Incorporating Patient Safety & Quality Improvement into GME

Frederick M Schiavone MD FACEP
Professor of Emergency Medicine
DIO and Vice Dean for GME
Director of the Center for Clinical Simulation and Patient Safety
By the end of this session, the learner will be able to:

- Contribute to a needs assessment of institutional and program patient safety and quality improvement learning opportunities
- Identify resident learning venues and activities that should incorporate safety and quality data and personnel
- Discuss the impact of establishing a “patient safety resident” role in each program, including specific expectations and deliverables
No conflict to disclose
I am a volunteer CLER site visitor
Stony Brook University Hospital

CLER PS/QI Initiatives

Example: PSF without GME

Example: PSF with GME

Hospital PS/QI Initiatives

Stony Brook Medicine
How do we know what is expected of us?
CLER assesses each hospital in 6 areas

CLER Focus Areas

Patient Safety
Supervision
Professionalism
Transitions of Care
Duty Hours Fatigue Management
Healthcare Quality
Healthcare Disparities

...by visiting floors/units and asking similar questions of residents and fellows, faculty, program directors, C-suite
Who and what form the infrastructure?
Organizational structures/processes to support GME learning in PS?

How integrated is GME leadership and faculty current infrastructure?
Their role to support resident and fellow learning in PS?

How engaged are the residents and fellows in the infrastructure?
How involved are residents/fellows in using these structures and processes?
• What are the patient safety priorities of the institution(s)?
• Is the system retaliatory to “get back at” a coworker?
• Is the reporting system difficult to use?
• What SHOULD be reported?
• Do residents/fellows know mechanisms to use?
• Who should report?
• Do residents remember educational content?
• Do the residents understand their responsibility for event reporting and near misses?
  – Feedback mechanism/lessons learned for all
  – Is there teaching around near misses?
• Is there feedback to the reporter of an event?
• Are residents/fellows involved in RCA?
• How do they know/learn about RCAs? (what the acronym means?)
If you ask 30 residents if they have witnessed an adverse event or safety issue …

And if, of those 30, 12 say yes...

And if, of those 12, 5 will report it

And if, of those 5, only 1 will enter it into the reporting system him/herself… our system is broken.
• Are efforts underway for QI at your institution(s)?
• Are residents & faculty participating in QI?
• Is there a team approach to QI?
• Are residents involved in QI Committee work?
• Is QI routinely used by residents to resolve institutional/program/specialty issues?
• Are residents and faculty able to access their own clinical effectiveness data? (widespread challenge, according to ACGME Survey)
• Are institutional QI priorities identifiable?
• Do faculty and residents know how institution is assessed?
• Do they know whether the institution is successful?
• DISPARITIES

• How do you determine/study whether there are disparities in treatment/services/access/outcomes for vulnerable populations served in your specialty?

• What initiatives have you developed to address any disparities that you’ve identified?

• **Are residents aware of health care disparities in your community?**
• So what did we do to assess our current CLE?
• GOAL of the CLER program:
  “Create a new conversation around the concept of the CLE, important to lead by example.”

Get serious about changing patient safety and quality in our (teaching) health care systems
Assessment of our situation

- CLE Inventory (of programs)
- SWOT analysis (CLER)
- Inventory of safety and quality resident projects
- IHI Institutional Self-Assessment exercise with some residency groups and C-Suite. Compared their assessments to each other. Presented comparison “storyboard” at IHI meeting.
- Dashboard meetings with each program where we discuss six CLER areas with PD, RC and chief residents
- Some GME policies are outdated and need updating around CLER
- Came in all 3 days of Labor Day Weekend to observe handoffs in several specialties
- Met with Community Outreach hospital representative to determine that we do very little for disparate populations
- Met with Risk Management to determine whether our PSN (reporting system) was identifying residents as contributors of reports
## Example of possible template for categorizing CLER expectations

<table>
<thead>
<tr>
<th>Patient Safety</th>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident reporting of adverse events</td>
<td>We have an excellent PSN system</td>
<td>Residents know about the system. (told at orientation)</td>
<td>Utilization and number of PSN entered by residents</td>
<td>Feedback, impact and changes made based on resident input</td>
</tr>
<tr>
<td>Education on patient safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning environment culture of safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident experience with patient investigations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Focus Areas for the Clinical Learning Environment Review (CLER):
Institutional Review Program

Documentation in each of the 6 areas below is REQUIRED by the GMEC:

Program Name: [Redacted]
Program Director: [Redacted]
Program Coordinator: [Redacted]
Date returned to GMEC: [Redacted]

I. Patient Safety (GMEC Policies and Procedures Manual 2011-12, pg 75)

1. Does your Curriculum include a Patient Safety Curriculum? yes [ ] no [ ]

2. Do your residents/fellows participate in M&M Conferences? yes [ ] no [ ] n/a [ ]
   Frequency: weekly [ ] monthly [ ] quarterly [ ] other [ ]
   Does the M&M Conference include a root cause analysis? yes [ ] no [ ] n/a [ ]
   How is resident/fellow participation documented? [Redacted]

3. Do your residents/fellows participate in other review of medical decision making, patient outcomes and/or adverse events? yes [ ] no [ ] n/a [ ]
   If “yes”, give examples: [Redacted]

4. What opportunities do your residents/fellows participate in to promote and enhance safe care? (check those that apply)
   [ ] Emergency Room Callback Committee
   [ ] Radiation Oncology Quality Control Committee
   [ ] New Patient Conference/Chart Review/Rounds
   [ ] Tumor Board(s)
   [ ] Case Review
   [ ] Infection Control
   [ ] Radiation Safety
   [ ] Quality management
   [ ] Pharmacy Safety
   [ ] ICU Committee
   [ ] M&M
   [ ] Other: [Redacted]

