

GUEST EDITORIAL

Educating Leaders in Healthcare Quality and Safety

There's good news and bad news in the world of healthcare quality. First, the good news: educating future leaders in healthcare quality and safety (HQS) is now widely accepted and highly recommended. The not-so-good news is that there is no commonly accepted approach as to *how* this should be done.

Initial efforts in HQS education stressed *knowledge transfer*, a "read the book and take the test" method best exemplified by The National Patient Safety Foundation, the American Board of Medical Quality and the National Association for Healthcare Quality. In this approach, the learner is awarded a certificate of completion or a "quality/safety certificate" upon successfully completing a multiple choice test. The goal is to provide the learner with basic knowledge in medical quality management¹ or to "promote excellence and professionalism by documenting individual performance as measured against a predetermined level of knowledge about quality."² While the knowledge transfer approach was the first to attempt to fill the large void in quality and safety education, it did so at a time when the field was still in its infancy; content areas and competencies continue to vary from test to test. There is also growing recognition that knowledge transfer is not sufficient to produce real change in the delivery of quality and safety; an experiential or applied component is also needed.^{3,4}

In time, knowledge transfer methods were supplemented by accredited continuing education (CME, CNE) and professional development programs such as seminars, workshops and weeklong learning environments. These efforts presented informational content and some, depending on the provider, also offered limited

opportunities for application and practice in real-world settings. Finally, institutions such as Northwestern University (2007), Thomas Jefferson University's School of Population Health (2009) and George Washington University (2013) moved beyond non-credit offerings and developed comprehensive academic programs that culminated in a post-baccalaureate certificate or master's degree in healthcare quality and safety. The content of these academic programs, however, varies from school to school, as does the instructional balance between knowledge and application and the qualifications of the faculty or instructors who do the teaching. Recognizing these differences, the AAMC (Association of American Medical Colleges) is convening a meeting of experts in quality and safety education to develop a comprehensive outline for an HQS curriculum.⁵

At this point in the evolution of HQS education, three crucial questions need to be answered: *What* content should be included in the curriculum? *How* should the learning experience be structured? *Who* should comprise the faculty?

To answer these questions, the *learner* — the future healthcare leader — needs to be at the center of the discussion. Because experience in health care is essential for creating necessary culture change, future leaders must come from the healthcare system. This means that HQS students will be seasoned medical or health professionals (most JSPH HQS students, for example, are in their late 30s and early 40s) and that the learning environment must be grounded in adult education principles and based on active learning. The curriculum must provide a practical, "nuts and bolts" approach that includes all parts of the healthcare system

that intersect quality and safety; and it must assure a strong understanding of the facets of these intersections. Finally, faculty must be practitioners. They must have experiential, hands-on knowledge of what they are teaching; knowledge without practice is not sufficient.

The JSPH MS-HQS curriculum builds on a solid foundation of health care knowledge. It provides healthcare professionals an in-depth understanding of the US healthcare system and its regulatory and accreditation components. It reinforces this knowledge with the study of health law and health economics as realized by all stakeholders. It introduces health informatics, not simply as a bookkeeping tool, but as an integral part of the quality and safety system. Principles of population health pervade the entire curriculum. Quality and safety competencies and skills build upon this foundation and include organizational behavior and change management, data collection and analysis, quality tools, methods and advanced applications culminating in a work-based capstone project. JSPH faculty are recruited from the professional "working" world of HQS and thus provide an organic and holistic understanding of the basic principles being taught.

The JSPH approach to adult learning is active and case based. This method places the student "in the role of the decision maker as they read through various situations and identify the problems they are faced with and examine the causes and consider alternative courses of actions to come to a set of recommendations."⁶ As adult learners become active participants in their educational experience, they obtain skills and competencies that allow them to analyze and design quality environments.

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More importantly, they are prepared to lead healthcare quality and safety initiatives across a healthcare spectrum that, because of its multiple clinical and non-clinical disciplines, is unyieldingly complex in its interactions.

In responding to the growing need for education in healthcare quality and safety, the Jefferson School of Population Health has opted for a curriculum that stresses healthcare foundations, practical tools and

methods, informatics and organizational change — all taught by experienced practitioners utilizing best practices of active learning for an adult population. Going forward, there is need for a uniform or consensus-driven curriculum in HQS that recognizes the adult learner, stresses core competencies, and includes both didactic and experiential components. The unanswered questions are how to achieve this consensus and who should lead it... to be continued.

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