THEORY BURST: INTERPROFESSIONAL TEACHING/LEARNING STRATEGIES IN QUALITY AND SAFETY
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Resource List

Content
d. The Personal Continuous Quality Improvement Work Book by Duncan Neuhauser, Sylvia Myhre, and Farrokh Alemi [http://www.a4hi.org/education/eduQIWB.cfm]

Delivery Methods

Strategies
MedEdPORTAL interprofessional portal [https://www.mededportal.org/about/initiatives/ipe/]
Teaching for Quality [https://www.aamc.org/initiatives/cei/te4q]
iCollaborative non-peer reviewed [https://www.mededportal.org/icollaborative/]

Quality and Safety Education for Nurses (QSEN.org)
Teaching Strategies
Web modules Module 9: Managing curricular change for QSEN Integration.
Quality and Safety Education for Nurses (QSEN) Faculty Resources [qsen.org/modules/]

Academy for Healthcare Improvement [http://www.a4hi.org/education/index.cfm]
University of Washington Center for Health Sciences Interprofessional Education, Research, and Practice [http://collaborate.uw.edu/]
THEORY BURST: LEARNER ASSESSMENT
Terri Warholak, RPh, PhD, Associate Professor, University of Arizona, College of Pharmacy

References and Instruments


Core competencies for Interprofessional Collaborative Practice
http://www.aacn.nche.edu/education-resources/IPECReport.pdf


Handouts

DAY TWO KEYNOTE: SUCCESS STORIES FOR TEACHING QUALITY IMPROVEMENT AND PATIENT SAFETY
Esther Emard, RN, MSN, MSLIR, Former Chief Operating Officer, National Committee for Quality Assurance, Faculty, The George Washington University, School of Nursing

References

Clinical Microsystem Assessment Tool
Julie K. Johnson, MSPH, PhD, November 2001. Revised 2/21/2013
http://clinicalmicrosystem.org/assets/materials/worksheets/microsystem_assessment.pdf

Team Measurement Tool
# Clinical Microsystem Assessment Tool

**Instructions:** Each of the “success” characteristics (e.g., leadership) is followed by a series of three descriptions. For each characteristic, please check the description that best describes your current microsystem and the care it delivers OR use a microsystem you are MOST familiar with.

<table>
<thead>
<tr>
<th>Characteristic and Definition</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Leadership:</strong> The role of leaders is to balance setting and reaching collective goals, and to empower individual autonomy and accountability, through building knowledge, respectful action, reviewing and reflecting.</td>
<td>✓ Leaders often tell me how to do my job and leave little room for innovation and autonomy. Overall, they don’t foster a positive culture.</td>
</tr>
<tr>
<td><strong>2. Organizational Support:</strong> The larger organization looks for ways to support the work of the microsystem and coordinate the hand-offs between microsystems.</td>
<td>✓ The larger organization isn’t supportive in a way that provides recognition, information, and resources to enhance my work.</td>
</tr>
<tr>
<td><strong>3. Staff Focus:</strong> There is selective hiring of the right kind of people. The orientation process is designed to fully integrate new staff into culture and work roles. Expectations of staff are high regarding performance, continuing education, professional growth, and networking.</td>
<td>✓ I am not made to feel like a valued member of the microsystem. My orientation was incomplete. My continuing education and professional growth needs are not being met.</td>
</tr>
<tr>
<td><strong>4. Education and Training:</strong> All clinical microsystems have responsibility for the ongoing education and training of staff and for aligning daily work roles with training competencies. Academic clinical microsystems have the additional responsibility of training students.</td>
<td>✓ Training is accomplished in disciplinary silos, e.g., nurses train nurses, physicians train residents, etc. The educational efforts are not aligned with the flow of patient care, so that education becomes an “add-on” to what we do.</td>
</tr>
<tr>
<td><strong>5. Interdependence:</strong> The interaction of staff is characterized by trust, collaboration, willingness to help each other, appreciation of complementary roles, respect and recognition that all contribute individually to a shared purpose.</td>
<td>✓ I work independently and I am responsible for my own part of the work. There is a lack of collaboration and a lack of appreciation for the importance of complementary roles.</td>
</tr>
<tr>
<td><strong>6. Patient Focus:</strong> The primary concern is to meet all patient needs — caring, listening, educating, and responding to special requests, innovating to meet patient needs, and smooth service flow.</td>
<td>✓ Most of us, including our patients, would agree that we do not always provide patient centered care. We are not always clear about what patients want and need.</td>
</tr>
</tbody>
</table>

