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# Decentralizing Quality Improvement

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Despite spending more on health care than any other developed country, medical care in the United States has mediocre clinical outcomes. Rather than spending more, we need to turn our attention to improving quality of care, lowering costs, and improving population health.<sup>1</sup> In this commentary, we emphasize an emerging consensus for 1 important solution to achieving the triple aims mentioned above: decentralizing quality improvement (QI)—moving it out of administrative offices and into the hands of clinicians—and integrating it with team-based and interprofessional education and care.<sup>2,3</sup>

Hospitals and health systems have traditionally conducted QI within the walls of their QI departments without engaging frontline clinicians. Educational competencies, including in health sciences schools and continuing education programs, have not included a next step—translation of education to improved quality of care.<sup>2</sup> Only a third of physicians are engaged in clinical redesign efforts to improve care. Most physicians do not continually evaluate their own practice using quality-of-care data. Even if these data were available, many physicians feel that the general public should not be allowed access to performance data.<sup>4</sup>

Thus, the overall barrier to transforming systems of care is the failure to develop a robust workforce that is well prepared to actively drive sustainable change. These barriers were identified by the Institute of Medicine (IOM) in its report, *Health Professions Education: A Bridge to Quality*. The report emphasized that clinicians are inadequately prepared to provide the highest quality care and that ongoing proficiency in clinical QI is insufficiently assessed. The IOM called for urgent refocusing of health professions education on QI, aligning clinical education to be consistent with the needs of the health care system.<sup>2</sup>

Clinician engagement in QI is a key principle of the National Quality Strategy. The National Quality Strategy was developed under the Affordable Care Act to create goals and priorities to guide efforts to improve the quality of health care in the United States. Priorities in the National Quality Strategy include making health care delivery safer, engaging patients and caregivers as partners in care, and improving communication and care coordination. A key principle of the Strategy includes health care QI. The strategy elaborates that the best way to improve quality is to enable health professionals to

assess their and their colleagues' performance, tailor interventions to local needs and resources, rapidly learn if these interventions result in improvement, and share lessons learned.<sup>1</sup>

Several initiatives are designed to overcome these barriers. Robust workforce participation in QI, integrated across the continuum of clinician education, embraced as a lifelong commitment, and applied to patient care, is a critical approach to driving our National Quality Strategy. Competencies for health professions education include systems-based practice and practice-based learning and improvement—2 competencies at the core of QI. Health care professionals are expected to demonstrate knowledge of health care systems, specifically those related to delivery systems, financing, cost, efficient resource allocation, team-based care, and optimization of the value of health care.

Starting in 2013, the Accreditation Council for Graduate Medical Education's Next Accreditation System aims to enhance the ability of training programs to better prepare physicians for practice in the 21st century.<sup>5</sup> Systematic and robust workforce development in QI combined with strong institutional leadership support can be a key approach to integrating the missions of clinical excellence and education at teaching institutions.<sup>2</sup> Trainees are at the front lines of delivering care and guiding treatment plans. They are, however, infrequently engaged in organizational QI efforts. Programs that have successfully engaged trainees in institutionally aligned and strongly supported QI efforts have demonstrated improvements in trainee knowledge, processes of care, and patient outcomes.<sup>6–8</sup>

In addition to student and trainee education, it is critical to not miss opportunities for continuing professional development and lifelong learning, such as maintenance of certification, that focus on applying QI principles to patient care. Professional boards of medicine and nursing now require that clinicians in practice improve the quality of their patient care by continually demonstrating knowledge and skills in QI. Traditional forms of continuing health

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professions education are only modestly effective in changing clinician behavior, especially in the long term. Robust hands-on faculty and staff development in clinical QI is now being recognized as a more efficient method of health professions education and practice change.<sup>9</sup>

Improving the quality of health care and of health by integrating education with implementation science is a critical aspect of the institutional strategic plan at the University of California (UC) Davis Health System (UCDHS). This strategy has senior administrative support from our school of medicine, school of nursing, faculty practice group, and the medical center. Institutional structures include the Institute for Population Health Improvement, the Center for Health Policy and Research, and the strategic plan. Collaborative and visible interprofessional leadership has been critical to the success of our systemwide initiatives related to workforce development in QI.

Our learners are now exposed to QI education beginning on the first day of medical or nursing school and continuing on to residency training. We have modified our student home visit program and use it as a way to engage patients in identifying areas and strategies for improvement in our health system. We have introduced interprofessional courses that engage learners in completing QI projects aligned with organizational priorities throughout our health system. Students across disciplines at UCDHS have teamed up to join the national drive to incorporate QI over the range of medical education to enhance clinical care and training. A grassroots student initiative, the UC Davis student interest group in QI, brings together students from medicine, nursing, public health, public policy, informatics, management, law, business, and engineering. Members of this group are actively involved in working with faculty in designing and evaluating new curricula. These curricular changes are assessed by our Education Outcomes Evaluation program.

We recently held our second annual Integrating Quality Symposium. The goal of this annual event is to link high-quality clinical care with clinician education and implementation science. In 2011, the inaugural year of the symposium, there were 75 attendees and 13 podium and poster presentations on local QI initiatives; in 2012, there were 227 attendees and 68 presentations. A student who presented her QI work on reducing risks for deep vein thrombosis commented, "As a medical student, it is fascinating to take a step back from patient care and treatment and examine how processes work, or don't work. Small things that we can change consistently in the practice of medicine can have real benefits for preventing deaths and reducing complication rates."

The UC Office of the President's Center for Health Quality and Innovation funds and coordinates a learning network of all 5 UC health systems. This network engages trainees, faculty, and staff in QI in focus areas aligned with national and health system priorities. For example,

the current focus of this learning network is to improve the hospital discharge process, thereby reducing unplanned readmissions. The premise of the network is that sharing and collaborating on approaches that are successful or unsuccessful at one campus may disseminate best practices.

Recent studies and our own institutional experience show that students, trainees, and practicing clinicians are a large and infrequently tapped workforce of future QI practitioners. Given the urgent national imperative to improve the delivery and value of health care, their development, engagement, and empowerment in institutional QI efforts has the potential to greatly accelerate transformational changes.

In conclusion, weaving QI into the fabric of health care delivery organizations, combined with strategic and ongoing career development of interprofessional teams, can sustainably overcome barriers to improving health care delivery and population health. Clinicians are uniquely positioned to assess and modify pathways of care, recognize systems deficits, and support the IOM's quality aims to transform health care delivery.

### Authors' Note

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