Barrett, Lori J

From: Felix Ankel [ankel001@umn.edu]
nt: Thursday, June 07, 2007 7:08 AM
o: Lori Barrett
Subject: Fwd: "5 Million Lives" campaign and Reisdent Physicians

Begin forwarded message:

> From: "Ankel, Felix K" <Felix.K.Ankel@HealthPartners.Com>
> Date: February 5, 2007 3:10:07 PM CST
> To: ankel001@umn.edu
> Subject: FW: "5 Million Lives" campaign and Reisdent Physicians
>
>
> -----Original Message-----
> From: Ankel, Felix K
> Sent: Monday, February 05, 2007 2:47 PM
> To: EMD Residents 2007; EMD Residents 2008; EMD Residents 2009; EMD
> Senior MD Staff
> Subject: FW: "5 Million Lives" campaign and Reisdent Physicians
>
> FYI, there is a slow (but significant) movement occuring in GME
> centering around transitioning health care education into health
> care delivery education. e.g.
>
> 1. There is more synergy with the acgme and other organizations
> such as the IOM, IHI etc...(look at the homology of the board of
> directors of these organziations).
> 2. The ACGME is focusing on educational outcomes rather than
> educational content (e.g. chief complaint and procedural
> competency, portfolios etc...)
>
> Things are aligning at Regions where there is an opportunity to
> have the EM residency take a significant role in shaping the health
> care delivery education of the ED, be a major partner in pre-
> hospital and hospital health care delivery education, and be a
> major partner in shaping quality and value initiatives within the
> hospital. A new national steering committee of the AIAMC (alliance
> of independent academic medical centers...the "sundance film"
> equivalent to "hollywood" AAMC) will have significant HP
> representation (including our own Tara OConell and Jerome Siy) that
> may set the stage for this transition nationally.
>
> Please let me know if you have an ideas, thoughts, or would like to
> particpate more in these endeavors as they unroll in the next few
> years. The web site below is informative.
>
> Felix
>
>
>
> -----Original Message-----
> From: Patow, Carl A
> Sent: Friday, February 02, 2007 1:43 PM
> To: Ankel, Felix K; Boffeli, Troy J; Bretzman, Peter A; Das,
> Kamalini X; Frisch, Kelly K; Kehler, Chris; Kobrin, Jerry L; Levy,
> Bruce A; Roeber Rice, Heidi K.; Schubert, Warren V; Snyder, Bruce
> D; Wolpert, Seth I
> Cc: Canaan, Eugenia S; Leiterman, Gretchen M; Isham, George J;
> Rank, Brian H; Boese, Christine M; Holmen, Kenneth D; Nelson, Brock D
> Subject: "5 Million Lives" campaign and Reisdent Physicians

> At the GMEC meetings there has been an initial discussion about integrating the residents into quality improvement efforts at Regions Hospital using the IHI "5-Million Lives" campaign as a focus. As information is added to the IHI website about the campaign, I would like to pass it along to you. In the near future I am planning to meet with each of the program directors to discuss how the residency programs and the residents can help the hospital to achieve higher goals of patient safety.
>
>
> Frequently asked questions about the "5 Million Lives' campaign can be found at http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=6.
>
>
> Please consider which of the initiatives might be best suited to your residency program, and in which ways you might begin to meld quality improvement in these areas into the daily activities of the residents. These activities might also be seen as addressing the ACGME Core Competencies of system based practice and practice based learning.
>
>
> I look forward to our demonstrating to the hospital board, the administration and to patients how medical education can be an effective force in improving patient care. Your creativity and energy toward that end is greatly appreciated.
>
>
> Carl
>
>
> Carl Patow, MD, MPH
>
> Executive Director
>
> HealthPartners Institute for Medical Education
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>
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>

Felix Ankel

From: Felix Ankel [ankel001@tc.umn.edu]
ent: Friday, March 11, 2005 11:00 AM
o: 'robert knopp'; 'Brent.R.Asplin@HealthPartners.com'
Cc: 'Won.G.Chung@HealthPartners.com'
Subject: RE: clinical variation among staff

This is an area close to my heart and one that Brad G and I have been discussing from time to time. Brad calls this nodes of expertise. To get on my soapbox

"My vision is to increase the amount of medical knowledge that is effectively translated from what is known and what is practiced. My goal is to develop curricula and lead educational systems that are learner centered, multi-disciplinary, web based, "open source", continuously available and accessible, experientially focused, and outcomes based. I believe creating innovative curricula, continuously mentoring students, residents, and faculty, and systematically capturing the wisdom of learners and teachers for dissemination best achieve this."

