

THE FUTURE OF LEARNING: BUILDING A BRIDGE BETWEEN COMPETENCY AND PATIENT SAFETY THINK TANK

POST EVENT WHITE PAPER
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BACKGROUND

To err is human. Errors in the provision of health services, while they are readily understandable to the public, are events that should not happen (Institute of Medicine, 2000). As a result of this, confidence in the health care system is eroding (Coile, 2003). Historically, the health care system has been characterized by a culture of silence, fragmentation, and fear of punitive action (Byrne, 2005). Fortunately, the new millennium has seen the onset of a new culture of an envisioned future of safe, interdisciplinary care given by competent providers (Byrne, 2005). However, a cultural paradigm shift will be a major challenge for the health care system. Is this cultural change a shared vision for all health care providers? Are health care providers aware of the effect of errors and committed to a call to action? What steps can be taken now to focus on this critical issue and proactively create not only the vision, but the reality of safe patient care in the future?

What is the best way to prepare entry-level health care providers and then evaluate their competency throughout their careers?

THINK TANK DESIGN

To address these and other questions, the Competency and Credentialing Institute (CCI), formerly the Certification Board Perioperative Nursing (CBPN), convened a Think Tank in Philadelphia, Pennsylvania, on June 15-16, 2005. The purpose of the Think Tank was to provide an opportunity for discourse, dialogue, and innovations for cultural change surrounding patient safety and competency assessment. Thirty-six experts, representing a cross-section of medical, surgical, nursing, and pharmaceutical specialty groups; competency coalitions; councils of state medical and nursing boards; professional associations; hospital systems; academia; consumer advocacy; patient safety; learning technology and methodology leaders; and industry attended the event. CCI's commitment to the Think Tank was the belief that an action-oriented agenda could be created and implemented to promote innovations in competency and ultimately,

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patient safety. The agenda was one focused specifically on advancing competency development, assessment, and education and thereby creating a future vision for competency and patient safety.

The primary methodology used for the Think Tank was open space facilitation. This cutting edge approach pulled together the knowledge and experience of the participants and released their energy and creativity to uncover solutions and opportunities (Fulcrum Associates, Inc., 2005). Open space facilitation runs on two standards: passion and responsibility. Passion engages the group, and responsibility ensures that the deliverables come about. Open space facilitation acts on the principle that to gain maximum contribution and commitment, the participants must be given the free space and time to deal with issues about which they are passionate. The physical set-up of the Think Tank environment was consciously created to support the principle. Participants were seated at round tables, surrounded by blank white boards. The white boards would be completed over the two days with the thoughts, insights, and actions developed by the group. This “container” environment was intended to direct the participants out of their existing mental models to think critically and expansively.

The process began with defining the issue and then creating the theme. Activities over the two days included large and small group discussion sessions, panel discussions, experiential learning and review activities, breakout sessions, and use of audience response technology. The event also incorporated graphic recording to maximize the output from the participants, while capturing the event in real time.

Another key element of the Think Tank was the Gallery Walk. The Gallery Walk provided a forum for a more kinesthetic and self-driven learning experience and was designed to allow the participants to experience new technology and ask questions. The final activity of the Think Tank was action planning—to take the ensuing strategic solutions and brainstorm potential ideas and actions that could further the agenda of competency assessment and development associated with patient safety in health care.

PRIMARY CONCLUSIONS

The first topics addressed by the group were the driving forces and trends for the next ten years to 2015. It was agreed that technological advancements will continue at an unprecedented pace, which will directly affect the delivery of health care. One of the advantages of technology is that it can enhance human performance to the extent that the human plus the technology is more powerful than either alone (Norman, 1993). Technology, however, also can create new demands on practitioners (IOM, 2000). For example, a new piece of equipment may provide

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more precise measurements, but may also demand better precision from the operator for the equipment to work properly (Cook & Woods, 1994). Technology in the health care system also must be recognized as a “member” of the work team (IOM, 2000). When technology shifts workloads and work responsibilities, it also shifts system dynamics. For example, technology may enable a task to be completed by fewer people. This ultimately affects the distributed nature of the job in which tasks are shared among several people and may influence the ability to discover and recover from errors (Norman, 1993). The types of medical equipment and devices used by our diverse population will change health care. As more care shifts to ambulatory and in-home settings, the use of medical technology by non-health professionals will take on greater significance (IOM, 2000).