© Julie K. Johnson, MSPH, PhD, November 2001, Revised 2/21/03

Side A Please continue on Side B
<table>
<thead>
<tr>
<th><strong>Characteristic and Definition</strong></th>
<th><strong>Descriptions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Community and Market Focus:</strong> The microsystem is a resource for the community; the community is a resource to the microsystem; the microsystem establishes excellent and innovative relationships with the community.</td>
<td>☐ We focus on the patients who come to our unit. We haven’t implemented any outreach programs in our community. Patients and their families often make their own connections to the community resources they need. ☐ We have tried a few outreach programs and have had some success, but it is not the norm for us to go out into the community or actively connect patients to the community resources that are available to them. ☐ We are doing everything we can to understand our community. We actively employ resources to help us work with the community. We add to the community and we draw on resources from the community to meet patient needs.</td>
</tr>
<tr>
<td><strong>8. Performance Results:</strong> Performance focuses on patient outcomes, avoidable costs, streamlining delivery, using data feedback, promoting positive competition, and frank discussions about performance.</td>
<td>☐ We don’t routinely collect data on the process or outcomes of the care we provide. ☐ We often collect data on the outcomes of the care we provide and on some processes of care. ☐ Outcomes (clinical, satisfaction, financial, technical, safety) are routinely measured, we feed data back to staff, and we make changes based on data.</td>
</tr>
<tr>
<td><strong>9. Process Improvement:</strong> An atmosphere for learning and redesign is supported by the continuous monitoring of care, use of benchmarking, frequent tests of change, and a staff that has been empowered to innovate.</td>
<td>☐ The resources required (in the form of training, financial support, and time) are rarely available to support improvement work. Any improvement activities we do are in addition to our daily work. ☐ Some resources are available to support improvement work, but we don’t use them as often as we could. Change ideas are implemented without much discipline. ☐ There are ample resources to support continual improvement work. Studying, measuring and improving care in a scientific way are essential parts of our daily work.</td>
</tr>
<tr>
<td><strong>10. Information and Information Technology:</strong> Information is THE connector - staff to patients, staff to staff, needs with actions to meet needs. Technology facilitates effective communication and multiple formal and informal channels are used to keep everyone informed all the time, listen to everyone’s ideas, and ensure that everyone is connected on important topics. Given the complexity of information and the use of technology in the microsystem, assess your microsystem on the following three characteristics: (1) integration of information with patients, (2) integration of information with providers and staff, and (3) integration of information with technology.</td>
<td>☐ Patients have access to some standard information that is available to all patients. ☐ Patients have access to standard information that is available to all patients. We’ve started to think about how to improve the information they are given to better meet their needs. ☐ Patients have a variety of ways to get the information they need and it can be customized to meet their individual learning styles. We routinely ask patients for feedback about how to improve the information we give them.</td>
</tr>
<tr>
<td><strong>A. Integration of Information with Patients</strong></td>
<td>☐ Patients have access to some standard information that is available to all patients. ☐ Patients have access to standard information that is available to all patients. We’ve started to think about how to improve the information they are given to better meet their needs. ☐ Patients have a variety of ways to get the information they need and it can be customized to meet their individual learning styles. We routinely ask patients for feedback about how to improve the information we give them.</td>
</tr>
<tr>
<td><strong>B. Integration of Information with Providers and Staff</strong></td>
<td>☐ I am always tracking down the information I need to do my work. ☐ Most of the time I have the information I need, but sometimes essential information is missing and I have to track it down. ☐ The information I need to do my work is available when I need it.</td>
</tr>
<tr>
<td><strong>C. Integration of Information with Technology</strong></td>
<td>☐ The technology I need to facilitate and enhance my work is either not available to me or it is available but not effective. The technology we currently have does not make my job easier. ☐ I have access to technology that will enhance my work, but it is not easy to use and seems to be cumbersome and time consuming. ☐ Technology facilitates a smooth linkage between information and patient care by providing timely, effective access to a rich information environment. The information environment has been designed to support the work of the clinical unit.</td>
</tr>
</tbody>
</table>
## Appendix

### Team Measurement Tools

Adapted with permission from Valentine et al., *Measuring Teamwork in Health Care Settings: A Review of Survey Instruments* (in press).