I think this translation piece is the rate limiting factor for quality care and have been setting the groundwork for a Regions EM defined best practice in care (rather than relying on interpretation of former clinician of external proprietary guidelines)

This is what is set so far.
1. EMREL library to archive and search residency wisdom (e.g. can search Knopp + UTI) 2. Emres listserve that facilitates dialogue between practitioners inside and outside the department 3. 18 month curriculum that addresses breadth of EM content 4. 20+ faculty with defined core content "expert" designation

This is what we have but haven't tapped into for this
Education volunteer willing to focus speakers to ensure didactics are of appropriate eadth AND depth and facilitate wisdom posted on emrel in organized manner 2. EMR implementation with ability to link potential diagnosis to Regions defined best practices

These are thoughts I've considered
1. Each resident (27) is a core content expert when they start the residency and is paired with the core content expert faculty. One of their administrative projects is to develop one best practice guideline/per year with their faculty expert. They also review the other guidelines with their faculty on a yearly basis. This will allow each graduating resident to have the breadth of EM knowledge with and area of specified depth plus the experience of writing clinical guidelines 2. The clinical guidelines are living documents where proposed updates are presented on the emres list. Residents and faculty can be instructed to use JADE for this (journal articles delivered electronically) in a push me method. 3. The regions clinical guidelines are cross referenced and linked to our EMR 4. All 27 areas are reviewed in conference as a state of the art panel with the resident and faculty. E.g. we would have a state of the art panel every two weeks (state of the art panels would be 10-15% of all conference time, this will still allow for "core" board type material)

I think great discussion piece for strategic plan. This is one way of reducing MD variation and falls in nicely within the IOM,IHI, Leapfrog, ?Partners for health indicatives (the GE leapfrog equivalent). I think it would be more robust than milliman or Interqual, it addresses acgme issues such as systems based practice and practice based learning, it ultimately will help patient acre and health care education, and can serve as the foundation of our academic research, educational, and operational initiatives for our department.

Thoughts??

- lix

-----Original Message-----
From: robert knopp [mailto:knopp003@umn.edu]
Sent: Tuesday, March 08, 2005 11:43 AM

To: Brent.R.Asplin@HealthPartners.com
Cc: Felix Ankel; Won.G.Chung@HealthPartners.com
Subject: clinical variation among staff

Over the past six months, a recurring question has been posed to me: a resident or staff indicates that they recently reviewed a state of the art paper or attended a conference that reviewed best practices in a certain area and that there is substantial variation in how we do things in our ED regarding clinical condition X such that we are not achieving what we should be doing. Most recently the issue raised was management of CHF. But examples of other issues include aspects of trauma care, mesenteric ischemia, appropriate use of heparin for PE, airway management, antibiotic use.

I know that there are other issues consuming a lot of time. However, I do think for the more common clinical problems we need a strategy to narrow the variability and increase the frequency with which patients are treated with the latest information.

