A Quiz

• I am comfortable going to any healthcare provider or hospital anywhere in the country.

• I am comfortable going to any healthcare provider or hospital in my city/town.

• I am comfortable going to my hospital or any healthcare provider in my institution.
QUESTION: Should you consider yourself a high quality physician if you train in a health care system that is not systematically trying to improve the value of care it provides?

– Larry Casalino

Yes  

No  

What?!
**The “Good Doctor”**

**Past**
- Encyclopedic Knowledge
- Independent
- Always Available
- Master of Rescue Care

**Present**
- Solid Fund of Knowledge
- Gatherer of Information
- Team Player
- Embrace Quality, Safety, & Public Reporting
- Evidence-based
- Patient-centered

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How Do We Get There? What Do We Value & Teach?

- Commitments to recognize and address anomalies in professional behavior
- Continual pursuit of safety in healthcare
- Awareness of economics, healthcare costs, and social stewardship
- Continual reduction in waste
- Honesty, openness, transparency and disclosure
- Teamwork & accountability across disciplinary lines
- Patient-centeredness in all things

Berwick and Finkelstein, Acad Med, 2010
Quality & Patient Safety

Graduate Medical Education

Finally Coming Together
Jennifer S. Myers MD
December 5, 2014
Timeline for Quality and Safety Education

1999 - 2001
ACGME introduces a competency framework for residency training; understanding systems are now part of the required curriculum.

2003
IOM Reports

2010
ACGME introduces New Duty Hour Requirements with more quality and safety training expectations.

2011
IOM commissions a report on GME and safety.

2013
ACGME Next Accreditation System

2014
IOM Report on GME Funding
A Call to Action

Percent of Residency Programs Teaching the Following Topics; National Sample

- Patient Safety
- Quality Improvement
- Inpatient Handoffs
- Discharge Transitions
- High Value Cost Conscious Care

Bar chart showing the percentage of residency programs teaching these topics from 2012 to 2014.
Penn is Not That Much Better!

![Bar chart showing improvement trends across various categories including Patient Safety, Quality Improvement, Inpatient Handoffs, Discharge Transitions, and High Value Cost Conscious Care from QSEA 2012, QSEA 2013, QSEA 2014, and Penn Fall 2013.](image-url)
Barriers:

• Hidden Curriculum
• Lack of faculty expertise & buy-in
• Time
• Change
• “QI” can be seen as a bad word

Incentives:

• Public opinion
• External Regulations
• GME funding
• OUR PATIENTS
“...graduate medical education must include training and active participation in quality and safety initiatives by every resident physician”.

Dr. Tom Nasca; JAMA

ACGME has the aspirational goal of demonstrating to the public that America’s teaching hospitals and institutions are safe and of high quality.
The Next GME Accreditation System — Rationale and Benefits

Thomas J. Nasca, M.D., M.A.C.P., Ingrid Philibert, Ph.D., M.B.A., Timothy Brigham, Ph.D., M.Div., and Timothy C. Flynn, M.D.

MILESTONES:
Demonstrate Competency in Quality & Safety

Clinical Learning Environment Review Program:
Engage Residents & Faculty in Institutional Quality & Safety Efforts
Milestones for Quality & Safety

Patient Care

- Ready for unsupervised practice
  - Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion
  - Performs accurate physical exams that are targeted to the patient’s complaints
  - Synthesizes data to generate a

PBLI (QI)

- Ready for unsupervised practice
  - Analyzes own clinical performance data and actively works to improve performance
  - Actively engages in quality improvement initiatives

SBP (Safety)

- Ready for unsupervised practice
  - Identifies systemic causes of medical error and navigates them to provide safe patient care
  - Advocates for safe patient care and optimal patient care systems
  - Activates formal system

“Ready for Unsupervised Practice”

- Reflects upon and learns from own critical incidents that may lead to medical error
Clinical Learning Environment Review Program (CLER)

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

Key Questions:
- How engaged are the residents and fellows?
- How integrated is the GME leadership and faculty in the hospital/medical center efforts across the six focus areas?
University of Pennsylvania Health System

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

Acknowledgements:
PJ Brennan MD; CMO
Jeffrey Berns MD; DIO
Pat Sullivan PhD; VP QI/PS
Neha Patel; MD MS
Lisa Bellini MD; Vice-Dean Faculty Affairs
Penn’s Blueprint for Quality & Patient Safety (2009)

