

(QSEA) Quality & Safety Educators Academy

**“Point with Pride, View with Alarm and
End with Hope”**

March 7, 2013

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/>

www.facebook.com/jeffersonjosph

<https://twitter.com/JeffersonJSPH>



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**

INSIDE THIS WEEK: A 14-PAGE SPECIAL REPORT ON AGEING

The Economist

JUNE 27TH-JULY 3RD 2009

Economist.com

- Iran's agony
- The mystery of Mrs Merkel
- Asia's consumers to the rescue?
- The Greeks and those marbles
- Evolution and depression

Reforming health care

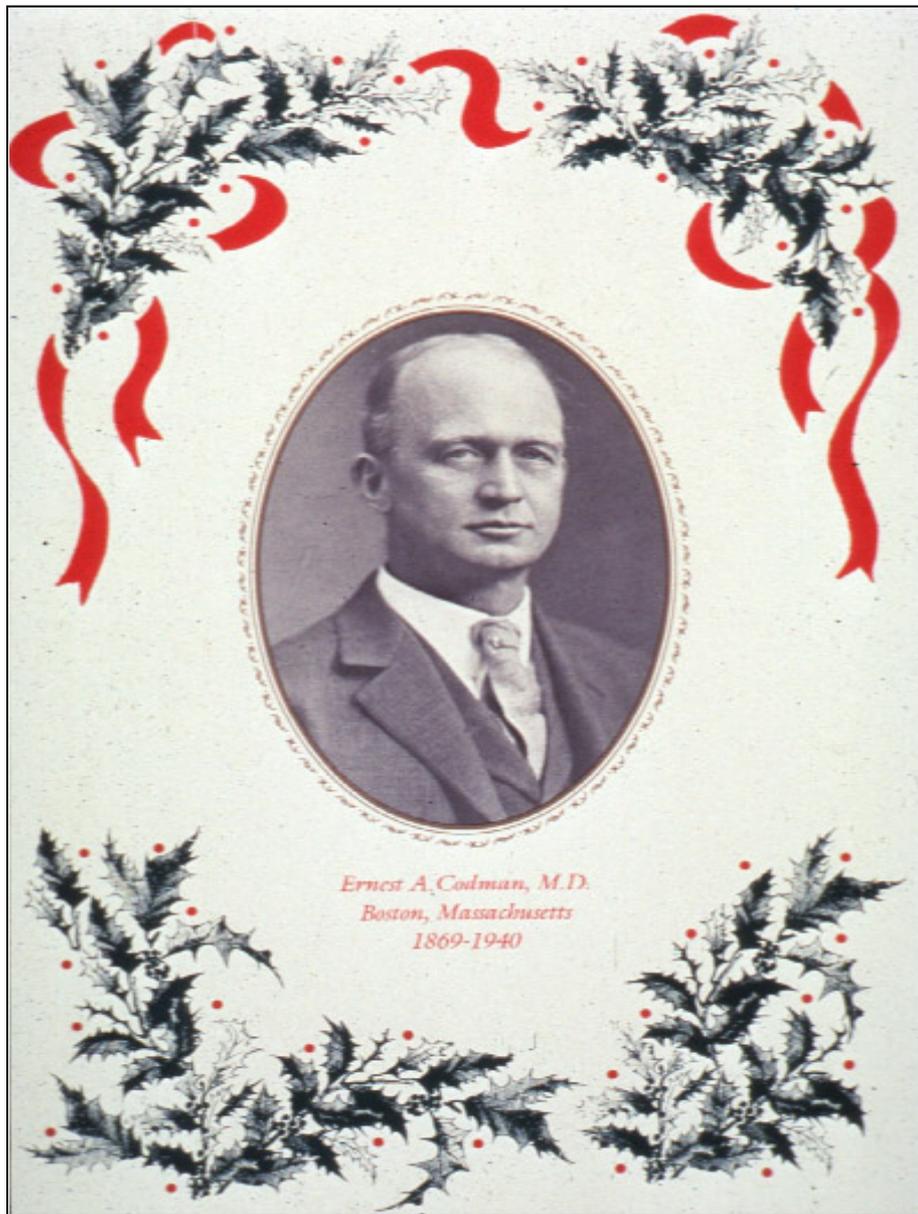
This is going to hurt



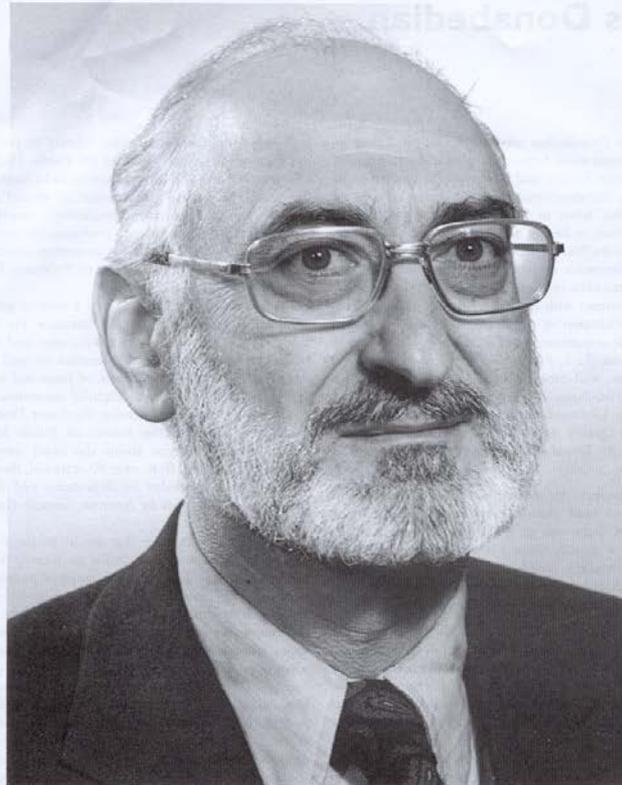
US\$6.99 • C\$7.99



Argentina.....	\$7.00	Canada.....	C\$7.99	Jamaica.....	J\$10	Trinidad & Tobago.....	T\$14
Bahamas.....	\$9.75	Chile.....	\$5.000	Mexico.....	M\$70	Turk & Caicos.....	\$9.50
Barbados.....	\$16.00	Colombia.....	C\$22,000	Peru.....	S/ 36.00	UK.....	£4.00
Bermuda.....	\$12.00	Costa Rica.....	¢6,900	Spain.....	€ 5.50	USA.....	US\$6.99
Brazil.....	R\$29.90	Guyana.....	G\$1,650	St. Maarten.....	ƒ9.25	Venezuela.....	Bz27



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



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.

... 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

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

IGAKU-SHOIN New York · Tokyo

FUTURE PRACTICE ALTERNATIVES IN MEDICINE

SECOND EDITION

DAVID B. NASH, M.D.

IGAKU-SHOIN New York • Tokyo

practicing **MEDICINE** **in the 21st century**

Edited by: David B. Nash MD, MBA
Alexandria Skoufalos, EdD
Megan Hartman, MS
Howard Horwitz, MPH



"When an entire profession is in a state of denial and caught in a whirlwind of confusion about its mission, its methods, and its effectiveness, facing the truth - however harsh - is the first step back from the brink. American medicine (read: American Healthcare) is in that precise tangle, and Demand Better! by Doctors David Nash and Sanjaya Kumar is the unmissable shot across the bow we've been waiting for at least a decade.

In 1999 the Institute of Medicine issued an embarrassing and pivotal report (to Err is Human) validating the annual unnecessary deaths of at least 48 thousand patients at the hands of medical error. Some eleven years later, while American Healthcare has become universally aware of the problem and equally aware that the solutions are far more difficult than thought, Patient Safety is still in the dark country with tens of thousands still killed by mistake every year. Worse, the entire country is confused about the utter failure of the fee-for-service model to provide even the slightest incentive to improve the health of Americans. Quite the contrary, as Nash and Kumar point out with crushing honesty, we have a system that only succeeds financially when people stay ill.

This book will be regarded in future years as a major turning point in the history of healthcare. In the wake of congressional failure to pass more than a strange health insurance bill powered off as healthcare reform, Demand Better! is our best hope for sparking the start of the real revolution Americans are quite literally dying for."

John J. Heneg, MD, Author of Why Hospitals Don't Fix The 2009 ACPE Book of the Year

Second River Healthcare Press • 25 Shawnee Way, Suite C • Bozeman, MT 59715



TO ORDER THIS BOOK VISIT OUR BOOKSTORE AT
SecondRiverHealthcare.com
 or call **406-586-8775**
 QUANTITY DISCOUNTS ARE AVAILABLE!

TO BOOK THESE AUTHORS AS WELL AS OTHER TOP HEALTHCARE SPEAKERS CONTACT

INNOVATIVE HEALTHCARE SPEAKERS
 a division of Second River Healthcare Press

at **406-586-8775**
 InnovativeHealthcareSpeakers.com

DEMAND BETTER!

REVIVE OUR BROKEN HEALTHCARE SYSTEM

Sanjaya Kumar, M.D., M.P.H.
 David B. Nash, M.D., M.B.A.



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 denies from uncertainty in clinical decision-making from persistent unexplained variation in physician practice patterns, from insufficient accountability for quality and patient safety from payment for piecemeal, and from medical training curriculum that is decades behind the curve. Fixing quality by addressing each of those 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 U.S. 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 by building a better research base to compare the effectiveness of different treatments for the same medical condition; devising accountability mechanisms that work, piloting 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 evolution 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 U.S., but has been jump-started by recent stimulus funding and age-old peer-review payments among physicians and hospitals to reverse perverse incentives of the fee-for-service system to minimize error and save 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.

Essential reader who thinks it 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 evolution.

About the Authors



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

Sanjaya Kumar, MD, MPH, 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 in many important 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* in 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.

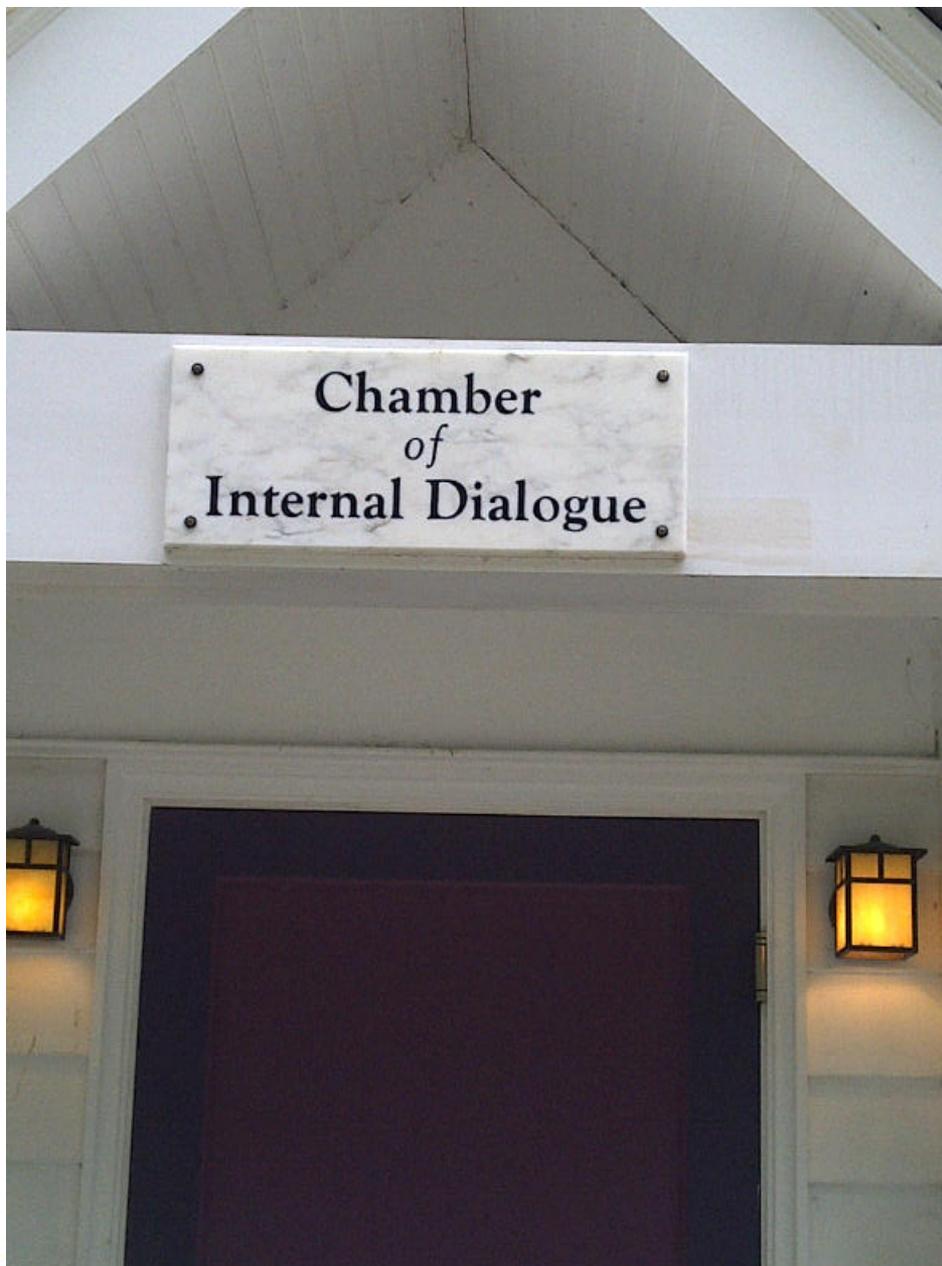
Dr. Nash is a board certified internist who is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement and has been repeatedly named to Modern Healthcare's list of the 100 Most Powerful Persons in Healthcare.