Bob

Alliance of Independent Academic Medical Centers

Committed to exc
medical education a
in independently
academic medica

6/7/2007 12:58 PM

2007 Annual Meeting - Presentations

AIAMC 2007 Annual Meeting
March 29-31, 2007
Barton Creek Resort & Spa
Austin, Texas

Speaker Slides

Kenneth Shine, MD
Executive Vice Chancellor, Health Affairs, U of TX
and Former President, IOM
Keynote Address
Click here to view slides

Charles Francis, MD
Jersey Shore Medical Center
and former Director, NHLBI
Plenary Session #1
Click here to view slides

George Higgins, III, MD
CMO and VP, Medical Affairs
Maine Medical Center
Plenary Session #2
Click here to view slides

Tim Miller, MD
Director, Medical and Academic Affairs
Jody Thompson
Director 6 Sigma
OSF St. Francis
Plenary Session #2
Click here to view slides

John Byrnes, MD
Sr. VP, System Quality
Spectrum Health
Plenary Session #2
Click here to view slides

Carol Aschenbrener, MD
Senior Vice President, Division of Medical Education
AAMC
Closing Session
Click here to view slides

All Other Educational Sessions Available for Viewing or Downloading

Special Interest Forums

Day 1: DIO and Research
John Littlefield, PhD & Neil Weissman, MD

Day 2:DIO
Doug Dorner, MD
Kevin Hinchey, MD
Carol Aschenbrener, MD

Organizational Updates

AAMC
Robert Dickler

ACGME
Patricia M. Surdyk, PhD

ACCME

News and Ev

- May 2007 Newslet (* login required)
- 2006 Annual Repo (* login required)
- National Initiative Video Message fro Don Berwick
- 2007 Annual Meet Photo Gallery
- National Initiative

Scope

The Alliance of Indepen Academic Medical Cent is a national membersh organization whose me major academic medica and health systems con quality patient care, me education and research
Read more >

Mission

The mission of the AIA assist members in achi highest standards of pa through the integration education and research clinical missions.
Read more >

Vision

The AIAMC will be an e national resource for de and sharing best practi medical education and
Read more >

Day 2:Research
Walter Rosenfeld, MD

Day 2:Executive Management
Robert Dickler

Kate Regnier

AMA
Paul Rockey, MD, MPH

The Alliance is where the leaders of independent academic medical centers turn for inf
ideas, and creative solutions to the challenges they have in common. Issues recently t
for special attention include utilizing medical education and research as strategic asset
integrating medical education and research into clinical missions, linking medical educ
research to quality outcomes and patient safety, and the changing dynamic and altera
the balance of power between teaching hospitals and medical schools.

**Learn about the benefits of joining the Alliance of Independent Academic Med
Centers >>**

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Improving Patient Care Through GME: A National Initiative of Independent Academic Medical Centers

National In
Participant
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- Meetings
- Resources
- Member Pr

ANNOUNCEMENT

The Alliance of Independent Academic Medical Centers (AIAMC) and HealthPartners Institute for Medical Education (HPI) have teamed together in planning a national series of substantive discussions entitled, *Improving Patient Care Through GME: A National Initiative of Independent Academic Medical Centers*. This national effort is a direct result of the AIAMC's updated mission and vision and serves to accomplish our identified strategic priority of identifying models that link medical education and research to quality patient care.

DESCRIPTION OF INITIATIVE

Four meetings are planned over the course of a year's time, with the first discussion scheduled for March 31 – April 1, 2007, immediately following the AIAMC Annual Meeting in Austin, Texas. Subsequent meetings will be held as follows: August 3rd & 4th in Minneapolis, MN; November 2nd & 3rd in Washington, DC (in conjunction with the AAMC Annual Meeting); and in late March 2008 at our AIAMC Annual Meeting in Amelia Island, FL.

National Initiative - See the Video Message from Don Berwick

Meeting participants will be selected based upon their demonstrated leadership in utilizing graduate medical education as a key driver in initiatives to improve quality, patient safety, and the cost-effectiveness of care. Participation in these discussions will be limited to 20 to 30 individuals, most of whom will be Alliance members. Also included in this select group will be national leaders in GME and QI. Simply stated, this series will bring together the nation's best and brightest.
At the end of the series, our findings will be professionally written and published.

STEERING COMMITTEE MEMBERS

Click here to view the names and contact information of Alliance members serving on the National Initiative Steering Committee.

CONSULTING FIRM

The National Initiative Steering Committee and AIAMC Board of Directors have selected The Bard Group to assist us in the facilitation of this important project. Click here to learn more about our vendor partner The Bard Group.

