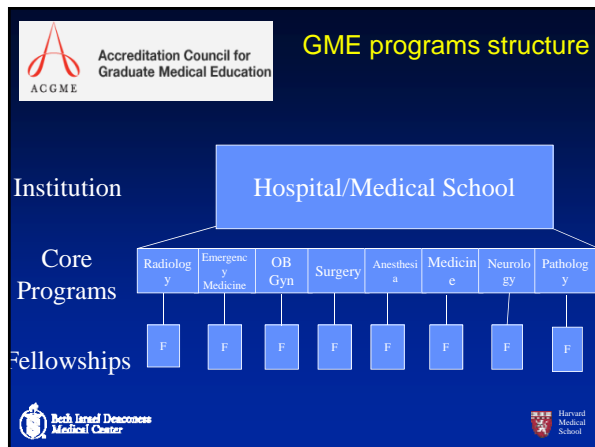
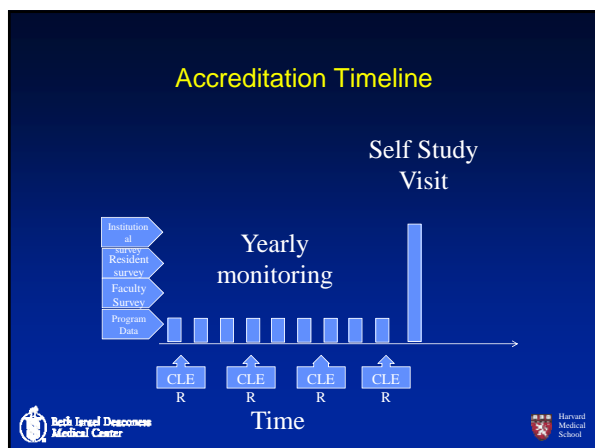


ACGME Accreditation and CLER visits

Integrating Trainees into QI and Safety







Clinical Learning Environment Review Visit

- Integration of residents into **Patient Safety** programs of the institution
- Integration of residents into **Quality Improvement** programs of the institution,
- Establishment, implementation, and oversight of **Supervision** policies
- Oversight of **transitions in care**
- Oversight of **duty hours** standards
- Honesty and **Professionalism** in all work



Anatomy of the CLER visit





CLER Pathways: Expectations for Safety

- 1: Reporting of adverse events, near misses
- 2: Education on patient safety
- 3: Culture of safety
- 4: Experience in investigations and follow up
- 5: Clinical site monitoring of reporting
- 6: Engagement of faculty member
- 7: Experience in error disclosure



Patient Safety Properties

- Error Reporting
 - Role, where, how, how many, what happens afterwards, feedback, faculty
- Education
 - Training, hands-on activities,
- Culture
 - Perceptions, support
- Disclosure
 - Training, participation

CLER Pathways: Expectations for Quality

- 1: Education on quality
- 2: Engagement in QI activities
- 3: Receipt of data on quality metrics
- 4: Engagement in planning for QI
- 5: Education on healthcare disparities
- 6: Engagement in healthcare disparities initiatives




Quality Properties



- Education
 - Training, institution priorities, hands-on activities,
- Data
 - Specialty specific data on own patient population
- Healthcare Disparities
 - Training, clinical site's initiatives




CLER Pathways: Expectations for Care Transitions

1. Education on care transitions
2. Engagement in change of duty hand-offs
3. Engagement in patient transfers between services/locations
4. Faculty assessment of resident practice
5. Communication between primary teams and consultants

Site monitoring of care transitions



Care Transitions Properties

- Education
 - Awareness of policies, simulated or real time training, faculty aware and assess
- Engagement
 - Common process, interprofessional, patients
- Patient transfers
 - Common process, interprofessional
- Consultation
 - Direct communication




How do you use this information?

- Think about what your DIO needs
- Make sure your curricula/programs also meet ACGME needs
- Think about what elements can cross specialties
 - Aim to become the best practice!
- Details are in the toolkit section on National Mandates

Assessing Milestones in Patient Safety and Quality Improvement in NAS

See it to believe it!

Cheryl W. O'Malley, MD



Objectives

- Compare Assessment in Traditional vs Competency Based Medical Education
- Define the role of the clinical competency committee, semi-annual reporting and annual program evaluations ACGME's Next Accreditation System(NAS)
- Discuss the SHM Patient Safety assessment table and review examples of incorporating it into existing assessment systems.