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 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.

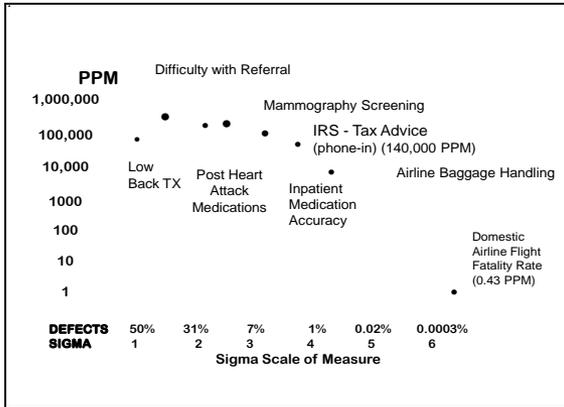
Dr. Nash received his BA in economics (Phi Beta Kappa) from Vassar College; his MD from the University of Rochester School of Medicine and his MBA in Health Administration (with honors) from the Wharton School where he was a former Robert Wood Johnson Foundation Clinical Scholar.





Point with Pride

The Quality & Patient Safety Imperative: *The Full Monty*



“The First Law of Improvement”

Every system is perfectly designed to achieve exactly the results it gets.



American health care "gets it right" 54.9% of the time.

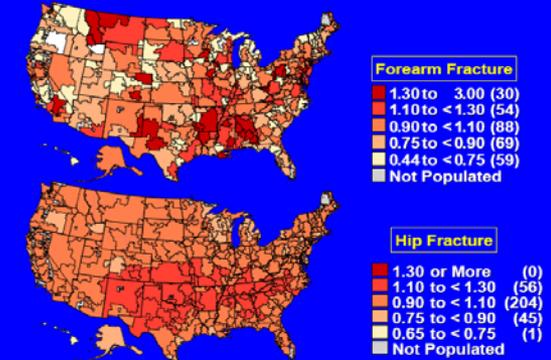
McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003; 348(26):2635-45 (June 26).

The Chain of Effect in Improving Health Care Quality

Patient and Community	Experience	Aims (safe, effective, patient-centered, timely, efficient, equitable)
Micro-system	Process	Simple rules/Design Concepts (knowledge-based, customized, cooperative)
Organizational Context	Facilitator of Processes	Design Concepts (HR, IT, finance, leadership)
Environmental Context	Facilitator of Facilitators	Design Concepts (financing, regulation, accreditation, education)

Page 8

Patterns of Variation in Hospitalization Rates



International Comparison of Spending on Health, 1980–2004

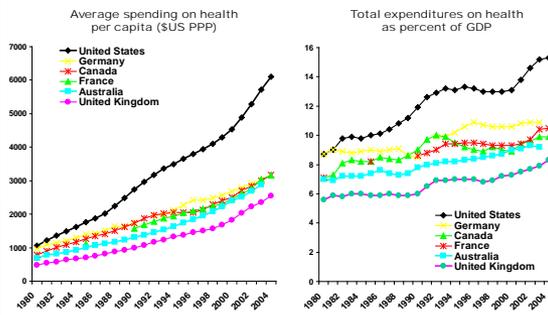
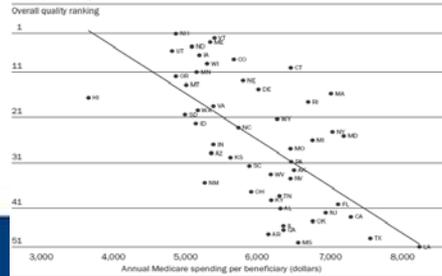
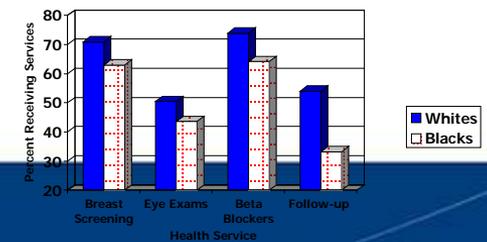


EXHIBIT 1 Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



Katherine Baicker, Amitabh Chandra, Jonathan S. Skinner, and John E. Wennberg
Who You Are And Where You Live: How Race And Geography Affect The Treatment Of Medicare Beneficiaries
Health Affairs Web Exclusive, October 7, 2004

Among Medicare Beneficiaries Enrolled in Managed Care Plans, African Americans Receive Poorer Quality of Care (Schneider et al., *JAMA*, March 13, 2002)



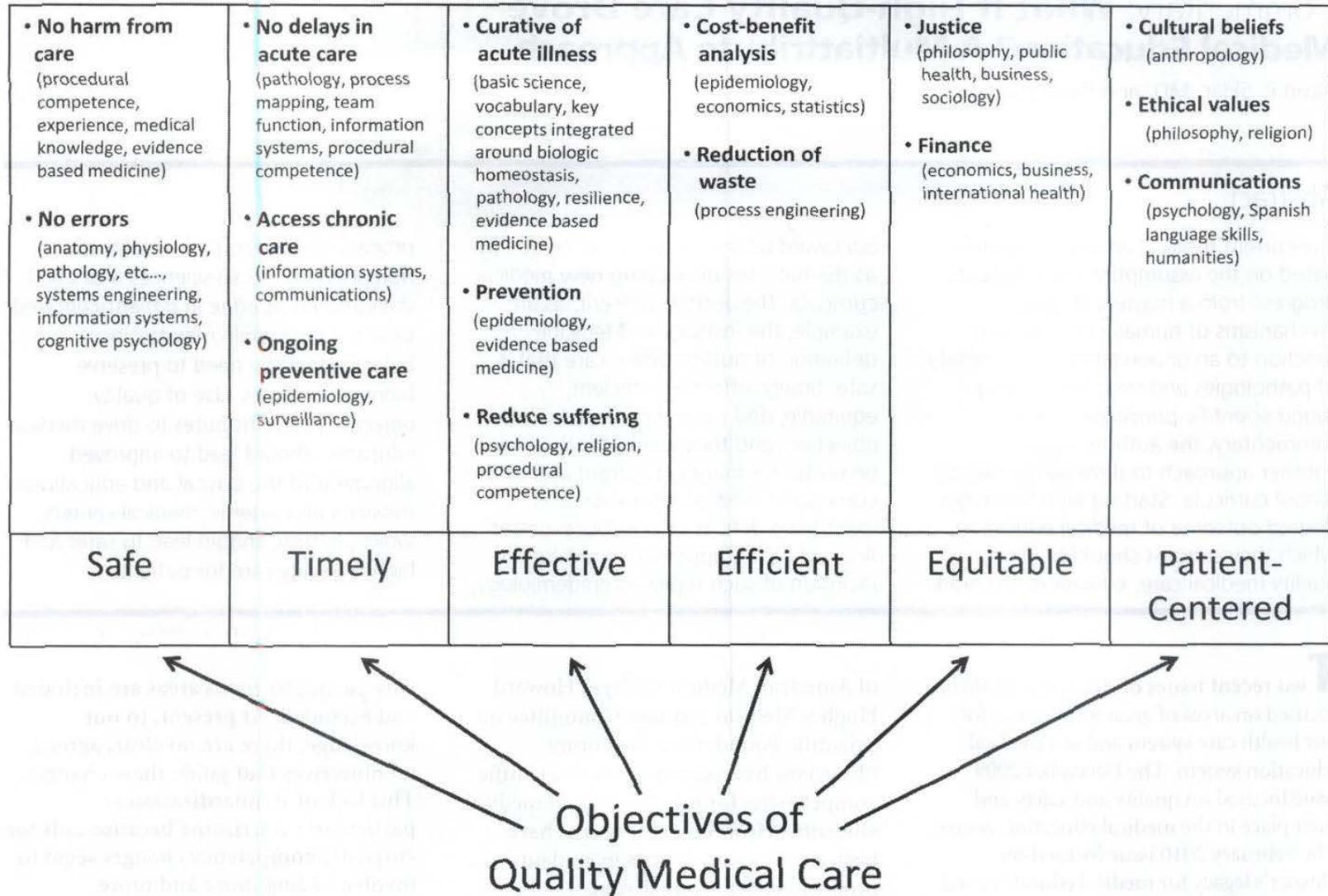


Figure 1 Attributes of the Institute of Medicine quality objectives with related curriculum areas.

ACADEMIC MEDICINE

Journal of the Association of American Medical Colleges



December 2009

Volume 84

Number 12



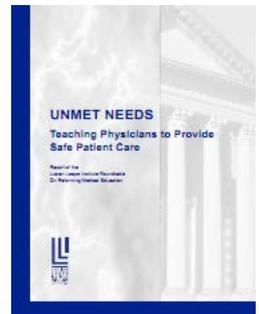
Quality and Safety in Medicine

- 1651** Physician Leadership to Foster Quality
- 1657** Improving Inpatient Mortality in Academic Medical Centers
- 1663** Restructuring for Quality and Safety at an Academic Health Center
- 1672** Patient Safety Education in North American Schools
- 1677** Quality-Improvement Curricula for Physicians In Training
- 1713** Successful Management of Product Recalls
- 1741** The VA's National Quality Scholars Fellowship Program
- 1757** Residents' Engagement in Quality Improvement

www.academicmedicine.org

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

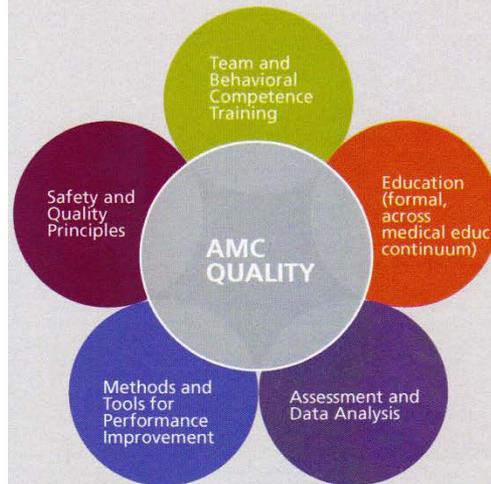




Tomorrow's Doctors, Tomorrow's Cures®

AAMC INTEGRATING QUALITY (IQ) INITIATIVE

www.aamc.org/iq

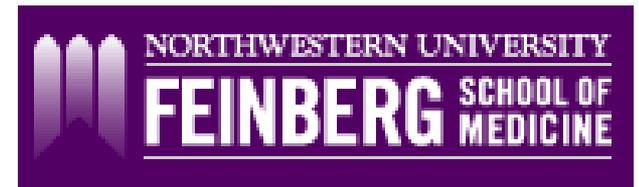


The IQ mission is to assist AAMC members in enhancing the culture of quality in their organizations by providing resources and activities for sharing strategies that build coordinated approaches to quality, patient safety, and performance improvement across the continuum of clinical care and medical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

Association of
American Medical Colleges

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.

UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE
AT CHICAGO

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

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.

	MBA	MMM	MMM	MS-HQSM
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	<ul style="list-style-type: none"> • Practical business knowledge • Emphasis on best practices • Easily applied to health care 	<ul style="list-style-type: none"> • Leadership • Strategy development • Information technology 	<ul style="list-style-type: none"> • Physician executive as a leader • Entrepreneurship — internal and external • Fully implementable business plans 	<ul style="list-style-type: none"> • 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.