#### Team Effectiveness Surveys

(One of several dimensions measured)

<table>
<thead>
<tr>
<th>Survey Name</th>
<th>Psychometric Validity*</th>
<th>Related to Outcomes‡</th>
<th>Team Behaviors Measured</th>
<th>Team Emergent States Measured§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Group Effectiveness (Campion 1993)</td>
<td>No</td>
<td>Yes</td>
<td>Workload sharing</td>
<td>Social support</td>
</tr>
<tr>
<td>Crossfunctional Cooperation (Pinto 1993)</td>
<td>No</td>
<td>No</td>
<td>Cooperation</td>
<td>none</td>
</tr>
<tr>
<td>Group Effectiveness/Interdisciplinary Collaboration (Vinokur-Kaplan 1995/Armer 1978)</td>
<td>No</td>
<td>Yes</td>
<td>Effort</td>
<td>none</td>
</tr>
<tr>
<td>Team Process Domain (Denison 1996)</td>
<td>No</td>
<td>No</td>
<td>Workload sharing</td>
<td>Norms</td>
</tr>
<tr>
<td>Psychological Safety &amp; Team Learning (Edmondson 1999)</td>
<td>Yes</td>
<td>Yes</td>
<td>Team learning behaviors</td>
<td>Psychological safety</td>
</tr>
<tr>
<td>Team Effectiveness Audit Tool (Bateman 2002)</td>
<td>Yes</td>
<td>No</td>
<td>Use of resources</td>
<td>Team synergy</td>
</tr>
<tr>
<td>Team Process (Doolen 2003)</td>
<td>No</td>
<td>No</td>
<td>Information sharing</td>
<td>none</td>
</tr>
<tr>
<td>Team Diagnostic Survey (Wageman 2005)</td>
<td>No</td>
<td>Yes</td>
<td>Effort</td>
<td>none</td>
</tr>
<tr>
<td>Team Survey (Senior 2007)</td>
<td>No</td>
<td>No</td>
<td>Task interactions</td>
<td>Social support</td>
</tr>
</tbody>
</table>

#### Teamwork Surveys for Bounded Teams

(groups of people who work together routinely)