   How is participation documented? n/a [ ]
   [ ] New Innovations
   [ ] the conference sign-in “green sheet”
   [ ] program generated attendance record

II. Quality Improvement (GMEC Policies and Procedures Manual 2011-12, pg 29, 30)

5. What opportunities do residents/fellows have to report errors, unsafe conditions and near misses?
   [ ] verbal and/or written report to program director, department chairman or faculty supervisor
   [ ] verbal and/or written report to regular department meeting
   [ ] report to hospital safety committee
   [ ] other: [Redacted]

II. Quality Improvement (GMEC Policies and Procedures Manual 2011-12, pg 29, 30)

1. Questions 2 & 3 in Part I above also answer Quality Improvement activity

2. Do your residents/fellows have opportunity to attend autopsies and/or review autopsy findings with the attending pathologist? yes [ ] no [ ] n/a [ ]

3. Identify the Multi-Disciplinary Conferences that your residents/fellows attend.
   a. [Redacted]
   b. [Redacted]
   c. [Redacted]
   d. [Redacted]
   e. other: [Redacted]

4. Identify all Department/Program Committees on which your residents/fellows serve.
   a. [Redacted]
   b. [Redacted]
   c. [Redacted]
   d. [Redacted]
   e. other: [Redacted]

5. Identify hospital committees on which your residents/fellows currently participate. (Check the appropriate boxes.)

   AGH Committees
   [ ] Graduate Medical Education Committee
   [ ] Critical Care Committee (ICU Directors)
   [ ] Pharmacy and Therapeutics Committee
   [ ] Information Resources (Library)
   [ ] Infection Prevention Committee
   [ ] Medical Ethics
   [ ] Nutritional Care
   [ ] Quality Management Committee
   [ ] Patient Safety
   [ ] Radiation Safety
   [ ] Medical Records
   [ ] Tissue Committee
   [ ] Institutional Review Board
   [ ] Other: [Redacted]

   GMEC Subcommittees
   [ ] Education & Evaluation
   [ ] Faculty Development
   [ ] Ombudsman
   [ ] Quality & Accreditation
   [ ] Scholarly Activity
• Conducted a self-assessment using Institute for Healthcare Improvement (IHI) areas for GME and CLER.
• C-Suite and residents asked to assess Stony Brook’s preparedness
• The results follow
• Where does your department see itself?
Graduate Medical Education Organizational Self-Assessment

The levels below are intended to provide a basic indication of the components of an effective Clinical Learning Environment at your Academic Medical Center. This information is confidential; the more honest the assessment, the more likely the initiatives selected will be aligned with current ability and probability of success.

### Quality Improvement – including how sponsoring institutions engage residents in the use of data to improve systems of care, reduce health care disparities and improve patient outcomes.

<table>
<thead>
<tr>
<th></th>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Few if any quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>improvement projects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>involving residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>are underway. Multidisciplinary teams that include residents are formed and actively engaged.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Residents: 1% 50% 36% 10% 0%
C-Suite: 25% 37% 13% 25% 0%
### Patient Safety

- including opportunities for residents to report errors, unsafe conditions, and near misses, and to participate in interprofessional teams to promote and enhance safe care.

<table>
<thead>
<tr>
<th></th>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff members, residents, faculty and fellows feel like event reports are held against them. There is no clear process or venue to address errors, unsafe conditions or near misses.</td>
<td>Patient safety issues are self-reported using an online system. Staff members, residents, faculty and fellows are not engaged in discussing reported events and the learning system to communicate patient safety issues is not reliable.</td>
<td>The organization has a non-punitive policy to address patient safety adverse events including medical staff members, residents, faculty fellows and organization employees. Safety events are discussed on an ongoing basis in an established forum.</td>
<td>Leadership encourages reporting of adverse events and near misses. Safety events are discussed on an ongoing basis in an established forum and learning from this forum is communicated within the units where the safety events occur. Multi-disciplinary teams, including residents, identify and test changes on an ongoing basis to prevent future patient safety events.</td>
<td>Leadership encourages and rewards recognition and reporting of adverse events and near misses. Safety events are discussed on an ongoing basis in an established forum and learning from this forum is communicated throughout the organization. Actions are taken to prevent the same event from happening across the organization. Multi-disciplinary teams, including residents, identify and test changes on an ongoing basis to prevent future patient safety events.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Residents: | 0% | 12% | 45% | 39% | 4% |
| C-Suite:    | 0% | 37% | 13% | 50% | 0% |</p>
<table>
<thead>
<tr>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents are told about the error reporting system at orientation. A few residents who have a particular area of interest are members of QI committees within the hospital</td>
<td>The GME Office engages the CQO who is a voting member of the Graduate Medical Education Council. Chief residents are engaged by hospital leadership to become involved in QI projects.</td>
<td>Residents in most core programs have had training in QI and patient safety. They are aware of patient safety/QI projects within the hospital and are active participants in most of these initiatives.</td>
<td>Residents are co-leaders on several QI projects within the organization and there are measurable positive outcomes from these initiatives.</td>
<td>Residents are an integral part of all QI initiatives within the hospital. They are key leaders who identify QI initiatives and with hospital leadership obtain measurable improvements in key areas. They are teaching PS/QI to junior residents and students and are working towards black belts in LEAN training.</td>
</tr>
</tbody>
</table>

Residents: 16%  16%  41%  26%  0%
C-Suite:  13%  88%  0%  0%  0%
### Engaging Faculty

- **Residents:** 0% 53% 42% 3% 0%
- **C-Suite:** 13% 63% 13% 0% 13%

<table>
<thead>
<tr>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty have neither the capacity nor the will to participate in quality and safety activities. Residents go through clinical training without integrated quality and safety training.</td>
<td>Many departments have faculty who are knowledgeable and involved in quality and safety. Some faculty have published papers on improvement science projects. Only the faculty leadership in quality and safety are compensated.</td>
<td>Most departments have faculty who are knowledgeable and trained in quality and safety and act as mentors to residents. It is possible, but much harder to be promoted based on quality and safety work. All faculty are compensated for their quality and safety work.</td>
<td>All departments have skilled faculty mentors for the residents in quality and safety. There is a promotion track based on quality and safety, but it has been rarely used.</td>
<td>All departments have strong skilled faculty mentors in quality and safety, as well as all faculty see quality and safety as an integral part of their everyday work. The Academic Medical Center has a well-defined promotion track based on quality and safety work. Every faculty is expected to be involved in quality and safety and have protected time and are compensated at the level of their involvement.</td>
</tr>
</tbody>
</table>
### Transitions in Care – including how sponsoring institutions demonstrate effective standardization and oversight of transitions of care.