Because quality and
safety *aren't* electives.

 IHI OPEN SCHOOL
for health professions

www.IHI.org/OpenSchool

 **New York-Presbyterian**
HOUSESTAFF QUALITY COUNCIL

WHERE

Harkness Courtyard
York Avenue Between 69th and 70th

HOUSESTAFF QUALITY COUNCIL
COCKTAIL RECEPTION

Top Ten Avoidable Medical Errors

****FREE USB DRIVE TO ALL THAT ATTEND****

OPEN TO ALL HOUSESTAFF

TIME

5:30-7:30

DATE

July 30, 2009

EVENT

Hors D'oeuvres and Open Bar

New York Weill Cornell Medical
Center Alumni Council

Supported by the New York-Weill
Cornell Medical Center Alumni
Council (CAC) and Synectics, Inc.

2011 John M. Eisenberg Patient Safety and Quality Awards

The Effect of a Novel Housestaff Quality Council on Quality and Patient Safety

Innovation in Patient Safety and Quality at the Local Level

Peter M. Fleischut, MD; Susan L. Faggiani, RN, BA, CPHQ; Adam S. Evans, MD, MBA; Samantha Brenner, MD, MPH; Richard S. Liebowitz, MD; Laura Forese, MD, MPH; Gregory E. Kerr, MD, MBA; Eliot J. Lazar, MD, MBA



From left: Adam S. Evans; Karen Scott, MD, MPH, Vice President, Quality and Patient Safety, New York-Presbyterian Hospital (NYP); Susan L. Faggiani; Eliot J. Lazar; Samantha Brenner; Peter M. Fleischut; Laura Kent, MD, Assistant Clinical Professor of Medicine and Psychiatry, Columbia University Medical Center; Aileen Alapan, MBA, Divisional Administrator for Quality and Patient Safety, NYP

Many innovative strategies have been implemented to improve quality and patient safety.¹⁻⁵ Clinical leaders, medical educators, and experts in quality and patient safety are faced with the challenge of committing precious organizational resources to determine which of these new innovations have the potential to deliver sustainable results. The vast number of quality and safety initiatives/interventions available today, and the increasing recognition of unintended consequences of some of these, further compounds this challenge.⁶⁻¹³

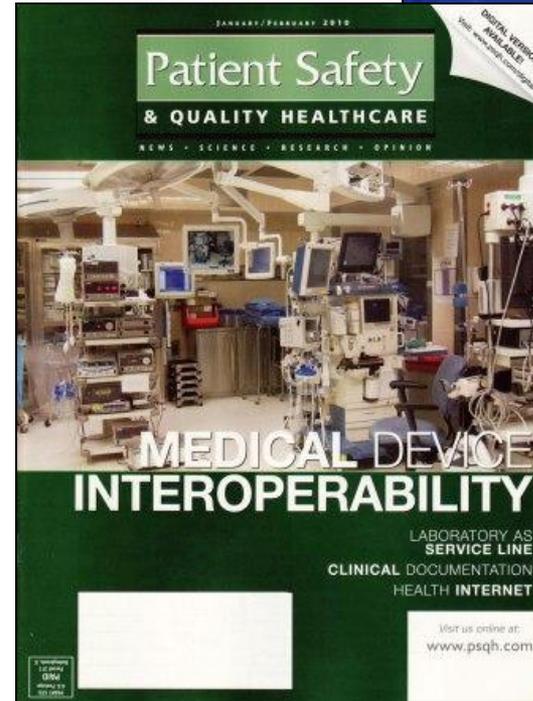
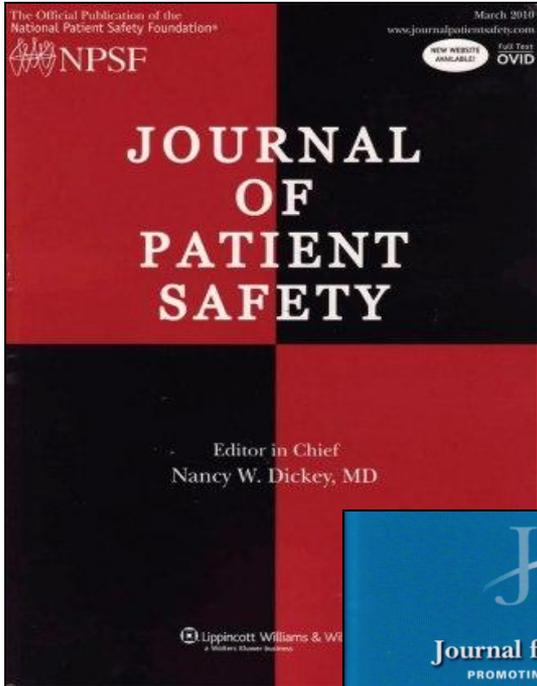
The Institute of Medicine (IOM) report *To Err Is Human* presents an imperative for reducing preventable medical errors.¹⁴⁻¹⁷ In its follow-up report, *Crossing the Quality Chasm*, the IOM maps out a fundamental strategy that aligns accountability in quality of care with payment incentives by promoting evidence-based practice and the use of clinical information systems.^{18,19} Subsequently, The Joint Commission established the National Patient Safety Goals (NPSGs) campaign, implemented in January 2003.²⁰⁻²² The NPSGs were then incorporated into the Joint Commission standards. These events, among others, catalyzed a redesign of the approach to quality and

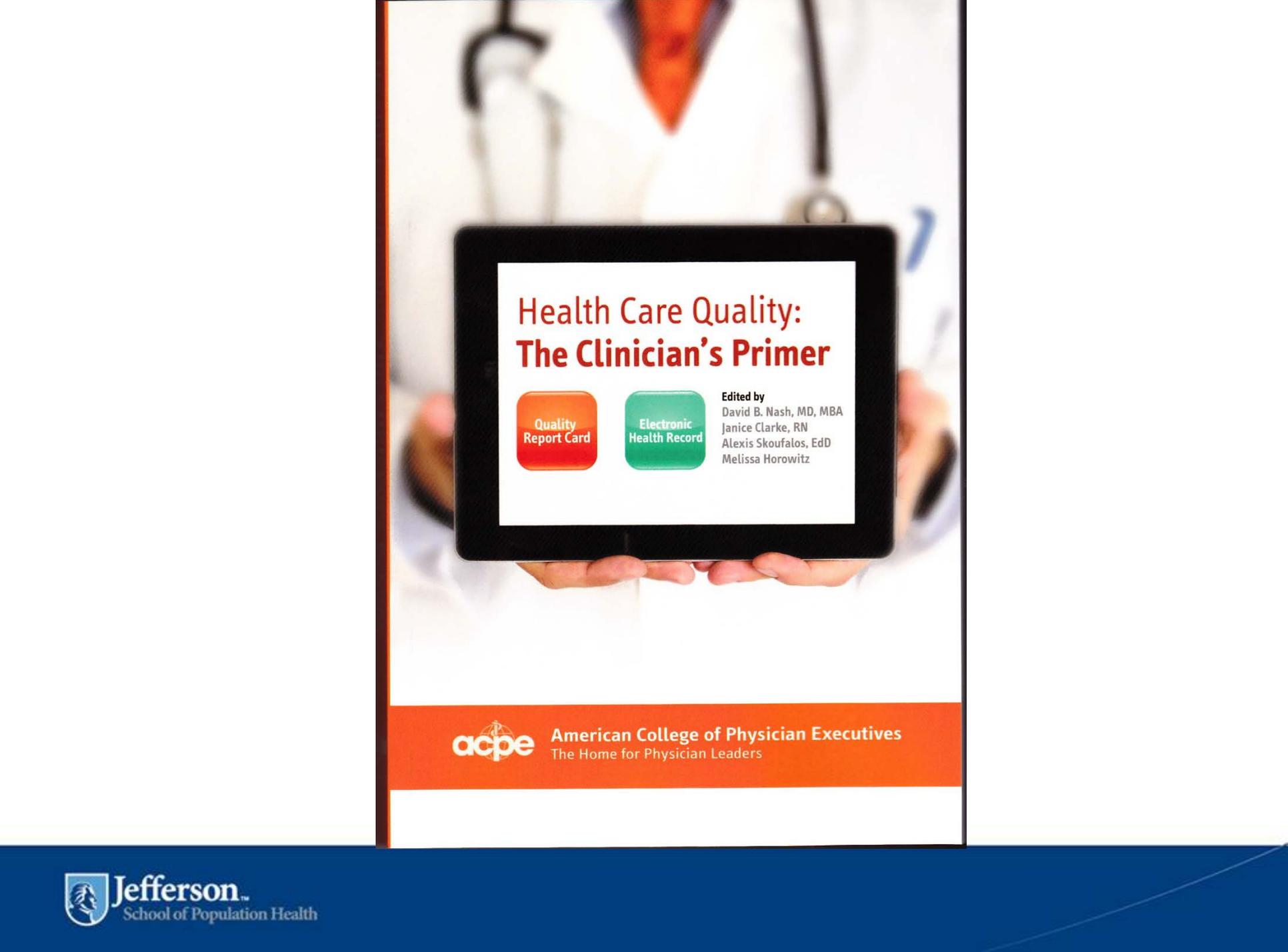
Article-at-a-Glance

Background: In 2008 New York-Presbyterian Hospital (NYP)/Weill Cornell Medical Center, New York City, the largest not-for-profit, nonsectarian hospital in the United States, created and implemented a novel approach—the Housestaff Quality Council (HQC)—to engage housestaff in quality and patient safety activities.

Methods: The HQC represented an innovative collaboration between the housestaff, the Department of Anesthesiology, the Division of Quality and Patient Safety, the Office of Graduate Medical Education, and senior leadership. As key managers of patient care, the housestaff sought to become involved in the quality and patient safety decision- and policy-making processes at the hospital. Its members were determined to decrease or minimize adverse events by facilitating multimodal communication, ensuring smart work flow, and measuring outcomes to determine best practices. The HQC, which also included frontline hospital staff or managers from areas such as nursing, pharmacy, and information technology, aligned its initiatives with those of the division of quality and patient safety and embarked on two projects—medication reconciliation and use of the electronic medical record. More than three years later, the resulting improvements have been sustained and three new projects—hand hygiene, central line-associated bloodstream infections, and patient handoffs—have been initiated.

Conclusions: The HQC model is highly replicable at other teaching institutions as a complementary approach to their other quality and patient safety initiatives. However, the ability to sustain positive momentum is dependent on the ability of residents to invest time and effort in the face of a demanding residency training schedule and focus on specialty-specific clinical and research activities.





Health Care Quality: The Clinician's Primer

Quality
Report Card

Electronic
Health Record

Edited by

David B. Nash, MD, MBA
Janice Clarke, RN
Alexis Skoufalos, EdD
Melissa Horowitz



American College of Physician Executives
The Home for Physician Leaders



Safety on the syllabus

Training in quality improvement and patient safety is making its way into medical education. But some physician leaders say the change is coming too slowly. [Story by Kevin B. O'Reilly]

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 necessarily 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



PHOTO BY TED GRUZZINSKI

Medical schools need a new approach, says David B. Nash, MD, of Thomas Jefferson University in Pennsylvania. "This is not even on their radar — that quality and safety should be part of the curriculum."