Case

- 5 years from now, a close friend is admitted to the hospital following a diagnosis of leukemia.
- Despite being in another state, you are surprised when a new graduate from your program walks in as their hospitalist.
- Unfortunately, you developed amnesia following Mefloquine for an African safari (another story) and can't remember how she performed...



Traditional model

```

    graph LR
      Curriculum[Curriculum] --> Objectives[Educational objectives]
      Curriculum --> Assessment[Assessment]
      Objectives -.-> Assessment
  
```

Competency-based education model

```

    graph LR
      Health[Health needs  
Health systems] --> Competencies[Competencies  
Outcomes]
      Competencies --> Curriculum[Curriculum]
      Competencies --> Assessment[Assessment]
  
```

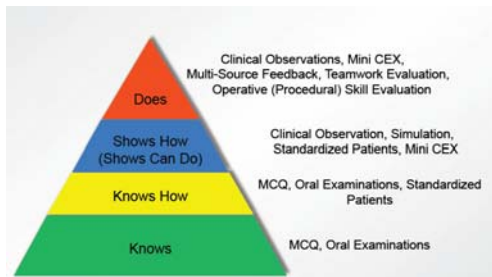
Traditional vs CBME Assessment

	TRADITIONAL TIME/PROCESS BASED	COMPETENCY BASED MEDICAL EDUCATION
Assessment tool	Proxy	Authentic (mimics real tasks of profession)
Setting for evaluation	Removed (gestalt)	Direct observation
Evaluation	Norm-referenced	Criterion-referenced
Timing of assessment	Emphasis on summative	Emphasis on formative

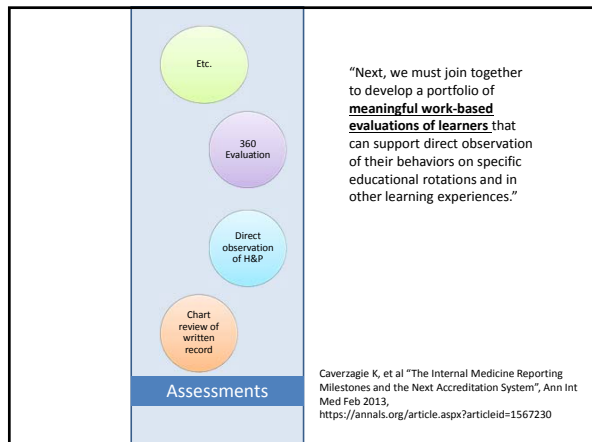
Carraccio, et al. 2002.

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Miller's Pyramid of Clinical Competence

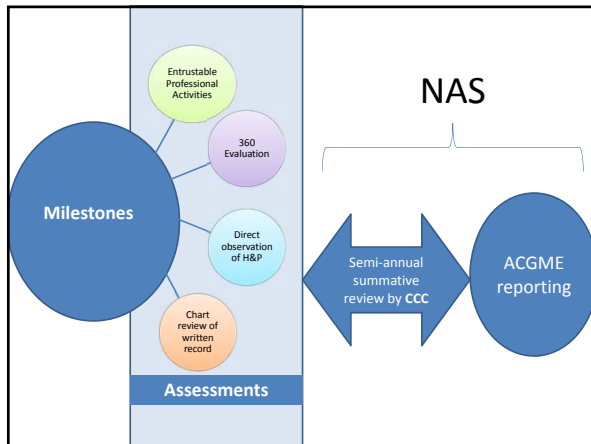


Miller, GE. Assessment of Clinical Skills/Competence/Performance Academic Medicine (Supplement) 1990. 65. (S63-S67)
van der Vleuten, CPM, Schuwirth, LWT. Assessing professional competence: from Methods to Programmes. *Medical Education* 2005; 39: 309-317



"Next, we must join together to develop a portfolio of meaningful work-based evaluations of learners that can support direct observation of their behaviors on specific educational rotations and in other learning experiences."

