Handouts

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

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Resource List

Content

a. Ogrinc, G. S., Headrick, L. A., Moore, S. M., Dolansky, M. A., Madigosky, W. Barton, A. (2011). Fundamentals of Health Care Improvement. 2nd Edition. Oakbrook: Joint Commission Resources.
b. Singh, M.K. and Dolansky, M. A. (2009).Editors for the special issue titled Education and Quality Management. Quality Management in Health Care, 18(3).
c. IHI Open School http://app.ihi.org/lms/home.aspx and new module 'Quality Improvement Practicum' http://www.ihi.org/offerings/IHIOpenSchool/Courses/Pages/OpenSchoolUpcomingCourses.aspx
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

Team based Learning Team-Based Learning for Health Professions Education: A Guide to Using Small Groups for Improving Learning [Paperback]Larry K. Michaelsen, Dean X. Parmelee , Kathryn K. McMahon , Ruth E. Levine , Diane M. Billings

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/

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THEORY BURST: LEARNER ASSESSMENT

Terri Warholak, RPh, PhD, Associate Professor, University of Arizona, College of Pharmacy

References and Instruments

http://www.kirkpatrickpartners.com/OurPhilosophy/TheKirkpatrickModel/tabid/302/Default.aspx

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

Jackson TL. Application of quality assurance principles: Teaching students medication error reduction skills in a "real world" environment. *American Journal of Pharmaceutical Education*. 2004; 68(1) Article 17.

Warholak TL. Preceptor perceptions of pharmacy student team quality assurance projects. *Journal American Journal of Pharmaceutical Education*. 2009. 73(3) Article 47. PMID: 19564990. PMCID: PMC2703284.

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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
Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc.

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.

	Characteristic and Definition	Descriptions			
Leadership	**1. Leadership:** 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.	☐ 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.	☐ Leaders struggle to find the right balance between reaching performance goals and supporting and empowering the staff.	☐ Leaders maintain constancy of purpose, establish clear goals and expectations, and foster a respectful positive culture. Leaders take time to build knowledge, review and reflect, and take action about microsystems and the larger organization.	☐ Can't Rate
Leadership	**2. Organizational Support:** The larger organization looks for ways to support the work of the microsystem and coordinate the hand-offs between microsystems.	☐ The larger organization isn't supportive in a way that provides recognition, information, and resources to enhance my work.	☐ The larger organization is inconsistent and unpredictable in providing the recognition, information and resources needed to enhance my work.	☐ The larger organization provides recognition, information, and resources that enhance my work and makes it easier for me to meet the needs of patients.	☐ Can't Rate
Staff	**3. Staff Focus:** 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.	☐ 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.	☐ I feel like I am a valued member of the microsystem, but I don't think the microsystem is doing all that it could to support education and training of staff, workload, and professional growth.	☐ I am a valued member of the microsystem and what I say matters. This is evident through staffing, education and training, workload, and professional growth.	☐ Can't Rate
Staff	**4. Education and Training:** 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.	☐ 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.	☐ We recognize that our training could be different to reflect the needs of our microsystem, but we haven't made many changes yet. Some continuing education is available to everyone.	☐ There is a team approach to training, whether we are are training staff, nurses or students. Education and patient care are integrated into the flow of work in a way that benefits both from the available resources. Continuing education for all staff is recognized as vital to our continued success.	☐ Can't Rate
Staff	**5. Interdependence:** 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.	☐ 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.	☐ The care approach is interdisciplinary, but we are not always able to work together as an effective team.	☐ Care is provided by a interdisciplinary team characterized by trust, collaboration, appreciation of complementary roles, and a recognition that all contribute individually to a shared purpose.	☐ Can't Rate
Patients	**6. Patient Focus:** 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.	☐ 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.	☐ We are actively working to provide patient centered care and we are making progress toward more effectively and consistently learning about and meeting patient needs.	☐ We are effective in learning about and meeting patient needs — caring, listening, educating, and responding to special requests, and smooth service flow.	☐ Can't Rate

