University of Utah Health Sciences Center, Salt Lake City, UT

Aligning Resident Quality Improvement Activities with Institutional Strategic Goals

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Background: As a result of our CLER visit, we determined that an unacceptable percentage of our residents understood the hospital's priorities for quality improvement, were engaged with hospital leadership in advancing the hospital's quality strategy, had linked their quality projects with hospital goals, were engaged in interprofessional quality improvement teams, understood quality improvement terminology and methods, and had access to organized systems for collecting and analyzing data for quality improvement. Consequently, the purpose of our project was to develop action plans for addressing these opportunities for improvement.

Methods: A GME Value Council was established under the GMEC to oversee and coordinate alignment and integration of resident quality improvement projects with the hospital's goals and priorities; provide expertise and resources for residents in developing and implementing their projects; develop a quality improvement curriculum and educational experiences for residents; and promote resident participation in interprofessional quality improvement teams within the hospital system. Members of the GME Value Council included the DIO, GMEC chair, chief medical officer, chief quality officer, program directors, residents, and a value engineer.

Results: The project is still in progress.

Conclusions: We believe that integration of resident quality improvement activities and the hospital's strategic quality improvement goals with GME Value Council oversight and support will enhance the residents' clinical learning environment while engaging them as active contributors in creating and implementing the institution's strategic plan for quality.

FINAL WORK PLAN – University of Utah Health Sciences Center

Team Charter/Objectives	The purpose of our project was to develop action plans for addressing the opportunities to improve resident understanding of quality improvement strategy, goals, terminology, and projects.
Project Description	A GME Value Council will be established to oversee and coordinate alignment and integration of resident quality improvement projects with the hospital's goals and priorities; provide expertise and resources for residents in developing and implementing their projects; develop a quality improvement curriculum and educational experiences for residents; and promote resident participation in interprofessional quality improvement teams within the hospital system. The council will be comprised of program directors/associate directors, chief residents, residents/fellows, Quality Department staff, GME office staff, and hospital administration. Council members will work with the health system's quality and patient safety professionals/ experts to align departmental quality improvement efforts with the system's priorities, goals, and strategic initiatives; develop quality improvement educational experiences for residents; and ensure residents' active participation in interdisciplinary clinical quality improvement and patient safety programs. The GME Value Council will be organized as a subcommittee of the GMEC.
Vision Statement	We will increase resident awareness of the hospital system's goals and priorities for quality improvement, increase resident engagement with hospital leadership in developing the hospital's strategic goals for quality improvement, increase alignment between resident quality improvement projects and hospital goals and strategies, and increase resident engagement in interprofessional quality improvement teams.
Success Factors	The project is still in progress.

Barriers	The GME Value Council was initially formed under the hospital's Value Council and then moved to the GMEC. We lost valuable time in developing the council's mission, vision, and goals and in operationalizing the committee during this transition. Gaining program director leadership of the group was also a challenge.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	The project is still in progress.

Virginia Mason Medical Center, Seattle, WA

The "Silent" Disparity - Health Literacy: Enhancing Provider Awareness

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Background: Health literacy is an essential concept in patient-centered medical care. It represents the combination of literacy skills and the ability to understand, process, and engage in healthcare to further one's own health and provide a sense of patient autonomy. Deficiency in this skill is a common problem, and the Institute of Medicine estimates that half the adult population in the United States, approximately 90 million people, have difficulty understanding and acting upon health information. The impact of poor health literacy is striking. Lower health literacy levels are associated with a nearly 2-fold increase in mortality. Patients with limited health literacy often have difficulty with treatment adherence and are likely to misinterpret instructions such as medication labels. This, in turn, leads to progression of disease, subsequent hospitalizations, poor health outcomes, and increased costs. We investigated the incidence of limited health literacy in a subset of the Virginia Mason Medical Center patient population in one of our primary care clinics.

Methods: Members of the healthcare team (attending physicians, residents, and nurse practitioners) were assessed for their ability to accurately identify patients with deficiencies in health literacy. We selected the Rapid Assessment of Adult Literacy in Medicine (REALM-R) as our literacy assessment tool. Designated medical team members administered REALM-R surveys to patients. They were scored and kept anonymous and confidential. Providers were then asked 2 questions: (1) have you met this patient before? and (2) does this patient have a problem with health literacy? Answers provided by healthcare providers were then compared to the objective data provided by the REALM-R survey to assess provider identification of health literacy deficiencies. A multidisciplinary team was assembled to develop an educational intervention/curriculum using the ADDIE (analysis, design, development, implementation, evaluation) model and based on previously published literacy interventions. Videos highlighting individual stories from patients who experienced an inability to understand their own healthcare were created and made available through a website devoted to addressing the topic of health literacy.

Results: Preliminary data collection with the REALM-R tool was done in a general internal medicine outpatient clinic. Participating providers included physicians and nurses in an integrated care management team. Following survey administration, we determined that 20% of patients with health literacy deficits were identified correctly by their providers.

Conclusions: Our provider teams have difficulty consistently identifying patients with health literacy deficiencies, and this difficulty is consistent with national trends. Rather than focus on identifying patients at risk, we are examining the benefit of assuming that every patient may be at risk for health literacy and target communication to alleviate and address this issue. We are disseminating tools that improve provider communication, and our measure will be determining if provider perception of the scope of the problem has changed.