Caverzagie K, et al "The Internal Medicine Reporting Milestones and the Next Accreditation System", Ann Int Med Feb 2013, <https://annals.org/article.aspx?articleid=1567230>



The Internal Medicine “Reporting” Milestones

The Internal Medicine Milestone Project

A Joint Initiative of
The Accreditation Council for Graduate Medical Education
and
The American Board of Internal Medicine



American Board
of Internal Medicine®

Full document accessible at: <http://www.acgme-nas.org/assets/pdf/Milestones/InternalMedicineMilestones.pdf>

13. Learns and improves via performance audit (PBLI2)

13. Learns and improves via performance audit (PBLI2)			
Critical Deficiencies	Basic	Ready for unsupervised practice	Aspirational
Disregards own clinical performance data	Limits use of clinical performance data	Analyzes own clinical performance data and identifies opportunities for improvement	Analyzes own clinical performance data and actively improves performance
Demonstrates no inclination to participate in or even consider the results of quality improvement efforts	Nontrivially participates in quality improvement projects	Effectively participates in a quality improvement project	Actively engages in improvement initiatives
	Not familiar with the principles, techniques or impact of quality improvement	Understands common principles and techniques of quality improvement and appreciates the responsibility to assess and improve care for a panel of patients	Demonstrates the ability to apply common principles and techniques of quality improvement to improve care for a panel of patients
Common	Competency	Competency	Competency

“Sub-competency”

ACGME reporting Milestones

9. Recognizes system error and advocates for system improvement (SPB2)

9. Recognizes system error and advocates for system improvement. (SPB2)				
Critical deficiencies			Ready for unsupervised practice	Aspirational
<p>Ignores a risk for error within the system that may impact the care of a patient</p> <p>Ignores feedback and is unwilling to change behavior in order to reduce the risk for error</p>	<p>Does not recognize the potential for system error</p> <p>Makes decisions that could lead to error which are otherwise corrected by the system or supervisor</p> <p>Resistant to feedback about decisions that may lead to error or otherwise cause harm</p>	<p>Recognizes the potential for error within the system</p> <p>Identifies obvious or error or notifies supervisor accordingly</p> <p>Recognizes the potential risk for error in the immediate system and takes necessary steps to mitigate that risk</p> <p>Willing to receive feedback about decisions that may lead to error or otherwise cause harm</p>	<p>Identifies systemic causes of medical error and navigates them to provide safe patient care</p> <p>Advocates for safe patient care and optimal patient care systems</p> <p>Activates formal system resources to investigate and mitigate real or potential medical error</p> <p>Reflects upon and learns from own critical incidents that may lead to medical error</p>	<p>Advocates for system leadership for formally engaged in quality assurance and quality improvement activities</p> <p>Viewed as a leader in identifying and advocating for the prevention of medical error</p> <p>Teaches others regarding the importance of recognizing and mitigating system error</p>
Comments				

Your role in NAS

- Assess learners through direct observation using milestones
- Assess novel areas that might not be currently part of the structure (QI and patient safety)
- Have those assessments “map” to the ACGME reporting milestones

SHM Patient Safety Assessment Table

- Identified “Tasks”
- Defined “Observed Behaviors” in a developmental progression
- Tasks mapped to IM sub-competencies
- Incorporate language into a program’s assessment system to measure outcomes

Society of Hospital Medicine Internal Medicine Education Redesign Subcommittee:
Feldman, L, Caverzagie, K, Bowman, J, Breau, T, Habaicht, B, Lukela M, Markoff, B,
O'Malley, C, Puig, Alberto, Tad-y, D. Released December 2014

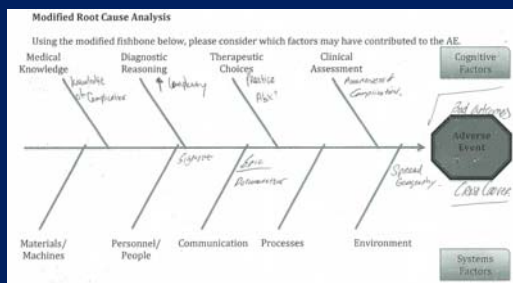
SHM Patient Safety Assessment Table

Task	Observed behavior
Task 1	Patient safety principles and techniques (PBL1, SBP2)
Task 2	Act upon possible/actual patient safety risk (SBP1, SBP2, PROF3)
Task 3	Inter-professional collaborationL: Performing Tasks (PROF1, ICS2, SBP1)
Task 4	Inter-professional collaboration: Communication (SBP1, PROF1, ICS2)
Task 5	Engage local health institution / local system (SBP2, PBLI2)
Task 6	Critical Reflection (PBLI1, PBLI2)