The prevailing insight of the group was that the status quo of the health care system is no longer acceptable.

The disparities that exist in our population today, in terms of economics and demographics will continue to influence the health care system. Health care facilities continue to face the ongoing challenges of rising costs and uncompensated care (Coile, 2003). Consumers also face similar economic challenges. Understanding today’s health care consumers—who they are and how they are changing—is imperative for all health care providers, suppliers, employers, and policy makers.

Providing culturally appropriate care will be a challenge as the demographics of the U.S. population continue to diversify. Cultural diversity tests the ability of health care providers to truly care for patients—to demonstrate not only clinical proficiency, but also cultural competency (Setness, 1998). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) views the provision of culturally and linguistically appropriate health services as an important quality and safety issue and a key element in individual-centered care (JCAHO, 2005).

Will health care providers and organizations respond to the challenge to make individual consumers vital members of the care team and channel their interests and energy into improving care delivery and outcomes?

The shortage of practitioners is a bleak reality affecting health care. The nursing shortage persists; other health care workers such as pharmacists and technicians also are in short supply; and there are early warning signs of a physician shortage, particularly in specialty practice areas (Coile, 2003). Therefore, the pressure to prepare competent, entry-level practitioners will persist.

The Think Tank participants were asked to generate a list of what they considered to be the top future needs of the practitioner. They explored how practitioners can be effective in delivering patient centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics, as recommended by the Institute of Medicine (IOM, Health Professions Education: A Bridge to Quality, 2003). An environment that supports interdisciplinary learning and problem solving was the most significant perceived need for the practitioner in the future. The participants agreed that one of the principles for the design of safety systems in health care organizations outlined in *To Err is Human* is the creation of a learning environment that fosters free-flowing communication regardless of authority gradient and non-punitive mechanisms of feedback and learning from error (IOM, 2000).

How can technology be used more effectively in the future? Can we make it simpler to share information, enhance communication, and overlap boundaries to make seamless care a reality?

The appropriate application of technology to incremental productivity and competency also was cited as a key need for the future of patient safety. It is important that technological advancements be integrated into the changes that are envisioned for health care and education (Byrne, 2005). There is intense pressure to implement new technologies to reduce “human error,” such as the electronic medical record, computerized provider order entry, bar coding for patients and medications, robots and automated systems for medication dispensing, and “smart” infusion pumps that identify abnormally high doses (Alvarado & Cao, 2004). The use of information technology to demonstrate quality care and support evidence-based medicine capabilities will increase in frequency and importance for care delivery organizations, as well as individual providers (American College of Physicians, 2004).

Communications and efficiencies within systems and between individuals must be improved in the future. The migration in the push to adopt information technology systems for improvements in both safety and efficiency will be successful only if it is accompanied by process adaptation and change management techniques that promote acceptance among staff members and clinicians (Pexton, 2005). This will require improved communication among individual practitioners and clients, as well as within health care systems.

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These experts also explored strategic offerings to meet the needs of practitioners. On-going, multi-disciplinary education was noted as the most important change for the future. Other aspects of expert recommendations included the development of multidisciplinary training, collaboration among facilities and academic departments, cooperation and collaboration among educational institutions, promotion of active learning, and evaluation of outcomes (both learner and patient).

Will we get to a point when examination of clinical practices demonstrates that the care provided is based on reliable evidence of what works and what does not?

Continued research on the effectiveness of patient care strategies to support evidence-based practice was cited as another key factor in the delivery of safe patient care. Access to and appropriate use of evidence-based data also were noted as key considerations. In January 2005, the American Medical Association (AMA) released a set of supplemental tracking codes in its Current Procedural Terminology® (CPT). It is anticipated that the use of tracking Category II codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care (AMA, 2005). These codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care (AMA, 2005). In addition, the AMA convened The Physician Consortium for Performance Improvement that also includes experts in methodology. The Consortium's vision is to fulfill the responsibility of physicians to patient care, public health, and safety by becoming the leading source organization for evidence-based clinical performance measures and outcomes reporting tools for physicians that enhance quality of patient care and that also foster accountability (AMA, 2005). Optimal health care outcomes can only be achieved when the best scientific evidence is fully incorporated into clinical practices (Delbanco, 2005).

