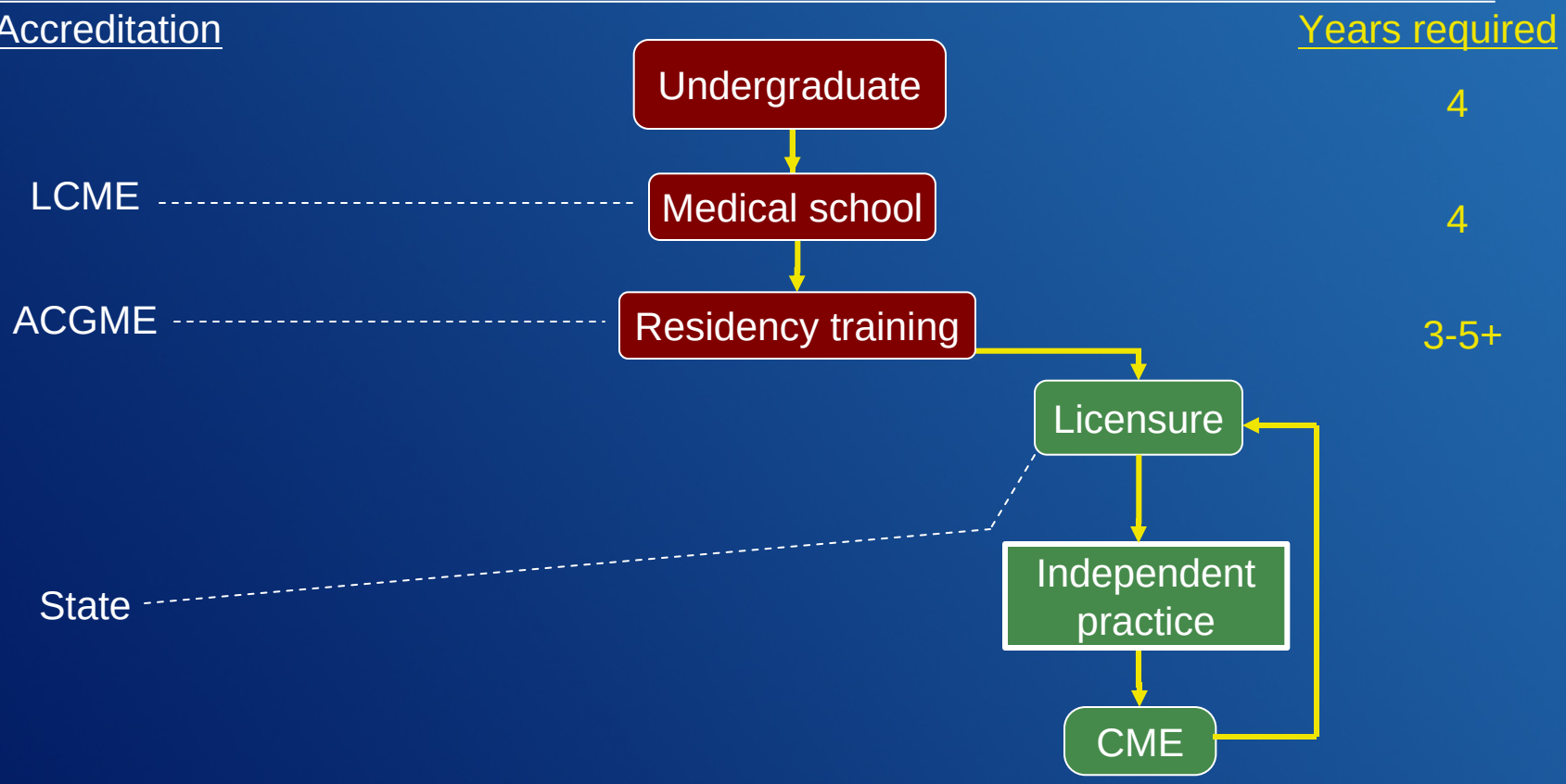
Is medical education training our physicians for health care delivery in the 21st century?

