THE AMERICAN BOARD OF PATHOLOGY
PATIENT SAFETY COURSE APPLICATION

Requirements: Component I – Patient Safety Self-Assessment Program

Programs must meet the following criteria to be an ABP approved Patient Safety Course:

Course Requirements

1. The course must address key themes of patient safety that cut across disciplines and clinical settings. The five required key themes are:
    - epidemiology of error
    - systems thinking and the effect of the system on patient safety
    - human factors
    - creating a culture of safety
    - fundamentals of quality improvement

    Additionally, the program must contain at least <u>two</u> of these eight elective content areas:
    - safety enhancing technology
    - methods and tools for evaluating safety events
    - methods and tools for avoiding medical errors
    - managing and assessing risk
    - effective communications
    - role of the patient
    - health care-associated infections
    - diagnostic errors.

2. The course must provide learners with high quality content that is free of commercial bias and control of a commercial interest, as currently specified in the *Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support.*™ The program must meet accepted standards for reliability and validity as stated by the ACCME Clinical Content Validation policy. The ACCME Clinical Content Validation policy is designed to ensure that patient care recommendations made during CME activities are accurate, reliable and based on scientific evidence. (http://www.accme.org/requirements/accreditation-requirements-cme-providers/standards-for-commercial-support and http://www.accme.org/requirements/accreditation-requirements-cme-providers/policies-and-definitions/cme-clinical-content-validation)

3. The course must present a curriculum that addresses each of the required key themes and elective content areas. The curriculum must contain three to five learning objectives for each key theme and elective content areas as well as a pre- and post-test to evaluate learner progress.

4. The provider must have a plan that clearly identifies the method by which the course content and materials will be reviewed and updated at least every three years.

5. Programs are required to incorporate the following reference into the curriculum:
    Institute of Medicine. *To Err is Human: Building a Safer Health System.* Washington: National Academy Press; 1999.

Testing

1. The curriculum must include pre-test(s) and post-test(s) of multiple choice, single best answer questions drawn from the curriculum content. The number of questions should adequately cover the content and there should be at least 3-5 questions for each half hour of instructional time. The provider must meet ABP

standards for item/question quality as detailed in the ABP's "SAMs Provider Toolkit" available on our website www.abpath.org.

2. Assessment methods must meet standards for self-evaluation in the field. According to the ACCME criteria, self-assessments must describe and demonstrate a process of establishing a gap and the underlying educational need. (http://www.accme.org/requirements/accreditation-requirements-cme-providers/criteria/criterion-2)

3. The curriculum must be completed by participants prior to taking the post-test(s).

4. A passing score of 80% is required on the post-test(s) for successful completion and to earn *AMA PRA Category 1 Credit*™. Providers can allow more than one attempt to pass the post-test(s).

Curriculum
The curriculum includes the required key themes and selected elective content:

A) The following five required key themes must be incorporated into a Component 1 program:

1. Epidemiology of error
   Core concepts – The epidemiology of error curriculum should prepare physicians to discuss the key definitions that underpin current patient safety efforts as well as the historical journey of the patient safety movement in the United States, in particular the release of the IOM report, *To Err is Human*. Rates of errors and adverse events should be discussed. The curriculum should include a discussion of the most common types of errors and adverse events, including (1) communication problems, (2) inadequate information flow, (3) human (or performance) problems, (4) patient-related issues, (5) organizational transfer of knowledge, (6) staffing patterns/work flow, (7) technical failures and (8) inadequate policies and procedures. A discussion of latent failures vs. active failures should be included.

2. Systems thinking and the effect of the system on patient safety
   Core Concepts – Physicians should be able to describe the system in which they provide care. The core elements of that system include the providers, patients, support staff, clinical processes, administrative processes, technology and information that all come together to produce the care. The curriculum should also address how a well performing system can prevent patient harm.

3. Human Factors
   Core Concepts – Human factors is the study of the interrelationships between humans, the tools they use and the environment in which they work. The curriculum should discuss specific human factor interventions to improve systems and processes such as simplifying and standardizing procedures, building a redundancy into the system, improving communication within healthcare teams, redesigning equipment to improve the human-machine interaction.