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

AMERICAN MEDICAL NEWS IS PUBLISHED BY THE AMA AND IS INTENDED TO SERVE AS A FORUM FOR INFORMATION AFFECTING PHYSICIANS AND THEIR PRACTICES. THE CONTENTS OF ARTICLES AND OPINIONS EXPRESSED IN AMNEWS ARE NOT NECESSARILY ENDORSED BY THE AMA. REPUBLISHED FROM AMERICAN MEDICAL NEWS • APRIL 26, 2010 • WWW.AMEDNEWS.COM

Vol. 3, No. 1, Spring 2008

Simulation in Healthcare

Journal of the Society for Simulation in Healthcare

A multidisciplinary journal encompassing all areas of healthcare simulation technology. Relevant to a broad range of specialties, this journal publishes original basic, clinical, and translational research, review articles, and other materials. In this issue:

- Team Performance Assessment in Healthcare: Facing the Challenge
- 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?
- Selected Abstracts of Free Papers Presented at SimTecT Health Conference

*An Official Journal of the Society in Europe
for Simulation Applied to Medicine*

*The Official Journal of the Australian Society
for Simulation in Healthcare*

*An Official Journal of the Association for
Standardized Patient Educators*

www.simulationinhealthcare.com

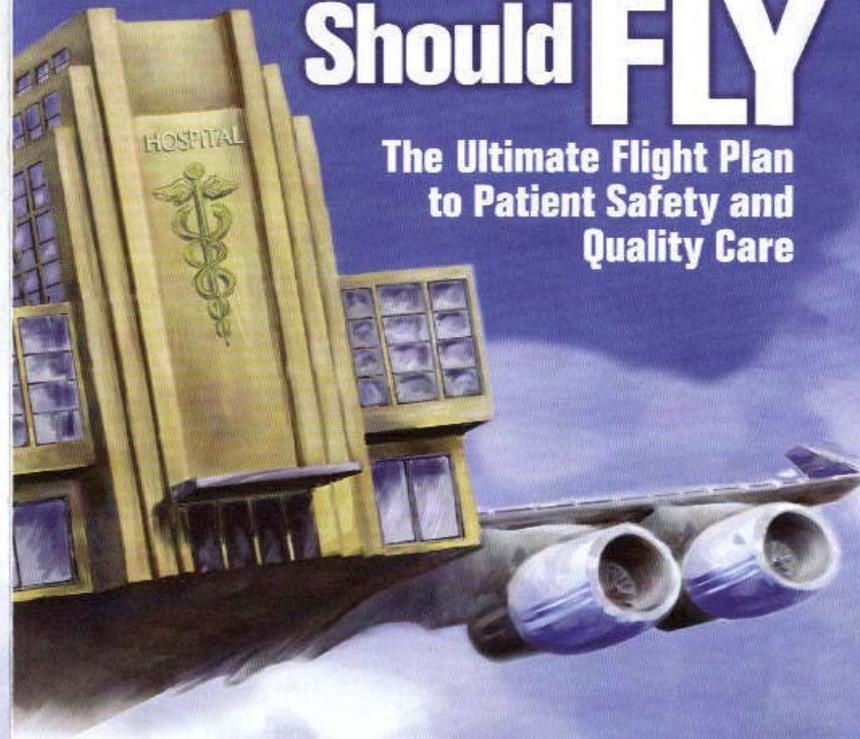


Wolters Kluwer
Health

Lippincott
Williams & Wilkins

Why Hospitals Should **FLY**

The Ultimate Flight Plan
to Patient Safety and
Quality Care



Foreword by David B. Nash, MD, MBA
Introduction by Lucian L. Leape, MD

John J. Nance, JD





BRIGHAM AND WOMEN'S HOSPITAL
Harvard Medical School
Harvard Graduate School of Education



Fellowship in Medical Simulation

This 24 month, fully-funded fellowship in medical simulation and education that begins in July 2013 is based at the STRATUS Center for Medical Simulation at Brigham and Women's Hospital in Boston. STRATUS is a 7,000 sq. ft. multidisciplinary, state-of-the-art simulation center. Fellows will complete the Masters of Education Program at the Harvard Graduate School of Education, learn how to educate using a variety of simulation-based learning techniques and complete two research projects with a mentor.

Components of Simulation at STRATUS:

- High-Fidelity Human Patient Simulation
- Microsimulation
- Simulation Research
- Virtual Reality
- Human Factors
- Psychometrics
- Part-Task Simulation
- Other Innovative Applications

Applicant Qualifications:

- Graduation from an AAMC accredited (or equivalent) medical school.
- Graduation from or successful completion of the second year of an approved ACGME residency program.
- Successful completion of USMLE parts 1, 2 and 3.
- A strong interest in the application of simulation technology and research in medical education

Inquiries should be addressed to:

Charles Pozner, M.D.
Fellowship Director
Brigham and Women's Hospital
Neville House, Suite 120, 10 Vining Street,
Boston, MA 02115
cpozner@partners.org
www.STRATUS.Partners.org

BWH is an Equal
Opportunity /Affirmative
Action Employer



CHIEF RESIDENT IN QUALITY IMPROVEMENT AND PATIENT SAFETY

The Department of Medicine at the Syracuse VA Medical Center is seeking a full-time PGY-4 Internal Medicine chief resident in Quality Improvement and Patient Safety. This is an exciting academic opportunity for a motivated, responsible physician who would like to work in a dynamic and collegial atmosphere with our house staff and clinical staff on innovative process improvements throughout our facility. The successful applicant will be paid full time to work at the VA through our academic affiliate hospital, SUNY Upstate Medical University, at the PGY-4 level beginning July 1, 2013.

Qualified applicants must be board eligible or board certified in Internal Medicine, and must have a full and unrestricted license in a State.

Responsibilities will include medical inpatient care, systems redesign activities, teaching, and active participation and leadership in quality improvement efforts aimed at improving patient safety and quality in our facility. There will also be an opportunity to be involved in committee and leadership activities, as well as for research. 100% of our Medicine teams are covered with resident house staff, and we have a robust fellowship program through our affiliate. The successful applicant will be required to have an academic appointment with the Department of Medicine at the SUNY Upstate Medical University. US citizenship or permanent resident alien status required.

Interested candidates should E-mail a cover letter and current curriculum vitae to

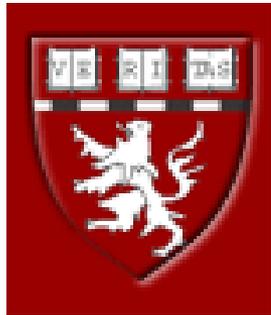
Joan M. Mitchell MD @ Joan.Mitchell@va.gov

Mail address is:

**VA Medical Center
800 Irving Avenue
Syracuse, NY 13210
Phone (315) 425-4662**

Information on Upstate New York VISN 2 VA Healthcare Network can be found at www.syracuse.va.gov.
Position is subject to random drug testing.

Equal Opportunity Employer



Harvard Medical School

Fellowship in Patient Safety and Quality

By Darrell G. Kirch and Philip G. Boysen

DOI: 10.1377/blthaff.2010.0776
 HEALTH AFFAIRS 29,
 NO. 9 (2010): 1600-1604
 ©2010 Project HOPE—
 The People-to-People Health
 Foundation, Inc.

Changing The Culture In Medical Education To Teach Patient Safety

Darrell G. Kirch (dgkirch@aacn.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

View with Alarm



MILLENNIALS:

A PORTRAIT OF

GENERATION

N E X T

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.**

PHOTOGRAPH BY BRAND NEW IMAGES

TRUST FALL 2010

15

HealthLeaders

WWW.HEALTHLEADERSMEDIA.COM

JULY 2009 \$8.00



Prepare for the
Cancer Boom p 33

Reform and the
Bottom Line p 38

Employees as
Cost-Cutters p 43

TIME FOR 'DR. NEXT'?

What kind of healthcare can we
expect from life-balancing, tech-
oriented, younger doctors? p 14



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

Development and evaluation of a 3-day patient safety curriculum to advance knowledge, self-efficacy and system thinking among medical students

Hanan J Aboumatar,^{1,2} David Thompson,^{2,3} Albert Wu,^{4,5} Patty Dawson,⁶ Jorie Colbert,⁷ Jill Marsteller,^{2,4} Paula Kent,^{2,8} Lisa H Lubowski,^{2,3} Lori Paine,^{2,8} Peter Pronovost^{2,3,4}

► An additional appendix is published online only. To view this file please visit the journal online (<http://qualitysafety.bmj.com/content/early/2012.01.15>).

For numbered affiliations see end of article.

Correspondence to

Dr Hanan J Aboumatar, Assistant Professor, Department of Medicine, Division of Internal Medicine, Johns Hopkins School of Medicine, Education & Research Associate, Center for Innovations in Quality Patient Care, Johns Hopkins Medicine, 601 North Caroline Street, Suite 2080, Baltimore, MD 21287-0765, USA; habouma1@jhmi.edu

Other disclosures: The lead author of this paper 'had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis'. This manuscript is not under consideration at any other journal. All those who qualify to be authors of this work are listed above and meet criteria for authorship. The authors take responsibility for and agree with the data presented and report no conflict of interest. No similar manuscript based on this study has been submitted or published.

Accepted 25 January 2012

ABSTRACT

Purpose: To develop a patient safety curriculum and evaluate its impact on medical students' safety knowledge, self-efficacy and system thinking.

Methods: This study reports on curriculum development and evaluation of a 3-day, clinically oriented patient safety intercession that was implemented at the Johns Hopkins School of Medicine in January 2011. Using simulation, skills demonstrations, small group exercises and case studies, this intercession focuses on improving students' teamwork and communication skills and system-based thinking while teaching on the causes of preventable harm and evidence-based strategies for harm prevention. One hundred and twenty students participated in this intercession as part of their required second year curriculum. A pre-post assessment of students' safety knowledge, self-efficacy in safety skills and system-based thinking was conducted. Student satisfaction data were also collected.

Results: Students' safety knowledge scores significantly improved (mean +19% points; 95% CI 17.0 to 21.6; $p < 0.01$). Composite system thinking scores increased from a mean pre-intercession score of 60.1 to a post-intercession score of 67.6 ($p < 0.01$). Students had statistically significant increases in self-efficacy for all taught communication and safety skills. Participant satisfaction with the intercession was high.

Conclusions: The patient safety intercession resulted in increased knowledge, system-based thinking, and self-efficacy scores among students. Similar intercessions can be implemented at medical, nursing, pharmacy and other allied health schools separately or jointly as part of required school curricula. Further study of the long-term impact of such education on knowledge, skills, attitudes and behaviours of students is warranted.

Far too many patients suffer preventable harm from medical errors, adding needless patient suffering and healthcare costs.¹ An estimated 2.9–16.6% of hospitalised patients are subject to at least one adverse event and half of those are judged to be preventable.^{2–5} Though the number of preventable deaths is uncertain, approximately 100 000 people die each year in the USA from healthcare-associated infection,⁶ another 100 000 from venous thromboembolism,^{7 8} and between 40 000 and 80 000 from diagnostic errors,⁹ making medical error one of the leading causes of death. Despite efforts to remedy this problem over the last decade, there has been limited progress in reducing preventable harm.¹⁰

A major contributor to preventable harm is the lack of training for clinicians in the science of patient safety. The science of safety includes identifying and mitigating hazards, improving teamwork and communication (T&C), and ensuring patients receive recommended practices. The science of safety is based on human factors and systems engineering, sociology, psychology and health services research, disciplines often absent from the faculties of American medical colleges. The Institute of Medicine has called for education reform of health professions to advance healthcare safety and quality.¹¹ The Liaison Committee on Medical Education has required medical schools to provide 'specific instruction' in communication skills including 'communication with patients, families, colleagues, and other health professionals'. The Association of American Medical Colleges has incorporated

Development and Assessment of Quality Improvement Education For Medical Students at The Ohio State University Medical Center

Iahn Gonsenhauser, Eliza Beal, Fadi Shihadeh, Hagop S. Mekhjian, Susan D. Moffatt-Bruce

Abstract: This study tested the feasibility of a quality improvement (QI) program that provided first and second year medical students with education in QI processes and demonstrate their utility within the framework of a real-world QI project. Medical students assessed the use of the Surgical Safety Checklist at The Ohio State University Medical Center. Before performing audits students were required to complete a self-paced online program that provided preliminary education in QI, patient safety, leadership, teamwork, and patient-centered care. A 2.5-hr orientation introduced basic operating room protocol, and the surgical checklist audit tool. Orientation included a multimedia simulation of checklist usage and a role-playing exercise simulating its use. Students completed pre- and postparticipation assessments. Results included an increased knowledge of QI methodology, an improved understanding of the evidence supporting the need for QI projects within health systems, and a greater awareness of available QI projects. Students' perspectives changed to indicate an increased belief that QI is the responsibility of all health professionals including physicians, administrators and other staff. This study concluded that QI education can be effectively disseminated to medical students early in their education using existing online tools and experiential QI projects, and can result in actionable QI data supporting hospital improvement initiatives.

Keywords
 medical education
 patient safety
 quality of care
 surgery checklist

The Institute of Medicine's (IOM) 2001 report, *Crossing the Quality Chasm*, suggests that a wide variety of skills are required by health professionals to meet the healthcare aims for the 21st century (Institute of Medicine, 2001). These aims, as outlined by the IOM are: healthcare that is safe, effective, timely, equitable, efficient, and patient-centered. One necessary skill is to, "identify errors and hazards in care; understand and implement basic safety design principles such as standardization and simplification" (Institute of Medicine, 2000). Following this initial report, the 2001 Association of American Medical Colleges (AAMC) report: *Contemporary Issues in Medicine* was fully devoted to "Quality of Care" (AAMC, 2001) and further outlined the need for QI focused curricula and research.

