2012

Patient Safety, Quality Management and Quality Improvement - Course Syllabus

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
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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)

1. Jan 18	Introduction – the science of safety Medical Error & Metacognition
2. Jan 25	Investigating an Error/ Root cause analysis Responding to Adverse events
3. Feb 1	Error reporting systems Disclosure
4. Feb 8	Health Literacy and Patient Safety Human Factors Engineering
5. Feb 15	Teamwork and Communication Culture of Safety/ Leadership
6. Feb 22	Thinking about Quality 1 Thinking about Quality 2
7. Feb 29	Components of Measurement Measure development and evaluation
8. Mar 7	Regulation and accountability Case Mix Adjustment
9. Mar 14	Spring Break
10. Mar 21	Patient Satisfaction Using large datasets for quality evaluation
11. Mar 28	Quality Measure Presentations
12. Apr 4	Introduction to Quality Improvement Innovation and Adoption
13. Apr 11	Knowledge Translation Evaluation of Implementation
14. Apr 18	Lean Methodology and Problem Solving Audit and Feedback; Process mapping; Trigger tool
15. Apr 25	Information Technology in Quality Improvement
16. May 2	Quality Improvement Project Presentations

The Science of Safety

1. Berwick, DM. Escape Fire: Lessons for the future of health care. The Commonwealth Fund, 2003.
2. Kohn LT, Corrigan JM, Donaldson MS, eds. To err is human. Building a safer health system. Washington DC: National Academis Press 1999, Executive Summary.
3. Leape L. Error In Medicine. JAMA 1994 272(23), 1851-1857Reason J. The contribution of latent human failures to the breakdown of complex systems. Phil Trans R Soc Lond 1990;327:475-484
4. Smetzer, J., Cohen, M. Lesson from the Denver medication error/criminal negligence case: Look beyond blaming individuals. *Hospital Pharmacy* 1998; 33(6): 640-657.
5. Roberts, K.H., Tadmor, C.T. Lessons learned from non-medical industries: the tragedy of the USS Greeneville. *Quality & Safety in Health Care* 2002; 11(4): 355-7.
6. Mohr JJ et al. Microsystems in Health Care: Part 6. Designing Patient Safety into the Microsystem. 2003 Aug Vol29(8). 401-8

Metacognition and Cognitive Error

1. Norman GR Eva KW. Diagnostic Error and Clinical Decisionmaking. Medical Education 2010: 44: 94–100
2. Croskerry P. A universal model of diagnostic reasoning. Acad Med. 2009 Aug;84(8):1022-8.
3. Sandhu H, Carpenter C, Freeman K. Clinical Decisionmaking: Opening the Black Box of Cognitive Reasoning. Annals of Emergency Medicine. Volume 48, Issue 6, December 2006, Pages 713-719

Human Factors Engineering

1. The Joint Commission. Using Human Factors Engineering to Improve Patient Safety, Second Edition. Chapter 1 - Introduction

Teamwork and Communication

1. Pronovost P et al. Using Human Factors Engineering to Improve Patient Safety, Second Edition. J Crit Care. 2008 Jun;23(2):207-21.

Responding to Adverse Events/ Error reporting

1. Leape, L.L. Reporting of Adverse Events, *New England Journal of Medicine*, 2002; 347(20):1633-8.

Disclosure

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

2. Berman S. Reporting Outcomes and Other Issues in Patient Safety: An Interview with Albert Wu. Journal on Quality Improvement 200228(4) 197-204

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

1. Institute of Medicine. Crossing the Quality Chasm. Washington, DC: National Academy Press, 2001, ch. 1, pp. 23-38.

2. Schuster, M.A, McGlynn, E.A., Brook, R.H. How good is the quality of health care in the United States? Crossing the Quality Chasm, pp. 231-308

3. Jencks, S. F., Cuerdon, T., Burwen, D.R., Fleming, B. et al. Quality of medical care delivered to Medicare beneficiaries: a profile at state and national levels. *JAMA*, 2000; 284(13): 1670-76.

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