4. Culture of safety
   Core Concepts – The culture of safety curriculum should identify the specific elements i.e., the beliefs, attitudes, and values about work and risks that contribute to safety culture. The curriculum should identify the value of learning in creating and sustaining patient safety and recognize the relationship between reporting and learning. The program should make the distinction between errors resulting from deliberate unsafe acts and errors that are a result of system failures. In addition, the curriculum should identify the detriments to patient safety from hierarchical gradients among members of the health care team.

5. Fundamentals of quality improvement
   Core Concepts – The Model for Improvement, developed by Associates in Process Improvement, is a simple yet powerful tool for accelerating improvement. The model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement. The model consists of two parts: (1) three fundamental questions (What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?), which can be addressed in any order, and (2) the Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement. (*Institute for Healthcare Improvement, IHI—Science of Improvement, How to Improve—www.ihi.org*)

B) Two of the following eight elective content areas must be incorporated into the Component1 program:

1. Safety enhancing technology
   Core Concepts – The curriculum should address how technology can provide an effective means for preventing and mitigating the effect of some types of errors. The curriculum should also address how technology may have unintended consequences which actually lead to more errors or additional types of errors that weren't anticipated.

2. Methods and tools for evaluating safety events
   Core Concepts – There are several common tools that are used to assess and evaluate risk as well as adverse events. Methods that should be included in the curriculum are: root cause analysis, failure modes effects analysis and probable risk assessment. In addition, the tools to identify safety events and trends such as error reporting systems and national reporting efforts should be discussed.

3. Methods and tools for avoiding medical errors
   Core Concepts – Medical errors can occur anywhere in the health care system, including in hospitals, clinics, surgery centers, doctor's offices, nursing homes, pharmacies, and patients' homes. Errors can involve medicines, surgery, diagnosis, equipment, or lab reports. Most errors result from problems created by today's complex health care system. Errors also happen when doctors and patients have problems communicating. (*Agency for Healthcare Research and Quality—Patient Safety Primers, www.ahrq.gov*)

4. Managing and assessing risk
   Core Concepts – Numerous methods and tools are available for analyzing adverse events to prevent further errors and patient harm from occurring. Error analysis can be performed either retrospectively or prospectively. Root cause analysis (RCA) is the most common method to investigate serious adverse events. It is more difficult to measure errors than adverse events, because there is a subjective component to defining errors, and because errors must be understood in the context of the system in which they occur. Near misses are valuable opportunities to understand how the process has failed and could be improved.

5. Communication
   Core Concepts – The curriculum on communication will demonstrate how communication plays a role in achieving patient safety. Several barriers may affect both the physician-nurse and the patient-practitioner communication including safety culture and the authority gradient. Transitions of patient care are a particularly vulnerable time for patients and the curriculum should address the specific transitions that are related to the discipline, including a specific strategy for conducting the transition of care. Disclosure of adverse events should be addressed specifically and should include the strategies for accomplishing the necessary steps in effective disclosure, including: (1) telling the patient and family what happened, (2) taking responsibility, (3) apologizing and (4) explaining what will be done to prevent similar errors. The curriculum should include a discussion of the SBAR technique to facilitate communication between physicians and other members of the care team.

6. Role of the patient
   Core Concepts – The traditional paternalistic model of medicine, in which patients have little voice in their care, has slowly but surely been evolving toward a model in which patients and clinicians work in a partnership toward the common goal of improved health. As articulated in the seminal IOM report *Crossing the Quality Chasm,* such patient-centered care should be "respectful of and responsive to individual patient preferences, needs, and values and ensure that patient values guide all clinical decisions." Efforts to engage patients in safety efforts have focused on three areas: enlisting patients in detecting adverse events, empowering patients to ensure safe care and emphasizing patient involvement as a means of improving the culture of safety. (*Agency for Healthcare Research and Quality—Patient Safety Primers, www.ahrq.gov*)

