University of Iowa Fellows' Quality Improvement Project

By Cari Bermel

THE UNIVERSITY OF IOWA

What is Quality Improvement?

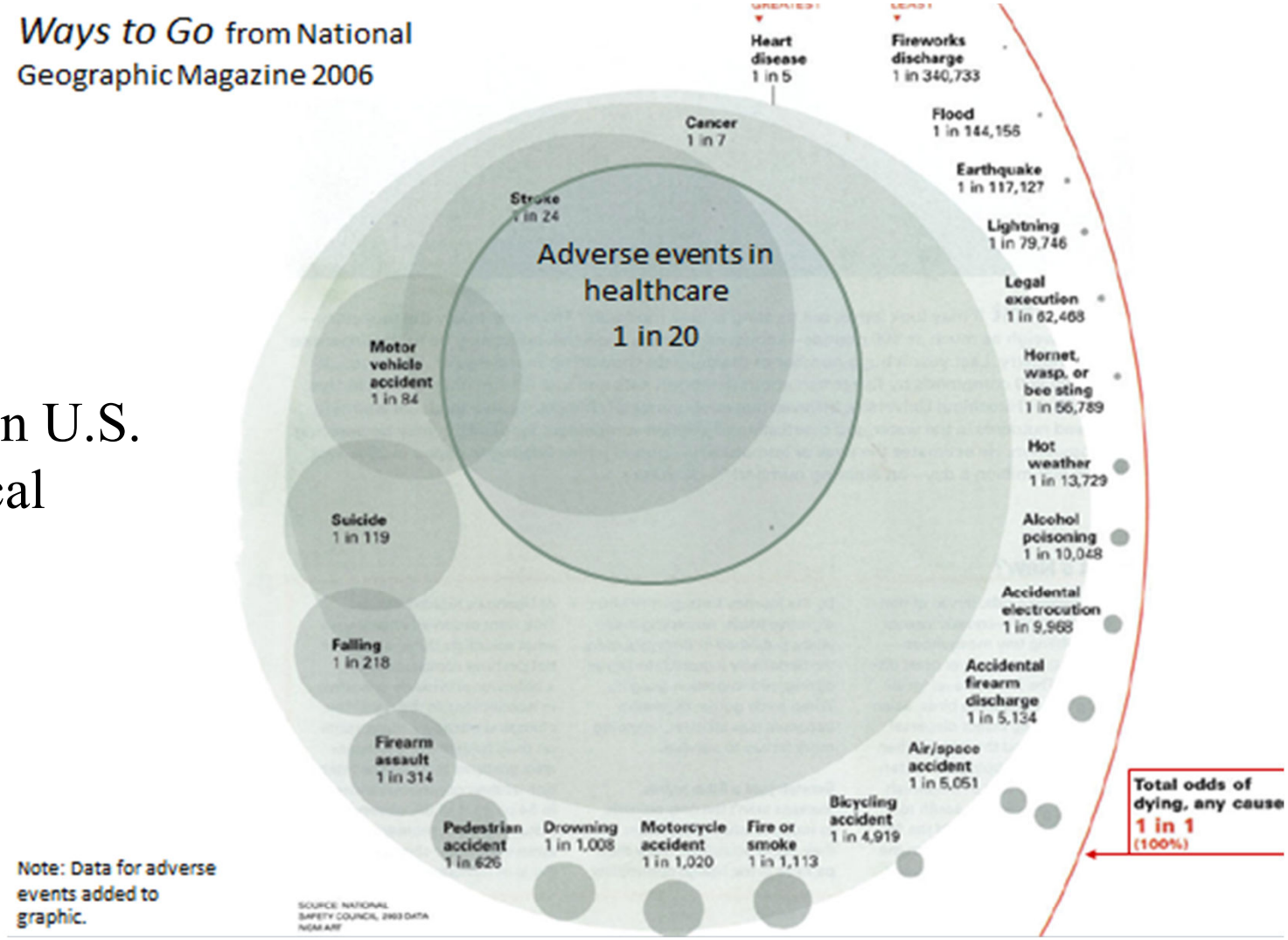
The Bridge:

"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

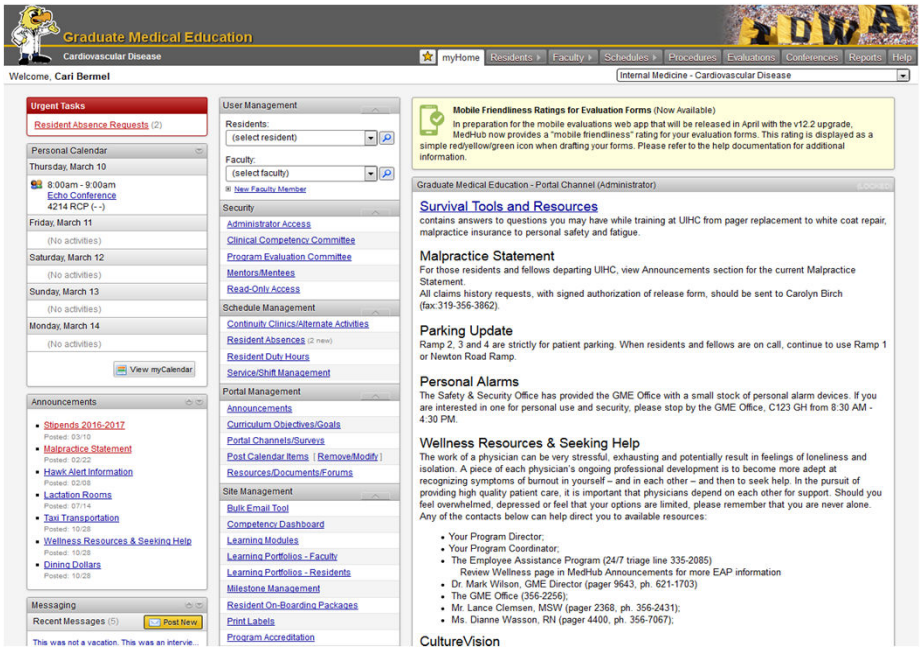
44 -98,000 deaths/year in U.S. due to medical errors

