

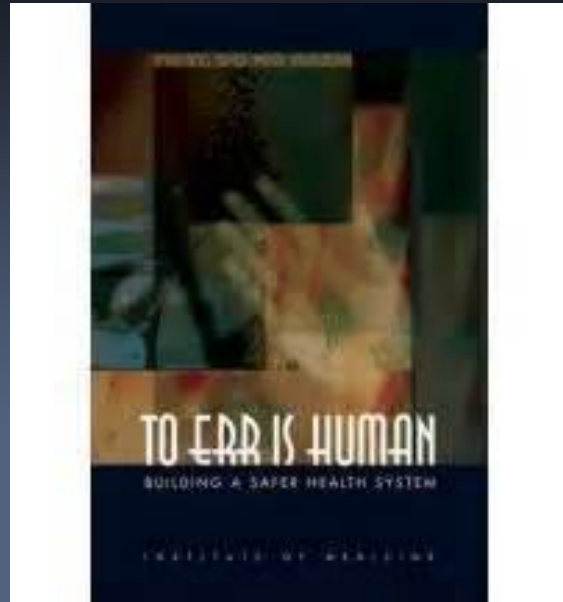
# **Incorporating Quality Improvement into Fellowship Training: Training Directors Symposium III**

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# Objectives

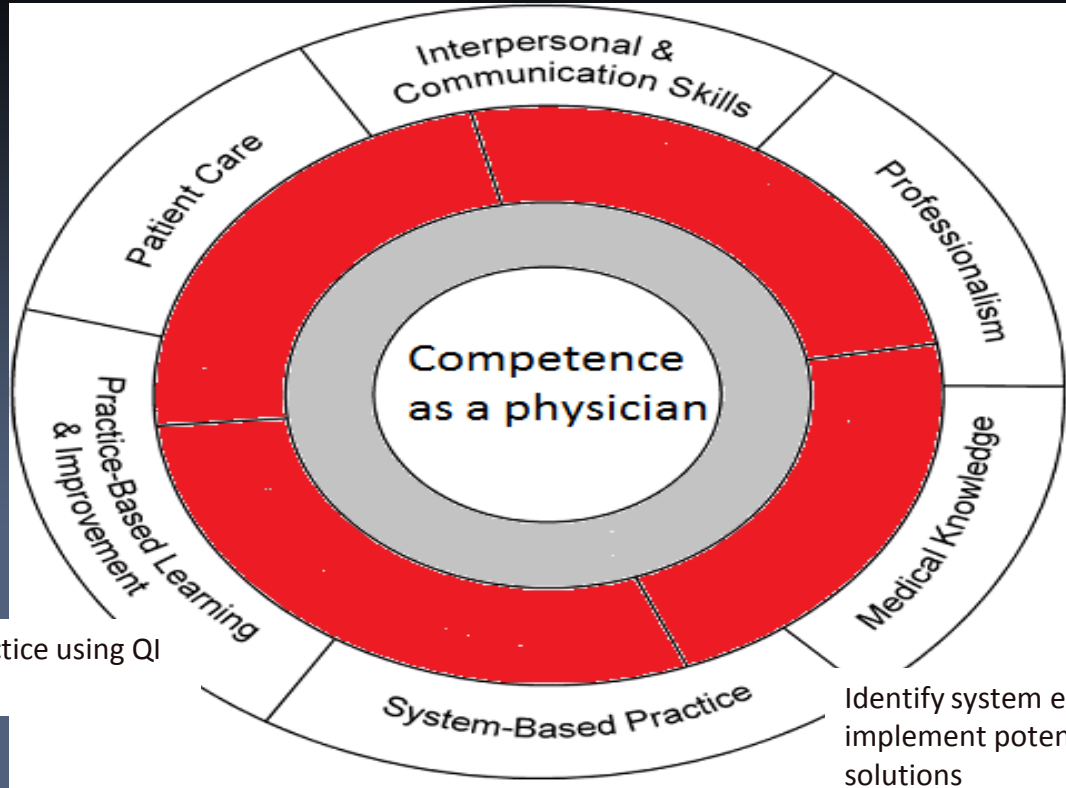
- To understand the role of Patient Safety/Quality Improvement (PSQI) in Fellowship Training
- To identify best practices as related to PSQI
- To identify key resources for PSQI

# Patient Safety/Quality Improvement



- >1 million preventable adverse events occur in the US each year
- 44,000-98,000 deaths from preventable errors
- \$17-\$29 billion per year
- Equivalent of 3 jumbo jet crashes every two days
- Set forth national agenda for change