DISCUSSION SERIES PARTICIPANTS

Click here to view the names and contact information of Alliance-member participants. (* member login required)

Alliance of Independent Academic Medical Centers

HealthPartners®

Improving Patient Care Through GME:
A National Initiative of Independent Academic Medical Centers

Identifying the Key Players: AIAMC

- The Alliance of Independent Academic Medical Centers (AIAMC) is a national membership organization made up of nearly 60 major academic medical centers and health systems.
- 280 DIOs, CMOs, CEOs, Vice Presidents of Academic Affairs and VPs and Directors of Research are AIAMC members.
- The mission of the AIAMC is to assist members in achieving the highest standards of patient care through the integration of medical education and research into their clinical missions.

Identifying the Key Players: AIAMC

AIAMC Members:

- Regard medical education and research as strategic assets in providing patient-centered care;
- Operate independently of medical school ownership or governance while maintaining major medical school affiliations;
- Care for a patient population that mirrors their local communities;
- Provide teaching and research that is innovative, applicable to practice and community responsive.

(Insert Institution Name) Is an Alliance Member.

Identifying the Key Players: HealthPartners

HealthPartners Institute for Medical Education (IME)

- Is located in Minneapolis, Minnesota;
- Was created in 1996 as a 501(c)3 non-profit corporation that oversees all health professional education activities of the HealthPartners system;
- Sponsors five of its own residency programs, has one joint program and 11 affiliated programs with the University of MN;
- Has been an active AIAMC member for the past eight years.

Identifying the Key Players: IHI

Institute for Healthcare Improvement: 5-Million Lives Campaign

- The 5M Lives Campaign is an initiative to protect patients from five million incidents of medical harm over two years (12/06 – 12/08);
- Campaign builds on the IHI's previous *100 Thousand Lives Campaign*, which focused on preventing unnecessary deaths;
- Six new interventions have been added to the original six interventions from the 100K campaign;
- For a complete overview of the 5M Lives Campaign, visit www.ihi.org/programs/campaign.

How Did the NI Get Started?

•The AIAMC strategic plan was updated in 2005-06 and identified quality of care as a key issue for Alliance members. New vision statement announced, "…the AIAMC will be an essential national resource for developing and sharing best practices in medical education and research."

•HealthPartners was interested in linking emerging quality and safety initiatives with residents' education and agreed to provide funding to support this initiative in partnership with the AIAMC.

•Additional grant funding is currently being sought in an effort to sustain this project.

Why a National Initiative?

- The public and profession acknowledge quality and safety are falling short.
- Hospitals and healthcare systems are seeking rapid improvements in patient care.
- Residents play an important role in patient care at teaching institutions.
- Resident quality improvement efforts, shared across multiple programs, have the potential to improve care more quickly and effectively.

Linking Residents and QI

- Residents have always been aware and responsive to efforts to improve quality of care and patient safety.
- Organizations, like the Institute for Healthcare Improvement (IHI), are leading new process improvements nationally.
- Residents have not generally been visible in these efforts.

"On the national level, residents are invisible in the patient safety journey"
-Jim Conway, Sr. Vice President, IHI

The Work of the National Initiative

- In late 2006, thirty-four participants from 21 AIAMC-member teaching hospitals in the United States were selected to participate based upon a written application and their demonstrated leadership.
- The National Initiative will feature four meetings over the course of a year's time (03/07 – 03/08). The meetings are touchstones for ongoing quality improvement in the participating organizations.
- The National Initiative uses the IHI "5-Million Lives" campaign as the backbone for linking residents with improvements in patient care.

Opportunity

- In the next year, the National Initiative aims to:
  - Discover together residents' current contributions to quality of care and patient safety
  - Explore new means of integrating residents with care improvement and patient safety
  - Join the "5-Million Lives" campaign, aligning residents with national and hospital care goals
  - Create a vibrant network of residencies within the AIAMC sharing improvement strategies
  - Think about the next steps in advancing quality of care and safety for patients every day.