<table>
<thead>
<tr>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital focuses on internal care processes only and efforts are not made to communicate with the next setting of care upon a patient’s discharge from the hospital. Residents do not communicate with other members of the clinical team or with the patients and family members themselves regarding the overall plan of care for the patient once discharged from the hospital. Patients are provided with a bolus of information at the time of discharge regarding their post-discharge needs but the clinical team does not utilize methods such as Teach Back or Ask Me 3 to confirm understanding and elicit discussion relative to concerns. Family members are not proactively sought out for inclusion in care planning discussions.</td>
<td>The hospital initiates a few smaller projects to improve discharge planning or care transitions. For example, assessing risk of readmission (may only be based upon medical need), reconciling medications prior to discharge, or improving the discharge summary process. Residents communicate with nurses and other clinical staff when needed to discuss patient post-discharge needs but it is not yet part of standard processes.</td>
<td>The hospital seeks to engage community providers (i.e. primary care, home health, and SNFs) to identify possible work/projects for improving post-discharge transitions in care. Internally-focused projects, with residents actively involved are well underway. Efforts are made to bring the clinical team together regularly to communicate around and plan for patient post-discharge needs.</td>
<td>The hospital engages with community providers and community-based agencies regularly and a portfolio of projects are underway for improving care transitions and ensuring patient post-discharge needs are met. Examples of projects might include: incorporating input from community providers in the initial and on-going assessment of the patient’s post-discharge needs, utilizing Teach Back with patients and families to ensure understanding, scheduling post-discharge primary care visits in advance of discharge, having a direct phone conversation with the next clinical provider to &quot;hand-off&quot; care of the patient to be discharged. Staff at the hospital communicate regularly (for example, through daily multi-disciplinary rounds) to contribute to an overall plan of care.</td>
<td>The hospital regularly engages with community providers and community-based agencies (i.e. aging service organizations) to ensure patients receive needed medical and social support once discharged from the hospital. Standard care processes are reliably in place with a focus on assessing patient post-discharge needs and coordinating necessary support in advance of discharge. Residents and other clinical staff communicate with one another, with providers at the next setting of care, and with the patients and family members themselves to contribute to an overall plan of care for the patient once they leave the hospital. Everyone is “on the same page” regarding the needs of the patient – including the patient and their supporting family members.</td>
</tr>
</tbody>
</table>

| Residents: 1% | 32% | 59% | 7% | 0% |
| C-Suite: 0% | 63% | 38% | 0% | 0% |
### Quality Improvement

<table>
<thead>
<tr>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>A number of quality improvement projects are underway. Multidisciplinary teams that include residents are formed and actively engaged.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient Safety

<table>
<thead>
<tr>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety issues are self-reported using an online system. Staff members, residents, faculty and fellows are not engaged in discussing reported events and the learning system to communicate patient safety issues is not reliable.</td>
<td>The organization has a non-punitive policy to address patient safety adverse events including medical staff members, residents, faculty fellows and organization employees. Safety events are discussed on an ongoing basis in an established forum.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Aligning GME with your Organizational Quality Goals

<table>
<thead>
<tr>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>The GME Office engages the CQO who is a voting member of the Graduate Medical Education Council. Chief residents are engaged by hospital leadership to become involved in QI projects.</td>
<td>Residents in about 50% of core programs have had training in QI and patient safety. They are aware of patient safety/QI projects within the hospital and are active participants in some of these initiatives.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Engaging Faculty

<table>
<thead>
<tr>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many departments have faculty who are knowledgeable and involved in quality and safety. Some faculty have published papers on improvement science projects. Only the faculty leadership in quality and safety are compensated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Transitions in Care

<table>
<thead>
<tr>
<th>Just Beginning</th>
<th>Developing</th>
<th>Making Progress</th>
<th>Significant Impact</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital initiates a few smaller projects to improve discharge planning or care transitions. For example, assessing risk of readmission (may only be based upon medical need), reconciling medications prior to discharge, or improving the discharge summary process. Residents communicate with nurses and other clinical staff when needed to discuss patient post-discharge needs but it is not yet part of standard processes.</td>
<td>The hospital seeks to engage community providers (i.e. primary care, home health, and SNFs) to identify possible work/projects for improving post-discharge transitions in care. Internally-focused projects, with residents actively involved are well underway. Efforts are made to bring the clinical team together regularly to communicate around and plan for patient post-discharge needs. (true in some specialties)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Conduct a CLE Inventory
• Ask your programs some basic and important questions about the six CLER domains
• Allows differentiation of “CLE” from “CLER” visits
• Upload backup documentation to create a library of best practices/examples/policies
• Conduct a SWOT analysis using the CLER Pathways document.