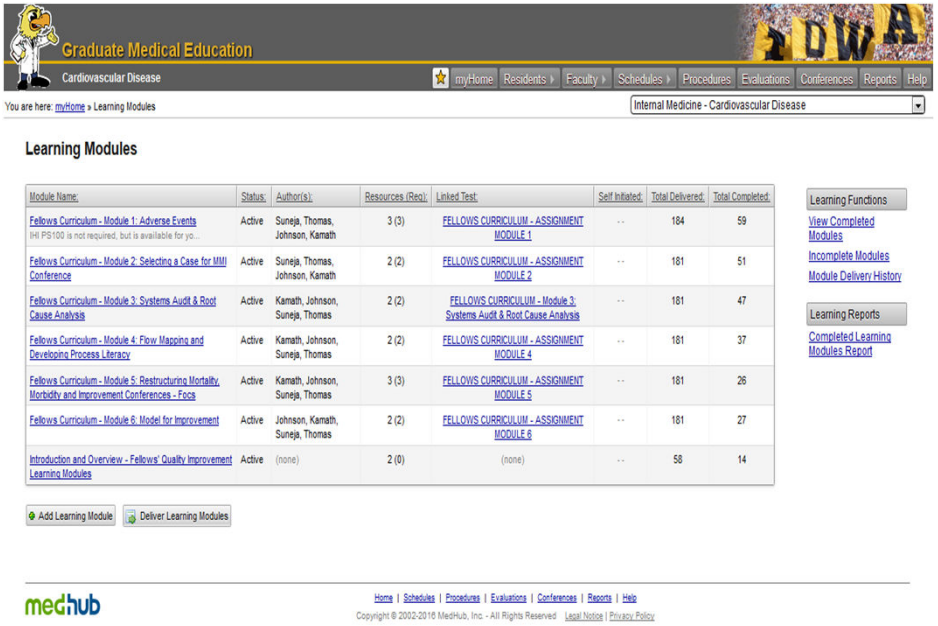


Goals and Objectives of Fellows Quality Improvement Curriculum

- 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





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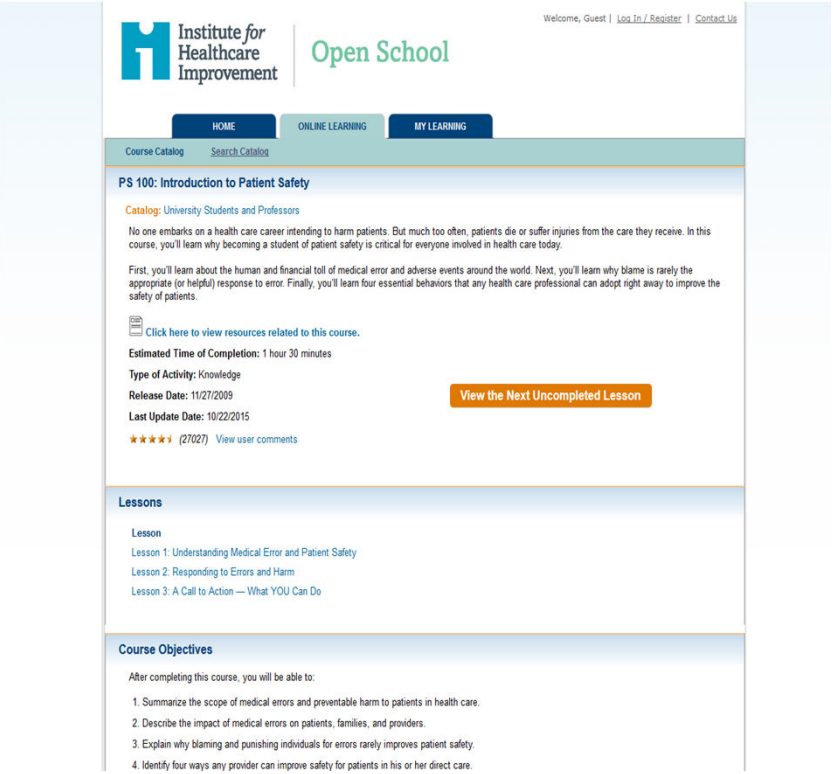
Module 1: Adverse Events

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



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?

THE UNIVERSITY OF IOWA – DEPARTMENT OF INTERNAL MEDICINE

QUALITY IMPROVEMENT & PATIENT SAFETY FELLOWS' CURRICULUM

THIS CERTIFIES THAT

[Student Name]

has successfully completed the required curriculum modules and is therefore awarded this

CERTIFICATE OF COMPLETION

Given this___day of_____, 20__

Gary R. Rosenthal, M.D.
Interim Chair, Department of Internal Medicine

Beau M. Gehlbach, M.D.
Internal Medicine Fellowship Program Director

Kiran M. Johnson, M.D.
Educational Director, Safety and Quality
Department of Internal Medicine

Fellowship Program Director

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

Questions?