Although the IOM described the need for increased education in the areas of quality improvement (QI) and patient safety a decade ago, many health professional faculty and students agree that this need is not currently being met (Norcini & Banda, 2011; Tsai, Bohnen, & Hafiz, 2010).

Medical education is now experiencing one of the most prolific periods of change in the past century (Berwick & Finkelstein, 2010; Gonsenhauser, George, & Whitehouse, 2007; Irby, Cooke, & O'Brien, 2010). To, "redesign the way health professionals are trained to emphasize the aims for improvement . . . including teaching evidence-based practice and using multidisciplinary approaches" it is necessary to develop novel learning opportunities. Many institutions are currently experimenting with new approaches to deliver integrated educational experiences that incorporate the delivery of QI knowledge through both traditional study and real-world projects (Greg, et al., 2003; Wong, Etchells, Kuper, Levinson, & Shojania, 2010). In fact most large health-systems and hospitals in the United States engage in QI programs that can serve as platforms for QI education. Current literature suggests that many of the program elements needed to create QI education are already in place within colleges of medicine and nursing, but require integration to form cohesive curricula (Greg et al., 2003).

If experience-based QI education is to continue development it is necessary to assess the efficacy with which these programs deliver proficiency to students and their utility in delivering meaningful QI projects to the health systems that host them. In fact, for medical education as a whole to evolve appropriately, an active effort to incorporate research and evidence-based programming is increasingly important (Norcini & Banda, 2011). Herein we describe our recent success with piloting an integrated QI curriculum delivered through a student-driven QI experience designed to monitor the use of the Surgical Safety Checklist

Journal for Healthcare Quality
 Vol. 34, No. 6, pp. 36-42
 © 2012 National Association for
 Healthcare Quality

The authors declare no conflict of interests.

 My Filters 

Faculty

Resources

Discussions

Professional
DevelopmentGraduate Medical
Education (GME)
Interest GroupIHI Open School
Alumni NetworkIHI Open School de
Latinamerica y el
Caribe Subscribe

You are here: [Home](#) > [IHI Offerings](#) > [IHI Open School](#) > [Chapters & Communities](#) > [Chapter Groups](#) > [Faculty](#) > [Graduate Medical Education Interest Group](#)



Graduate Medical Education Interest Group

Graduate Medical Education (GME) Interest Group Mission: Enable a Graduate Medical Education community to collaborate through the IHI Open School in order to share concepts, ideas, projects, and resources related to Quality Improvement education and program development. Develop a framework to further share this collective knowledge, so as to continually support improvement work among all of GME.

Who should join the Graduate Medical Education Interest Network?

Are you interested in teaching QI to residents? Are you a resident interested in learning QI? Are you involved in GME administration and working on developing your Quality infrastructure?

Join the Graduate Medical Education Interest Network for collaboration, information and opportunities for involvement on a national level!

To join or for more information - E-mail openschool@ihi.org



Tools and Resources

Click [here](#) for faculty-submitted resources and more information on:

- Curricular models for QI and Patient Safet
- Evaluation tools for QI assessment of learners
- Forms and documents – useful for educational programs

Please consider if you have any programs or resources that would be helpful to share among the GME interest group – if so, please E-mail openschool@ihi.org



Join the group



www.npsf.org



National Patient Safety Foundation®

Advancing patient safety knowledge, practice, and community

Join a growing number of health care organizations in the new

Patient Safety Immersion Initiative

This innovative program, designed by NPSF to drive sharing of patient safety knowledge and sustainability of practical application, bundles together the foundational NPSF online patient safety curriculum, society membership, and new patient safety credentialing.

Online Patient Safety Curriculum

Self-Paced, Affordable – with audio lectures, presentations, videos

This 10-module, online course provides the context, key principles, and competencies associated with the discipline of patient safety, and how these tenets and skills are applied in everyday practice. Accredited for 10 CME hours and 10–12 CE hours (pharmacy, ACHE, nursing, risk management, and quality management).*

American Society of Professionals in Patient Safety at NPSF

ASPPS is the first and only multidisciplinary, individual membership society with patient safety as its organizing principle. It was established to advance patient safety as a distinct and vital health care discipline and to build an engaged community dedicated to the delivery of safe patient care. Demonstrate your commitment to patient safety. Join ASPPS today. Two-year discounted membership now available.

Certification Board for Professionals in Patient Safety

The CPPS credential establishes the standard for patient safety competency and distinguishes health care professionals who meet knowledge requirements in safety science, human factors engineering, and the practice of safe care. The evidence-based exam is intended for all health care professionals, recognizing that patient safety knowledge is crucial across the care continuum and the multiprofessional team.

*For more information on CME and CE, please visit www.npsf.org/curriculum

Find out more. Contact David Coletta, SVP Strategic Alliances, at dcoletta@npsf.org or 617.391.9908

APM Perspectives

The Association of Professors of Medicine (APM) is the national organization of departments of internal medicine at the US medical schools and numerous affiliated teaching hospitals as represented by chairs and appointed leaders. As the official sponsor of The American Journal of Medicine, the association invites authors to publish commentaries on issues concerning academic internal medicine.

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 Annetiese M. Schleyer, MD,^a Diane P. Martin, PhD,^b Wendy Levinson, MD,^c William J. Bremner, MD, PhD^a

^aDepartment of Medicine, ^bDepartment of Health Services, University of Washington, Seattle; ^cDepartment 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

Funding:

None.
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

■ **Scam Alert**
Outsmart the
Travel Thieves PAGE 28

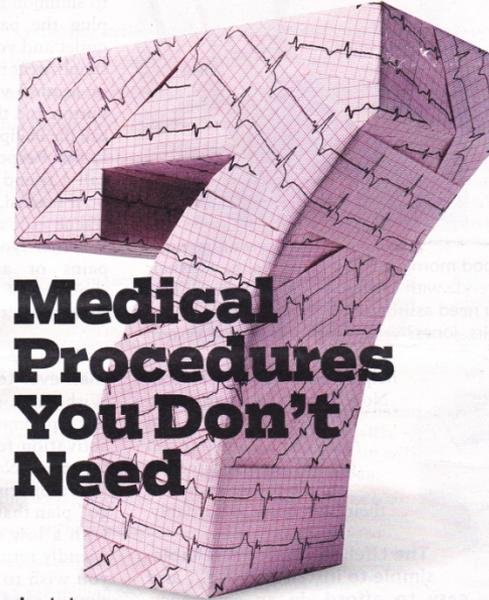
■ **Outrage**
\$5,800 Fine for
Planting Flowers PAGE 6

■ **Hi, Neighbor!**
Friendly New Place
To Live PAGE 16

AARP Bulletin

YOUR HEALTH • YOUR MONEY • YOUR WORLD aarp.org/bulletin

MAY 2012 Vol. 53 No. 5



Medical Procedures You Don't Need

Doctors Point to **Overused Tests** and Treatments PAGE 10

#BXBDMMK *****CR LOT 0105D**C-009
#313644182/5/A OH FEB2017 15/271/0486
DAVID B NASH
4071 OAK LN
LAFAYETTE HILL PA 19444-2612



Money & Love

How to Leave Both to Your Kids PAGE 26

■ **Smart Living**
Fun on a Fixed Income PAGE 20

■ **Hired!**
Older Workers Snag New Jobs PAGE 4

■ **Tipping Point**
Why 50+ Voters Have the Power PAGE 42

Kathleen Turner
Being a Mom And Letting Go PAGE 38



AARP Bulletin Special Report: News From Your State PAGE 12



BASEBALL PREVIEW

Two pages on the 2012 season. **SPORTS**



MR. NICE GUY

A daily good deed. **STYLE & SOUL**

Philadelphia Inquirer

philly.com

Wednesday, April 4, 2012 ★ Philadelphia Media Network ★ \$1

123rd Year, No. 309 • City & Suburban Edition

\$1.25 in some locations outside the metro area

Medical groups raise cry against unneeded tests

By Tom Avril
INQUIRER STAFF WRITER

The patient suffers from headaches and wants to undergo the dull roar of an MRI machine to make sure everything is all right. Good idea?

Probably not.

How about the drip-drip of chemo for the cancer patient who is near death? A CT scan for someone who has fainted but shows no neurological symptoms? Or an annual electrocardiogram for a person with low risk of heart disease?

No, no and no.

These are among dozens of recommendations that nine medical societies are announcing Wednesday, in an effort led by the ABIM Foundation, an affiliate of the American Board of Internal Medicine, based in Philadelphia.

Nine medical societies will announce lists of tests that may not be worth the cost.

With governments and insurers bemoaning the soaring costs of health care, the medical profession is increasingly offering its own solutions. The new campaign, dubbed Choosing Wisely, is not the first such effort but is among the most comprehensive.

Now comes the tricky part: getting patients and doctors to go along with it.

Various estimates have pegged spending on unnecessary tests at \$200 billion to \$250 billion each year in the United States, a phenomenon blamed on such factors as overcautious doctors who seek to avoid malpractice claims and patients who don't realize how much their treatments cost.

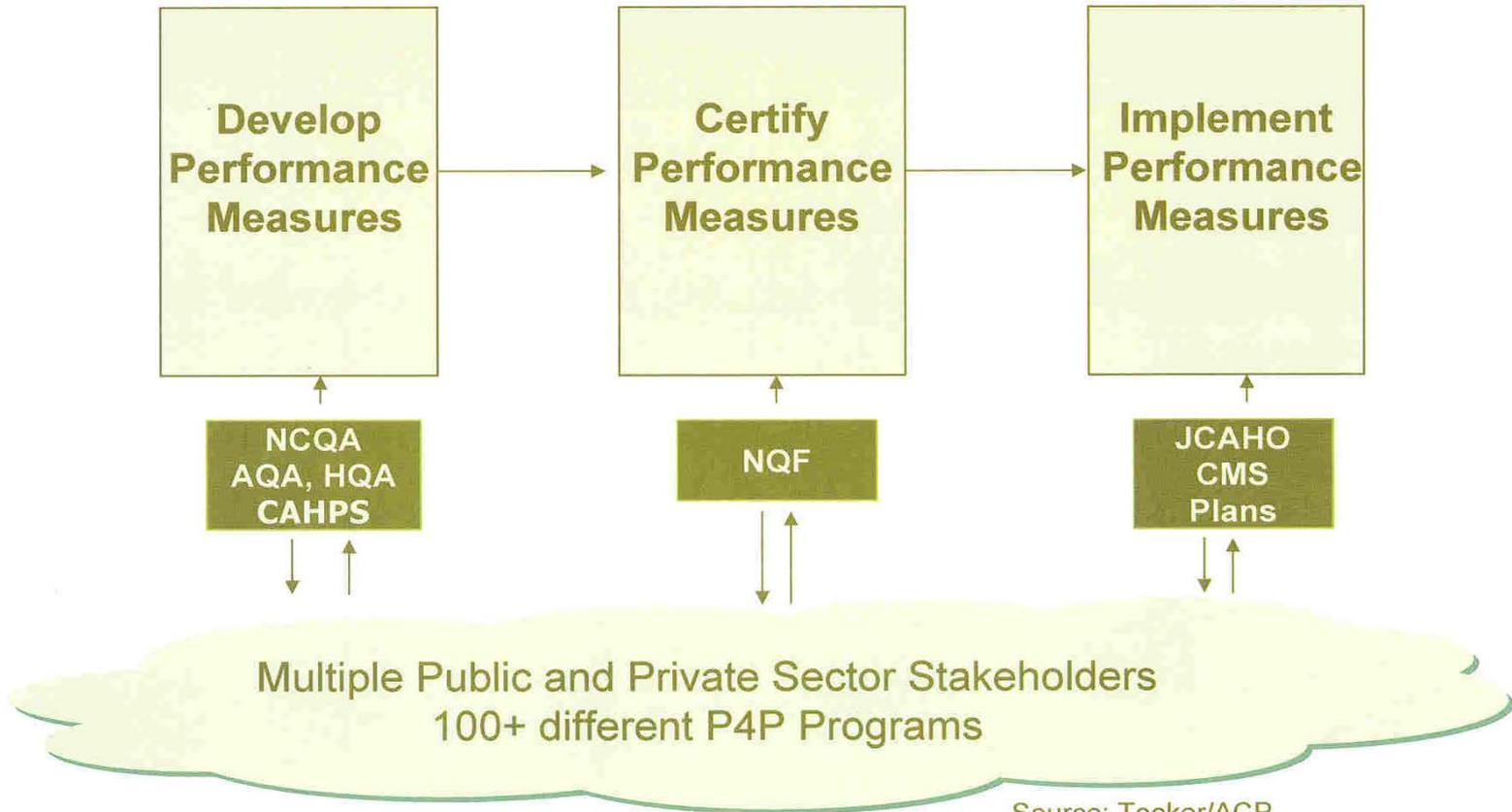
Organizers of Choosing Wisely say See **TESTS** on A13