Health care practitioners of the future may need to be incentivized based on quality of care. According to a recent report, incentives for health care providers are changing (Accenture, 2005). In almost every company in every industry, employees are financially incented and rewarded for the quality of their work and the extent to which it contributes to the performance of the organization as a whole. Health care, however, is the exception to this

practice. In general, the provider's revenue is independent of the quality of care they provide and instead depends on the volume of patients seen and complexity of procedures performed, regardless of quality. While new thinking about how to pay health care providers is evolving, pay-for-performance programs use incentives to encourage evidence-based practice that promote better outcomes and ultimately transform the health care system. Simply put, they are an attempt to directly link reimbursement and quality (Accenture, 2005).

Do health care professionals view continuing competency assessment as a positive in their career development or an unwelcomed burden?

The workplace of the future needs to be well designed with a focus on competency. The Citizen Advocacy Center (CAC) cited an evidence-based approach as one of the principles underlying its vision for maintaining and improving health professional competence (CAC, 2004). Research should be initiated that focuses on examining the link between periodic continuing competency assessment and assurance and changes in behavior that lead to improved clinical outcomes. There are distinct differences between competence and competency, which in turn, affect the overall competency assessment process and structure of a competency assessment program (D'Alfonso & Moss, 2004). Competence typically refers to an individual's capacity to do the job. Competency adds the element of actually performing the specific job. Competence assessment is the process of establishing an individual's potential knowledge and skills. Competency assessment is a process that continually verifies the individual's knowledge, skills, and attitudes. Distinguishing and documenting ongoing competence and competency will be key components, as well as challenges, for all health care settings in the future.

After identifying the future needs of practitioners, current offerings, and top qualities of the future of health care, the Think Tank participants explored the challenges and barriers to addressing these needs and listed tools, products, and services needed to create these qualities. Surprising to the group, money was not the top category of choice. Rather, it was the degree of stagnation that is created from the siloed, fragmented, and paternalistic nature of today's health care systems, workplaces, education curricula, governing agencies, and professionals themselves that was cited as the principle negative force to overcome.

Although money was not the top barrier identified by these experts, it did run a close second. The U.S. health care system suffers primarily from fragmentation, misaligned incentives, and an inability to differentiate between effective and ineffective care. These problems increase the cost of care

dramatically and unnecessarily, and therefore greatly reduce the quality of care received by patients. The goal of any comprehensive reform effort should be to ensure that the financial resources that flow into the health care system are directed to pay for services that actually improve patient outcomes (O’Conner, 2003).

Will comprehensive reform efforts in the future ensure that health care dollars are allocated for services that actually improve patient outcomes?

PILLARS AND TACTICS

Throughout the two-day Think Tank, the convened experts articulated several strategic pillars that are necessary to support the bridge between the current reality and the ideal future state of health care. Those pillars, as listed below, frame the specific tactics that follow:

- Health Care Culture Revolution - Local, Political, Global
- Information Technology
- Change Readiness and Collaboration
- Money and Incentives
- Educational Systems/Models
- Leadership/Vision

In light of these pillars, the experts identified several tactical areas that, when implemented, could create an improved and safer patient experience:

1. Create a model and allocate resources that result in interdisciplinary team teaching and development for institutions that includes core curriculum, licensure, assessment of core competencies, leadership development, and competency assessment.
2. Engage senior leadership of health care organizations to cultivate a shared vision of patient safety as the driving force. The group recommended sending the white papers from this Think Tank to various professional organizations and interested groups and also present the findings at national meetings on patient safety/competency issues. In addition, experts recommended developing and sending “Best Practices Fact Sheets” on core issues to administrators, and suggested funding sources from foundations and other organizations such as Macy, Commonwealth, Pew, Kellogg, Robert Wood Johnson, and the Agency for Healthcare Research and Quality (AHRQ).