<table>
<thead>
<tr>
<th>Survey Name</th>
<th>Psychometric Validity*</th>
<th>Related to Outcomes‡</th>
<th>Team Behaviors Measured</th>
<th>Team Emergent States Measured§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Process Scale (Brannick 1993)</td>
<td>No</td>
<td>No</td>
<td>Communication</td>
<td>Group cohesion</td>
</tr>
<tr>
<td>Team Member Exchange Quality Scale (Seers 1995)</td>
<td>No</td>
<td>No</td>
<td>Communication Coordination Workload sharing</td>
<td>Understanding roles</td>
</tr>
<tr>
<td>Collaboration Scale (Kahn 1997)</td>
<td>No</td>
<td>No</td>
<td>General teamwork quality Communication</td>
<td>Shared objectives</td>
</tr>
<tr>
<td>Team Climate Inventory (Anderson 1998)</td>
<td>Yes</td>
<td>Yes</td>
<td>Communication Coordination Collaboration Use of all members’ expertise Share workload Shared decision making</td>
<td>Respect Group cohesion Social support Psychological safety Shared objectives</td>
</tr>
<tr>
<td>Team Process Quality (Hauptman 1999)</td>
<td>No</td>
<td>No</td>
<td>Communication Coordination Collaboration Use of all members’ expertise</td>
<td>none</td>
</tr>
<tr>
<td>Team Survey (Millward 2001)</td>
<td>Yes</td>
<td>No</td>
<td>Communication Coordination Use of all members’ expertise Share workload</td>
<td>Respect Understanding roles Shared objectives</td>
</tr>
<tr>
<td>Team Effectiveness (Pearce 2002)</td>
<td>Yes</td>
<td>No</td>
<td>General teamwork quality Communication</td>
<td>none</td>
</tr>
<tr>
<td>Team Functioning (Strasser 2002)</td>
<td>No</td>
<td>No</td>
<td>Communication Collaboration Use of all members’ expertise Active conflict management</td>
<td>Respect Psychological safety Understanding roles Shared objectives</td>
</tr>
<tr>
<td>Cross-Functional Team Processes (Alexander 2005)</td>
<td>Yes</td>
<td>Yes</td>
<td>Communication Shared decision making</td>
<td>Respect Social support Psychological safety</td>
</tr>
<tr>
<td>Teamwork Quality Survey (Hoegl 2001)</td>
<td>Yes</td>
<td>Yes</td>
<td>Communication Coordination Collaboration Use of all members’ expertise Share workload Shared decision making Active conflict management Effort</td>
<td>Respect Group cohesion Social support</td>
</tr>
<tr>
<td>Teamwork Scale (Friesen 2008)</td>
<td>No</td>
<td>No</td>
<td>none</td>
<td>Respect Group cohesion Social support</td>
</tr>
<tr>
<td>Survey Name</td>
<td>Psychometric Validity*</td>
<td>Related to Outcomes‡</td>
<td>Team Behaviors Measured</td>
<td>Team Emergent States Measured§</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td>ICU Nurse Physician Collaboration (Shortell 1991)</td>
<td>Yes</td>
<td>Yes</td>
<td>Communication Coordination Use of all participants’ expertise Shared decision making Active conflict management Effort</td>
<td>Respect</td>
</tr>
<tr>
<td>Collaboration &amp; Satisfaction about Care Decisions (Baggs 1994)</td>
<td>No</td>
<td>Yes</td>
<td>Communication Coordination Collaboration Use of all participants’ expertise Shared decision making</td>
<td>none</td>
</tr>
<tr>
<td>Professional Working Relationships (Adams 1995)</td>
<td>No</td>
<td>No</td>
<td>General teamwork quality Communication Coordination Collaboration Use of all participants’ expertise Share workload Shared decision making Active conflict management Effort</td>
<td>Respect Social support Understanding roles</td>
</tr>
<tr>
<td>Relational Coordination (Gittell 2002)</td>
<td>No</td>
<td>Yes</td>
<td>Communication Use of all participants’ expertise Active conflict management</td>
<td>Respect Shared objectives</td>
</tr>
<tr>
<td>Hospital Survey on Patient Safety (AHRQ 2004)</td>
<td>Yes</td>
<td>Yes</td>
<td>Communication Coordination Collaboration</td>
<td>Respect Psychological safety Social support</td>
</tr>
<tr>
<td>Survey Type</td>
<td>Communication</td>
<td>Coordination</td>
<td>Collaboration</td>
<td>Use of all participants’ expertise</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------</td>
<td>--------------</td>
<td>---------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Perceptions about Interdisciplinary Collaboration (Copnell 2004)</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teamwork Scale (Hutchinson 2006)</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Attitudes Questionnaire (Sexton 2006)</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td>Communication</td>
</tr>
<tr>
<td>Leiden Operating Theater &amp; Intensive Care Safety (LOTICS) (Van Beuzekom 2007)</td>
<td>No</td>
<td>No</td>
<td>General teamwork quality</td>
<td>Understanding roles</td>
</tr>
<tr>
<td>Collaboration Scale (Masse 2008)</td>
<td>No</td>
<td>No</td>
<td>Communication</td>
<td>Use of all participants’ expertise</td>
</tr>
<tr>
<td>Nurse Physician Collaboration (Ushiro 2009)</td>
<td>No</td>
<td>No</td>
<td>Communication</td>
<td>Coordination</td>
</tr>
<tr>
<td>Nursing Teamwork Survey (Kalisch 2010)</td>
<td>No</td>
<td>Yes</td>
<td>Communication</td>
<td>Coordination</td>
</tr>
</tbody>
</table>

*Surveys determined to display psychometric validity if they met reasonable standards in four domains: internal consistency/reliability, interrater agreement and reliability, discriminant validity, and content/external validity.

‡Outcomes defined as clinical measures, nonclinical process measures, or both.

§Emergent states are defined as “affective, cognitive and motivation states that emerge during the course of [teamwork].”
QUALITY IMPROVEMENT AND PATIENT SAFETY RESOURCES VIRTUAL TOUR
Mary A. Dolansky, PhD, RN, Associate Professor, School of Nursing & Director, QSEN Institute Case Western Reserve University

Training Programs in Quality Improvement and Patient Safety

Courses for Developing Competence in QI/PS

1. **Patient Safety Practitioner Certificate Program**
   Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine

2. **Patient Safety Leadership Training**
   Patient Safety Center, Duke University Health System

3. **Quality and Safety Leadership in Academic Medicine (QSLAM)**
   Institute for Quality and Patient Safety, University of Virginia

4. **Advanced Training Program and miniAdvanced Training Program**
   Institute for Health Care Delivery Research, Intermountain Healthcare