Please continue on Side B

Clinical Microsystem Assessment Tool

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	Characteristic and Definition		Descriptions			
Patients	**7. Community and Market Focus:** 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.		☐ 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.	☐ Can't Rate
Performance	**8. Performance Results:** Performance focuses on patient outcomes, avoidable costs, streamlining delivery, using data feedback, promoting positive competition, and frank discussions about performance.		☐ 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.	☐ Can't Rate
Performance	**9. Process Improvement:** 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.		☐ 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.	☐ Can't Rate
Information and Information Technology	**10. Information and Information Technology:** 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.*	A. Integration of Information with Patients	☐ 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.	☐ Can't Rate
		B. Integration of Information with Providers and Staff	☐ 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.	☐ Can't Rate
		C. Integration of Information with Technology	☐ 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.	☐ Can't Rate

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 *(teamwork one of several dimensions measured)*				
Survey Name	**Psychometric Validity***	**Related to Outcomes‡**	**Team Behaviors Measured**	**Team Emergent States Measured§**
Work Group Effectiveness (Campion 1993)	No	Yes	Workload sharing Communication	Social support Potency
Crossfunctional Cooperation (Pinto 1993)	No	No	Cooperation	none
Group Effectiveness/Interdisciplinary Collaboration (Vinokur-Kaplan 1995/Armer 1978)	No	Yes	Effort Use of expertise Strategy	none
Team Process Domain (Denison 1996)	No	No	Workload sharing Use of expertise Strategy	Norms Teamwork Values
Psychological Safety & Team Learning (Edmondson 1999)	Yes	Yes	Team learning behaviors	Psychological safety Team efficacy
Team Effectiveness Audit Tool (Bateman 2002)	Yes	No	Use of resources	Team synergy
Team Process (Doolen 2003)	No	No	Information sharing Team processes	none
Team Diagnostic Survey (Wageman 2005)	No	Yes	Effort Use of expertise Strategy Social interactions	none
Team Survey (Senior 2007)	No	No	Task interactions	Social support
Teamwork Surveys for Bounded Teams *(groups of people who work together routinely)*				
Survey Name	**Psychometric Validity***	**Related to Outcomes‡**	**Team Behaviors Measured**	**Team Emergent States Measured§**
Team Process Scale (Brannick 1993)	No	No	Communication Coordination Collaboration	Group cohesion

Team Member Exchange Quality Scale (Seers 1995)	No	No	Communication Coordination Workload sharing	Understanding roles
Collaboration Scale (Kahn 1997)	No	No	General teamwork quality Communication	Shared objectives
Team Climate Inventory (Anderson 1998)	Yes	Yes	Communication Coordination Collaboration Use of all members' expertise Share workload Shared decision making	Respect Group cohesion Social support Psychological safety Shared objectives
Team Process Quality (Hauptman 1999)	No	No	Communication Coordination Collaboration Use of all members' expertise	none
Team Survey (Millward 2001)	Yes	No	Communication Coordination Use of all members' expertise Share workload	Respect Understanding roles Shared objectives
Team Effectiveness (Pearce 2002)	Yes	No	General teamwork quality Communication	none
Team Functioning (Strasser 2002)	No	No	Communication Collaboration Use of all members' expertise Active conflict management	Respect Psychological safety Understanding roles Shared objectives
Cross-Functional Team Processes (Alexander 2005)	Yes	Yes	Communication Shared decision making	Respect Social support Psychological safety
Teamwork Quality Survey (Hoegl 2001)	Yes	Yes	Communication Coordination Collaboration Use of all members' expertise Share workload Shared decision making Active conflict management Effort	Respect Group cohesion Social support
Teamwork Scale (Friesen 2008)	No	No	none	Respect Group cohesion Social support

Team Organization (La Duckers 2008)	No	No	Communication Coordination	none
Teamwork Surveys for Unbounded Teams *(groups of people who work in shifting/changing configurations)*				
Survey Name	**Psychometric Validity***	**Related to Outcomes‡**	**Team Behaviors Measured**	**Team Emergent States Measured§**
ICU Nurse Physician Collaboration (Shortell 1991)	Yes	Yes	Communication Coordination Use of all participants' expertise Shared decision making Active conflict management Effort	Respect
Collaboration & Satisfaction about Care Decisions (Baggs 1994)	No	Yes	Communication Coordination Collaboration Use of all participants' expertise Shared decision making	none
Professional Working Relationships (Adams 1995)	No	No	General teamwork quality Communication Coordination Collaboration Use of all participants' expertise Share workload Shared decision making Active conflict management Effort	Respect Social support Understanding roles
Relational Coordination (Gittell 2002)	No	Yes	Communication Use of all participants' expertise Active conflict management	Respect Shared objectives
Hospital Survey on Patient Safety (AHRQ 2004)	Yes	Yes	Communication Coordination Collaboration	Respect Psychological safety Social support