Craig Lisk

October 2, 2008

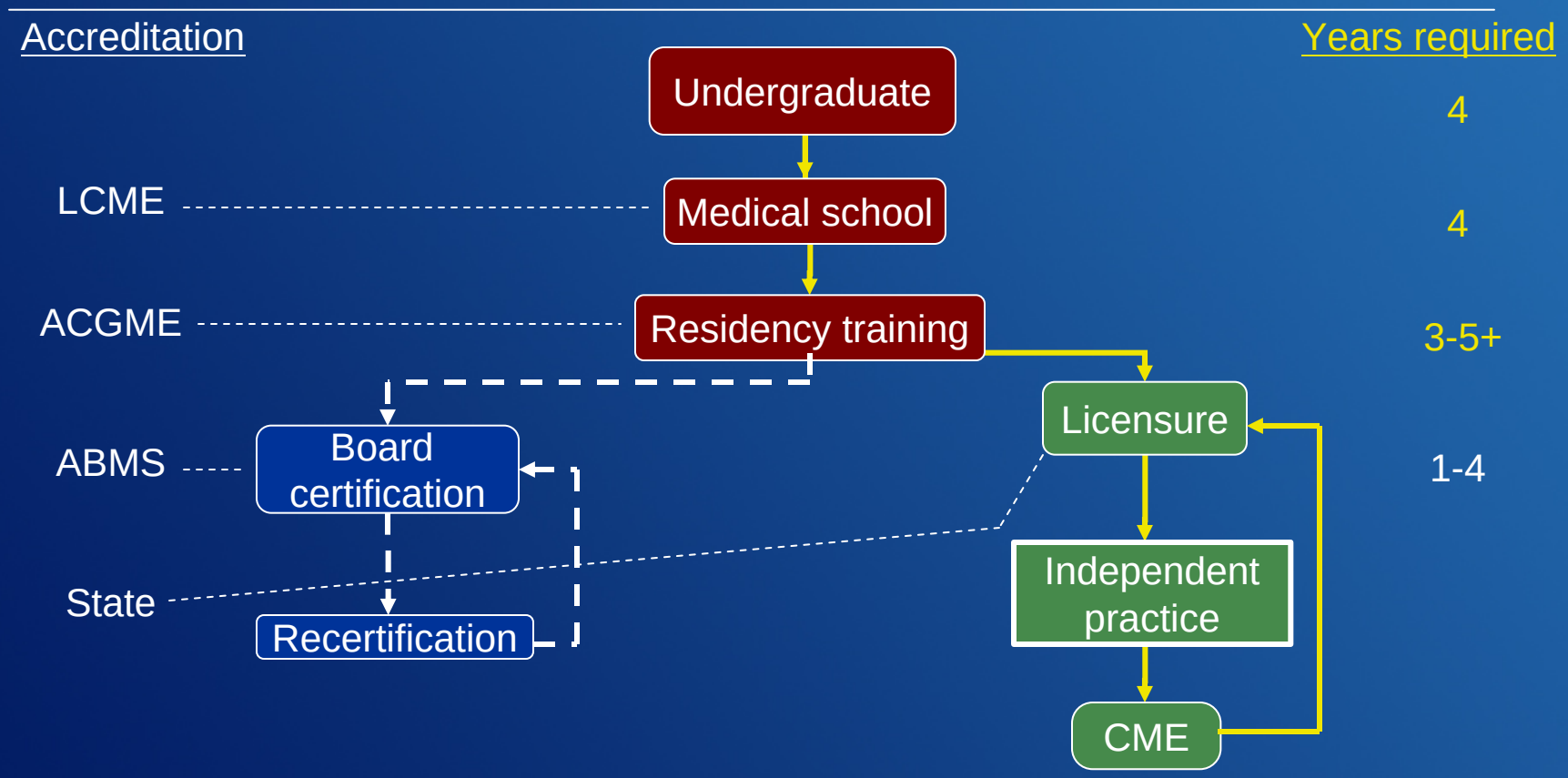
MEDPAC

The path to becoming a physician



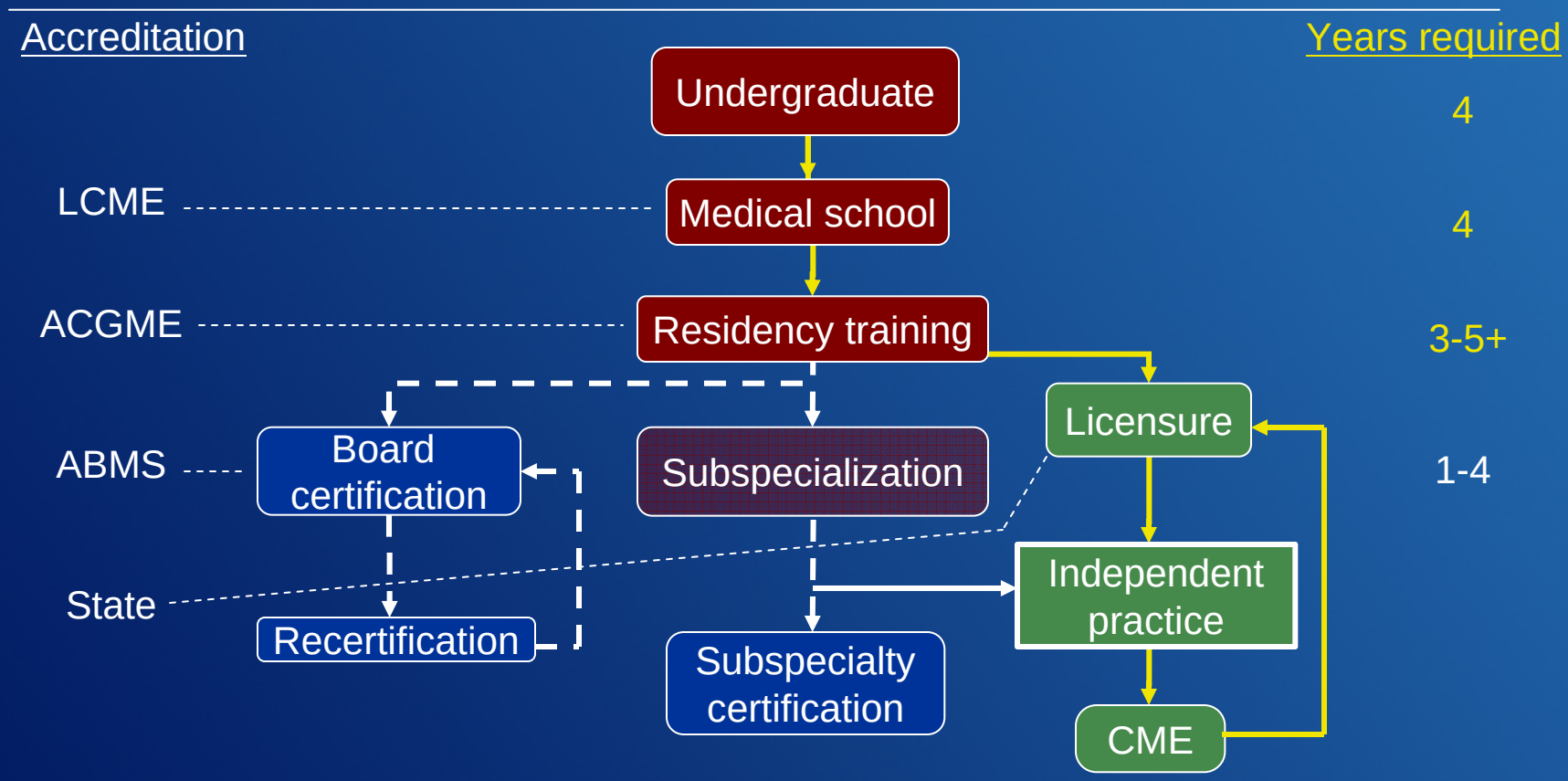
MEDPAC

The path to becoming a physician



MEDPAC

The path to becoming a physician



MEDPAC

Medical schools and graduate medical education 2007-8

- Medical schools
  - Over 150 accredited allopathic and osteopathic medical schools
  - Almost 86,000 students
  - About 21,800 first year students
  - New medical schools opening and class sizes growing
- Graduate medical education (GME)
  - Over 9,000 ACGME or AOA approved residency training programs
  - More than 110,000 residents and fellows

Medicare provides substantial support for graduate medical education

- Over 1,100 hospitals receive Medicare payments in support of GME
- Direct graduate medical education (GME) payments
  - Cover Medicare's share of hospitals' direct costs of approved resident training programs
  - $2.8 billion in 2006
- Indirect medical education (IME) adjustment
  - Covers higher patient care costs associated with teaching activities
  - $5.8 billion in 2006

Commission's concerns

- IME payments set more than twice what can be empirically justified (MedPAC 2003, 2007, 2008)
- Payments provided to hospitals without accountability for how they are used or without targeting policy objectives consistent with Medicare goals (MedPAC 2003)
- Concern whether we are adequately training physicians to be leaders in shaping and implementing needed changes in health care delivery (MedPAC 2007)

Panel

- **Thomas Nasca, MD** – Executive Director and CEO, ACGME
- **Michael Whitcomb, MD** – former SVP of Medical Education, AAMC and past Editor in Chief of *Academic Medicine*
- **Benjamin Chu, MD** – President, Kaiser Permanente Southern California Region

Accreditation Council for Graduate Medical Education

ACGME

"Is Medical Education Training our Physicians for Health Care Delivery in the 21st Century?"

The ACGME
Who Are We, and Where are We Going

October 2, 2008

Thomas J. Nasca, M.D., MACP
Chief Executive Officer

Answer: Question 1 - “Is Medical Education Training our Physicians for Health Care Delivery in the 21st Century?”

- Grade, C
- Reasons to follow

The ACGME

Accreditation Council for Graduate Medical Education

- Not for Profit 501 (c) (3) corporation
- Mission is to improve the health of the public through enhancement of the education of the next generation of physicians
- Board of Directors (n=26) nominated by
  - 5 Member Organizations
    - Association of American Medical Colleges
    - American Board of Medical Specialties
    - American Hospital Association
    - American Medical Association
    - Council of Medical Specialty Societies
  - Public Members
  - Resident Members
  - Chair of the Council of Review Committee Chairs
- Delegate authority to accredit to 28 Review Committees
  - Members nominated by:
    - American Board of Medical Specialties (related Board)
    - American Medical Association (specialist in the field)
    - Council of Medical Specialty Society (related College or Academy)

Peer Review Roles of the Review Committees

Accreditation Council for Graduate Medical Education

ACGME

- Establish and periodically revise standards
- Periodically review each and render accreditation decisions
  - Initial Accreditation (9%)
  - Continued Accreditation (88%)
  - Probation/Warning (3%)
  - Withdrawal of Accreditation (1%)
- Formal Appeals Process (External Specialist Panel) recommendation to Board of Directors

Scope of ACGME Accredited Programs

Accreditation Council for Graduate Medical Education

ACGME

- Over 8,500 accredited Residency and Fellowship Programs
- Over 650 Accredited Institutional Sponsors in all 50 states
- Over 107,000 Residents and Fellows currently enrolled in ACGME Accredited Programs
  - "Pipeline" for approximately 25,500 physicians per year
- Approximately 300 new programs accredited each year (75-90% first time success rate), and 90-100 withdrawn per year (majority Voluntary)
  - Almost all new programs are Sub-Specialty Programs
- Over 1,100 new Program Directors per year (~15% turnover rate)

Getting the Balance Correct Between Trailing Edge Accreditation and Leading Edge Innovation

Accreditation Council for Graduate Medical Education

ACGME

Minimal Standards Accreditation

Active Fostering of Change/Innovation Through Standards

Trailing Edge Phenomena

Accreditation Set Point

Leading Edge Phenomena

What Currently Drives the Curricula of our Residency Programs?

Accreditation Council for Graduate Medical Education

ACGME

Curriculum
"Time Based"
"FCIM Curriculum"

Choose Educational Experiences
within Institution, Faculty

Educate Residents

Identify/Develop Evaluation Tools
- Formative and Summative
- Experience Tracking

- Drivers:
  - The patient care needs of the Sponsoring Institution – *meeting the <u>immediate</u> needs of the public served*
  - The patient care and research needs/interests of our Faculty
  - The tradition of program structure within the discipline
  - The minimum standards of the discipline's ACGME Program Requirements
  - Only measurable outcome is in Medical Knowledge

The ACGME Core Physician Competencies

Accreditation Council for Graduate Medical Education

ACGME

- Medical Knowledge (and Technical Skills)
- Patient Care (and Surgical Competence)
- Interpersonal and Communication Skills
- Professionalism
- Practice Based Learning and Improvement
- Systems Based Practice

The Continuum of Medical Education
Dreyfus Conceptual Model[1]

