

University of Iowa Fellows' Quality Improvement Project

By Cari Bermel

What is Quality Improvement?

The Bridge:

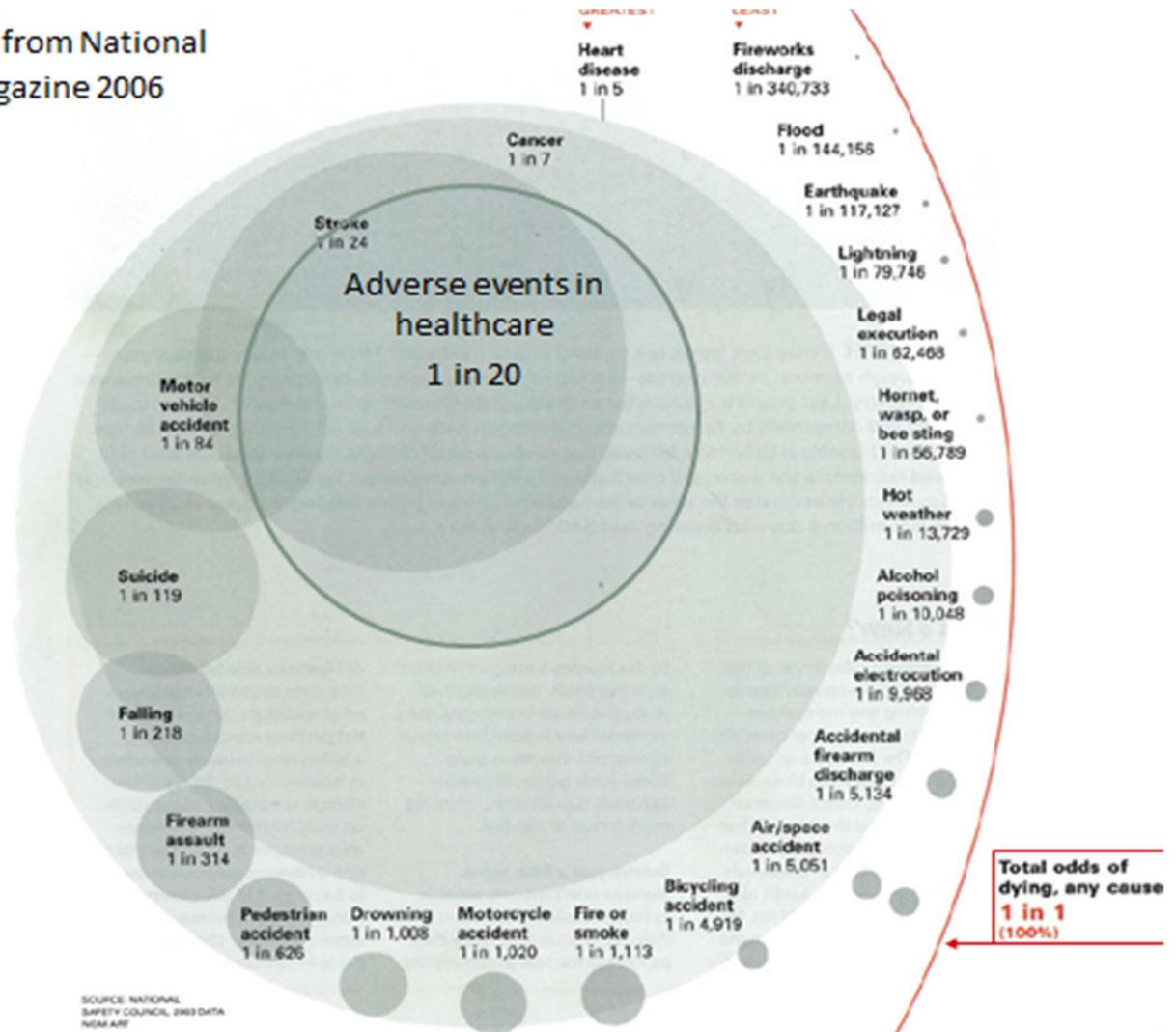
“The combined and unceasing efforts of everyone - healthcare professionals, patients and their families, researchers, payers, planners and educators – to make the changes that will lead to better patient outcomes (health), better system performance (care), and better professional development (learning)”

Why does this matter?