3. Improve communication and the sharing of pertinent information. Recommendations included the development of a patient safety web site for multidisciplinary and specialty groups. This web site would be interactive (knowledge, scenarios, patient data, comparison to best practices, process improvement, change packages and re-measurement) and would provide links to various sites, such as continuing education, licensure, certification, state, Centers for Medicare and Medicaid (CMS), and insurers. Other suggestions were to partner with the business community for just-in-time education, training, and technology development; promote the use of the electronic health record (EHR) for outcomes and improvements in continuity of care; and develop consolidated patient safety alerts for medical products and devices.
4. Enhance interdisciplinary communication across disciplines, teams, and professionals, at multiple levels by convening Think Tanks and creating more communication channels. Strategies included:
 - devoting board positions to representatives from other disciplines;
 - encouraging licensing boards and certification bodies to name multidisciplinary positions for input in creation of exams;
 - increasing presence on accreditation bodies for schools;
 - establishing interdisciplinary requirements;
 - assisting with faculty development/teambuilding and administrative development in health care facilities.
5. Review of research or literature for multidisciplinary teams and preventive care competencies that link to reimbursement. Suggestions included:
 - review the literature that addresses cross-cultural, cross-generational team management to identify common models for effective teams, communication, transition;
 - develop a national web-based database;
 - develop a blog of interdisciplinary team group processes;
 - create an annotated bibliography list with a search engine;
 - research and analysis of interdisciplinary accreditation criteria to identify common threads and content, and also to look for omissions such as team building, teaching, technology, systems, safety, and communication;
 - locate and develop experts in the field of interdisciplinary competency, such as key leaders and champions to create a speakers' bureau;
 - seek personal readings/references related to conference topics;
 - publish a list of web sites;
 - produce a publication summarizing the various topics addressed in the Think Tank.

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6. Assemble a task force to seek the requirement that all professionals have continuous assessment of competencies. Continuous competency assessment needs to be driven by senior management, but the practitioners must be highly engaged to clearly address “what’s in it for me?” Other suggestions included that the information be easy to submit; feedback is non-punitive; professional esteem is maintained and improved; competency is clearly defined across disciplines; and partnerships with regulators and insurers be established.
7. Establish consumer and/or patient partnership through the use of web-based patient education. The consumer then becomes an advocate for patient safety. Established patient advocacy groups across the country can be sought out to help with this work. The partnership must address the wide diversity of patients, taking into account factors such as socio-economic status; language and cultural needs; educational levels; and living conditions (including the transient and homeless). Other recommendations were to connect patient groups with local community health providers, including patient representation on health care facility boards and executive level committees.

Implications for the Future

CCI is actively continuing to engage the participants in ongoing dialogue on these issues. This effort includes the use of technology to support communication among the participants, as well as organizing topic-specific task forces in the areas of interest identified by the attendees. Of particular interest are the issues of evidence-based practice, interdisciplinary education, and continued competency assessment. In addition, CCI will seek to serve as a repository for information regarding the competency assessment and patient safety action initiatives that have been implemented by the attendees. CCI also is considering the opportunity to convene a similar group of thought leaders in the near future.

We can only build the bridge between competency and patient safety through collaboration and continued exchange of ideas. This Think Tank provided its participants an unparalleled forum within which to dialogue with other thought leaders to identify the vision for competency and its relationship to patient safety over the next ten years. The vision will become reality by ongoing, active conversations with leading experts, and also the implementation of the prescribed research and action agendas. Patient safety is the responsibility of every health care practitioner. This responsibility is especially important today, as practitioners seek to restore America’s trust in its health care system. The future of patient safety depends on our actions now.

ACKNOWLEDGEMENTS

- **Bonfire Communications – Educational Design & Facilitation**
- **Leading Solutions Group – Executive Summary**
- **Sponsors**
 - Immersion Medical
 - Laerdal
 - McKesson Provider Solutions
 - Medical Education Technologies
 - Thomson Delmar Learning
 - Zimmer, Inc.

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