Accreditation Council for Graduate Medical Education

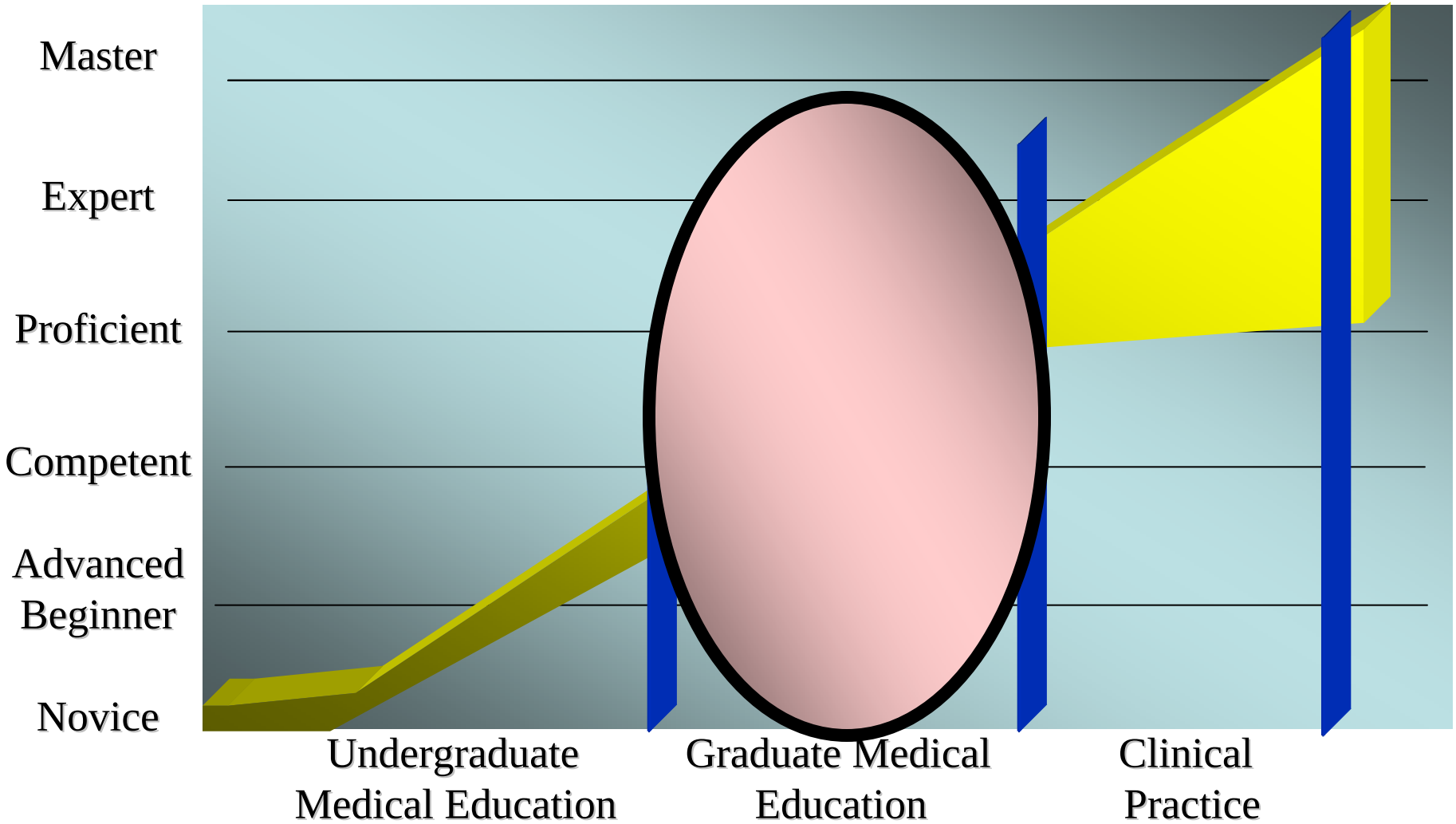
ACGME

- **Novice** – Don't know what they don't know
- **Advanced Beginner** – Know what they don't know
- **Competent** – Able to perform the tasks and roles of the discipline – restricted breath and depth
- **Proficient** – Consistent and efficient in performance of the tasks and roles of the discipline - know what they know and don't know
- **Expert** – In depth knowledge concerning the discipline – often rule based – know what they know
- **Master** – Expert who relishes the unknown, or the situation that breaks the rules – who the experts go to for help – don't know what they know

[1] *as presented by Leach, D., modified by Nasca, T.J. American Board of Internal Medicine Summer Retreat, August, 1999*

The Goal of the Continuum of Professional Development

Accreditation Council for Graduate Medical Education

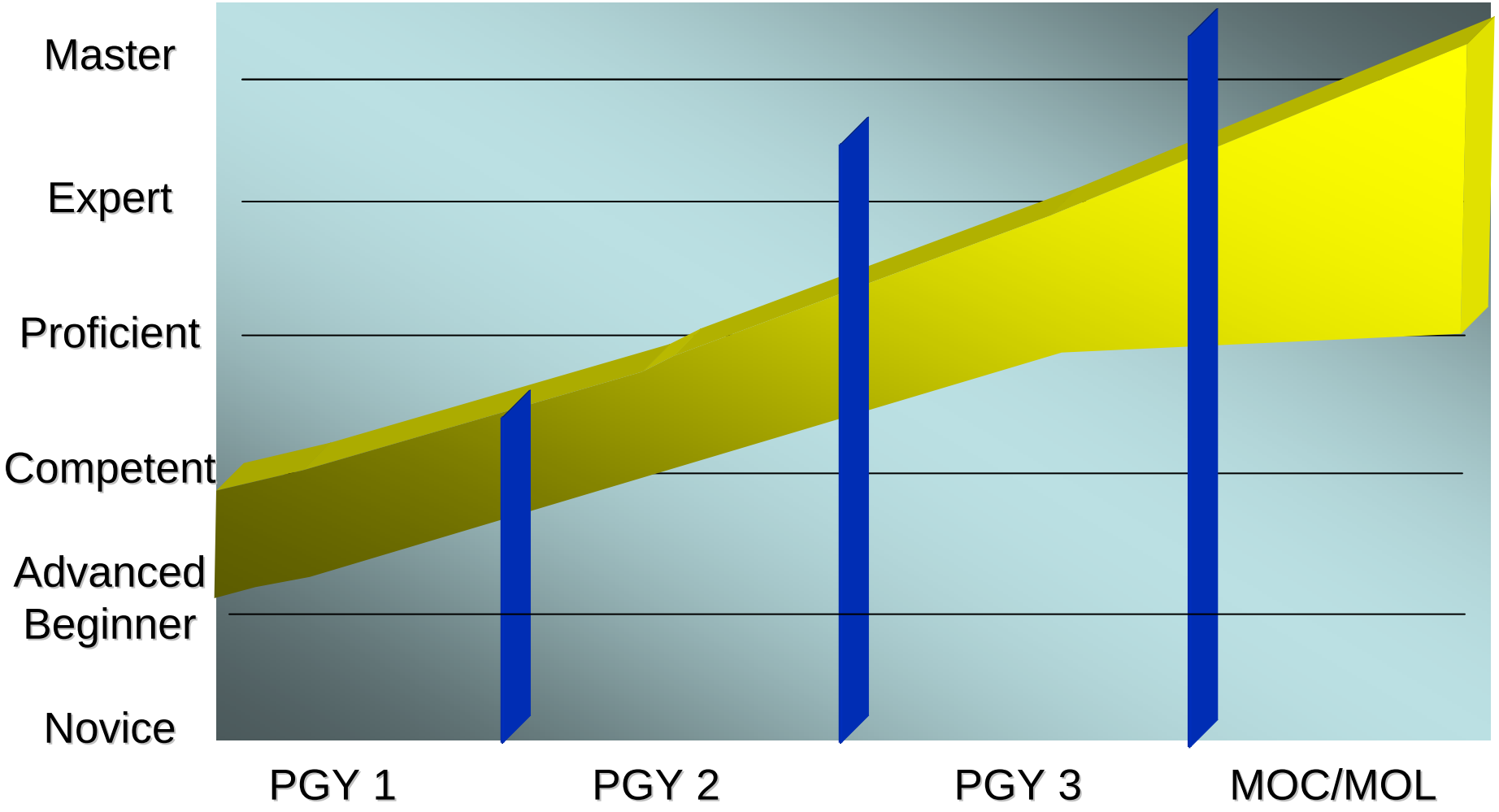


Increase the Accreditation Emphasis on Educational Outcomes

The Goal of the Continuum of Professional Development in a 3 Year Specialty Program

Accreditation Council for Graduate Medical Education

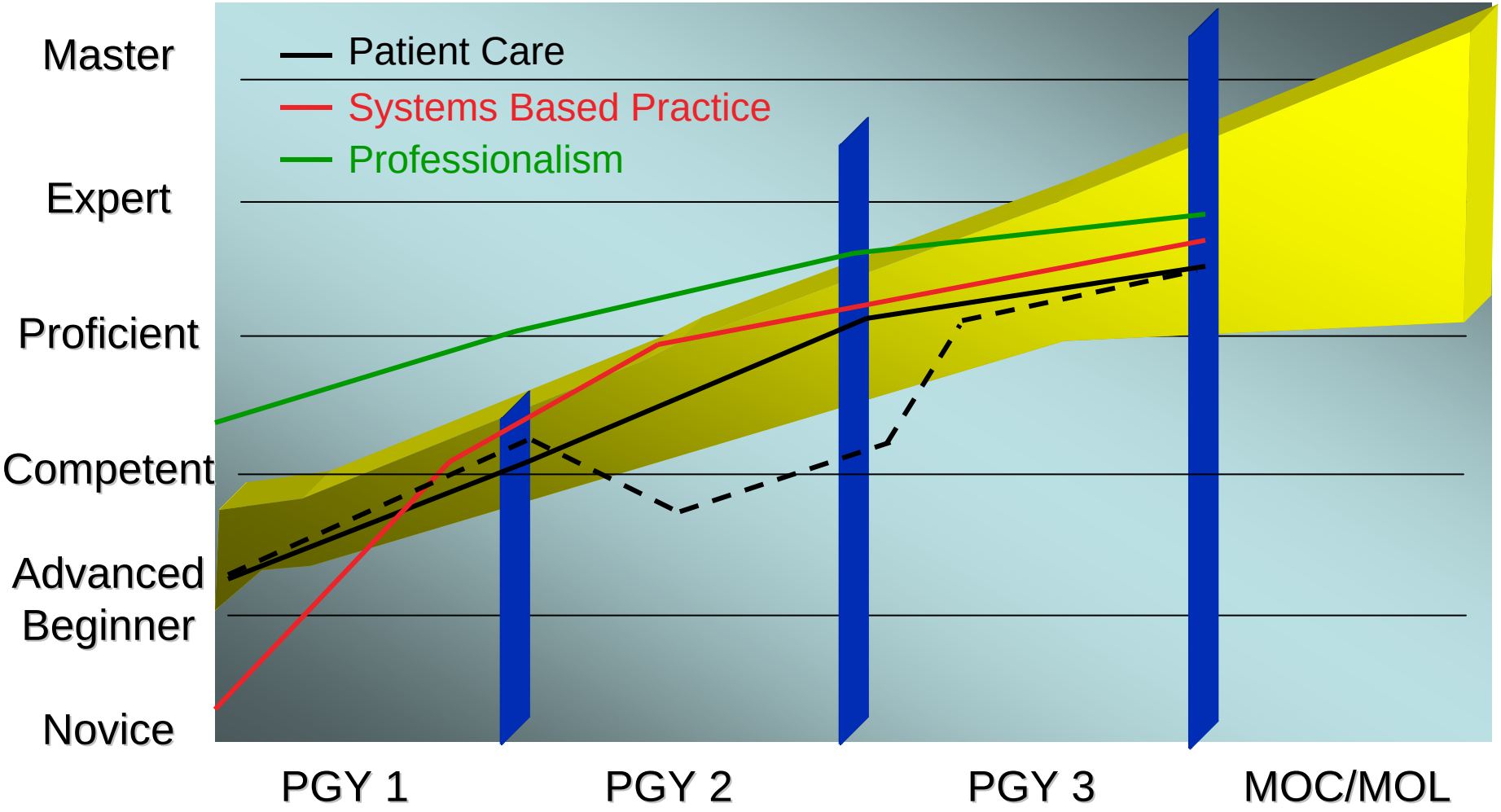
ACGME



Increase the Accreditation Emphasis on Educational Outcomes

The Goal of the Continuum of Professional Development

Accreditation Council for Graduate Medical Education



Increase the Accreditation Emphasis on Educational Outcomes

Where are we in Operationalizing Outcomes?

