

Jersey Shore University Medical Center, Neptune, NJ

Process Improvement Training in Resident Education

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Background: Patient safety and quality have become the major focus of healthcare, but residents are provided with little or no process improvement training. The ACGME requires residency programs to include patient safety and healthcare quality as 2 of the 6 core competencies, so teaching institutions must develop structured process improvement training programs and incorporate them into the resident educational tract. Standardized tools for measuring the effectiveness of training programs are limited.

Methods: We developed a process improvement curriculum titled “Becoming an Agent of Change.” The training included IHI Open School patient safety and quality improvement modules, 8 classroom sessions during 6 months, team/individual coaching, and group/independent activities to develop process improvement projects. The curriculum was implemented in the Ob/Gyn and pediatrics residency programs. We administered a Quality Assessment and Improvement Curriculum Toolkit 12-question pretest to measure self-perception of 12 core process improvement/quality improvement skills and benchmarked the scores against 2 scoring models: Oyler from the University of Chicago Medical Center and O’Neill from the Northwestern University Feinberg School of Medicine. A posttest was administered at the completion of the training program.

Results: Pretest results indicated that Jersey Shore University Medical Center (JSUMC) and Feinberg residents demonstrated similar baseline self-assessments of the 12 core quality improvement skills. JSUMC residents demonstrated a higher comfort level in 11 of 12 skills compared to residents at the University of Chicago. However, JSUMC residents possessed only slight to moderate comfort with quality improvement skills, with the lowest comfort assessed in PDSA methodology. The posttest was administered in April 2015. The results are to be reported in June 2015.

Conclusions: A structured process improvement training program built into resident education increases comfort with process improvement methodology/tools and facilitates awareness and involvement in future process improvement initiatives.

FINAL WORK PLAN – Jersey Shore University Medical Center

Team Charter/Objectives	All categorical residents at JSUMC need to participate in formal training in quality improvement as well as take on a practical experience to be prepared for the healthcare environment of the future. These objectives need to be met through a combination of online learning and engagement with process improvement and clinical mentors who can offer guidance as they design and lead their own hands-on quality improvement project.
Project Description	In 2012-2013, the Ob/Gyn program director, in conjunction with a coach from Medical Management, championed a pilot process improvement course called “Agent of Change” for selected residents at JSUMC. The curriculum included didactic sessions and participation in a process improvement project. Our team will evaluate this pilot experience through written feedback and interviews with participating residents and mentors, as well as best practices from other institutions, to generalize the program to meet the needs of the entire resident community at JSUMC.
Vision Statement	Every categorical resident at JSUMC understands the principles of performance improvement and has, or is working on, a project to improve some aspect of the care they see around them. Residents will be confident in making meaningful contributions to improve patient safety and quality in their fellowship program or practice.
Success Factors	The most successful component of our work was the enthusiasm of our resident champion and process improvement/quality improvement leader who drove the process at our institution. They were constant cheerleaders for the importance of the project. It was also gratifying to share our project with our site visitors during our CLER visit. We were inspired by the growing recognition of near misses and safety events and the need to not just assign blame but to work through processes to understand what happened and how to prevent such events in the future.

Barriers	The largest barrier we encountered was limited engagement and involvement by several of our program directors, limiting the residents' participation in those programs. We worked to overcome this obstacle through significant engagement with senior/chief residents who were passionate about the project.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Have explicit expectations of the responsibilities for all members of the project team and hold them accountable to their original commitment!

JPS Health Network, Fort Worth, TX

Teaching Process Improvement, Quality, and Patient Safety to Adult Learners in GME

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Background: The traditional medical education curriculum provides limited training in quality, performance improvement, and patient safety. When discussing quality and patient safety with new residents, 100% reported they had no prior training in this subject area. Residents were interested in expanding the basic training given during orientation. In the initial needs assessment session done with new residents, the residents reported a desire to participate in projects but stated they would need guidance on the logistics of developing projects and initiatives given their work requirements and time constraints. The overall goal of this project was to teach performance improvement, quality, and patient safety in GME through experiential learning with program directors, faculty, residents, and other professionals on the healthcare team. Our team recognized that a major barrier to moving forward was limited knowledge of standardized process methods among leaders, residents, faculty, and other healthcare team members in the context of interprofessional education and participation.

Methods: The investigative team chose to use a pre/post intervention evaluation method to assess the quality of the 5 types of training and of the trainees' projects. (1) For the abbreviated training, during their orientation, participants attended a 2-hour workshop on quality metrics, the PDSA method, and the importance of this training to long-term performance improvement and patient safety. (2) The Quality and Patient Safety Institute (QPSI) consisted of 2 full days, 90 days apart. Ten focus areas were chosen based on CLER or quality requirements. At the end of the program, each participant was given assignments to complete based on the QPSI sessions. (3) The 1-hour family medicine program-directed sessions were coordinated and given by a member of the quality team during weekly conference time. The Moderate Sedation training (4) and Lean Six Sigma training (5) were covered at various forums. Certificates were awarded for the QPSI, Moderate Sedation, and Lean Six Sigma trainings.

Results: Seventy-four participants attended the abbreviated 2-hour session. All 15 participants attended the first session of the QPSI 2-day training course, and 87% attended the second session. At the 7 program-directed monthly sessions, attendance averaged 51.5% ± 25.7%. The 2-hour Moderate Sedation training had a 77% attendance rate, and the 1-hour Lean Six Sigma white belt training had a 100% attendance rate.

Conclusions: Interdepartmental and interprofessional education is underutilized in the medical education curriculum and healthcare setting. Integrating interprofessional education into GME is necessary to improve healthcare quality and patient safety. This mode of education is core to teaching communication skills and teamwork in the healthcare setting. In alignment with the governing bodies and accrediting agencies, interprofessional and interdepartmental education can assist with removing barriers.