Medical Staff Structure

- Anachronism
- Slavish adherence to consensus
- Incentives under prospective payment

A need for unified governance

No American Quality Improvement Community



Source: Tooker/ACP

Edited by
John Spandorfer
Charles A. Pohl
Susan L. Rattner
Thomas J. Nasca



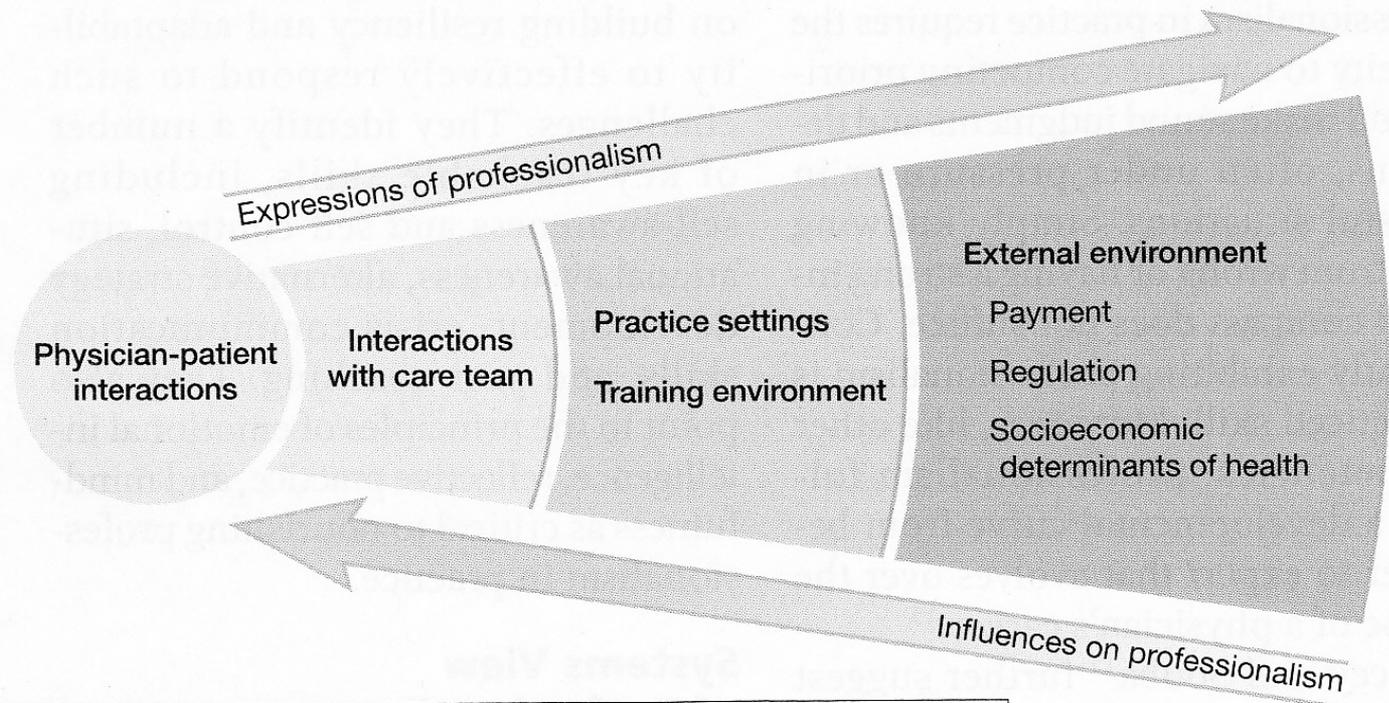
Professionalism in Medicine

A Case-Based Guide for Medical Students

CAMBRIDGE

Medicine

Figure. Systems View of Professionalism



Strategies to strengthen professionalism

- Develop individual competencies
- Promote physician leadership and supportive organizational culture
- Encourage physician advocacy and engagement in system reform



Medical Education

Palm Beach Medical Education Corporation seeks to lead the dynamic convergence of medicine, technology and education through an innovative and integrated approach. Uniting the best practices of all three industries will establish a 21st century model for communication, collaboration and knowledge creation. Leveraging medical education that is dramatically enhanced through technology and innovation, will result in new pinnacle of quality education, a higher quality, lower cost healthcare system and an enhanced economic vitality for our community.



Main Menu

- [Home](#)
- [High-Tech Model](#)
- [Investing](#)
- [Medical Education](#)
- [Faculty Practice Plan](#)
- [Clinical Research](#)
- [Technology Solutions](#)
- [Real Estate](#)
- [Leadership](#)
- [Contact Us](#)

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.

Join our Mailing List

[Click Here](#)

End with Hope





10th Annual Interclerkship Day

IMPROVING PATIENT SAFETY



Monday, January 7, 2013

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



Sponsored by:

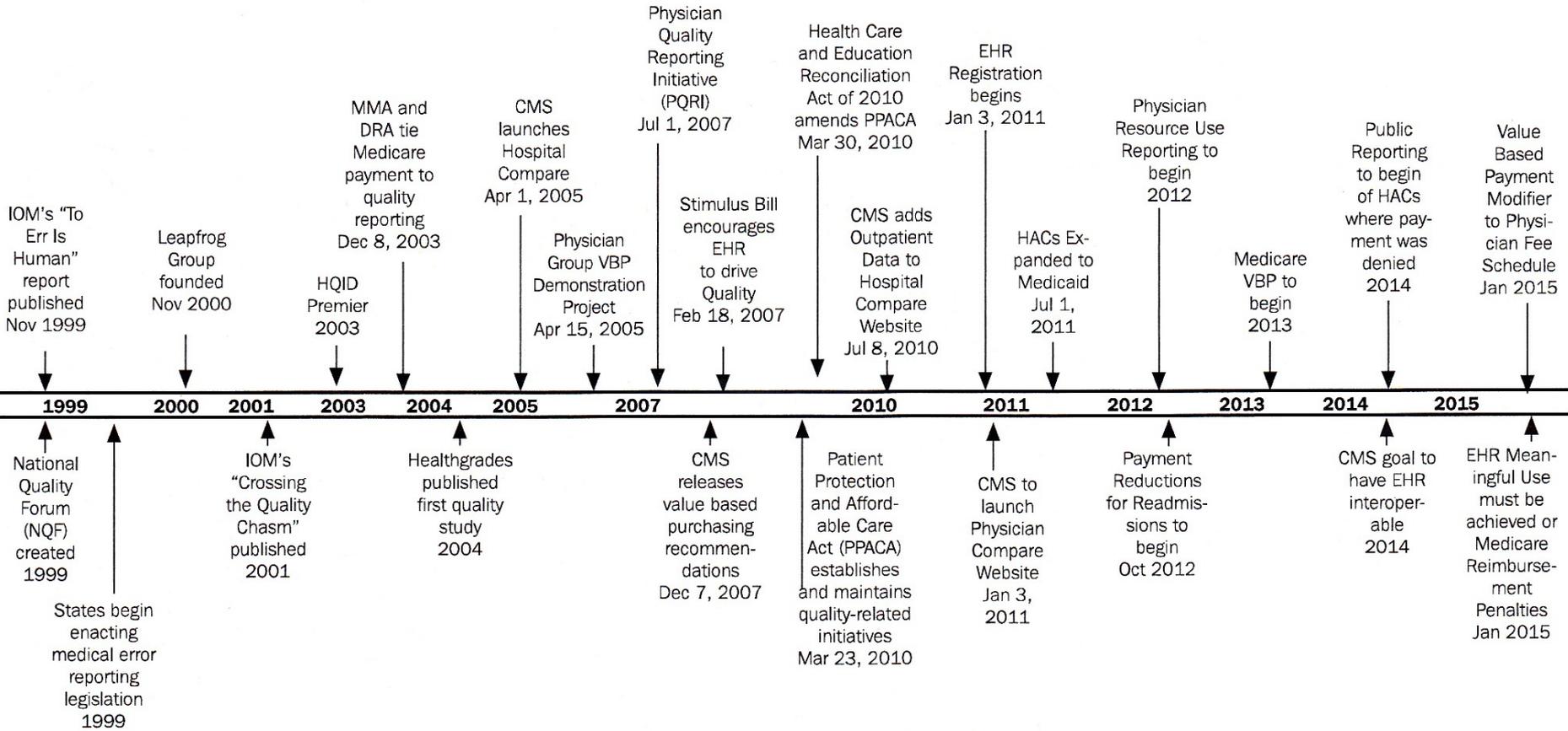
Jefferson School of Population Health
and Office of the Dean, Jefferson Medical College

THOMAS JEFFERSON UNIVERSITY

JG 13-0960 MC 12-05061

Payment Reform: The Evolution of Incentives for Quality, Efficiency

Chicago attorneys Joseph Van Leer and Janice Anderson presented this timeline depicting the slow shift of Medicare away from being a passive payer for services to become a more active payer for patient outcomes and satisfaction. Contact Van Leer at vanleer@polsinelli.com and Anderson at janderson@polsinelli.com.



CMS = Centers for Medicare & Medicaid Services; DRA = Deficit Reduction Act; IOM = Institute of Medicine; MMA = Medicare Prescription Drug, Improvement and Modernization Act; QI = Quality Improvement;

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

MANY 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.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

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.

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

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 hemor-

rhage, 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).

©2009 American Medical Association. All rights reserved.

(Reprinted) JAMA, September 23/30, 2009—Vol 302, No. 12 1277

Downloaded from www.jama.com at Thomas Jefferson University on October 15, 2010

Science-Based Training in Patient Safety and Quality

Peter J. Pronovost, MD, PhD, and Myron L. Weisfeldt, MD

The American public has benefited tremendously from its investments in biomedical research. The increase in life expectancy is a testament to this benefit (1). Patients with AIDS grow old; most children with cancer survive; patients undergoing dialysis receive kidney transplants; patients with orthopedic conditions have hip replacement and can play tennis again; patients with lung cancer receive chemotherapy targeted to their unique genes; and patients with heart failure live longer, more active lives with carefully titrated drug therapies.

Consider the Marfan syndrome. This genetic disease dilates the aorta until it ruptures. Twenty years ago, we lacked methods to diagnose and treat this condition, and patients uniformly died before their 30th birthday, often leaving a young family behind. Now, we can diagnose and treat this syndrome. Patients are screened for the disease, imaging studies allow physicians to monitor the size of the aorta, new drugs slow aortic dilatation, and once-fatal aortic replacement surgery is now successfully performed (2, 3).

Another example is chronic myelogenous leukemia. Ten years ago, this diagnosis was a death sentence—now, it is a chronic disease controlled by popping a pill.

These advances were not accidental. They happened because the U.S. government invested wisely in training researchers and funding specific research projects. Both types of investments are essential. In the early 1990s, the United States realized that basic researchers produced various promising therapies that were not being studied in patients because there were few skilled researchers to rigorously conduct the clinical research.

Congress responded by providing funding to the National Institutes of Health to train physicians to be clinician-researchers (4). Numerous programs emerged, providing physicians with doctoral and master's level training in clinical investigation. Skilled researchers now test promising new therapies, helping patients live longer, healthier lives.

Nonetheless, the full benefits of these investments in training and research often fail to reach patients (1, 5). Hundreds of thousands of patients die needlessly every year: 100 000 from health care-acquired infections; 100 000 from blood clots; approximately 100 000 from diagnostic errors; and scores of thousands from teamwork errors, pressure sores, and omission of recommended therapies (6–8). In addition to the toll on human life, these errors are expensive. Approximately one third of all health care spending, \$900 billion annually, is needlessly spent on these complications and other inefficient practices (9).