• The Pathways represent the gold standard

• All of these pathways are desirable, eliminating the possibility of either weaknesses or threats. So, categorize all of these as either Strengths or Opportunities.
### Simple SWOT Analysis

<table>
<thead>
<tr>
<th>Strengths:</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have it</td>
<td>Have it</td>
</tr>
<tr>
<td>Want it</td>
<td>Don’t want it</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t have it</td>
<td>Don’t have it</td>
</tr>
<tr>
<td>Want it</td>
<td>Don’t want it</td>
</tr>
</tbody>
</table>
• The Pathways represent the gold standard

• Faculty are mentioned 61 times – evidence that CLER is about the Clinical Learning Environment for ALL OF US, not just the residents and fellows
### Pathway

#### PS Pathway 1: Reporting of adverse events, close calls (near misses)
- Residents, fellows, faculty members, and other clinical staff members (nurses, pharmacists, etc.) know how to report patient safety events at the clinical site.
- Residents, fellows, faculty members, and other clinical staff members know their roles and responsibilities in reporting patient safety events at the clinical site.
- Faculty members report patient safety events via the clinical site’s preferred system.
- Residents/fellows report patient safety events via the clinical site’s preferred system.
- Patient safety events reported by faculty members and residents/fellows are aggregated into the clinical site’s central repository for event reporting.

#### PS Pathway 2: Education on patient safety
- Residents/fellows receive patient safety education that includes information specific to the clinical site.
- Faculty members are proficient in the application of principles and practices of patient safety.
- Residents/fellows are engaged in patient safety educational activities where the clinical site’s systems-based challenges are presented, and techniques for designing and implementing system changes are discussed.
- Residents/fellows and faculty members receive education on the clinical site’s proactive risk assessments (e.g., FMEAS/HFMEAs).
- The clinical site’s patient safety education program is developed collaboratively by patient safety officers, residents/fellows, faculty members, nurses, and other staff members to reflect the clinical site’s patient safety reporting processes, risk mitigation systems, experience, and goals.

#### PS Pathway 3: Culture of safety
- Residents/fellows and faculty members perceive that the clinical site provides a supportive culture for reporting patient safety events.
<table>
<thead>
<tr>
<th>Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HQ Pathway 1: Education on quality improvement</strong></td>
</tr>
<tr>
<td>• Residents/fellows receive progressive education and training on quality improvement that involves experiential learning.</td>
</tr>
<tr>
<td>• Residents/fellows and faculty members are engaged in quality improvement educational activities where the clinical site’s systems-based challenges are presented, and techniques for designing and implementing systems changes are discussed.</td>
</tr>
<tr>
<td>• Residents/fellows and faculty members are familiar with the clinical site’s priorities for quality improvement.</td>
</tr>
<tr>
<td>• The clinical site’s quality improvement education program is developed collaboratively by quality officers, residents/fellows, faculty members, nurses, and other staff members to reflect the clinical site’s quality program’s experience and goals.</td>
</tr>
<tr>
<td>• Faculty members report that they are proficient in clinical quality improvement.</td>
</tr>
<tr>
<td>• Residents/fellows are engaged in periodic quality improvement educational activities in which systems-based challenges are highlighted and approaches to designing and implementing system changes are discussed.</td>
</tr>
</tbody>
</table>

| HQ Pathway 2: Resident/fellow engagement in quality improvement activities |
| • Residents/fellows are actively involved in the quality improvement activities at the clinical site. |

| HQ Pathway 3: Residents/fellows receive data on quality metrics |
| • Residents/fellows receive, from the clinical site, specialty-specific data on quality metrics and benchmarks related to their patient populations. |

| HQ Pathway 4: Resident/fellow engagement in planning for quality improvement |
| • Residents/fellows participate in departmental and clinical site-wide QI committees. |
| • The clinical site monitors resident/fellow efforts in QI. |
**HQ Pathway 5: Resident/fellow and faculty member education on reducing health care disparities**

- Residents/fellows and faculty members receive education on identifying and reducing health care disparities relevant to the patient population served by the clinical site.
- Residents/fellows and faculty members receive training in cultural competency relevant to the patient population served by the clinical site.
- Residents/fellows and faculty members know the clinical site’s priorities for addressing health care disparities.

**HQ Pathway 6: Resident/fellow engagement in clinical site initiatives to address health care disparities**

- Residents/fellows are engaged in QI activities addressing health care disparities for the vulnerable populations served by the clinical site.
### CT Pathway 1: Education on care transitions
- Residents/fellows and faculty members know the clinical site’s transitions of care policies and procedures.
- Residents/fellows participate in simulated or real-time interprofessional training on communication to optimize transitions of care at the clinical site.
- Faculty members participate in simulated or real-time interprofessional training on transitions of care at the clinical site.

### CT Pathway 2: Resident/fellow engagement in change of duty hand-offs
- Residents/fellows use a common clinical site-based process for change of duty hand-offs.
- Resident/fellow change of duty hand-offs involve, as appropriate, interprofessional staff members (e.g., nurses) at the clinical site.
- Resident/fellow change-of-duty hand-offs involve, as appropriate, patients and families at the clinical site.

### CT Pathway 3: Resident/fellow and faculty member engagement in patient transfers between services and locations
- Residents/fellows use a standardized direct verbal communication process for patient transfers between services and locations at the clinical site.
- Resident/fellow transfers of patients between services and locations at the clinical site involve, as appropriate, interprofessional staff members (e.g., nurses).
- Residents/fellows participate with clinical site leadership in the development of strategies for improving transitions of care.

### CT Pathway 4: Faculty member engagement in assessing resident-/fellow-related patient transitions of care
### Pathway

**S Pathway 1: Education on supervision**
- The clinical site educates residents/fellows and faculty members on their expectations for supervision and progressive autonomy throughout the residency/fellowship experience at the clinical site.
- The clinical site provides education to residents/fellows and faculty members on how to provide effective supervision.

**S Pathway 2: Resident/fellow perception of the adequacy of supervision**
- Residents/fellows perceive that they are receiving adequate supervision at the clinical site.
- Residents/fellows perceive that the clinical site provides a supportive culture for requesting assistance.