# ACGME Core Competencies



Analyze practice using QI methods

Identify system errors/  
implement potential systems  
solutions

# Milestones

10. Recognizes system error and advocates for system improvement. (SBP2)					
Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	<p> Ignores a risk for error within the system that may affect the care of a patient</p> <p> Ignores feedback and is unwilling to change behavior in order to reduce the risk for error</p>	<p> Does not recognize the potential for system error</p> <p> Makes decisions that could lead to errors that are otherwise corrected by the system or supervision</p> <p> Resistant to feedback about decisions that may lead to error or otherwise cause harm</p>	<p> Recognizes the potential for error within the system</p> <p> Identifies obvious or critical causes of error and notifies supervisor accordingly</p> <p> Recognizes the potential risk for error in the immediate system and takes necessary steps to mitigate that risk</p> <p> Willing to receive feedback about decisions that may lead to error or otherwise cause harm</p>	<p> Identifies systemic causes of medical error and navigates them to provide safe patient care</p> <p> Advocates for safe patient care and optimal patient care systems</p> <p> Activates formal system resources to investigate and mitigate real or potential medical error</p> <p> Reflects upon and learns from own critical incidents that may lead to medical error</p>	<p> Advocates for system leadership to formally engage in quality assurance and quality improvement activities</p> <p> Viewed as a leader in identifying and advocating for the prevention of medical error</p> <p> Teaches others regarding the importance of recognizing and mitigating system error</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

# Clinical Learning Environment Review

- Assesses sponsoring institutions in the following six areas
  - Patient Safety
  - Quality Improvement
  - Transitions in Care
  - Supervision
  - Duty Hours Oversight, Fatigue Management and Mitigation
  - Professionalism

# Clinical Learning Environment Review

## Patient Safety

- Opportunities for residents:
  - To report errors, unsafe conditions and near misses
  - To participate in inter-professional teams to promote and enhance safe care

## Quality Improvement

- Engage residents in the use of data:
  - To improve systems of care
  - To reduce health care disparities
  - To improve patient outcomes

# Program Directors' Poll

- What opportunities do you have for fellows to participate in QI?
- How do you track their participation?
- Do you have a faculty members with expertise in QI?
- What do you think your program does well?
- What could your program do better?
- How would you rate your fellows QI experience during their training (poor, adequate, very good, excellent)
- Any other comments?



# Program Directors' Poll

- 10/18 responded
- Do you have a faculty members with expertise in QI?
  - Yes - 5 ; 2 of these are Cardiologists
  - No -4
  - “Somewhat” -1
- How would you rate your fellows QI experience during their training (poor, adequate, very good, excellent)
  - Adequate -8
  - Good -2

# NYU Langone Medical Center

- #1 in PSQI amongst academic medical centers past two years
- Opportunities
  - NYU Patient Safety Day
    - Presentation of any posters/projects that result from PSQI projects
  - Monthly Patient Safety Rounds
  - Weekly Patient Satisfaction Rounds
  - Chief of Quality at NYU - Cardiology Attending
  - Quality Champion for the Cardiology Division
  - Fellows work closely with Champion and Chief of Clinical Cardiology

# What do you do well?

- Finding projects for all the fellows/Assigning fellows to committees
- Very well-organized quarterly Cardiology M and M
  - Focused specifically on quality
- Focus on QI division wide
- Formal QI training
- Third year fellows do an audit/QI project looking at their own evolution from first through third year in the cath lab
  - Ties in with personal clinical effectiveness review

# Tracking Progress - NYU

Fellow Quality Involvement								
Fellow	RCA	QIC	ORM	ER M&M	VA M&M	Medicine M&M	Q&S day poster	OR
<b>First Year</b>								
			2/19/2014					6/10/2014
			1/29/2014			2/7/2014		6/3/2014
								6/3/2014
			4/16/2014					6/3/2014
						5/2/2014		
						3/7/2014		
<b>Legend</b>								
RCA-Root Cause Analysis								
QIC-Quality Improvement Committee								
ORM-Occurrence Review Meeting								
Q&S-Quality and Safety								
OR-Occurrence Review								

How would you rate your fellows QI experience during their training ?

- Adequate

# Creating opportunities - Vanderbilt

## **Curriculum Evaluation for Rotation/Competency:** Practice Based Learning and Improvement

**Description:** Investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care

Objectives/Skills	Competency Addressed	Teaching Method	Assessment Method
Define a clinical problem, identify the stakeholders, and gather baseline data to assess the problem.	PBLI	QI project	Presentation of project and data
Design and implement a change to the current processes that addresses the problem and assess the change using data.	PBLI	QI project	Presentation of project and data
Interact effectively with other members of the health care team to improve patient care.	ICS	QI project	Presentation of project and data 360 degree evaluation
Understand and navigate the health care system in which you work most effectively to improve patient care.	SBP	QI project	Presentation of project and data