Task 1: Patient safety principles and techniques

Tasks	Observed behavior 1	Observed behavior 2	Observed behavior 3	Observed behavior 4	Observed behavior 5
Patient safety principles and techniques (PBL1, SBP2)	Endorses that providing safe care is a core physician skill and will be part of his/her future practice	Defines the general principles and approaches to patient safety	Using the language and principles in real-world settings	Appropriately applies techniques to analyze a patient safety event	Teaches and disseminates basic strategies and techniques to ensure patient safety

M&M conference Resident Reflection Form



University of Colorado-Darlene Tad-Y (2012 QSEA graduate!)

Discussion and reflection

Please answer all questions.

1. Was there a medical error in the adverse event that occurred in today's discussion? Was that error preventable? *Yes - error in patient history taking. No - no discussion of history taking.*

2. What were the health system forces that contributed to the error? How can these systems be changed to prevent a similar adverse event from occurring in the future?

- *Bringing discussion, PMS w/ 4 hr rounds.*
- *Language barrier of the*
- *Not in real time. Not in discussion. Not in discussion.*

3. Was there a cognitive error that contributed to the error? How would you address the cognitive error?

- *Not a cognitive error. Not a cognitive error.*
- *Not a cognitive error. Not a cognitive error.*

4. Please recommend one course of action that our institution can take to prevent an event like this in the future. Who else should be involved in this process? What would be the role of the residents and students?

Add an intern/resident cross over help desk staffed by fellow on RS or Chief on. Can take on consult. Can take on.

Example 2: Monthly Evaluation

BSMC/Phoenix VA 2014 Monthly Resident Work Assessment (abbreviated)

Learning Goals

1. Resident can consistently perform this skill, even with assistance.

2. Resident can perform this skill but only under direct (i.e. physically present or immediately available) supervision by a more senior member of the team.

3. Resident can perform this skill with indirect supervision (i.e. immediately available by phone or voice mail) but only after completing.

4. Can do this at the level of a general IM attending.

5. Expert, advanced skill beyond that of general IM.

Skills

1. Synthesizes all data to generate a prioritized differential diagnosis.	10. Appropriately interprets the results of CXR, EKG, basic abdominal imaging, ABGs, and body fluid analyses (CP, urine and synovial) (R2, R3, R4).	
2. Seeks and reports relevant information from secondary sources.	11. Translates medical information needs into well-formulated clinical questions independently and utilizes literature searches and point of care resources with sophistication to answer them (R4).	
3. Performs and documents accurate physical exams that are descriptive of cardiac murmurs, assessment of volume status (R3).	12. Incorporates cost-awareness principles into standard clinical judgments and decision-making, including recognizing unnecessary daily tests (R3/R4).	
4. Consistently develops appropriate care plans and modifies additional data, patient preferences, and patient goals to meet them (R3/R4).	13. Prioritizes multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner (R2/R3, R4/R5).	
5. Health records are timely, organized, accurate, complete, consistent, and reflect the patient's history and current status (R3/R4).	14. Willingness to assume professional responsibility regardless of the situation and only defers management to another team or outpatient provider in appropriate circumstances (R3/R4).	
6. Applies updated medical knowledge to manage important patient problems, with these exceptions: (R3/R4) pneumonia, COPD exacerbations, diarrheas, HUS, acute renal failure, delirium, acute, severe mental disorders, stroke, diabetes, seizures, and meningitis (R3, R4, R5).	15. Solicits feedback from all members of the interprofessional team and patients and incorporates it into practice (R3/R4).	
7. Recognizes situations that require urgent or emergent action (R3/R4).	16. Fully understands the rationale and risks associated with common procedures and is able to effectively consent patients (R3/R4).	
8. Recognizes situations that require urgent or emergent action (R3/R4).	17. Demonstrates empathy, compassion and respect to patients and caregivers from all disciplines in all situations and quickly establishes a therapeutic relationship with patients and caregivers (R3/R4, R5).	
9. Recognizes situations that require urgent or emergent action (R3/R4).	18. Able to maintain a therapeutic relationship during conflict and stressful situations including diffusing conflict or disagreements (R3/R4).	
10. Recognizes situations that require urgent or emergent action (R3/R4).	19. Appropriately weighs and discusses recommendations from consultants in order to effectively manage patient care (R3, R4/R5).	
11. Recognizes situations that require urgent or emergent action (R3/R4).	20. Proactively reinforces their medical knowledge by teaching topics daily in teams, to patients, during morning report, and during rounds (R3/R4).	
12. Recognizes situations that require urgent or emergent action (R3/R4).	21. Efficiently coordinates activities of all team members to optimize care (Attending, student, pharmacist, CM, SW, PT, etc.) (R3/R4, R5).	
13. Recognizes situations that require urgent or emergent action (R3/R4).	22. Appropriately delegates tasks to team members to coordinate care and ensure safe and effective patient care (R3/R4).	
14. Recognizes situations that require urgent or emergent action (R3/R4).	23. Activates formal system resources (incident reports and communication to the chief resident in quality and safety) to investigate and mitigate real or potential medical error (R3/R4).	