Accreditation Council for Graduate Medical Education

ACGME

ACGME Learning Portfolio (ALP)

Alpha Testing
Beta 7/2009

Computer Hardware & Software Infrastructure

ACGME Assessment Committee

Report Accepted 9/2008

Evaluation & Recommendations for Tools

Specialty Specific Teams

- Board
- PD Association
- College
- RRC
- Residents

Milestones & Core Evaluation Requirements

ACGME

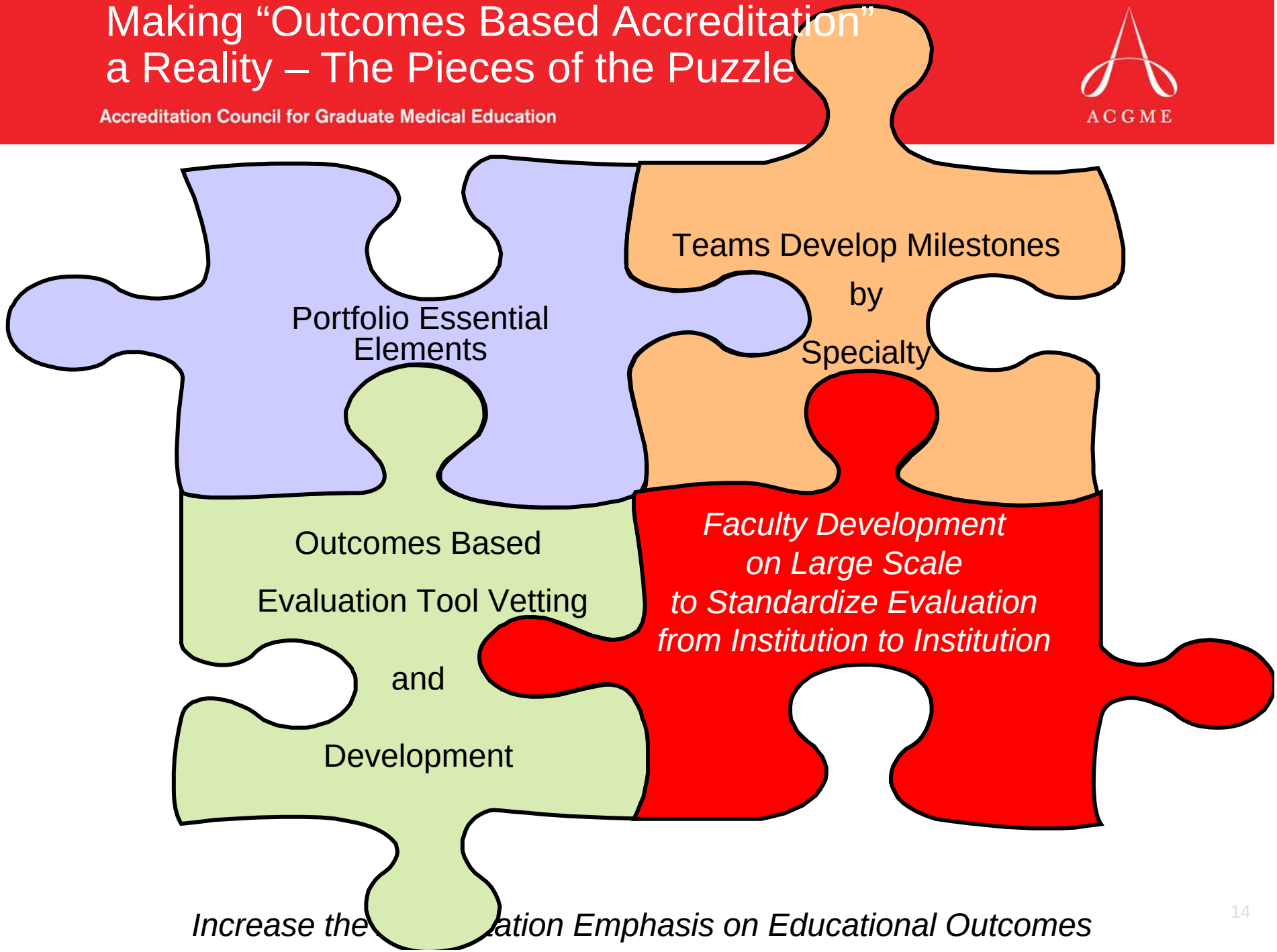
Specialty Specific Competency Evaluation Program Requirements for reporting (Outcomes)

Increase the Accreditation Emphasis on Educational Outcomes

Making "Outcomes Based Accreditation" a Reality – The Pieces of the Puzzle

Accreditation Council for Graduate Medical Education

ACGME



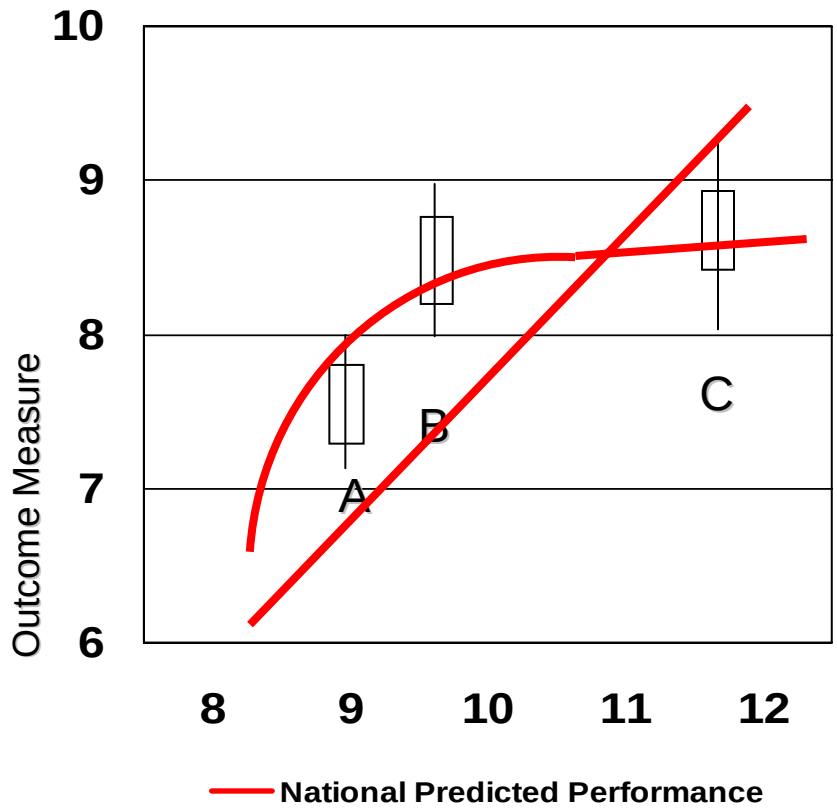
Increase the [illegible]ation Emphasis on Educational Outcomes

