2012

Patient Safety, Quality Management and Quality Improvement - Course Syllabus

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Introduction to Patient Safety, Quality Measurement & Quality Improvement
M19-526

Instructor:
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Spring 2012: Jan – May; Wed 9a-12p
Location: Farrell Learning Center, Classroom TBA
Office Hours: By appointment

Course Overview:
The goal of this course is to introduce the fundamentals of patient safety, evaluation of quality and quality measures and principals of quality improvement to students working in any aspect of health care or in health services research. The course will be divided into these three overlapping topic areas and will consist of lectures, group activities and project work. We will survey important topic areas in patient safety. We will explore the components of quality measures and their construction and evaluation in the current healthcare milieu. Students will review and create quality measures within their chosen field and develop a quality improvement project to improve a process or outcome.

Competencies
1. Understand the fundamental principles and lessons of the patient safety movement
2. Understand the terminology and basic methodology of quality measurement
3. Understand the principles of designing and evaluating quality measures
4. Assume a leadership role in the design and implementation of a quality monitoring system for use in quality improvement

Your Grade is based on:

1. Class Participation (15 points)
2. Formal review of Patient Safety journal article – review and present in class a recent patient safety study from among selected journals/sources. (15 points)
3. Patient Safety Project – draft a 1-3 page proposal for a patient safety intervention in your area (15 points)
4. Using the methods learned in class submit a 1-3 page evaluation of a quality measure, addressing the strengths and weaknesses (measure provided) (15 points)
5. Develop a new quality measure in your field of interest, using the components of measurement discussed in class (20 points)
6. Draft a quality improvement project, addressing barriers and leveraging strengths to achieve improvement (written & presented) (20 points)

DRAFT SCHEDULE (order may change)
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The Science of Safety


Metacognition and Cognitive Error


Human Factors Engineering


Teamwork and Communication


Responding to Adverse Events/ Error reporting


Disclosure

1. Patients’ and Physicians’ Attitudes Regarding the Disclosure of Medical Errors. JAMA 2003 289 (8) 1001-1007

Investigating a defect/ Root Cause Analysis

Medication Safety

Culture of Safety/ Leadership
1. Weeks W. Bagina J. Developing a Culture of Safety in the Veterans Health Administration. Effective Clinical Practice 2000: 270-276
2. To Err is Human: Chapter 4: Building Leadership and Knowledge for Patient Safety p 59-73
3. To Err is Human: Chapter 8: Creating Safety Systems in Health Care Organizations p 134-173

Health Literacy

Thinking about quality


Regulation and accountability

Components of Measurement

Measure Development and evaluation

Case Mix Adjustment

Introduction to Quality Improvement

Innovation and Behavioral Change

Knowledge Translation

Evaluation of Implementation