7. Health care-associated infections
   Core concepts – Health care-associated infections (HAIs) are the most common complication of hospital care. Such infections were long accepted by clinicians as an inevitable hazard of hospitalization. However, recent efforts have demonstrated that relatively simple measures can prevent the majority of common HAIs, and as a result, hospitals and providers are under intense pressure to reduce the burden of these infections. Four specific infections together account for more than 80% of all HAIs: Surgical site infections (SSI), catheter-associated urinary tract infections (CAUTI), central venous catheter-related bloodstream infections (CRSBI), and ventilator-associated pneumonia (VAP). Reduced infection rates have been demonstrated following implementation of preventive measures, particularly for SSI and CRBSI. (*Agency for Healthcare Research and Quality—Patient Safety Primers, www.ahrq.gov*)

8. Diagnostic errors
   Core Concepts – Diagnostic error has received limited attention, despite the fact that landmark patient safety studies have consistently found that diagnostic error is common. An extensive body of research has examined causes of diagnostic error at the individual clinician level. Given that many diagnostic errors are caused by subtle biases in clinicians' thought processes, some diagnostic errors may be prevented by systems to mitigate the effect of these biases and provide physicians with objective information to assist with decision-making. More progress has been made in addressing systems' causes of diagnostic error. Information technology has improved clinicians' ability to follow up on diagnostic tests in a timely fashion, which should reduce the incidence of delayed diagnoses. Structured protocols for telephone triage, teamwork and communication training and increased supervision of trainees may also lead to improved diagnostic performance. (*Agency for Healthcare Research and Quality—Patient Safety Primers, www.ahrq.gov*)

Requirements Checklist

Component I – MOC Patient Safety Program

Yes

- ☐ Application
- ☐ Copy of the program
- ☐ Copy of the approval from the accredited CME provider
- ☐ Learning objectives
- ☐ Update plan
- ☐ Pre-test with answer key
- ☐ Post-test with answer key

Application for ABP Approval: Component I Patient Safety Program

Name of Organization**:**

Name and Title of Organization Contact Person:

Contact Phone Number:

Contact Email:

Today's Date:

Please indicate your organization's target implementation date:

Can ABMS or other Member Boards contact your organization with questions regarding this Patient Safety Program?
☐ Yes
☐ No

1. Name of the Patient Safety Program:

   ☐ Copy of the Patient Safety Program attached.

2. Developer of Patient Safety Program:

3. For which type(s) of CME credit is this program certified?
   Select all that apply.
   ☐ *AMA PRA Category I Credit™*
   ☐ AAFP Prescribed Credit
   ☐ ACOG cognates
   ☐ AOA Category 1A
   ☐ Other, please list:

4. ☐ This Patient Safety Program includes content that is free of commercial bias and control of a commercial interest as currently specified in the ACCME Standards for Commercial Support™.

5. ☐ This Patient Safety Program meets the accepted standards for reliability and validity as stated by the ACCME Clinical Content Validation policy.

6. ☐ This Patient Safety Program includes the five required key themes.

7. Please indicate at least two elective content areas included in the Patient Safety Program:

   ☐ Safety enhancing technology
   ☐ Methods and tools for evaluating safety events
   ☐ Methods and tools for avoiding medical errors
   ☐ Managing and assessing risk
   ☐ Communication
   ☐ Role of the patient
   ☐ Health care-associated infections
   ☐ Diagnostic errors

8. ☐ This Patient Safety Program contains three to five learning objectives for each of the required key themes as well as each of the elective content areas.
   ☐ Learning objectives attached

9. ☐ A plan has been developed that clearly identifies the method by which the course content and materials will be updated every three years
   ☐ Update plan attached

10. ☐ The Patient Safety Program incorporates the following reference:
    Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington: National Academy Press: 1999

11. ☐ The Patient Safety Program contains a pre-test of multiple choice questions that establishes a gap and educational need
    ☐ Pre-test and answer key attached

12. ☐ The Patient Safety Program contains a post-test of multiple choice questions that evaluates learner progress?
    ☐ Post-test and answer key attached

13. ☐ The Patient Safety Program requires content completion prior to taking the post-test(s).

14. ☐ The Patient Safety Program's post-test(s) require a passing score of 80% or higher for successful completion.