Measurement of Outcomes in Accreditation

Accreditation Council for Graduate Medical Education

ACGME

Program	Comp. Score
A	7.4 ± 0.17
B	8.3 ± 0.15
C	8.6 ± 0.20

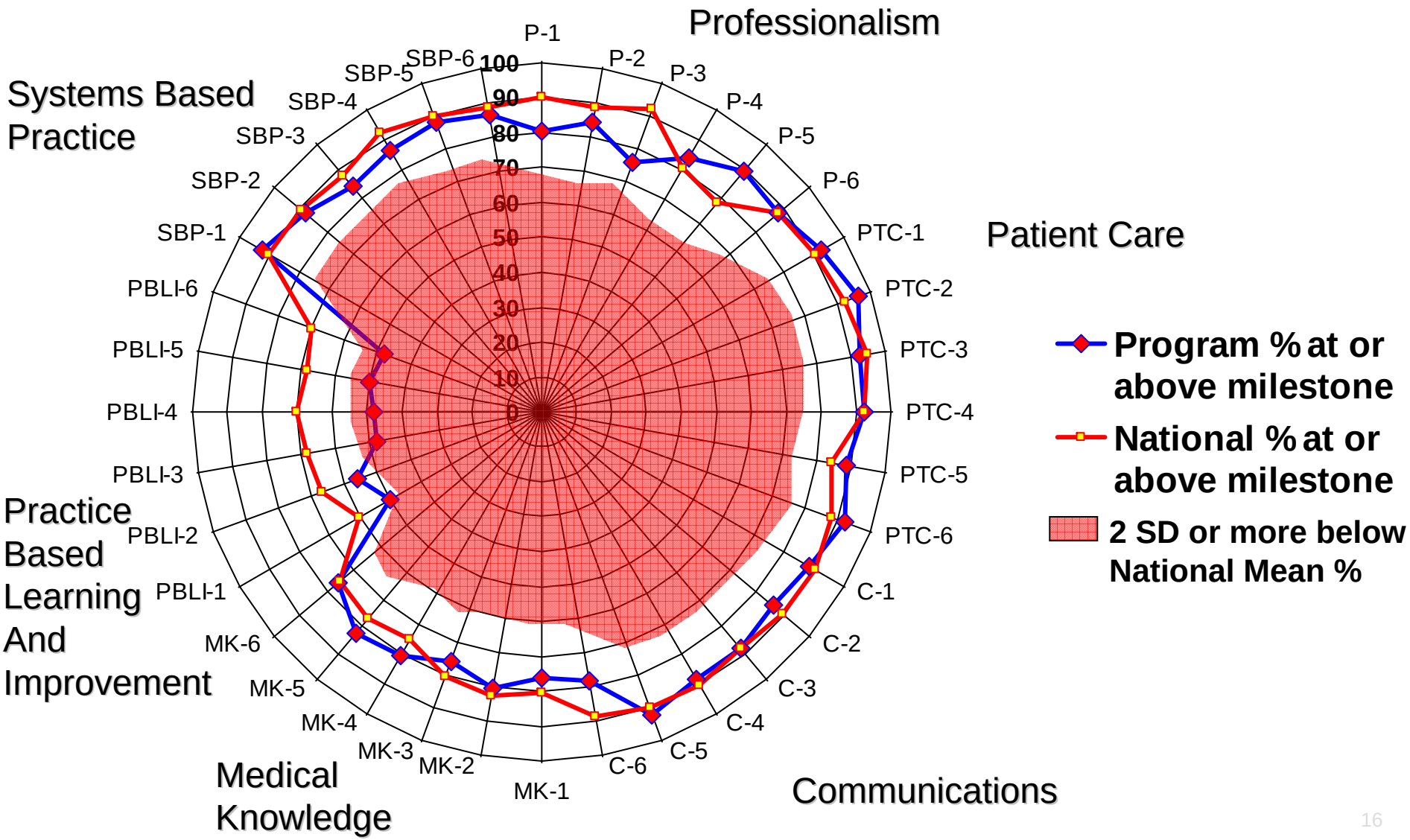


Predictive Parameter

Theoretical Competency Report Card Summary, Program X
All Residents, All Levels

Accreditation Council for Graduate Medical Education

ACGME

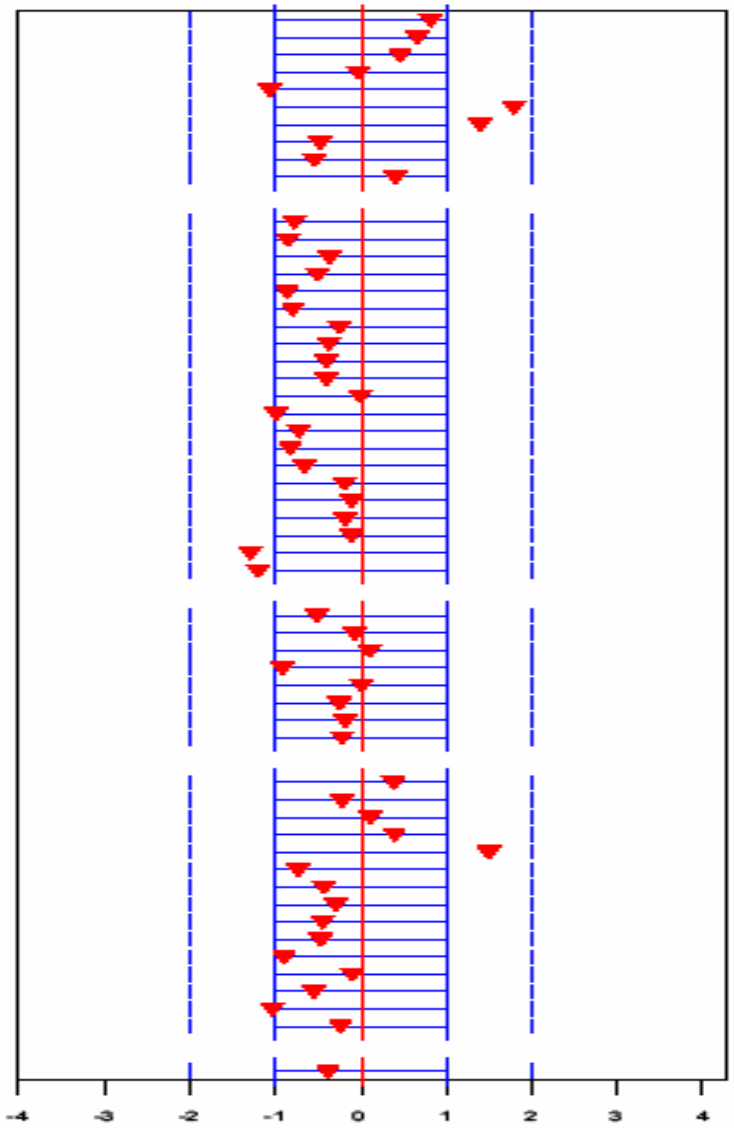


COLON AND RECTAL SURGERY: PROGRAM REPORT (Standard Deviations Summary Graph)

Reporting Period: Total Experience of Residents Completing Programs in 2005-2006
Residency Review Committee for Colon and Rectal Surgery

PROGRAM=060XXXXXXX- Sample Program Two

AREA	TYPE	All Index Procedures
Anorectal Procedures (Index)	Excisional hemorrhoidectomy (to	50
	- Coventional	38
	- PPH	13
	Fistulotomy	22
	Endorectal advancement flap	1
	Rectocele	7
	Pilonidal procedure	13
	Sphincteroplasty	4
	Internal sphincterotomy	11
	TOTAL - Anorectal (Index)	108
Abdominal Procedures (Index)	Small bowel resection	3
	Ileocolic resection	8
	Stricture plasty	0
	Segmented colectomy	42
	Low anterior resection (total)	19
	- Straight anastomosis	16
	- With colon pouch or colopl	2
	Abdominoperineal resection	7
	Transanal excision (total)	10
	- Coventional excision	10
	- TEM	0
	Prodtocolectomy (total)	3
	- With ileostomy	1
	- With ileoanal reservoir	1
	Prodtectomy/ileoanal reservoir	1
	Prolapse repair (total)	8
	- Abdominal	3
	- Perineal	5
	Pelvic exenteration	0
	Total pelvic dissections	30
	TOTAL - Abdominal (Index)	103
Endoscopy/Pelvic Floor (Index)	Prodoscopy	21
	Colonoscopy (total)	225
	- Diagnostic	206
	- With polypectomy	17
	- Other Therapeutic	2
	ERUS/EAUS	13
	Pelvic Floor Evaluation	10
	TOTAL - Endoscopy/Pelvic Floor	269
Diagnoses (Index)	Anorectal (total)	129
	- Anal fissure	14
	- Anal fistula	40
	- Hemorrhoids	61
	- Pilonidal	13
	Abdominal (total)	115
	- Cardinoma of the colon	28
	- Cardinoma of the rectum	32
	- Crohn's disease	14
	- Diverticular disease	19
	- FAP/Gardener's	1
	- Prolapse	10
	- Ulcerative colitis	11
	- Volvulus	0
	TOTAL - Diagnoses (Index)	244
TOTAL OF ALL INDEX PROCS	TOTAL OF ALL INDEX PROCEDURESS	480



National Average +/- One and Two Standard Deviations ▼ Program Average

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What Will Drive the Curricula of our Residency Programs in the Near Future?

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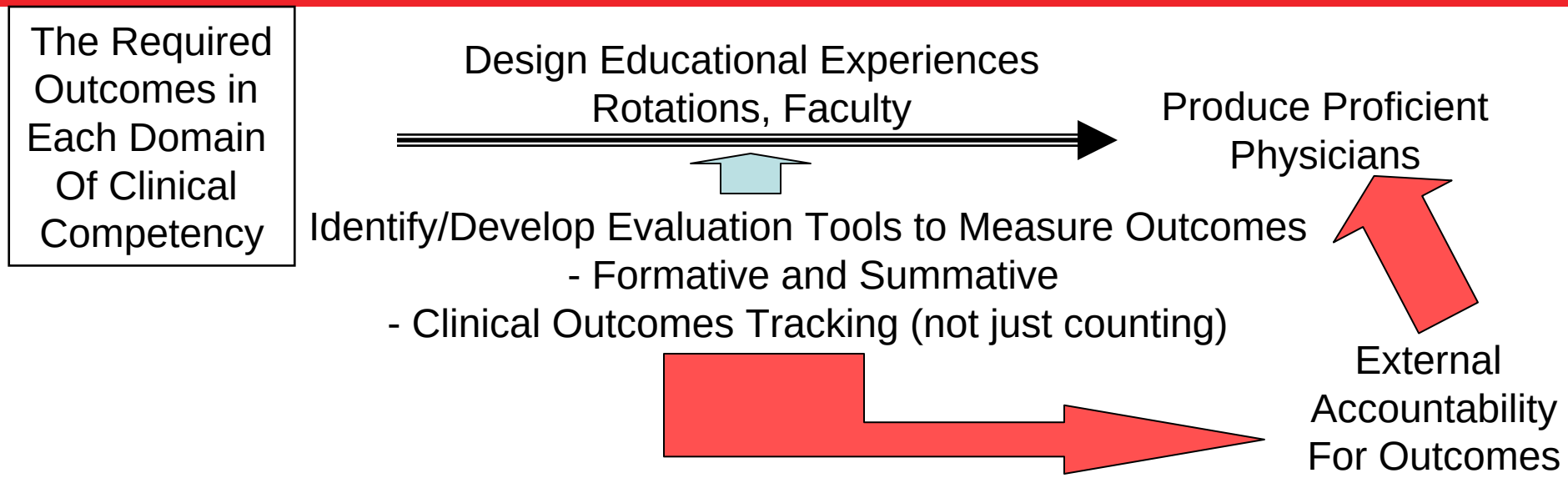