Example 2: Monthly Evaluation

Efficiently coordinates activities of all team members to optimize care (attending, student, pharmacist, CM, SW, PT, etc.)

1	2	3	4	5	N/A
0	0	0	0	0	0
Comments					
SBP 1 PC 3 ICS 2					
Remaining Characters: 5,000					

Activates formal system resources (incident reports and communication to the chief resident in quality and safety) to investigate and mitigate real or potential medical error

Did not complete an incident report	Completed an incident report together with another team member	Completed an incident report but had to be prompted to do so	Independently completed an incident report of an observed medical error or near miss	N/A
0	0	0	0	0

Tasks 4 and 5

	1	2	3	4	5
Inter-professional collaboration Communication (SBP1, MCR1, IC2)	Participates in team discussion only when required	Participates in team discussion	Shares view point and elicits and works to understand differing views of others in a meaningful way	Shares view point, readily and openly acknowledges differences of others; seeks understanding and compromise to resolve differences	Invites the views of others transparently and openly; navigates complex interactions and is able facilitate discussions in a productive and respectful manner even if compromise cannot be attained
Engage local health institution / local system (SBP2, PBL2)	Recognizes the potential for error within the system and the importance of learning how to effectively engage the system at multiple levels.	Explain the reporting framework in a specific system and the steps needed to engage that system.	Demonstrate engagement in the health system by reporting patient safety problems to appropriate personnel using the reporting framework of a given system.	Join a team and actively participate to operationalize solutions to patient safety problem.	Lead an effort that incorporates multiple levels of the healthcare system to attempt to improve a patient safety issue.



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Example 3: Faculty Development

Continuity Clinic PDF 3 Assessment

Participation as a member of the practice				
	Intimacy score (1-5)	Frequency	Expected time to "3"	Expected time to "5"
Effectively partners with members of the office-based care team to provide appropriate care completes forms/checks notes & responds to tasks in timely manner (SBP, front office, social worker, CDE care, prior authorization)		clinic team members	3	12
Professional Practice				
	Intimacy score (1-5)	Frequency	Expected time to "3"	Expected time to "5"
Recognize limits of ability and ask for observation or assistance when needed; identifies gap need for urgent care - MCR, MCR, MCR, MCR, MCR			1	6
Population management - makes changes to improve in preventative & chronic condition care follow guidelines MCR, MCR		to report	18	30
Provide timely follow up on incident oriented for work and practice partner's patients (documents patient satisfaction and plan MCR, MCR, MCR)		clinic team members	3	6

Task 3: Inter-professional collaboration-performing tasks

	1	2	3	4	5
Inter-professional collaboration Performing tasks (MCR1, IC2, SBP1)	Performs expected clinical duties autonomously.	Able to complete expected clinical duties and will offer to help other team members with their clinical duties	Shares in the team's clinical duties; allows others to work to the top of their skill set	Shares in the team's clinical duties; anticipates the needs of the team and shares in developing solutions	Shares in the team's clinical duties; able to anticipate, identify, access and coordinate internal and external resources to assist the team



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