**S Pathway 3: Faculty member perception of the adequacy of resident/fellow supervision**
- Faculty members and program directors perceive that residents/fellows receive adequate supervision at the clinical site.
- Faculty members perceive that the clinical site provides residents/fellows with a supportive culture for requesting assistance.

**S Pathway 4: Roles of clinical staff members other than physicians in resident/fellow supervision**
- Clinical staff members other than physicians are knowledgeable about the clinical site’s expectations for supervision and progressive autonomy throughout the residency/fellowship experience.
- Clinical staff members other than physicians perceive that the clinical site/department provides residents/fellows with a supportive culture for requesting assistance from supervising physicians.
- Clinical staff members other than physicians play an active role in ensuring that the supervision policies and procedures are followed at the clinical site.
### Pathway 1: Culture of honesty in reporting of duty hours
- Residents/fellows, faculty members, and program directors perceive that there is honest reporting of duty hours at the clinical site.

### Pathway 2: Resident/fellow and faculty member education on fatigue and burnout
- Residents/fellows and faculty members are aware of general and site specific strategies for managing fatigue and burnout.

### Pathway 3: Resident/fellow engagement in fatigue management and mitigation
- Residents/fellows believe that the clinical site has a culture that supports fatigue management and mitigation.
- Residents/fellows believe that their program has a culture that supports fatigue management and mitigation.
- Residents/fellows have used (or have witnessed colleagues use) fatigue management and mitigation strategies that are available at the clinical site.

### Pathway 4: Faculty member engagement in fatigue management and mitigation
- Faculty members and program directors believe that the clinical site has a culture that supports resident/fellow fatigue management and mitigation.
- Faculty members and program directors believe that the clinical site has a culture that supports faculty fatigue management and mitigation.
- Faculty members and program directors exercise non-judgmental triggering of fatigue management and mitigation for residents/fellows at the clinical site.
- Program directors conduct active surveillance of triggering of resident/fellow fatigue management and mitigation strategies at the clinical site.

### Pathway 5: Clinical site monitoring of fatigue and burnout
<table>
<thead>
<tr>
<th>Pathway</th>
<th>PR Pathway 1: Resident/fellow and faculty member education on professionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Residents/fellows and faculty members receive education about the clinical site’s expectations for professionalism, including identifying and responding to specialty-specific risks to patient care.</td>
</tr>
<tr>
<td></td>
<td>• Residents/fellows and faculty members receive training on policies and procedures regarding appropriate documentation of clinical care in the clinical site’s electronic health record and other electronic forms of communication approved by the clinical site.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PR Pathway 2: Resident/fellow attitudes, beliefs, and skills related to professionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Residents/fellows perceive that the clinical site provides an environment of professionalism (including authority figure and supervisor role-modeling) that supports honesty and integrity and respectful treatment of others.</td>
</tr>
<tr>
<td>• Residents/fellows are aware of and, if needed, would use the clinical site’s process(es) for reporting possible mistreatment.</td>
</tr>
<tr>
<td>Faculty members and nurses perceive that residents/fellows are aware of and, if needed, would use the clinical site’s process(es) for reporting perceived unprofessional behavior</td>
</tr>
<tr>
<td>• Residents/fellows follow the clinical site’s professional guidelines when documenting in the electronic medical record.</td>
</tr>
<tr>
<td>Faculty members perceive that residents/fellows follow the clinical site’s policies, procedures, and professional guidelines when documenting in the electronic medical record.</td>
</tr>
<tr>
<td>• Residents/fellows acknowledge the professional responsibility to report unsafe conditions that have required an immediate deviation from usual practice at the clinical site.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PR Pathway 3: Faculty engagement in training on professionalism</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Faculty members are aware of and report that they would use the clinical site’s process(es) for reporting perceived unprofessional behavior.</td>
</tr>
<tr>
<td>Pathway</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>SWOT?</td>
</tr>
<tr>
<td>PS Pathway 1: Reporting of adverse events, close calls (near misses)</td>
</tr>
<tr>
<td>• Residents, fellows, faculty members, and other clinical staff members (nurses, pharmacists, etc.) know how to report patient safety events at the clinical site.</td>
</tr>
<tr>
<td>• Residents, fellows, faculty members, and other clinical staff members know their roles and responsibilities in reporting patient safety events at the clinical site..</td>
</tr>
<tr>
<td>• Faculty members report patient safety events via the clinical site’s preferred system..</td>
</tr>
<tr>
<td>• Residents/fellows report patient safety events via the clinical site’s preferred system..</td>
</tr>
<tr>
<td>• Patient safety events reported by faculty members and residents/fellows are aggregated into the clinical site’s central repository for event reporting..</td>
</tr>
<tr>
<td>PS Pathway 2: Education on patient safety</td>
</tr>
<tr>
<td>• Residents/fellows receive patient safety education that includes information specific to the clinical site..</td>
</tr>
<tr>
<td>• Faculty members are proficient in the application of principles and practices of patient safety..</td>
</tr>
<tr>
<td>• Residents/fellows are engaged in patient safety educational activities where the clinical site’s systems-based challenges are presented, and techniques for designing and implementing system changes are discussed..</td>
</tr>
<tr>
<td>• Residents/fellows and faculty members receive education on the clinical site’s proactive risk assessments (e.g., FMEAs/HFMEAs)..</td>
</tr>
<tr>
<td>• The clinical site’s patient safety education program is developed collaboratively by patient safety officers, residents/fellows, faculty members, nurses, and other staff members to reflect the clinical site’s patient safety reporting processes, risk mitigation systems, experience, and goals..</td>
</tr>
</tbody>
</table>

Example of SWOT Analysis for CLER Pathways of Excellence
What did we do to start changing the CLE?
What have we done so far?