- Drivers:
  - The desired (required) outcomes in each competency must drive educational planning, (not the immediate patient care needs of the Sponsoring Institution)
  - Components of the patient care and research needs/interests of our faculty/institution must be supported in other ways
  - The continuous improvement standards of the discipline's ACGME Program Requirements
  - External accountability of the program for its outcomes

Barriers to Success

Accreditation Council for Graduate Medical Education

ACGME

- Relative success of current model
  - Global
  - Institutional
  - Individual
- Lack of “newer competencies” within the faculty (“Building the Airplane while you Fly It”)
  - Information Technology
  - Scientific Information Management Skills
  - Team Membership and Leadership principles
  - Practice Based Learning and Improvement Tools
  - Understanding of Systems of Care with an eye towards change
    - Conceptual framework of Patient Safety Systems in addition to individual responsibility
- Evolving traditional sense of Professionalism and individual physician duty to patients in an era that may require change in those relationships

"Is medical education training our physicians for health care delivery in the 21st century?"

Accreditation Council for Graduate Medical Education

- Grade for training for the current system, B to A-
- Grade for caring for the under/uninsured, B+ to A

For the Future Needs of the Country:

- Current Grade, C
- Up from a D five years ago
- Goal to reach the promise of the ACGME Outcomes Project, and B+/A- by 2012 and movement towards leading edge requirements
- We will never get an A+, but we will always try!

Educating Doctors to Provide High Quality Medical Care

Michael Whitcomb, MD

2 October 2008

Fundamental Issue

Doctors learn how to practice medicine during residency training. In caring for patients, doctors use very little of the knowledge and skills they acquire in medical school.

Residency programs are responsible for preparing doctors to provide high quality care when they enter practice.

State of Residency Training

Results of survey research have shown that residents completing training and physicians who recently entered practice do not feel adequately prepared to care for certain common medical conditions.

This situation is being aggravated by changes in the nature of medical practice and the growing numbers of individuals afflicted with one or more chronic diseases.

Major specialty organizations have acknowledged the need to redesign residency training in their specialty.

Residency Redesign Initiatives

Initiatives have been underway in family medicine, internal medicine, and surgery since early in this decade.

The initiatives have not yet resulted in fundamental changes in residency training, and will not do so for years to come, if then.

[Academic Medicine 2007 82: 1200-1227 (3 articles).]

Redesign of Residency Training Impediments to Change

Medical education infrastructure linked to teaching hospitals

Clinical faculty have vested interest in retaining resident duty responsibilities

Fragmentation of professional oversight and governance

Financing of GME linked to hospital based experiences

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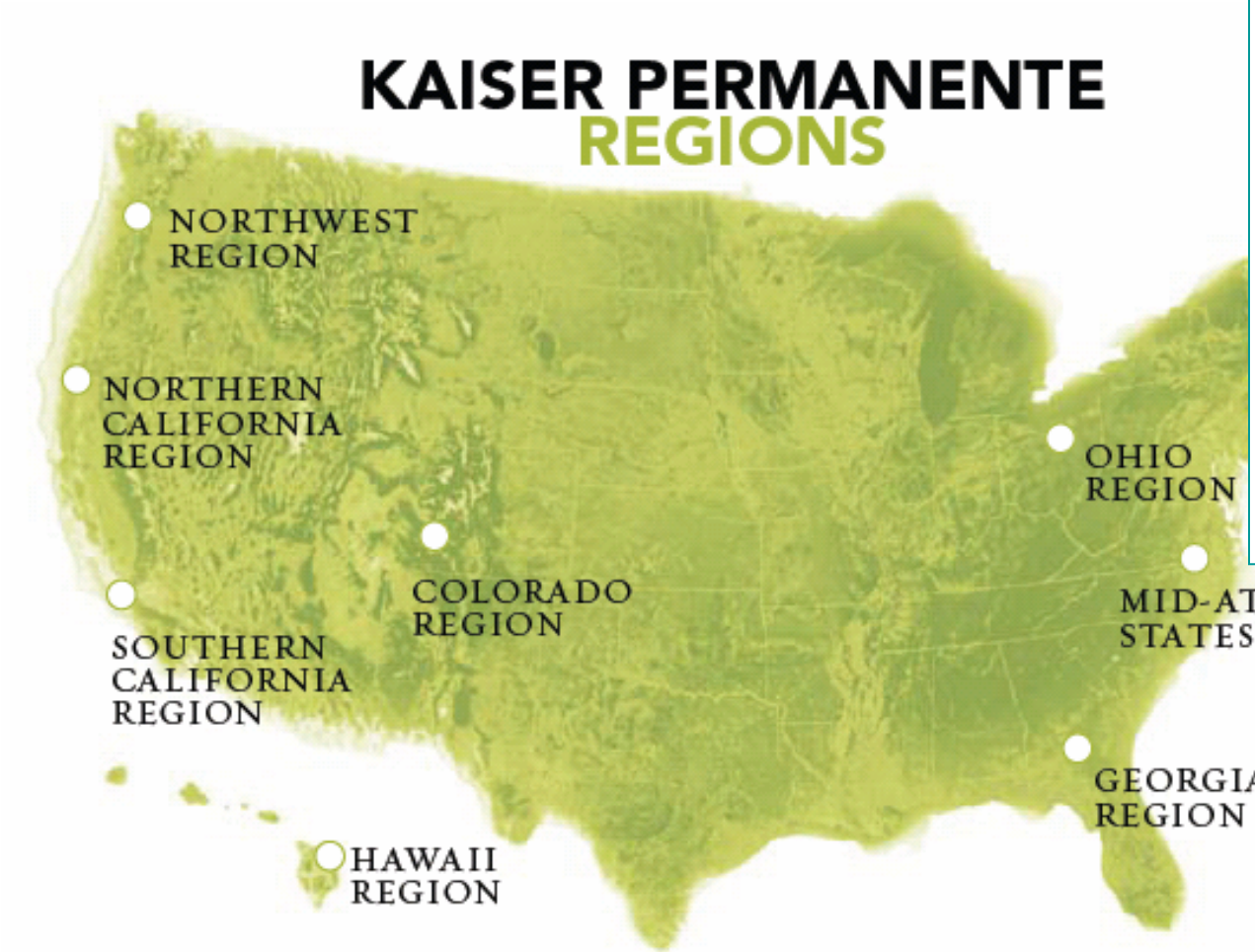
Medical Education in the 21st Century

Addressing Gaps in Training

Kaiser Permanente: Who, What, Where

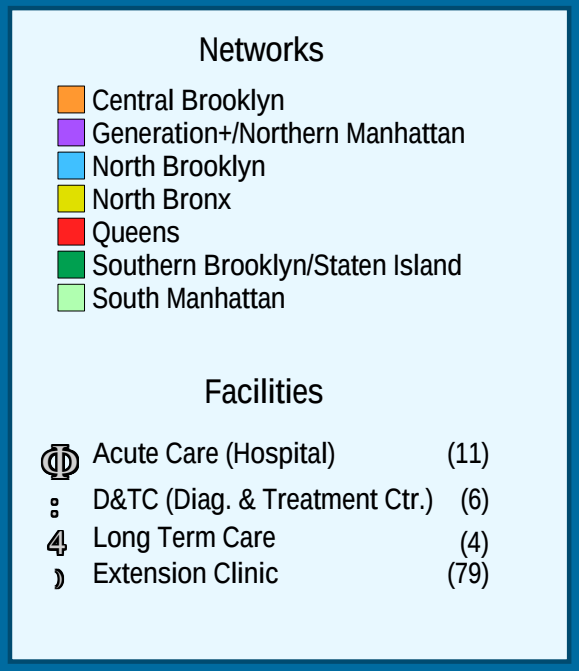
KAISER PERMANENTE®



KP Programwide

- 8.7 Million Members
- 32 Hospitals
- 420 Medical Office Buildings
- 14,000 Physicians
- 156,853 Employees
- $40B Annual Revenue
- 600 – 700 Residents and Fellows
- $4 Billion Health IT Investment

NYC Health & Hospitals Corporation Networks and Facilities



Prepared by HHC Corporate Planning & HIV Services, May 2002

Health and Hospitals Corporation – Public Hospital Model for Change

KAISER PERMANENTE®

- Serve 1.3 million discrete individuals annually (1 of 6 NYC residents) – 400,000 uninsured
- 11 Acute Care Hospitals, 4 nursing homes, 100 outpatient site, home health agencies, two managed care plans serving 400,000 patients
- One million ER and 5 million clinic visits
- 45% Hispanic, 40% African American, 10% Asian & 5% Others
- 3,000 Residents and Fellows
- Early adopter of electronic record with registry capabilities
- Leader in Patient Safety movement in NYC