### Imperatives

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<tr>
<th>Imperative</th>
<th>Priority Actions</th>
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<tr>
<td><strong>Accountability For Perfect Care</strong></td>
<td>- “Always” events - strive to provide perfect care</td>
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<td>- Implement clear lines of accountability that span inpatient and ambulatory environments</td>
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<td><strong>Patient And Family Centered Care</strong></td>
<td>- Provide consistent and thorough communication regarding plan of care</td>
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<td>- Increase patient and family involvement in UPHS forums and integrate patient feedback into clinical and service improvement efforts</td>
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<td><strong>Transitions In Care/Coordination Of Care</strong></td>
<td>- Redesign clinical processes to ensure that patients and their information are safely transitioned from one setting of care to another</td>
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<td><strong>Reducing Unnecessary Variations In Care</strong></td>
<td>- Eliminate variations in care processes where evidence exists</td>
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<td>- Balance conformity in practice with needs for personalized care</td>
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<td>- Improve the value of our health care processes and outcomes</td>
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<td><strong>Provider Engagement, Leadership, And Advocacy</strong></td>
<td>- Strengthen organizational capacity and capability for continuous improvement</td>
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<td>- Increase involvement of housestaff in quality, safety and service excellence efforts</td>
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Penn Medicine will eliminate preventable deaths and preventable 30-day readmissions by July 1, 2014

Increase involvement of house staff in quality, safety and service excellence efforts
The Beginning of Our Story

Identifying & Engaging the Residents and Fellows Who Wanted to be Leaders and Change Agents for Healthcare Improvement

Rogers, Diffusion of Innovation Curve
Healthcare Leadership in Quality Track

- UBCL physician leaders
- Process improvement specialist
- Quality/safety leaders
- QI research mentors

- QI Operation Project
- QI Research Project
- 2 years timeline
- Abstract (minimum requirement)

- UBCL teams (Ambulatory, CICU, CCU, MICU, Founders 12/14, Oncology)
- IT (mobile health, clinical decision support)

Established in 2009-2010

Housestaff & Advanced Practitioner
Quality Council

A forum for QI “problem-solving” with residents from diverse departments

Connect health system quality priorities with resident/AP ideas & leadership

Annual QI Project

Established 2011 at UPHS
The Middle of our Story: Reaching the Majority

Rogers, Diffusion of Innovation Curve
What Do The Residents Think?

**TIME**
- Limited time in day for “non clinical” tasks
- Competing learning priorities
- Limited protected time for QI

**CULTURE**
- Apathy / learned helplessness / lack of confidence in ability to affect change
- Little or no role modeling by attending or upper year residents
- Fear of repercussions / punitive nature of reporting

**EDUCATION/AWARENESS**
- Lack of Formal Curriculum
- Lack of awareness of “back end” of QI/PS processes

**STRUCTURE**
- Transient nature of residency: residents float from floor to floor; hospital to hospital
- Large, difficult system to change

**Lack of Resident Engagement in Quality & Safety Activities**

Created by Penn Healthcare Leadership in Quality Track Residents (n=24); August 2013
Conceptual Framework for Resident Engagement in Quality & Safety

- Culture
- Health System-GME Alignment
- Educational Resources
- Faculty Development
- Inter-Professional Collaboration
- Infrastructure

Resident & Fellow Engagement in Quality & Safety

A Tess & JS Myers
Shared Responsibility:
*New Relationships, Roles, and Work*

- Hospital Quality Office
- GME Office
- Core QI/PS Faculty
- Frontline Faculty & All Staff
- Curriculum development, Teaching, Mentorship

Daily supervision, role modeling, & practice enforces local quality/safety culture

Infrastructure, Shared Work Plan

Oversight Centralized resources

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# Penn’s GME Quality/Safety Efforts

## Culture
- Safety Reporting Campaign
- FOCLE “Walk Rounds”

## Educational Resources
- Quality & Safety Toolkit on GME website
- Video-based Orientation Module to Introduce Penn’s Culture of Quality & Safety

## Faculty Development
- Faculty Development – as much as humanly possible!

## Interprofessional Collaboration
- RN/NP involvement in HS Council
- Partnering with Nurses for svc orientation

## Infrastructure
- Associate DIO for QI/PS – new position
- Quality/Safety Educator(s) in each department
- Hstaff Quality/Safety Leadership Council
- Healthcare Leadership in Quality Track
- New relationships with Quality Data managers to make data more accessible to programs and trainees

## Health System – GME Alignment
- Associate DIO for QI/PS – sits in both worlds
- Shared QI-CLE “Dashboard” with Outcome measures to focus our work measure progress