The reason for this tale of 2 American health care systems—one that leads the world in discoveries and the other that often harms rather than heals—is complex and may stem from many factors, such as a patient's access to care, financial incentives, or even competing recommendations to improve care. Here, we discuss the failure of health care to invest in the science of patient safety and quality improvement as a substantial factor in allowing patient harm.

A minimal investment has trained a small number of clinician-researchers in the science of improving patient safety. This limited funding, which trained young faculty largely through K awards from the Agency for Healthcare Research and Quality, has been substantially reduced. Yet, these young researchers offer hope by enhancing health care value, reducing preventable harm, reducing health care costs, improving patient-reported outcomes, and ensuring that patients receive the best possible health care for the public's investments in them.

We have seen what is possible when wise investments are made in patient safety research and researchers. One success story in health care's struggle to decrease preventable patient harm is the reduction of central line-associated bloodstream infections in intensive care units (10–14). These infections kill nearly as many people as breast cancer each year in the United States (6). A safety program was associated with substantially reducing these infections in Michigan, in children's hospitals, and now across the United States, saving tens of thousands of lives and hundreds of millions of dollars (12, 15–17). It is no accident that the lead investigators and most of the research team conducting these efforts were formally trained through research fellowships. Because research fellowships in patient safety did not exist, these researchers trained in clinical research programs, piecing together a study, hoping to obtain the skills to improve patient safety and quality of care.

The limited progress in reducing preventable harm during the past decade was, to a large extent, because the science underlying this field was dynamic, was evolving, and had little funding. However, the field too often sought quick fixes rather than a deeper understanding of whether an intervention worked and why, undertaking less robust evaluations, failing to partner with social scientists, and downplaying or being incognizant of the need for formal degree programs in patient safety research. For example, sentinel events recur despite investigations; yet, human factors engineers are rarely involved in these investigations (18). Moreover, many state that the data obtained from these investigations are for quality improvement, not research, and thus ignore basic clinical research methods for

APM Perspectives

The Association of Professors of Medicine (APM) is the national organization of departments of internal medicine at the US medical schools and numerous affiliated teaching hospitals as represented by chairs and appointed leaders. As the official sponsor of The American Journal of Medicine, the association invites authors to publish commentaries on issues concerning academic internal medicine.

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 Annetiese M. Schleyer, MD,^a Diane P. Martin, PhD,^b Wendy Levinson, MD,^c William J. Bremner, MD, PhD^a

^aDepartment of Medicine, ^bDepartment of Health Services, University of Washington, Seattle; ^cDepartment 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

Funding: None.

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

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 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

ACGME October 31, 2011

Context, culture and (non-verbal) communication affect handover quality

Correspondence to
Dr Richard M Frankel,
Center for Implementing
Evidence Based Practice,
Richard L. Roudebush
Veterans Affairs Medical
Center, Indianapolis, IN,
USA;
rfrankel@iupui.edu

Richard M Frankel,^{1,2} Mindy Flanagan,³ Patricia Ebright,⁴ Alicia Bergman,¹
Colleen M O'Brien,⁵ Zamal Franks,¹ Andrew Allen,¹ Angela Harris,¹
Jason J Saleem¹



Figure 1 Joint focus.

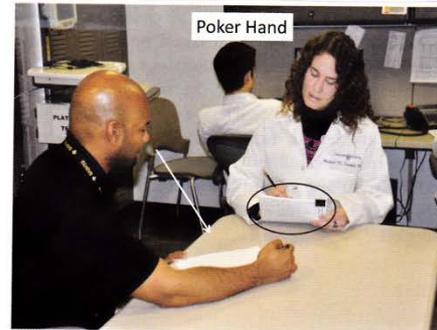


Figure 2 Poker hand.

i124

BMJ Qual Saf 2012;21:i121-i127. doi:10.1136/bmjqs-2012-001482



Figure 3 Parallel play.

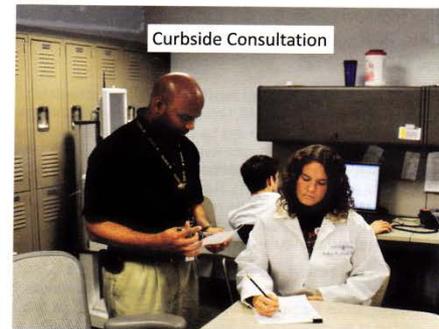


Figure 4 Kerbside consultation.

BMJ Qual Saf 2012;21:i121-i127. doi:10.1136/bmjqs-2012-001482

i125

Teaching for Quality

**Integrating Quality Improvement and Patient Safety
across the Continuum of Medical Education**

Executive Summary of an Expert Panel Report

Learn

Serve

Lead

Association of
American Medical Colleges

By Linda Ann Headrick, Amy J. Barton, Greg Ogrinc, Carly Strang, Hanan J. Aboumatar, Myra A. Aud, Paul Haidet, Deborah Lindell, Wendy S. Madigosky, and Jan E. Patterson

Results Of An Effort To Integrate Quality And Safety Into Medical And Nursing School Curricula And Foster Joint Learning

ABSTRACT Improvements in health care are slow, in part because doctors and nurses lack skills in quality improvement, patient safety, and interprofessional teamwork. This article reports on the Retooling for Quality and Safety initiative of the Josiah Macy Jr. Foundation and the Institute for Healthcare Improvement, which sought to integrate improvement and patient safety into medical and nursing school curricula. In one academic year, 2009–10, the initiative supported new learning activities (87 percent of which were interprofessional, involving both medical and nursing students) in classrooms, simulation centers, and clinical care settings that involved 1,374 student encounters at six universities. The work generated insights—described in this article—into which learning goals require interprofessional education; how to create clinically based improvement learning for all students; and how to demonstrate the effects on students' behavior, organizational practice, and benefits to patients. A commonly encountered limiting factor for the programs was the lack of a critical mass of clinically based faculty members who were ready to teach about the improvement of care. What's more, the paucity of robust evaluation strategies for such programs suggests a future research agenda that deserves to be funded.

Among the many reports released by the Institute of Medicine on improving the quality, safety, and value of US health care, two in particular stand out. In 2001 *Crossing the Quality Chasm* recommended fundamental changes in the health care system to create care that is safe, effective, timely, efficient, equitable, and patient centered.¹ In 2003 *Health Professions Education: A Bridge to Quality* recommended that "all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics."²

However, progress toward these bold visions

in the clinical setting has been slow, in part because nurses and doctors lack critical skills. To be sure, organizations dealing with health professions education have taken some crucial steps.

In medical education, the Accreditation Council for Graduate Medical Education requires all residency programs to demonstrate that their graduates are competent in systems-based practice and practice-based learning and improvement.³ The Medical School Objectives Project of the Association of American Medical Colleges recommended that medical students gain the ability to critically evaluate the knowledge base supporting good patient care; demonstrate an understanding of the gap between prevailing

DOI: 10.1377/hlthaff.2011.0121
HEALTH AFFAIRS 31,
NO. 12 (2012): 2669–2690
©2012 Project: HOPE—
The People-to-People Health
Foundation, Inc.

Linda Ann Headrick (lheadrick@health.missouri.edu) is senior associate dean for education and a professor of medicine at the University of Missouri School of Medicine in Columbia.

Amy J. Barton is an associate dean for clinical and community affairs at the University of Colorado College of Nursing, in Aurora.

Greg Ogrinc is an associate professor of community and family medicine and of medicine at the Geisel School of Medicine at Dartmouth, in Hanover, New Hampshire.

Carly Strang is director of operations at the Institute for Healthcare Improvement Open School for Health Professions, in Cambridge, Massachusetts.

Hanan J. Aboumatar is an assistant professor of medicine at the Johns Hopkins University School of Medicine, in Baltimore, Maryland.

Myra A. Aud is an associate professor at the University of Missouri Sinclair School of Nursing, in Columbia.

Paul Haidet is a professor of medicine, humanities, and public health sciences at the Pennsylvania State University College of Medicine, in Hershey.

Deborah Lindell is an assistant professor at the Frances Payne Bolton School of Nursing at Case Western Reserve University, in Cleveland, Ohio.

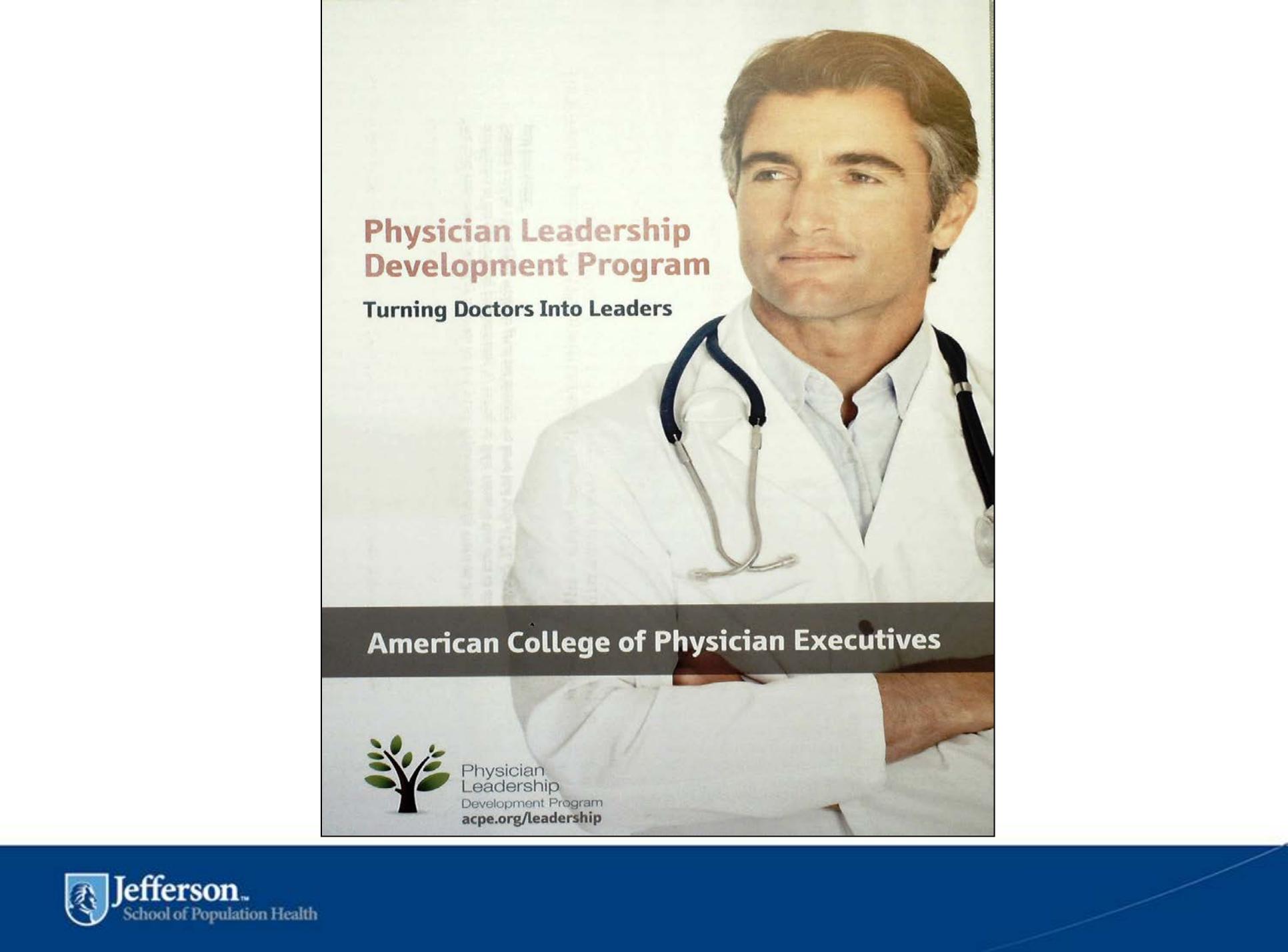


DOCTORS

must have a seat at the **leadership table**



American College of Physician Executives **acpe** Inspiring physician leaders — Improving health



Physician Leadership Development Program

Turning Doctors Into Leaders

American College of Physician Executives



Physician
Leadership
Development Program
acpe.org/leadership

Perspective: **A Framework for Career Paths in Health Systems Improvement**

D. Clay Ackerly, MD, MSc, Ami Parekh, MD, JD, and Daniel Stein, MD

Abstract

The difference between the U.S. health care system's potential and the outcomes it delivers is vast and well documented. Fortunately, many medical trainees recognize this challenge and aspire to careers that will enable them to help close this gap by improving the systems of care around them. However, the career paths in health systems improvement are not well defined, and interested trainees are frequently left without clear direction. The circuitous and often serendipitous routes that many current leaders in health systems improvement—including

medical researchers, health system managers, and policy experts—have navigated to reach their positions of influence do not provide consistent road maps for the trainees who wish to follow in their footsteps.