Don Berwick Video

http://www.aiamc.org/ihivideo.php

For More Information…

www.AIAMC.org

Alliance of Independent Academic Medical Centers
401 North Michigan Avenue Suite 1200
Chicago, IL 60611
312.836.3712
Kimberly@aiamc.org

(Speaker can insert personal contact information here)

Closing the Quality Chasm: Educational Initiatives

Felix Ankel, MD
Regions Hospital
Saint Paul, MN
ankel001@umn.edu

IOM and ACGME

- Model of the Clinical Practice of Emergency Medicine
- ACGME Core Competencies
- Integration
- IOM Quality Chasm recommendations
- Integration
- IOM Health Professional education recommendations
- Integration
- Examples

First

The Model of the Clinical Practice of Emergency Medicine

Note from the Core Content Task Force II:
The Core Content Task Force II endorses The Model of the Clinical Practice of Emergency Medicine in its current version. However, the Task Force's endorsement does not extend to future documents resulting from this original work.
This article also appears in the June 2001 issue of Academic Emergency

Core Content Task Force II
Robert S. Hockberger, MD, Chair
Louis S. Binder, MD
Mylissa A. Graber, MD
Gwendolyn L. Hoffman, MD
Debra G. Perina, MD
Sandra M. Schneider, MD
David P. Sklar, MD
Robert W. Strauss, MD
Diana R. Viravec, MD

[Hockberger RS, Binder LS, Graber MA, Hoffman GL, Perina DG, Schneider SM, Sklar DP, Strauss RW, Viravec DR, Koenig WJ, Augustine JJ, Burdick WP, Henderson WW, Lawrence LL, Levy DB, McCall J, Parnell MA, Shoji KT. The model of the clinical practice of emergency medicine. *Ann Emerg Med.* June 2001;37:745-770.]

PREAMBLE

Then

General Competencies

Minimum Program Requirements Language
Approved by the ACGME, September 28, 1999

Educational Program

The residency program must require its residents to obtain competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
b. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
f. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

Then

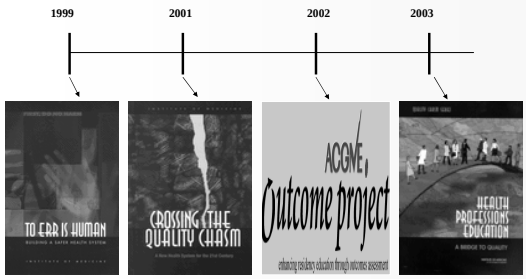
SPECIAL CONTRIBUTIONS

Integrating the Accreditation Council for Graduate Medical Education Core Competencies into the Model of the Clinical Practice of Emergency Medicine

Dane M. Chapman, MD, PhD, Stephen Hayden, MD, Arthur B. Sanders, MD, Louis S. Binder, MD, Ann Chinnis, MD, Kelly Corrigan, MD, Tony LaDuca, PhD, Pam Dyne, MD, Debra G. Perina, MD, Rebecca Smith-Coggins, MD, Larry Sulton, PhD, Susan Swing, PhD

In response to public pressure for greater accountability from the medical profession, a transformation is occurring in the approach to medical education and assessment of physician competency. Over the past 5 written and oral certification examinations in emergency medicine and is fully supportive of the effort to more fully define and integrate the ACGME core competencies into training emergency medicine

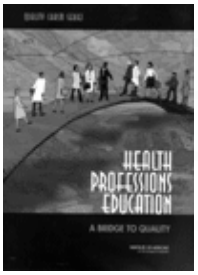
Recent Events



IOM

- Safety -- As safe in health care as in our homes
- Timeliness -- Less waiting for both patients and those who give care
- Effectiveness -- Matching care to science; avoiding overuse of ineffective care and under-use of effective care
- Efficiency -- Reducing waste
- Equity -- Closing racial and ethnic gaps in health status
- Patient Centeredness -- Honoring the individual, and respecting choice

IOM Health Professions Education



- Provide patient centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Utilize informatics

Linking ACGME Core Competencies to the Outcomes of Care: A Matrix Solution

John Bingham, MHA
Doris Quinn, PhD

Vanderbilt University Medical Center
Nashville, TN

Hypothetical One resident's learning

A resident prepared for a case presentation on CVA and addressed the following cells.