## Strengths

Fellows from different institutions have different ideas

Culture shift towards more open discussion  
Faculty participation in conference

## Weaknesses

No division patient safety officer

Lack of knowledge about PSQI

Conference tends to focus on medical decision making rather than system problems

# WUSM SWOT

## Opportunities

Career development for faculty in PSQI

Statistical and data support available

BJH/WashU Safety and Quality Symposium

## Threats

Lack of interest in PSQI

Lack of time to complete project

"QI project du jour"- lots of work with no impact

# What about your program?



# Resources

- “Basics of Quality Improvement in Health Care”
  - Mayo Clin Proc. 2007;82(6):735-739
- ACC Program Directors’ Tool Kit
- ACGME Website
  - <http://www.acgme.org/acgmeweb/>
- Institutional Websites
  - <http://meded.dom.wustl.edu/psqi.html>

Washington University School of Medicine in St. Louis  
Faculty Practice Plan – Patient Safety

View: **Alphabetical**

Type	Name	ID	Modified	Modified By	Subject
	2001-A system of analyzing medical errors to improve GME programs	2991	6/30/2011 8:45 AM	Taylor, Mary	
	2005-A comprehensive collaborative patient safety training curriculum for residents to address ACGME CC	2992	6/30/2011 8:46 AM	Taylor, Mary	
	2005-PS Resident Training Curriculum-Core Comp	142	5/13/2009 5:24 PM	Soutsea, Kimberly	
	2006-GME and Patient Safety-Hazardous Crossroads	147	5/13/2009 5:24 PM	Soutsea, Kimberly	
	2007-Educational quality improvement report- outcomes from a revised morbidity and mortality format	149	5/13/2009 5:24 PM	Soutsea, Kimberly	
	2008-Involving Residents in Quality Improvement	2930	6/21/2011 10:36 AM	Taylor, Mary	
	2009-Relationship Between Performance in Major Teaching Hosp and Resident Knowledge of Quality and PS	1533	11/23/2009 7:55 AM	Taylor, Mary	
	2009-A case study of translating ACGME practice-based requirements-systems QI projects	1423	9/15/2009 1:38 PM	Taylor, Mary	
	2009-Creating Champions for Health Care Quality and Safety-Residents	1549	12/14/2009 12:21 PM	Taylor, Mary	
	2009-Integrating Quality Improvement and Residency Education	1582	12/14/2009 2:09 PM	Taylor, Mary	
	2009-Making Residents Visible in Quality Improvement	1583	12/14/2009 2:09 PM	Taylor, Mary	
	2009-Methodological Rigor of QI Curricula for Physician Trainees	1585	12/14/2009 2:09 PM	Taylor, Mary	
	2009-Residents Engagement in Quality Improvement	2993	3/7/2013 9:28 AM	Taylor, Mary	
	2009-Taking a Unified Approach to Teaching and Implementing QI Across Programs	1593	12/14/2009 2:12 PM	Taylor, Mary	
	2010-Changing The Culture in Medical Education to Teach Patient Safety	2262	9/13/2010 12:29 PM	Taylor, Mary	
	2010-Improving Resident Education and Patient safety--A Method to Balance Initial Caseloads at Academic Year-end Transfer	2292	9/13/2010 12:46 PM	Taylor, Mary	
	2011-A Patient Safety Curriculum for Medical Residents Based on the Perspectives of Residents and Supervisors	2939	6/21/2011 10:40 AM	Taylor, Mary	
	2011-Patient Safety Training Simulators Based on Competency Criteria of the ACGME	3314	11/16/2011 7:12 AM	Taylor, Mary	
	2011-Physicians-in-Training Attitudes on Patient Safety	3189	10/21/2011 8:42 AM	Taylor, Mary	
	2011-Residents' Reflections on Quality Improvement-Temporal Stability and Association with Preventability of Adverse Events	2854	5/17/2011 10:10 AM	Taylor, Mary	
	2011-Rethinking Resident Supervision to Improve Safety-From Hierarchical to Interprofessional Models	3258	10/21/2011 8:43 AM	Taylor, Mary	
	2011-Systems-Based Practice in Graduate Medical Education	2860	5/17/2011 10:11 AM	Taylor, Mary	
	2011-The Use of a Multidisciplinary Morbidity and Mortality Conference to Incorporate ACGME Competencies	2994	6/30/2011 8:47 AM	Taylor, Mary	
	2012-AAMC-EPBC-Quality and Safety Curriculum Across the Educational Continuum	3880	10/19/2012 12:19 PM	Taylor, Mary	
	2012-Changes in intern attitudes toward medical errors and disclosure	3649	11/21/2012 8:16 AM	Taylor, Mary	

# The Takeaway

- PSQI is an integral part of fellowship training
- Great opportunity to reflect on program
- SWOT Analysis
  - Next step is decision matrix
- Many opportunities
- Take it home!