The authors of this Perspective propose a framework to guide career development in health systems improvement. The framework is designed to help medical trainees and their mentors critically analyze various career options in three core focus areas (research, policy, management) and the intersections

where those areas overlap (policy advising, implementation science, policy translation). The authors provide examples of the types of work done in each focus area and each intersection to help trainees make explicit decisions concerning skill development and to select opportunities that best fit their interests and strengths. In all, the authors intend the framework to support the development of a generation of physician leaders equipped to drive the improvement that the U.S. health care system requires.

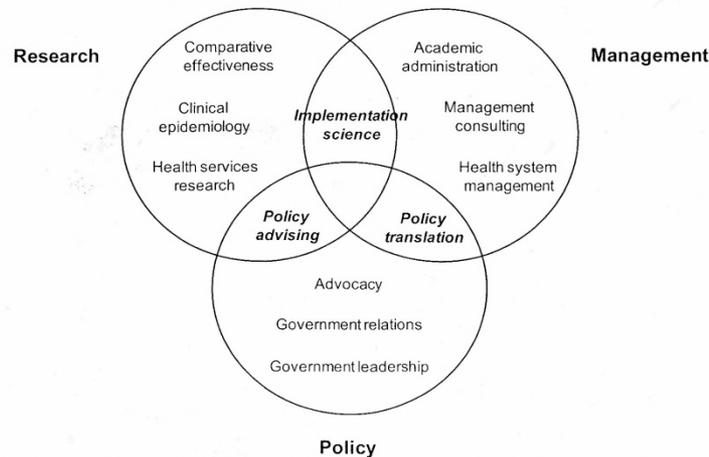


Figure 1 The health systems improvement career framework. This framework includes three core focus areas—research, policy, and management—and the three intersections where the core areas overlap—policy advising, implementation science, and policy translation. Examples of career types are provided for each core focus area.

Process Improvement, Quality, Safety and Efficiency

Process Improvement, Quality, Safety and Efficiency supports the *Strategic Initiatives* of Superior Patient Experience, Research and Financial Performance.

INDIVIDUAL CONTRIBUTOR	MANAGER	LEADER OF MANAGERS	ORGANIZATION LEADER
<p>Improving Process Improvement, Quality, Safety and Efficiency</p> <p>Demonstrates dedication to continually improving quality, safety and efficiency in order to enhance the patient experience and deliver superior service to all customers. Knows that safety is a priority in all areas of MLH.</p> <ul style="list-style-type: none"> • Speaks up for safety • Asks questions to confirm the accuracy of own and others' actions • Finds safety hazards and fixes them before they become problems • Regularly looks for and recommends incremental work process improvements that will enhance quality, safety and/or efficiency • Finds ways to eliminate activities that add no value • Volunteers to work on process improvement projects, even when not directly related to one's job • Understands how to contribute to a safe environment even if not active in direct patient care • Thinks before one acts, especially in high risk situations 	<p>Managing Process Improvement, Quality, Safety and Efficiency</p> <p>Analyzes and designs or improves organizational processes. Uses quality, safety and efficiency data to generate process improvement ideas and to enhance the patient experience and deliver superior service to all customers.</p> <ul style="list-style-type: none"> • Supports people who speak up for safety • Encourages reporting of safety events; eliminates fear of punishment for admitting an error • Handles safety violations by following the Performance Management Decision Guide • Identifies and uses quality, safety and efficiency trends to spot needs for process improvement • Takes the lead on process improvement projects, even when these are not in one's area or not confined to one's area • Shares information about process improvements that may benefit other parts of the organization • Sees and follows through on quality or safety issues or inefficiencies that need to be addressed 	<p>Sustaining a Culture of Process Improvement, Quality, Safety and Efficiency</p> <p>Sets clear goals to improve quality, safety and efficiency in all areas across the system, including clinical practices and business processes. Measures process improvement outcomes.</p> <ul style="list-style-type: none"> • Assists and supports efforts to analyze and design/redesign organizational processes. • Implements measurement and auditing systems to track the impact of process improvements on quality, safety and efficiency • Conducts surveillance to find and fix problems • Challenges direct and indirect reports to generate and implement novel and valuable ideas for new or improved processes • Rewards initiative and innovation in quality, safety and/or efficiency • Starts all meetings with a quality, safety or efficiency topic or story • "Rounds to influence"—that is, influences staff to use safety tools and behaviors in one's area of responsibility 	<p>Creating a Culture of Process Improvement, Quality, Safety and Efficiency</p> <p>Makes safety a core value, finds and fixes problems, and builds and sustains accountability for quality, safety and efficiency. Embeds process improvement—as the driver of quality, safety and efficiency—into the MLH culture. Ensures the sustainability of high-quality and safe clinical and non-clinical environments. Is an advocate for safety in all areas of MLH.</p> <ul style="list-style-type: none"> • Continually challenges the organization to find and fix problems • Continually challenges the organization to implement process improvements that will positively impact quality, safety and efficiency • Embeds process improvement into the culture by modeling behaviors and practices aimed at enhancing the patient experience and delivering superior service to all customers • Has a system-wide awareness of operational issues that impact the reliability of safety, quality and efficiency • Sets expectations for quality, safety and efficiency in every area of the organization, both clinical and non-clinical

Continued on next page >

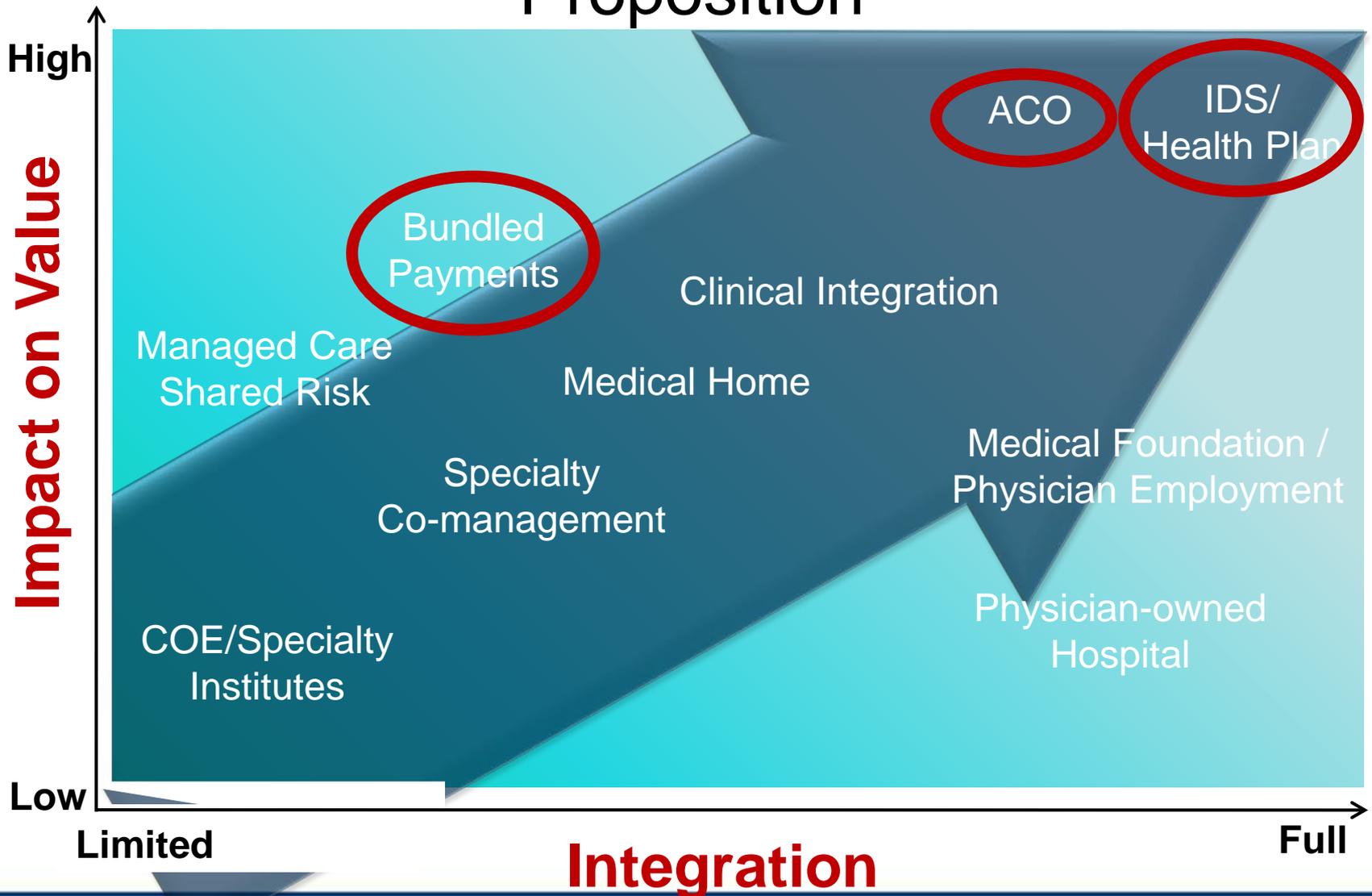
Process Improvement, Quality, Safety and Efficiency *(continued)*

Process Improvement, Quality, Safety and Efficiency supports the *Strategic Initiatives* of Superior Patient Experience, Research and Financial Performance.

INDIVIDUAL CONTRIBUTOR	MANAGER	LEADER OF MANAGERS	ORGANIZATION LEADER
<ul style="list-style-type: none"> • Takes the time to give complete information, ensuring understanding and ownership when handing off a patient, a task or materials • Complies with all safety procedures, rules and regulations 	<ul style="list-style-type: none"> • Models the right behaviors, establishing priorities in line with quality, safety and efficiency • Handles safety violations in a timely fashion and by following the Performance Management Decision Guide • Anticipates potential safety problems or obstacles and develops contingency plans to overcome them • Coaches others on safety and environmental issues and helps them to take appropriate safety precautions • Shares information about tools and programs for enhancing quality, safety and efficiency that may not be known around the system 	<ul style="list-style-type: none"> • Asks open-ended questions to get people thinking about quality, safety and efficiency in their work; for example, "How do you know you have no problems?" "How do you know that the tasks you are doing add value?" • Regularly communicates safety and environmental awareness as a priority • Gathers, analyzes and uses data to continually enhance the patient experience and to improve the quality and efficiency of services provided to all customers 	<ul style="list-style-type: none"> • Defines, in clear practical and behavioral terms, expectations for quality, safety and efficiency • Creates system-wide campaigns to promote process improvement quality, safety and efficiency • Advocates for patient, employee and visitor safety in all areas of the organization • Highlights examples of process improvements that have enhanced quality, safety, and/or efficiency, publicly recognizing individuals and teams who have contributed



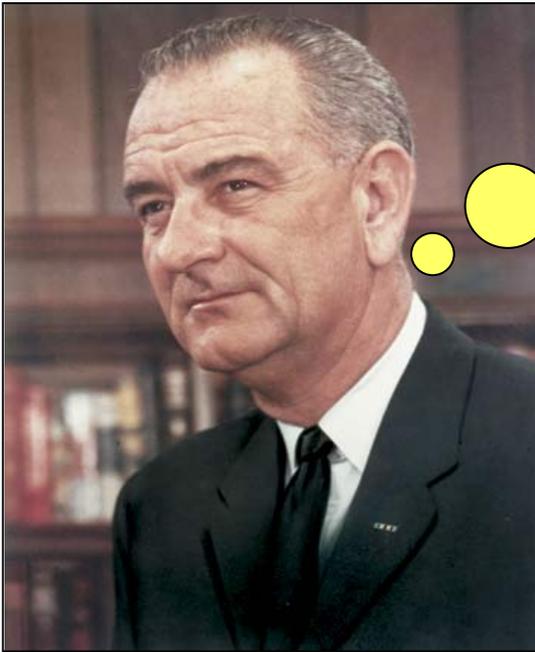
Physician-Hospital Integration: Driving the Value Proposition



Sacred Cows Make the Best Hamburgers



**"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