ACGME \ IOM	SAFETY	TIMELINESS	EFFECTIVE-NESS	EFFICIENCY	EQUITA-BILITY	PATIENT CENTERED-NESS
PATIENT CARE	No	No	No	No	No	No
MEDICAL KNOWLEDGE & APPLICATION	X		X			
PROFESSIONALISM						
INTERPERSONAL & COMMUNICATION SKILLS						
SYSTEMS- & TEAMS-BASED PRACTICE		X				
PRACTICE-BASED LEARNING & IMPROVEMENT (Process to Improve)						

After a dialogue with a faculty and using the Matrix, she then addressed all of the following cells in her presentation. The presentation resulted in the improvements outlined below.

ACGME \ IOM	SAFETY	TIMELINESS	EFFECTIVE-NESS	EFFICIENCY	EQUITA-BILITY	PATIENT CENTERED-NESS
PATIENT CARE						
MEDICAL KNOWLEDGE	X	X	X			X
PROFESSIONALISM		X	X		X	X
INTERPERSONAL & COMMUNICATION SKILLS	X	X	X	X		X
SYSTEMS- & TEAMS-BASED PRACTICE	X	X	X	X	X	
PRACTICE-BASED LEARNING & IMPROVEMENT (Process to Improve)	P and P changed patient arriving with CVA	Changed STAT pages for IR	Class on care of Patient w/CVA	Procedure outlined for fastest prep for IR		Communicates w/pt about risks/benefits of TPA vs IR.

Healthcare Matrix: Care of Patient(s) with….						
IOM / ACGME	SAFE	TIMELY	EFFECTIVE	EFFICIENT	EQUITABLE	PATIENT-CENTERED
Assessment of Care						
I. PATIENT CARE (Overall Assessment) Yes/No						
II. A MEDICAL KNOWLEDGE (What must I know)						
II. B INTERPERSONAL AND COMMUNICATION SKILLS (What must I say)						
II. C PROFESSIONALISM (How must I act)						
II. D SYSTEM-BASED PRACTICE (On whom do I depend and who depends on me)						
Improvement						
III. PRACTICE-BASED LEARNING AND IMPROVEMENT (How must I improve)						
Information Technology						

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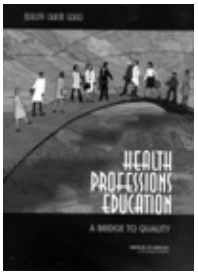
IOM Health Professions Education



- Provide patient centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Utilize informatics

Original Contributions

The Effects of a Physician-Nurse Patient Care Team on Patient Satisfaction in an Academic ED

DANIEL DEBEHNKE, MD AND M. CHRIS DECKER, MD

The objectives were to investigate the effects of a RN/MD patient care team operational change on ED patient satisfaction. In period 1, RNs had standard room assignments and MDs evaluated patients based upon physician availability and perceived patient load. In period 2, RNs and MDs were organized into 2 patient care "teams" and patients were assigned to teams on an alternating basis. Patient satisfaction was rated using the standard ED Press, Ganey survey instrument. A total of 508

their satisfaction with the hospital as a whole. The literature on ED patient satisfaction has generally focused on waiting times (real and perceived), information delivery and expressive quality (friendliness and courtesy).[1-6] It is clear from this body of literature that patients are most satisfied when they have a lower perceived waiting time, receive informa-

SYMPAL (SYstems-based Medical Practice And Learning): A Pilot Project

Kathleen Watson, MD, Irene Harris, PhD, Carl Paton, MD, James Breitenbacher, MD and Robert Howe, MD

Introduction

Future physicians must be able to understand and energetically engage in management of health care systems in order to secure excellent and safe care for their patients. Most clinicians–faculty and residents–have a rudimentary grasp of the components and processes to effectively improve systems of patient care, including daily advocacy for their individual patients. Yet, they generally have relegated improvements in the system of care to hospital administrators. Now, the ACGME has challenged programs to train residents to develop competency in "Systems Based Practice" (SBP) and "Practice-based Learning and Improvement" (PBLI).