Core Tenets of Medical Education

KAISER PERMANENTE®

- Professionalism Model – highly reliant on individual accountability for performance
- Largely hospital-based and acute illness-oriented
- Highly specialty-centric with limited emphasis on coordination and population health
- Little emphasis on team and system level accountability for high performance
- In the paper record world, did not know what we did not know – tolerance for poor performance

Evidenced-Based Medicine – Trends for the Delivery System

KAISER PERMANENTE®

- New Tools in Ambulatory Care – Population Care Management, Care Registries, Outcome Based Measures, Pay for Performance (for Outcomes?)
- Renewed Focus in In-patient Care – Patient Safety Initiatives, Team Based Accountability, Public Reporting, Never Events
- ??Payment Reform – Episode of Care Payments, Evidenced-based Case Rates, Sub-capitation and Capitation

Addressing Quality and Population Care Gaps Require Addressing Training Gaps

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- Paper to Electronic Health Records with Decision Support and Population Care Tools expose huge gaps in care that is possible
- Transparent Quality Performance Measures also highlight gaps in hospitalized care
- New physicians at Kaiser Permanente require extensive “on-boarding” and retraining on use of these tools to drive performance and team based approaches
- The plight of primary care and the myth that individual doctors can do it all in an age where information is instantaneous and overwhelming

Population Care Management Registries

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Drill Down to Facility, Physician or Group

POINT: Care Management - Microsoft Internet Explorer

Care Management

MPS | My Panel | Back | POINT

Home | Panel | Asthma | CVD | HF | Diabetes | HTN | CAD | CKD

Personalized For JOEL D HYATT Thursday, December 28, 2006

Diabetes

Live Help | Help | Print | Export

Sorting Order Ascending | Employer Group(s): None Search Group

Region : CS | Area : WDH |

Clinic	Possible Diabetes Patients	Hospitalized		Total Hospital Discharges	Hospital Days	Length of Stay = Hospital Days / Nr. of Discharges	Missing Retinal Exams in last 12 mos		Missing Lipid_lowering Rx for age 40+ in last 12 mos		Patients with Last LDL > 100 mg/dL		Missing ACEI/ARB Rx for age 55+ in last 12 mos		Having HgbA1C		HgbA1C > 9.0%		HgbA1C > 7.0%		No SM refills r
		Pats.	%	Freq.	Days	Days	Pats	%	Pats.	%	Pats.	%	Pats.	%	Pats.	%	Pats.	%	Pats.	%	Pats.
NA	158	19	12 %	27	91	3.4	34	21.5 %	52	40.9 %	108	128.6 %	36	28.3 %	90	57 %	77	48.7 %	102	64.6 %	114
COV	1253	226	18 %	350	1091	3.1	199	15.9 %	285	24 %	545	49.9 %	270	22.7 %	1088	86.8 %	245	19.6 %	481	38.4 %	805
ERW	1818	334	18.4 %	529	1847	3.5	247	13.6 %	457	26.8 %	873	54.9 %	420	24.6 %	1568	86.2 %	397	21.8 %	832	45.8 %	1096
GNZ	583	38	6.5 %	67	294	4.4	20	3.4 %	205	40.9 %	377	81.6 %	110	22 %	448	76.8 %	210	36 %	310	53.2 %	424
HRD	5	1	20 %	1	0	0	0	0 %	3	60 %	5	500 %	2	40 %	1	20 %	4	80 %	4	80 %	2
LPS	4	1	25 %	1	1	1	0	0 %	2	66.7 %	4	200 %	0	0 %	2	50 %	2	50 %	3	75 %	4
NRS	4236	719	17 %	1139	4244	3.7	590	13.9 %	1031	26.7 %	2023	54.8 %	900	23.3 %	3625	85.6 %	958	22.6 %	2013	47.5 %	2585
OXG	4	0	0 %	0	0	0	0	0 %	0	0 %	4	400 %	0	0 %	0	0 %	4	100 %	4	100 %	2
SIV	1543	262	17 %	443	1557	3.5	291	18.9 %	344	23.9 %	734	55.9 %	300	20.9 %	1291	83.7 %	366	23.7 %	661	42.8 %	1016
THO	487	88	18.1 %	132	436	3.3	57	11.7 %	105	22.1 %	232	54.7 %	103	21.6 %	415	85.2 %	103	21.1 %	198	40.7 %	331

Registry/Tracking System – KPSCAL
(Chronic Disease & Panel Management System)

KAISER PERMANENTE®

http://point.kp.org - POINT: Care Management - Microsoft Internet Explorer

Care Management

My Panel | Back | POINT

Home | Panel | Asthma | CVD | HF | Diabetes | HTN | CAD | CKD

Personalized For JOEL D HYATT Friday, February 22, 2008

Location Directory | Live Help | Help

Patient Search

Region: Southern California | MRN: | Patient Profile | Condition Summary

Most measures are based on a 12 month rolling window that refreshed yesterday. Pharmacy and Lab data may recent events made in the last 2-5 days. Information does not include outside contracted data. KP Hospital and do not reflect recent events made since last month.

Drill Use Location Directory to identify subdept, PCP etc.

Report: CVD | Region: CS | Area: ---- | Facility/MOB: ---- | Dept: ----

SubDept/Module: ---- | PCP: ---- | Find Patients | Get View

CS | OH

Southern California Data Specifications

POINT-PCS Care Management populations are identified on a nightly basis using criteria and algorithms created by Clinical Analysis. Each population contains patients who are currently active members. They may differ in age range time period.

- The **Asthma**population contains patients between the ages of 5 and 56 years using a rolling 12 month window
- The **CHF** population contains all adult patients (> 17 yrs of age) identified since January 1999.
- The **Diabetes** population contains all adult patients (> 17 yrs of age) identified since January 1999.
- The **CAD** population contains all adult patients (> 17 yrs of age) identified since 1995.
- The **CKD** population contains all adult patients (> 17 yrs of age) identified since 1997.
- The **CVD** population contains all adult patients (> 17 yrs of age) from CKD (excluding renal transplants), CAD, H diabetes.
- The **HTN** population contains all adult patients (> 17 yrs of age) identified since 2000.

Done | Internet

Eight Registries:

- Asthma
- Congestive Heart Failure
- Diabetes
- Coronary Artery Disease
- Chronic Kidney Disease
- Cardiovascular Disease
- Hypertension
- Panel Management

Clinical Decision Support and Practice Tools

KAISER PERMANENTE®

"Make It Easy to Do the Right Thing"

- Inreach (directed to any provider):
  - Best Practice and Health Maintenance Alerts
  - Care Management Summary Sheets (at encounter)
  - Medication Alerts (high-risk drugs/elderly)
  - Preventive Care Prompts
- Outreach:
  - Automated Mailings
  - Automated Telephonic Outreach
  - Care or Case Managers
- Links to other systems:
  - Lab system standing orders
  - Automated Telephonic
  - Lab Test Panel
- Panel Reports and Feedback
- Reporting/Tracking Performance
- Case Management Systems
  - Flags/Alerts/Protocols
- Self-Management Support

Proactive Encounter Experience

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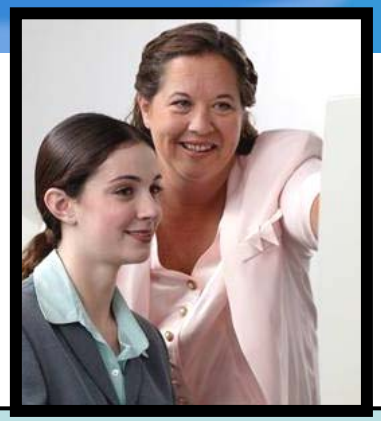

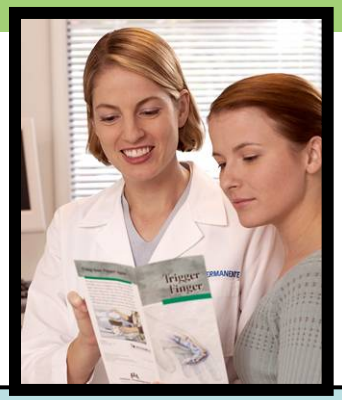

Pre-Encounter

Proactive Identification

- Identify missing labs, screening procedures, access management, kp.org status, etc.
- Provide member instructions before visit
- Contact member and document encounter in KP HealthConnect™

Office Encounter

Office Encounter Management

- Vital sign collection / documentation
- Identify and flag alerts for provider
- Room and prepare patient for necessary exams
- Pre-encounter follow-up

Back Office Support

- Letters
- E-mail
- Inbox Management

Post Encounter

Immediate

- After visit summary, after care instructions, follow-up appointments, Health Ed materials, how to access info on kp.org

Future

- Follow-up contact and appointments per provider

Proactive Pre-Encounter/ Encounter Checklists

KAISER PERMANENTE®

Print | Close X

Encounter Checklist

Generated on 06/04/2007 MSS details

Patient Name XXXXXXXXXXXX
Day Phone 6263031515
PCP Name MEZA, FRANK

MRN XXXXXXXXXXXX
Evening Phone 5627777817
Region CS

Appointments: PCP appointments only for 06/08/07

Appt Date/Time	Dr. Appt with	Appt Type	Appt Location
06/08/07 03:45 PM	MEZA, FRANK (M.D.)		FAMILY PRACTICE-E48FAM*

