • Centralized training for some groups  
                                • Slide on systems issues                                                        |
| Faculty Development          | • Centralized training                                                            |
Breakout 2: Organizational Next Steps

• Go back to the grid
• Write down one thing you are going to do in the next week and one thing you are doing to do in the next month
• Open it up for discussion
Thank You
Questions or Comments?