- Patient Safety First – every Friday interprofessional resident engagement
- The “Big Q” and five functional groups for implementation
- Big Q – institutional rollout, GMEC presentation, discussion with all resident leaders
- Big Q – DIO chairing the practice functional group
- Final draft of institutional Transitions of Care policy/process
- Patient Safety residents/GMEC Subcommittee PS/QI
- Chief Resident Quality Council
- Hospitalists have enhanced Supervision at night
- Simulation Center used to teach/evaluate CLER priorities
- RCA and FMEA activity – eg, preventing MRI orders for pacemaker (and other implant) recipients
- Residents and fellows joining several institutional efforts – thank you for continuing to invite them
What have we done so far?

- National engagement: DIO and Associate DIO
  - IHI meetings and conferences
  - AHME – giving national teleconferences and presenting at national institute
  - AAMC and GRA – Chair-Elect, GRA and national presentations
  - ACGME CLER faculty development group
- IPASS – establishment as Transition of Care standard, including IPASS pilot in medicine
- Faculty Development including Te4Q, actively engaged with Vice Dean, Faculty Affairs
- Installing new event and near miss reporting system – RL solutions (replacing PSN)
- IHI investment - modules completed by incoming residents, program directors
- AMA IPM (Introduction to the Practice of Medicine) – patient safety and quality modules completed
- The Academic article and the CEO blog focusing on PS/QI residents
- GME & resident representation on all Safety and Quality institutional Committees
- GME retreat - September 15 2014
## Identifying the Hospital’s TOP Quality Initiatives

<table>
<thead>
<tr>
<th>PRIMARY CORE MEASURES</th>
<th>FOR 100% COMPLIANCE...</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI and CLABSI</td>
<td>Target is reduction to zero (0) in Catheter Acquired UTI (CAUTI) and Central Line Acquired Blood Stream Infection (CLABSI)</td>
</tr>
<tr>
<td>Surgical Care Improvement Project (SCIP) post-op Glucose</td>
<td>Target Includes: Cardiac blood glucose measure now adjusted to: Controlled post-op blood glucose of ≤180 in the time frame of 18 to 24 hours after anesthesia end</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>Targets include: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy and Venous Thromboembolism Warfarin Therapy Discharge Instructions</td>
</tr>
<tr>
<td>Immunizations (inpatient)</td>
<td>Targets include: Influenza and Pneumococcal Immunization for various patient age groups</td>
</tr>
<tr>
<td>Readmission rates</td>
<td>Targets include a single composite risk-standardized readmission rate (RSRR) for surgery/gynecology, general medicine, cardiorespiratory, cardiovascular and neurology.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECONDARY CORE MEASURES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Safety Events</td>
<td>Target is 20% reduction</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>Target is 100% Hand Hygiene practices in all settings in all patient interactions</td>
</tr>
<tr>
<td>HCAHPS</td>
<td>Maintain our achievement in and improve HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems)</td>
</tr>
<tr>
<td>Patient Falls</td>
<td>Target is reducing falls to zero (0)</td>
</tr>
<tr>
<td>Acute Myocardial Infarction (AMI)</td>
<td>Targets include Beta-Blocker and Statin Prescribed at Discharge, Fibrinolytic Therapy Received within 30 minutes of Hospital Arrival and Primary PCI Received within 90 minutes of hospital arrival</td>
</tr>
</tbody>
</table>
THE DIO MUST BE INVOLVED

- Medical Director, Center for Clinical Simulation and Patient Safety
- Practicing Emergency Medicine physician
- Assistant CMO
- Big Q role:
  - Analytics
  - Process
  - Practice
  - Workforce Engagement
  - Outcomes

Asked to lead implementation group for Big Q institutional priorities. I SAID YES!
Aligning The Clinical Learning Environment: A Culture Change at Stony Brook

Monday
September 15 2014: 3-7pm

Agenda:
• DIO welcome, with presentations by:
  • CEO
  • Dean
  • Chair of Surgery
  • New Associate DIO
• “Family Dinner” in Subcommittees – first gathering of these teams
• created subcommittees to help with this work:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS/QI</td>
<td>Patient Safety/Quality Improvement</td>
</tr>
<tr>
<td>ARQ</td>
<td>Accreditation Review and Quality</td>
</tr>
<tr>
<td>ROAR</td>
<td>Recruitment/Orientation/Activities/Retention</td>
</tr>
<tr>
<td>CLE</td>
<td>Clinical Learning Environment</td>
</tr>
<tr>
<td>PD/PC PD</td>
<td>Program Director/Program Coordinator Professional Development</td>
</tr>
</tbody>
</table>
• Residents and fellows have THE BEST ideas
• Any committee they join is SO appreciative of their input
• They’ve been compared to “having new puppies” instead of… you know…
• Program directors and faculty are motivated to get involved in projects BY their residents
• Appoint PATIENT SAFETY residents
The Patient Safety Resident is a single training position dedicated to education in patient safety, quality improvement, and clinical system designs through departmental leadership, interdisciplinary activities and project oversight.

The Patient Safety Resident will be expected to achieve the following primary objectives:

• Understand the scientific basis of patient safety, including the epidemiology and nature of medical error, quality measurement and data analysis, research and evaluation design, improvement tools and techniques, as well as best practices.

• Develop competence in designing and conducting QI projects using rigorous methods, the results of which can be communicated through publication.

• Learn to facilitate/lead healthcare professionals in multi-disciplinary teams.

• Navigate and understand the complex dynamics of hospitals/clinical operations.