Perceptions about Interdisciplinary Collaboration (Copnell 2004)	No	No	Communication Coordination Collaboration Use of all participants' expertise Shared decision making	none
Teamwork Scale (Hutchinson 2006)	No	No	General teamwork quality Communication	none
Safety Attitudes Questionnaire (Sexton 2006)	No	Yes	Communication Coordination Collaboration Use of all participants' expertise Active conflict management	Respect Psychological safety Social support
Leiden Operating Theater & Intensive Care Safety (LOTICS) (Van Beuzekom 2007)	No	No	General teamwork quality	Understanding roles
Collaboration Scale (Masse 2008)	No	No	Communication Use of all participants' expertise Active conflict management	Respect Psychological safety
Nurse Physician Collaboration (Ushiro 2009)	No	No	Communication Coordination Collaboration Use of all participants' expertise Share workload Active conflict management Effort	Respect Social support Understanding roles Shared objectives
Nursing Teamwork Survey (Kalisch 2010)	No	Yes	Communication Coordination Collaboration Use of all participants' expertise Share workload Active conflict management Effort	Respect Social support Understanding roles Shared objectives

*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]."

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QUALITY IMPROVEMENT AND PATIENT SAFETY RESOURCES VIRTUAL TOUR

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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
   http://www.hopkinsmedicine.org/armstrong_institute/programs/

2. Patient Safety Leadership Training
   Patient Safety Center, Duke University Health System
   https://www.aamc.org/external/269578?url=http://www.dukepatientsafetycenter.com

3. Quality and Safety Leadership in Academic Medicine (QSLAM)
   Institute for Quality and Patient Safety, University of Virginia
   https://www.aamc.org/external/269580?url=https://iqps.med.virginia.edu/cms/second.php?pageid=15

4. Advanced Training Program and miniAdvanced Training Program
   Institute for Health Care Delivery Research, Intermountain Healthcare
   https://www.aamc.org/external/270326?url=http://intermountainhealthcare.org/qualityandresearch/institute/courses/Pages/home.aspx

5. Intermediate Improvement Science Series (I2S2)
   Cincinnati Children's Hospital
   https://www.aamc.org/external/324868?url=http://www.cincinnatichildrens.org/service/j/anderson-center/education/i2s2/

6. Advanced Improvement Methods (AIM) Course
   Cincinnati Children's Hospital
   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

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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/

2. Leading Change to Improve Quality and Patient Safety – A Practical Workshop for Clinicians and Educators
   Tufts Health Care Institute
   http://www.thci.org/Programs/qualitysafety/2011/index.asp

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

4. Interprofessional Education Institute
   Interprofessional Education Collaborative (IPEC)
   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/

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

3. Master of Science in Health Care Quality
   George Washington University School of Medicine
   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

5. Fellowship in Patient Safety and Quality
   Harvard Medical School
   http://www.hms.harvard.edu/hfpsq/

6. VA Quality Scholars Fellowship Program
   U.S. Department of Veterans Affairs
   http://vaqs.org/

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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
   http://www.va.gov/oaa/specialfellows/programs/SF_patient_safety.asp?p=12

Teaching Strategies

1. Quality and Safety Education for Nurses (QSEN.org)
2. Med Ed Portal (https://www.**mededportal**.org)

Other

1. Department of Health and Human Services Health Resources and Services Administration – modules on quality improvement (pdfs on Bb) or go to http://www.hrsa.gov/quality/toolbox/methodology/index.html
   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://improvementskils.org

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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

American Evaluation Association (2004). Guiding principles for evaluators. Retrieved January 3, 2014 from http://www.eval.org/p/cm/ld/fid=51

Fitzpatrick, J.L., Sanders, J.R., & Worthen, B.R. (2011). Program evaluation: Alternative approaches and practical guidelines (4th ed.). Upper Saddle River, NJ: Pearson Education, Inc.
Kirkpatrick, D.L., & Kirkpatrick, J.D. (2006). Evaluating training programs: The four levels (3rd ed.). San Francisco: Berrett-Koehler Publishers.