- Our duty and desire to provide high quality, cost effective care in safe manner
- Good for patients, families, caregivers and society
- ACGME requirements
- ABIM recertification
- Pay for performance/Core Measures
- Will be part of your practice

Ways to Go from National Geographic Magazine 2006

44 -98,000
deaths/year in U.S.
due to medical
errors



Goals and Objectives of Fellows Quality Improvement Curriculum

- Systematically review a preventable adverse event
- Identify and analyze system weaknesses or breaches in evidence-based practice contributing to the patient adverse event
- Present findings at a mortality, morbidity, and improvement (MMI) conference.
- Propose prioritized system-based changes to prevent the adverse event from occurring again

6 Modules Delivered in MedHub

Learning Modules

Module Name	Status	Author(s)	Resources (Req)	Linked Test	Self Initiated	Total Delivered	Total Completed
Fellows Curriculum - Module 1: Adverse Events <small>(HR PS100 is not required, but is available for yo...)</small>	Active	Suneja, Thomas, Johnson, Kamath	3 (3)	FELLOWS CURRICULUM - ASSIGNMENT MODULE 1	--	184	59
Fellows Curriculum - Module 2: Selecting a Case for MUI Conference	Active	Suneja, Thomas, Johnson, Kamath	2 (2)	FELLOWS CURRICULUM - ASSIGNMENT MODULE 2	--	161	51
Fellows Curriculum - Module 3: Systems Audit & Root Cause Analysis	Active	Kamath, Johnson, Suneja, Thomas	2 (2)	FELLOWS CURRICULUM - Module 3: Systems Audit & Root Cause Analysis	--	181	47
Fellows Curriculum - Module 4: Few Missions and Developing Process Literacy	Active	Kamath, Johnson, Suneja, Thomas	2 (2)	FELLOWS CURRICULUM - ASSIGNMENT MODULE 4	--	161	37
Fellows Curriculum - Module 5: Restructuring Mortality, Morbidity and Improvement Conferences - Focus	Active	Kamath, Johnson, Suneja, Thomas	3 (3)	FELLOWS CURRICULUM - ASSIGNMENT MODULE 5	--	181	26
Fellows Curriculum - Module 6: Model for Improvement	Active	Johnson, Kamath, Suneja, Thomas	2 (2)	FELLOWS CURRICULUM - ASSIGNMENT MODULE 6	--	161	27
Introduction and Overview - Fellows' Quality Improvement Learning Modules	Active	(none)	2 (0)	(none)	--	58	14

Learning Functions

[View Completed Modules](#)
[Incomplete Modules](#)
[Module Delivery History](#)

Learning Reports

[Completed Learning Modules Report](#)

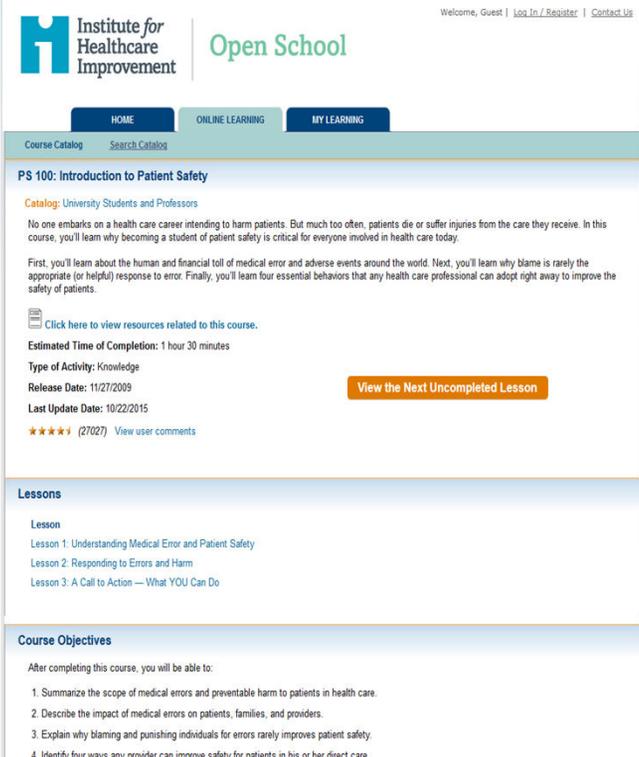
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Module 1: Adverse Events

