Professionalism, Patient Safety & Quality Improvement Curriculum

Prior to graduation, **each trainee is required to:**
1) Complete specific AMA Introduction to Practice of Medicine (IPM) and IHI on-line modules listed below to enhance base-line knowledge in Professionalism, Quality Improvement and Patient Safety;

2) Complete at least one Quality Improvement or Safety Improvement Project and present findings to at least one of the Annual Quality and Safety Summits ; and,

3) Write up and submit at least one Quality or Safety Improvement Project results to a peer-reviewed journal or magazine or submit at least one Quality or Safety Improvement Project for presentation to a regional or national meeting.

Core Competency	Topic	**AMA IPM Module Objectives**
Interpersonal & Communication Skills	**Residents as Teachers**	1. Orient a learner to you (the resident), the setting and the patient. 2. Describe the steps in the One-Minute Preceptor. 3. Identify the characteristics of formative feedback.
Interpersonal & Communication Skills	**Patient Handoffs**	1. Define the term "patient handoff". 2. Discuss the importance of patient handoffs and reasons why errors occur. 3. Walk through a popular protocol to identify essential qualities of a good patient handoff. 4. Identify tips for effectively receiving a patient handoff.
Professionalism	**Sleep Deprivation**	1. Review the effects of sleep deprivation on physician performance and patient safety. 2. Provide background on the ACGME's resident duty hour requirements and review subsequent effects on patient care. 3. Identify ways physicians can mitigate the effects of sleep deprivation.
Professionalism	**Cultural Competency In Healthcare**	1. Review and describe the demographic statistics and shifts in the United States related to health and healthcare disparities. 2. Define the meaning of cultural competency and rationale in medicine. 3. Describe healthcare disparities and the impact on patient care. 4. Discuss successful physician-patient interactions.

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IHI Module		Description
QI 102	**How to Improve with the Model for Improvement**	The Model for Improvement, developed by a group called Associates in Process Improvement, is simple to understand and apply. But it's powerful. This course will teach you how to use the Model for Improvement to improve everything from your tennis game to your hospital's infection rate. You'll learn the basic steps in any improvement project: setting an aim, selecting measures, developing ideas for changes, and testing changes using Plan-Do-Study-Act (PDSA) cycles. As you go along, you'll have the opportunity to use the same methodology to start your own personal improvement project.
PS:101	**Introduction to Patient Safety**	No one embarks on a health care career intending to harm patients. But much too often, patients die or suffer injuries because of their experiences within the health care system. In this course, you'll learn why becoming a student of patient safety is critical for everyone involved in health care today, and you will learn a framework for building safer, more reliable systems of care.
PS:104	**Teamwork and communication**	Effective teamwork and communication are critical parts of the design of safe systems. In this course, you'll learn what makes an effective team through case studies from health care and elsewhere. You'll analyze the effects of individual behavior for promoting teamwork, communication, and a culture of safety. You will learn several essential communication tools, such as briefings, SBAR, and critical language, and you will learn how to prevent common problems associated with lapses in communication during critical transition points in health care.

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PS:105	**Responding to Adverse events**	In this course, we're going to describe and advocate a patient-centered approach to use when things go wrong. This approach to adverse events and medical error centers on the needs of the patient, but it is also the best way to address the needs of a caregiver in the wake of an adverse event.
PS:201	**Root Cause Analyses and Actions**	This course introduces learners to a systematic response to error called Root Cause Analyses and Actions (RCA^2). The goal of RCA^2 is to learn from adverse events and near misses, and to take action to prevent them from happening in the future. By the end of this course, you'll have a step-by-step approach for investigating an event and improving after something goes wrong.

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