"Current models of quality improvement (QI) in teaching hospitals rarely take advantage of the observable fact that much of the care is provided by residents, whose daily insights into inefficiencies and potential hazards of systems of patient care are sophisticated, although untrained."

100k *lives* Campaign

SOME IS NOT A NUMBER. SOON IS NOT A TIME.

Proven Interventions

The 100,000 Lives Campaign aims to enlist thousands of hospitals across the country in a commitment to implement changes in care that have been proven to prevent avoidable deaths. We are starting with these six interventions:

- Deploy Rapid Response Teams
- Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction
- Prevent Adverse Drug Events (ADEs)
- Prevent Central Line Infections
- Prevent Surgical Site Infections
- Prevent Ventilator-Associated Pneumonia

In addition to these six interventions, IHI will continuously seek and add others that have been shown to save lives.

JAMA May 18, 2005

SPECIAL COMMUNICATION

Five Years After *To Err Is Human*
What Have We Learned?

Lucian L. Leape, MD
Donald M. Berwick, MD

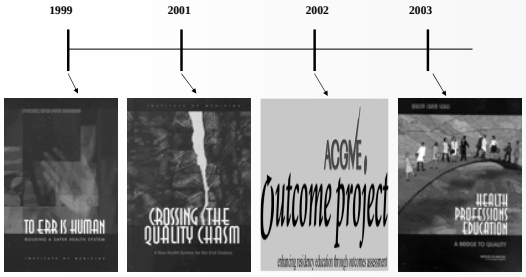
FIVE YEARS AFTER THE INSTITUTE of Medicine (IOM) reported that as many as 98 000 people die annually as the result of medical errors and called for a national effort to make health care safe, it is time to assess our progress. Is health care safer now? And, if not, why not?

The IOM's report, *To Err Is Human: Building a Safer Health System*,[1] galvanized a dramatically expanded level of conversation and concern about patient injuries in health care both in the United States and abroad. Patient safety,

Five years ago, the Institute of Medicine (IOM) called for a national effort to make health care safe. Although progress since then has been slow, the IOM report truly "changed the conversation" to a focus on changing systems, stimulated a broad array of stakeholders to engage in patient safety, and motivated hospitals to adopt new safe practices. The pace of change is likely to accelerate, particularly in implementation of electronic health records, diffusion of safe practices, team training, and full disclosure to patients following injury. If directed toward hospitals that actually achieve high levels of safety, pay for performance could provide additional incentives. But improvement of the magnitude envisioned by the IOM requires a national commitment to strict, ambitious, quantitative, and well-tracked national goals. The Agency for Healthcare Research and Quality should bring together all stakeholders, including payers, to agree on a set of explicit and ambitious goals for patient safety to be reached by 2010.

JAMA. 2005;293:2384-2390

Recent Events



IOM and ACGME

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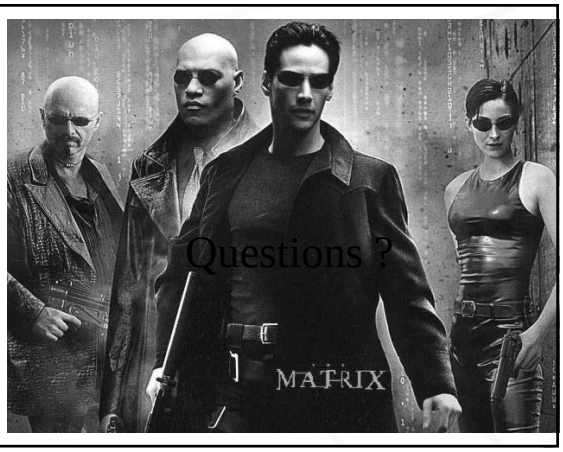

Closing the Quality Chasm: Educational Initiatives

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