Preventive Care:

- **Mammogram Due - (50-69 y/o females once every 2 years) Last Completed:5/31/2005 8:01:04 PM Next Due: N/A**
  - ☐ If on Health Connect, reviewed Best Practice Alert
  - ☐ Scheduled appointment for mammogram
  - ☐ Informed member of walk in appointment or gave member phone number to book appointment
  - ☐ If exclusion is applicable, pended exclusion for provider to code
- **Pap Smear Due - (21-65 y/o females once every 3 years) Last Completed: N/A Next Due:5/31/2004 8:01:04 PM**
  - ☐ If on Health Connect, reviewed Best Practice Alert
  - ☐ Prepared room and member for pap and pended pap/hpv order via BPA
  - ☐ Scheduled Future Pap appointment
  - ☐ If exclusion is applicable, pended exclusion for provider to code
- **Colorectal Cancer Screening Due - (52-80 y/o, FOBT yearly, Flex Sig every 5 yrs, Colonoscopy every 10 yr) Last Completed: N/A Next Due:N/A**
  - ☐ Informed provider member is due for colorectal cancer screening
  - ☐ Assisted provider with referral as necessary
  - ☐ Provided FOBT kit
  - ☐ If exclusion is applicable, pended exclusion for provider to code

Immunizations Due:

- **Tetanus Last Completed: N/A Next Due:5/31/1997 8:01:04 PM**
  - ☐ Ordered immunization

- **Checklists will be generated for *all* patients *identified* as having *gaps* in care.**

Simulations
Equipment - SimMan

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Training on:

- Human factors and team skills
- Reality and types of Human Errors
- Orientation to Simulator

Members Can Actively Participate in Care (kp.org My Health Manager)

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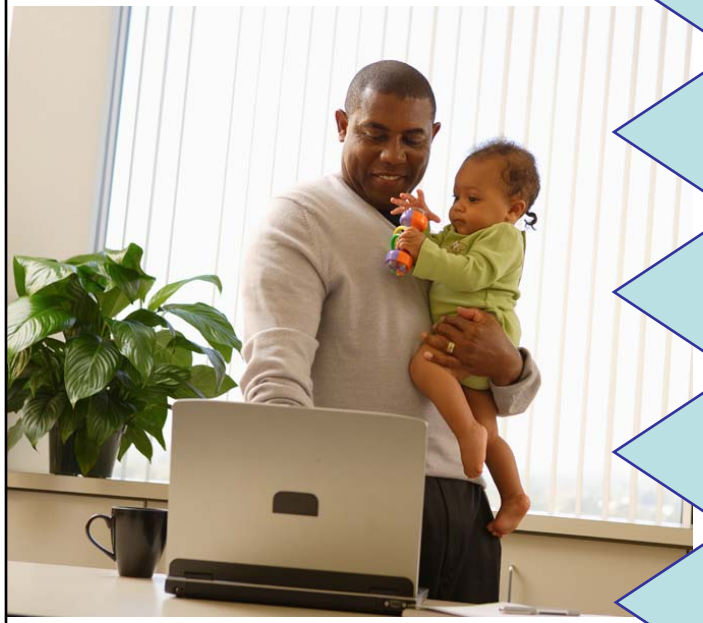
www.kp.org
Member Web Portal



Make/Change Appointments

Send messages to doctor

Check lab results

Access health Information

Access medical record

Refill prescriptions

Make payments

KP HealthConnect Care Delivery Core

Outpatient	Inpatient
Scheduling	Scheduling
Registration	Registration
Clinicals	Clinicals
Billing	Billing
	Pharmacy
	Emergency Department

KP Quality: On the Right Path

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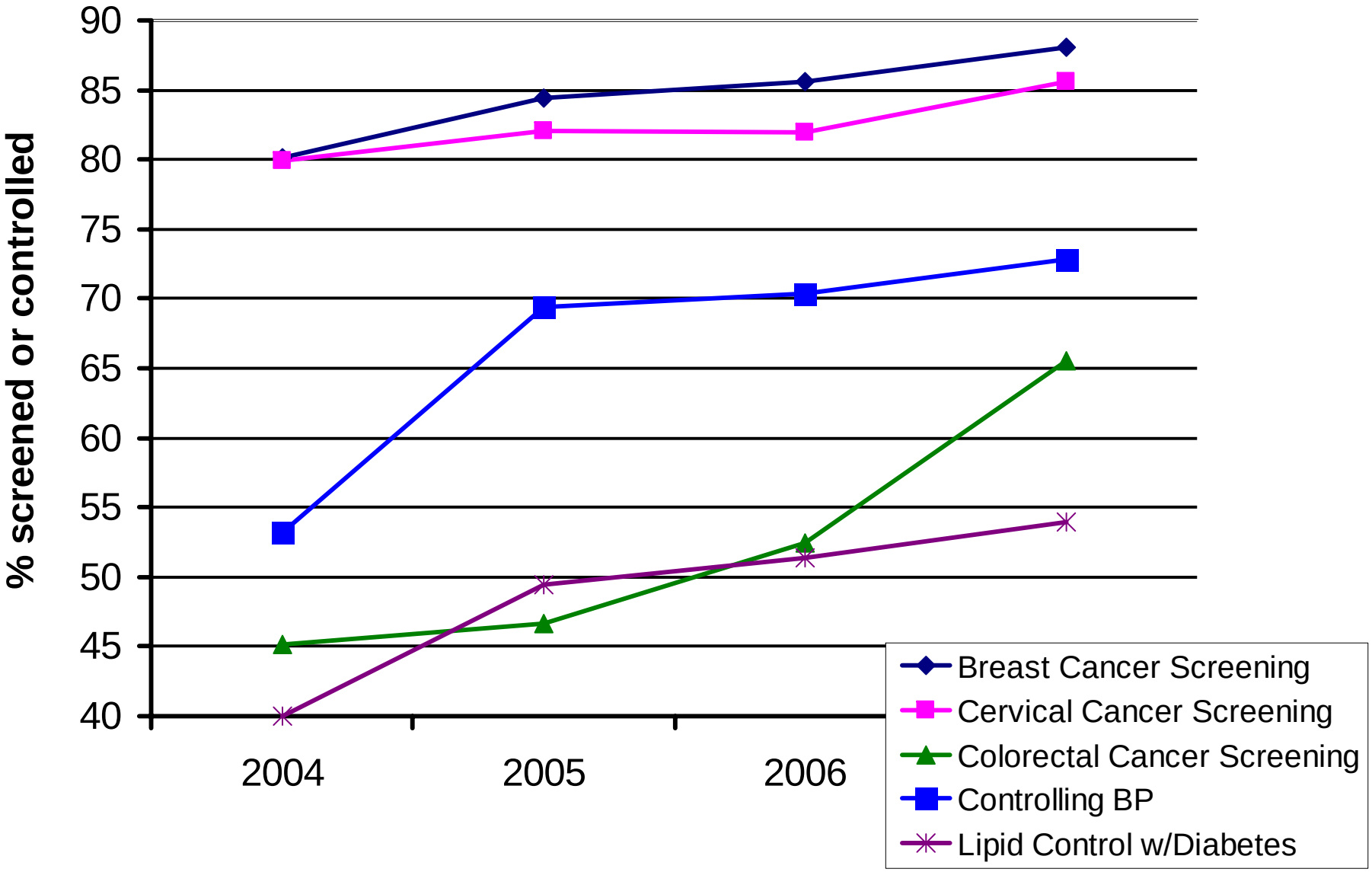

Quality: Prevention and Lives Saved

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Metric	Increase	Lives Saved per Decade
Cholesterol Control	13.4%	1077
BP Control	29.7%	4080
HbA1C < 9.0	6.9%	653
Smoking Cessation	8.0%	450
Breast Cancer Screening	11.0%	550 4234 (stage 4 cases Prevented)
Cervical Cancer Screening	5.0%	33
Colon Cancer Screening	23.1%	3664

Transforming Health Professions Education

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- Team Based Rounding with multiple health professionals and maybe even patients and their families
- Integration of Patient Safety and Performance Improvement in Training
- Computer Enhanced Simulation Training in multiple settings to emphasize team skills, coordination and adherence to safe and effective best practices
- Move to ambulatory training sites that incorporate new models of care using sophisticated care management tools and willingness to employ teams to drive for better outcomes

Toward a New Professionalism

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- Maintain and support patient-provider relationship
- Accountability to what is best for our patients
- Commitment to lifelong learning but support learning with powerful new tools
- Commitment to the best quality outcomes for patients using available and yet to be developed support tools
- Commitment to coordination of care
- Teamwork and leadership skills
- Individual, team and system accountability for patient and population health

What Can We Do to Transform Medical Education?

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- Continue to set high expectations for transparent and measurable performance outcomes for the healthcare system
- Do whatever it takes to encourage adoption of key tools to enhance performance (Health IT, registries, decision support and population care management tools) including tying continued graduate medical education funding to core infrastructure
- Require that graduate medical education training be conducted in environments with a commitment to high performance both on the in-patient and out-patient

Transforming Medical Education

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- Encourage cooperation with ACGME, Residency Review Committees and other accrediting bodies to push training to these environments
- Use of remote learning tools to augment gaps in training – IHI Patient Safety Academy
- Payment Reform to encourage greater system accountability for performance and population health approaches