5. **Intermediate Improvement Science Series (I2S2)**
   Cincinnati Children’s Hospital

6. **Advanced Improvement Methods (AIM) Course**
   Cincinnati Children’s Hospital
   [http://www.cincinnatichildrens.org/service/j/anderson-center/education/additional-programs/](http://www.cincinnatichildrens.org/service/j/anderson-center/education/additional-programs/)

Online Courses for Developing competence in QI/PS

7. Mayo Clinic continuous Professional Development QI/PS
8. Duke Patient Safety- Quality Improvement Online Modules
9. **Open School**
   Institute for Healthcare Improvement
   [http://www.ihi.org/offerings/IHIOpenSchool/Pages/default.aspx](http://www.ihi.org/offerings/IHIOpenSchool/Pages/default.aspx)
Handouts

Courses for Developing Educators in QI/PS

1. **Faculty Development Program in Healthcare Quality and Patient Safety**
   Northwestern University Feinberg School of Medicine
   [http://www.feinberg.northwestern.edu/sites/chs/](http://www.feinberg.northwestern.edu/sites/chs/)

2. **Leading Change to Improve Quality and Patient Safety – A Practical Workshop for Clinicians and Educators**
   Tufts Health Care Institute

3. **Quality and Safety Educators Academy (QSEA)**
   Society of Hospital Medicine and Alliance for Academic Internal Medicine
   [http://sites.hospitalmedicine.org/qsea/](http://sites.hospitalmedicine.org/qsea/)

4. Interprofessional Education Institute
   Interprofessional Education Collaborative (IPEC)
   [https://ipecollaborative.org/](https://ipecollaborative.org/)

Masters Programs/Fellowships

1. **Master of Science in Healthcare Quality and Patient Safety**
   Northwestern University Feinberg School of Medicine
   [http://www.feinberg.northwestern.edu/sites/chs/](http://www.feinberg.northwestern.edu/sites/chs/)

2. **Master of Science in Healthcare Quality and Safety**
   Jefferson School of Population Health, Thomas Jefferson University
   [http://www.jefferson.edu/population_health/academic_programs/quality_safety.html](http://www.jefferson.edu/population_health/academic_programs/quality_safety.html)

3. **Master of Science in Health Care Quality**
   George Washington University School of Medicine
   [http://www.gwu.edu/colleges-schools](http://www.gwu.edu/colleges-schools)

4. **Master of Science in Patient Safety Leadership**
   University of Illinois at Chicago College of Medicine
   [http://www.uic.edu/scs/patient-safety/faculty.html](http://www.uic.edu/scs/patient-safety/faculty.html)

5. **Fellowship in Patient Safety and Quality**
   Harvard Medical School
   [http://www.hms.harvard.edu/hfpsq/](http://www.hms.harvard.edu/hfpsq/)

6. **VA Quality Scholars Fellowship Program**
   U.S. Department of Veterans Affairs
Handouts

7. VA Interprofessional Fellowship Program in Patient Safety
   U.S. Department of Veterans Affairs
   http://www.va.gov/oaa/CRQS.asp

8. VA Chief Residency in Quality and Patient Safety (CQRS) Program
   U.S. Department of Veterans Affairs

Teaching Strategies
1. Quality and Safety Education for Nurses (QSEN.org)

Other
1. Department of Health and Human Services Health Resources and Services Administration – modules on quality improvement (pdfs on Bb) or go to
   a. Glossary
   b. Quality Improvement
   c. Improvement Teams
   d. Managing Data for Performance Improvement
   e. Performance Management and Measurement
   f. Developing and Testing A QI Plan
   g. Redesigning a System of Care to Promote QI
   h. Testing for Improvement
2. George Mason University, Process Improvement course on Health Care Quality Improvement (modules on specific topics)
   http://gunston.gmu.edu/healthscience/708/default.asp
3. American Society for Quality - Quality Tools
   http://asq.org/learn-about-quality/quality-tools.html
4. Institute for Healthcare Improvement
   www.ihi.org
   The Healthcare Improvement Skills Center
   http://improvementskills.org
Handouts

THEORY BURST: PROGRAM EVALUATION AND IMPROVEMENT

Jody Fitzpatrick, PhD, Associate Professor - President, American Evaluation Association, University of Colorado Denver, School of Public Affairs

Resource List

American Evaluation Association web site contains much interesting information including online materials, links to e-training sessions, blogs, and references. http://www.eval.org/p/us/in