• Identify high-yield Graduate Medical Education activities that are aligned with high-yield hospital operations activities.
Curriculum:

Formal and informal education
- Formal – participation in QIPS meetings (society meetings)
- Informal – mentoring, online learning modules

Teaching requirements
- Oversight and involvement of junior residents in quality and patient safety
- Oversight of the department’s longitudinal curriculum in quality improvement and patient safety.
- Provide foundational knowledge in QI and PS to all trainees
- Integration with institutional activities, risk management and quality management

Meeting attendance
- Attendance at Patient Safety Meetings at Stony Brook
- Attendance at Institute for Healthcare Initiatives (IHI) Annual Conference
- Participation in serious safety event meetings, PSN meetings, Patient Safety First’s and Patient Safety departmental committees.
- Be available to participate in other departmental meetings and be aligned with hospital patient safety initiatives related to their department.
Project
Implementation of a major study or quality improvement safety project that is in alignment with institution’s strategic plan.

Eligibility
The Patient Safety Resident will be selected by each core residency sponsored by Stony Brook Medicine. The Resident must be passionate about patient safety and quality improvement, and be willing to work with the hospital and program strategic initiatives regarding patient safety and quality improvement. The Resident must be approved by the Program Director and the Chair of the Department. The resident must be allowed (protected) to attend one Patient Safety First session a month and attend the Hospital Quality Committee meeting following the PSF session.

Roles and responsibilities:
Participate in patient safety rounds, root cause analyses, and appropriate use of clinical reminders.
Monthly review of hospital and departmental quality indicators and work directly with quality improvement and patient safety managers and their teams.
Oversee monthly Patient Safety longitudinal curriculum.
Promote professionalism and patient-centeredness within their training program.
Patient Safety Resident Agreement

Evaluation and Compensation:
Resident will be evaluated on achievement of desired competencies and other outcomes
Resident will be compensated $500/year for this position and will receive an official Certificate as the Patient Safety Resident in (Department) from the Graduate Medical Education Office.
Resident will be tracked by Patient Safety
Resident will be assessed on Residency program impact
Resident will be evaluated on Institutional outcomes
   Measurable outcomes need to be aligned with institution’s strategic plans (example: central line training to reduce catheter-associated infections).

I accept this position and understand the requirements and responsibilities as outlined above

Resident Name____________________Signature____________________ Date____________

I approve this position and will assure protected time for the resident named above to fulfill the requirements and responsibilities of Patient Safety Resident.

Program Director Name____________Signature____________________ Date____________

Department Chair Name____________Signature____________________ Date____________

49
Resident Engagement in Patient Safety

• To show our appreciation for the unique contributions made every single week by the residents to Patient Safety and Quality Improvement at Stony Brook Medicine, the GME Office chooses to shine the spotlight on just a few of our Resident Leaders. There are countless stories to tell – let us introduce you to some of them.

Rajarsi Gupta, MD, PhD – Pathology Chief Quality Resident
“Since arriving at Stony Brook in 2011, Dr. Rajarsi ‘Raj’ Gupta has had eight publications, three presentations at Pathology conferences and is currently working on an Evaluation of Neoadjuvant Chemotherapy in Invasive Breast Cancer and on a Pathologic Complete Response (pCR) with Neoadjuvant Therapy in Breast Cancer. For Raj, Pathology is a specialty focused on the patient and the critical information needed by other clinicians and the patients and their families in times of greatest need.

Jason Pollack, MD – Anesthesiology Chief Patient Safety Resident
“Dr. Pollack has been an Anesthesiology resident since 2012, and has become increasingly involved in patient safety improvements because “it is exciting to see the changes when you work hard to positively impact your institution.” Currently, Dr. Pollack is working on a specimen time out in the operating room to ensure the proper removal, handling, and transport of surgical pathology specimens and also focusing on an interdisciplinary simulation with the Emergency Department, the operating room, the nursing staff and the Department of Anesthesiology.

Charles Miller, MD – Internal Medicine Chief Quality Resident
“As Chief Quality Resident for Stony Brook’s largest residency, Chase Miller impacts the educational experience of the residents and advocates on their behalf. Some of his current Clinical Quality Improvement projects investigate: Debriefing post Cardiac Arrest, Cardiology Ward Coverage Scheme, Patient Continuity in General Medicine Clinic. Dr. Miller is also involved in clinical research in Cardiac Electrophysiology as part of the Long Island Seafood Study Group investigating the effect of cardiomyopathy and other heart disease on maternal and fetal outcomes in pregnancy.”

Jerome Wilkerson, MD – Emergency Medicine Chief Quality and Patient Safety Resident
Since his internship starting in 2012, Jerome Wilkerson has been involved in Patient Safety First. In this, his final year of training, Dr. Wilkerson has developed a role for himself that includes assisting the department’s faculty QA liaison (with small group resident discussion) cases referred via risk management, other departments and the PSN system. He is also working on several projects with the resident small groups including a Code Aorta protocol (for suspected ruptured AAAs), an educational program for the management of alcohol withdrawal in ED patients, criteria for obtaining an ECG in ED triage and revising the ED order sets.”
**CQI (RN) Practitioners**

<table>
<thead>
<tr>
<th>Service Group</th>
<th>Continuous Quality Improvement Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Chris Northam Schuhmacher</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Lisa Sokoloff</td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td>Lisa Sokoloff</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Sue Robbins</td>
</tr>
<tr>
<td>ICU</td>
<td>Lisa Sokoloff</td>
</tr>
<tr>
<td>Medicine</td>
<td>Dan Cammarata</td>
</tr>
<tr>
<td>Neurology</td>
<td>Pam Boremski</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Pam Boremski</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>Dan Cammarata</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Grace Propper</td>
</tr>
<tr>
<td>Perinatal</td>
<td>Chris Northam Schuhmacher</td>
</tr>
<tr>
<td>Perioperative</td>
<td>Pam Boremski</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Sue Robbins</td>
</tr>
<tr>
<td>Surgery</td>
<td>Pam Boremski</td>
</tr>
<tr>
<td>Transplant - Urology</td>
<td>Dan Cammarata</td>
</tr>
<tr>
<td>Trauma</td>
<td>Sue Robbins</td>
</tr>
</tbody>
</table>
IHI Modules on safety and quality
Event consists of:
  Didactic presentation of Big Q, PDSA, RCA, 5 Whys
  Quarterly Institutional M&M
  “Speed dating” to identify common areas of interest
  Projects are developed among participants
  Debriefing: description of projects to group
3 months later:
  Quarterly Institutional M&M
  Update on progress of projects
6 months later:
  Quarterly Institutional M&M
  Final report on resolution of projects