- PowerPoint with adverse event facts
- 3 IHI Modules
 - Introduction to Patient Safety
 - Fundamentals of Patient Safety
 - Human Factors and Safety



The screenshot shows the IHI Open School website interface. At the top, there is a navigation bar with 'HOME', 'ONLINE LEARNING', and 'MY LEARNING' buttons. Below this is a search bar and a 'Course Catalog' link. The main content area is titled 'PS 100: Introduction to Patient Safety'. It includes a description of the course, a 'View the Next Uncompleted Lesson' button, and a list of lessons: 'Lesson 1: Understanding Medical Error and Patient Safety', 'Lesson 2: Responding to Errors and Harm', and 'Lesson 3: A Call to Action — What YOU Can Do'. There is also a 'Course Objectives' section with four numbered points.

Institute for Healthcare Improvement | Open School

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HOME ONLINE LEARNING MY LEARNING

Course Catalog Search Catalog

PS 100: Introduction to Patient Safety

Catalog: University Students and Professors

No one embarks on a health care career intending to harm patients. But much too often, patients die or suffer injuries from the care they receive. In this course, you'll learn why becoming a student of patient safety is critical for everyone involved in health care today.

First, you'll learn about the human and financial toll of medical error and adverse events around the world. Next, you'll learn why blame is rarely the appropriate (or helpful) response to error. Finally, you'll learn four essential behaviors that any health care professional can adopt right away to improve the safety of patients.

 [Click here to view resources related to this course.](#)

Estimated Time of Completion: 1 hour 30 minutes

Type of Activity: Knowledge

Release Date: 11/27/2009

Last Update Date: 10/22/2015

★★★★★ (2/202) [View user comments](#)

View the Next Uncompleted Lesson

Lessons

Lesson

Lesson 1: Understanding Medical Error and Patient Safety

Lesson 2: Responding to Errors and Harm

Lesson 3: A Call to Action — What YOU Can Do

Course Objectives

After completing this course, you will be able to:

1. Summarize the scope of medical errors and preventable harm to patients in health care.
2. Describe the impact of medical errors on patients, families, and providers.
3. Explain why blaming and punishing individuals for errors rarely improves patient safety.
4. Identify four ways any provider can improve safety for patients in his or her direct care.

Module 2: Identifying the Quality Gap

- PowerPoint for Selecting a case for MMI conference
- Article titled *“Developing and Deploying a Patient Safety Program in a Large Health Care Delivery System: You Can’t Fix What You Don’t Know About”*

Module 3: Systems Audit & Root Cause Analysis

- PowerPoint discussing Systems Audit and Root Cause Analysis
- IHI Module: Root Cause and System Analysis
- Fellows are encouraged to talk to colleagues about preventable adverse events
- Pick one case to present at Future MMI conference
- Root Cause Analysis
 - “Process for identifying contributing/casual factors that underlie variations in performance associated with **adverse events** or **close calls**”

Module 4: Flow Mapping and Developing Process Literacy

- PowerPoint discussing process mapping
- Article titled *“Process mapping the patient journey: an introduction”*

Module 5: Restructuring Mortality, Morbidity, and Improvement conferences: Focus on system based issues

- PowerPoint discussing curriculum for this module
- IHI Module
 - Introduction to the Culture of Safety
- Abstract titled *“Transforming the Morbidity and Mortality Conference into an Instrument for Systemwide Improvement”*

Module 6: Model for Improvement

- Model for Improvement PowerPoint
- IHI Module
 - The Model for Improvement: Your Engine for Change

What happens when fellows complete the modules?



- Department looks at list of adverse events and program directors are asked to discuss the adverse events with fellows

Questions?