AMSPDC ANNUAL MEETING - MARCH 1, 2015
SMALL GROUP TABLE MEETINGS

Summaries of the small group table discussions from the Medical Education plenary session focused on safety and quality follow:

Faculty

1. Using IHI modules, a train the trainers program has been implemented. Twenty-five faculty each year do training with these modules and have a meeting once a month for two hours. Other smaller programs are also using IHI, but across several departments in their school rather than just pediatrics. Judy Aschner, Albert Einstein College of Medicine of Yeshiva University,

Fellows

1. Using "Solutions for Patient Safety"—Started in Ohio—now used widely-- incorporates learners *at all levels* in 75 children's hospitals. Michele Walsh (Interim Chair)- Case Western/Rainbow Babies-
2. Quality and safety council responsible for course on safety and quality used by fellows and other levels of learners. Fellow project required. Uses modules of IHI training. -Everything is on the web Sherin Devaskar at UCLA.
3. Elevated quality program for fellowships in that fellows now do a quality project. They have to write up a mini-IRB proposal to submit to the quality council to elevate the visibility of the work. All proposals are vetted by the quality officers and feedback given to make it better. Fewer quality projects result but more meaningful ones. Some can result in publications, so fellows appreciate that. Steven Webber-Vanderbilt

   Concerns: Need to train fellowship directors in quality since their background is basic, clinical or translational research and a number are less interested in focusing on safety and quality and in turn, some fellows are less interested as well.

   Solution: Set expectations on need to learn quality and safety science at start of fellowship programs if not during recruitment so it becomes par for the entire fellowship program.

Residents

1. Second year residents start year with a two day safety/quality boot camp. Projects run over the year and are presented / published. They are successful with faculty and hospital engagement. Joe Neglia (Minnesota)
2. Residents participate in a 'Toyota' safety/quality program. Any QI project at the hospital must have resident engaged. Morning safety meetings involve house staff. Bruder Stapleton (Seattle)
3. Difficult cases presented at grand rounds and dissected. Led by chief residents and is an interdisciplinary presentation/process. Senior residents meet with head nurses at the start of a rotation to see what did/did not go well last rotation. They get together at the end again to see how well they addressed the issues identified. Val Castle (Michigan)
4. Use of a simulation program to break down and understand interprofessional barriers to communication. 'Vocabulary' is different across the professions. Also use of iPass to improve quality of transitions. Mitch Cohen (UAB)
5. Resident QI projects are all presented to the faculty. Quarterly grand rounds are allocated to a difficult case in quality and safety and the case is dissected. Yasmin Tyler-Hill (Moorehouse)
6. Residents get a 3 hour training session that incorporates LEAN and Six Sigma principles. Judy Schaechter (Univ. of Miami)
7. Residents made aware of CLER issues by ACGME and thus work to integrate themselves into safety and quality issues on their rotations. Doug Carlson (Southern Illinois University)
8. One morning report devoted each month to the safety/quality issues that have been identified over the month. Jay Greenspan (Jefferson)
9. There is an optional elective on quality improvement and patient safety. Keith English (Michigan State)
10. Implemented a multi-disciplinary approach to resident quality improvement with residents doing projects. They use Solutions for Patient Safety (http://www.solutionsforpatientsafety.org/). They have multidisciplinary teams that include nurses, residents, child life specialists and pharmacists. These are data driven projects covering 10 hospital acquired conditions. Data is collected at baseline, intervention is completed and hospital data systems are utilized to complete a post-evaluation to assess the impact of their work. Tom Welch (SUNY-Syracuse)
11. Use of a proprietary system called "Just Culture" to teach QI to their residents. Jerold Stirling (Loyola)
12. Engaged the hospital in a discussion of how to enhance resident reporting of patient safety challenges, medical errors and near misses. Benchmark goals were established and residents were provided with a financial incentive to meet those goals. An

interesting observation is that even though there was a financial incentive, residents became more engaged in patient safety and now seem to be more aware of this important issue. They also require a mentored project and many residents choose a QI project. Steve Daniels (Children's Hospital of Colorado)

13. Established a resident council for patient safety. Led by two pediatric residents, we have developed and implemented a patient safety and QI curriculum that reviews the reporting system for potential medical errors and has tracked the increase in patient safety reports by residents after implementation of this system. The GME Department has purchased access to the IHI modules and all residents (all disciplines) are required to complete these IHI modules. Bob Vinci (Boston Medical Center)
14. Many of the programs have some kind of call / conference that occurs daily to review the previous days QI/Safety issues and residents are a part of it.

Students

Table participants acknowledged that safety and quality improvement training for medical students is largely handled at the School of Medicine's Office of Medical Education level rather than within departments.

That being said:

1. Have a CLIPP case built specifically to target learning objectives in patient safety and quality improvement. We all use CLIPP in our 3rd year clerkships and hopefully CLIPP has a case or cases or is building cases in this area.

2. Each chair should contact their respective Office of Medical Education to understand how their School of Medicine is integrating safety and quality training into the UME curriculum. The chair should offer to provide pediatric-specific educational content into that curriculum.