OCCURS TWICE EVERY ACADEMIC YEAR
SPEED DATING

Align AND Integrate these three groups by bringing hospital liaisons to GME environment

Outcome will be interprofessional PS/QI projects with sustainable changes
Success of program

- Each residency program will be able to identify their faculty and hospital quality liaison
- Each group will successfully create a sustainable QI project for their program
- Identify improved metrics that align with hospital’s Big Q quality parameters
• And then we had our CLER visit!!!
<table>
<thead>
<tr>
<th>Pathway</th>
<th>SWOT?</th>
<th>Additional comment</th>
<th>CLER Visit feedback</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PS Pathway 1: Reporting of adverse events, close calls (near misses)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Residents, fellows, faculty members, and other clinical staff members (nurses, pharmacists, etc.) know how to report patient safety events at the clinical site.</td>
<td>S*</td>
<td>Faculty have not been formally taught</td>
<td>On walkarounds, it was identified that there are too many way to report PS events (at least 3).</td>
<td></td>
</tr>
<tr>
<td>• Residents, fellows, faculty members, and other clinical staff members know their roles and responsibilities in reporting patient safety events at the clinical site.</td>
<td>S*</td>
<td>Not faculty</td>
<td>80% of residents have had exposure to adverse events. 33% state they reported them in PSN. 25% said they would not submit a report. 25% said they would not report near misses. 10% of faculty would not submit a report and 25% of program directors would not submit a report. Most RNs report having used PSN, but few would report known complications. Few were unaware of the system.</td>
<td></td>
</tr>
<tr>
<td>• Faculty members report patient safety events via the clinical site’s preferred system.</td>
<td>O</td>
<td>Need actual data from system</td>
<td>Most providers would communicate PS concerns verbally rather than via PSN, leading to inconsistency. Nurses would be more likely to phone the MD to change an order rather than use PSN.</td>
<td></td>
</tr>
</tbody>
</table>
| • Residents/fellows report patient safety events via the clinical site’s preferred system. | O | Variable | SEG recommends these ways to improve event & near miss reporting:  
• Develop PS/QI rotation  
• Increase interprofessional activities (M&M, case conferences)  
• Give faculty feedback, etc. | |
CONCLUSIONS FROM CYCLE 1

POSITIVE FINDINGS

• National Observations:
  • 6970 faculty / 7832 residents / 4948 program directors
  • Active and interested engagement of CEO with the DIO
  • Reports of CEO and C-Suite taking direct interest in resident/fellow and faculty development
  • Efforts to engage residents in patient safety event investigations
  • Interprofessional (nurses and other clinical staff) quality projects
  • Residents have sustainable projects
  • Observing a really good resident to resident patient are transition
  • Nurses engaging with residents in transitioning patient care
  • CLEs demonstrating a total INTOLERANCE of disrespectful behavior
  • Program directors working on collaborative efforts around one or more of the six CLER focus areas
  • Overall, an extremely talented GME community
  • High degree of interest in training the best possible physicians
  • Lots of feedback from nursing and other clinical staff on the value of GME presence
  • There has been progress in the nearly 15 years since the IOM publications on quality and patient safety
CONCLUSIONS FROM CYCLE 1: PATIENT SAFETY

NOT SO POSITIVE FINDINGS

• 90% of residents report participating in education on patient safety
  Most common at orientation
• 67% of Residents experienced a PS event (should be 100%)
• 46% experienced and reported a PS event
• 1.2% of PS events were reported by residents
  60% of CLEs didn’t or couldn’t track whether reporter was a resident
• Based on interviews with nurses and other clinical staff, residents
  infrequently report events. It was not unusual that the CLE’s
  system was used to report on individual behaviors
• Seldom ever done: reports need to be prioritized. Risk-based not
  harm-based (because harm shouldn’t be the precursor to doing
  something about it) prioritize based on risk.
CONCLUSIONS FROM CYCLE 1:
QUALITY IMPROVEMENT
NOT SO POSITIVE FINDINGS

- 70% of residents report they believed they knew the CLE’s priorities in Healthcare Quality
- Most common alignment around quality measures related to regulatory or value-based purchasing
- Residents and faculty knowledge often departmentally focused
- 70% of residents report participating in some type of quality improvement project commonly related to need to fulfill program requirements
- When participating in hospital/medical center project, role most common as implementer
- Occasional agent of change
The most dangerous phrase in the language is "we've always done it this way."
What do we need to do next?

- Align hospital and nursing initiatives with GME priorities
- Implement TeamSTEPPS training across institution with interprofessional rounds
- Implement 30 Te4Q institution-wide initiatives
- Finalize institutional Transitions of Care policy and develop local TOC policies
- Improve all aspects of attending supervision for residency training
- Implement RL Solutions and educate users
- Involve Quality Liaisons in Resident/Fellow Education
- Speed dating of quality liaisons and safety & quality residents
- Connect residents/fellows who want to pursue PS/QI projects to IT and QL resources
- Ensure nurses and others can access New Innovations to see resident credentials
- Determine/study whether there are disparities in treatment/services/access/outcomes for vulnerable populations served in each specialty and address them
Integrating quality and GME is a journey that takes time.

Be careful not to "over-estimate what you can do in one year or to under-estimate what you can do in ten years." - Unknown

THANK YOU!