Barriers	The largest barrier we encountered was having 2 geographically distinct campuses that made gathering residents across the system a logistical challenge. Faculty development is needed. Time is needed for local work, conference calls, and regional collaborative meetings. Two other barriers are resident turnover (graduation) and maintaining momentum.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Early involvement with the interdisciplinary Walk the Talk planning committee likely would facilitate resident involvement and provide more meaningful leadership roles. A booth at the event conceived by the residents would further enhance teaching and GME visibility in MLH's patient safety culture.

Maricopa Integrated Health System, Phoenix, AZ

Institutional Curriculum for Resident Engagement in Quality and Safety

Elizabeth N Ferguson, MD, FACS; Michael Grossman, MD, MACP; Phyllis Thackrah, MA

Background: Despite monthly publication of quality and safety indicators, including adverse events reported by residents, we found that faculty and residents were ill informed regarding the reporting function. Many adverse events identified by residents were not being reported. We determined that a silo structure was inhibiting our reporting efforts.

Methods: An institutional curriculum was created with a goal of didactic and experiential familiarization. We implemented and tested our theory. We initiated an interactive Jeopardy-type game for testing and validation. We conducted a PDSA cycle with self-reflection post outcomes. We used visual summaries for rapid assessment.

Results: From March 2013–February 2014, residents reported 74 adverse events. From March 2014–February 2015, residents reported 107 adverse events.

Conclusions: Educational processes can be effective if they are designed and tested using residents as a target audience to address knowledge and performance gaps. A careful PDSA rapid cycle with measured outcomes and resident participation can be used to develop an effective institutional curriculum.

FINAL WORK PLAN – Maricopa Integrated Health System

Team Charter/Objectives	Using the report from our CLER visit, we were able to identify a critical lack of information dissemination, leading to demonstration of gaps in knowledge and performance in quality and patient safety initiatives. Our team's goals were to identify those areas that have created significant gaps in knowledge and lack the participation of both our residents and many faculty.
Project Description	We determined the level of knowledge and level of engagement of our residents in these 2 areas by direct quiz or encounter. We used educational conferences to determine the preferred method of learning. Likewise, we established a benchmark for attending physician involvement. We used a cycle of PDSA to test educational tools that led to the most improved performance. We documented resident adverse event reporting before educational intervention and we will record resident reporting of these events posteducation. We anticipate a 50% increase.
Vision Statement	We will develop a systematic education and evaluation process that ensures all residents understand institutional quality and patient safety initiatives, leading to their full engagement in the processes. We envision the adoption of quality and safety parameters that measure continuous improvement in performance or knowledge gaps.

Success Factors	The most successful component of our work was the willing collaboration of several independent departments in designing and testing educational modalities and in tracking outcomes of education as well as identifiable resident responses. We were inspired by the ability of these teams to work within the framework of our developing institutional curriculum and by how this team interacted with our residents.
Barriers	The largest barrier we encountered was difficulty finding otherwise committed individuals with adequate time and resources to work with us. We overcame this barrier probably by pure luck. The departments that did cooperate were thorough and dedicated to developing meaningful data and measurable performance outcomes.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Have clarity in your expectations and recruit your associates carefully, recognizing their other demands.

Marshfield Clinic, Marshfield, WI

Delivering a Positive Patient Experience: Internal Medicine Residency Provider Pictorial

Matthew D'Costa, MD; Matthew Jansen, MD; Lisa Benson, MD; Lori Remeika, MD; Michael Roherty; Nicole Kumm

Background: Patient satisfaction data from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys revealed poor performance by internal medicine residents. Two recently published prospective cohort studies showed improvement in provider identification with face sheets or face cards and a trend toward improved patient satisfaction but no statistical significance. We postulated that knowledge of provider names and their roles via team pictorials would improve patient satisfaction scores.

Methods: The internal medicine program coordinator created My Health Care Team pictorials at the first of the month, and internal medicine resident teams distributed the pictorials to patients admitted to their service, ideally within 24 hours of admission. The pictorials are referenced by the patient, nurses, and consultants for coordination of care. A cohort study of internal medicine resident ward team patients was performed. Twenty-five patients were surveyed after 40 chart reviews were performed.

Results: Four of 25 patients reported receiving the pictorials. All 4 (100%) patients reported understanding their care plan, and 2 of 4 (50%) could recall care team names. These patients' average satisfaction score was 5.0. Among the 21 patients who reported they did not receive the pictorials, 19 (90.5%) reported understanding their care plan, and 5 (23.8%) could recall care team names. These patients' average satisfaction score was 4.57.

Conclusions: Creation of a pictorial for provider identification is achievable with the right support system. Team pictorials are well received by patients and other members of the care team. Distribution by ward teams is a major challenge; potential remedies are in the planning stages. Further data collection and patient randomization along with expansion to other departments may provide more insight.

FINAL WORK PLAN – Marshfield Clinic

Team Charter/Objectives	Our team's goal was to enhance effective communications between providers and patients, as well as among fellow providers.
Project Description	The internal medicine program coordinator created My Health Care Team pictorials at the first of the month, and Volunteer Services distributed these documents to a main floor of the hospital. Internal medicine resident teams then distributed the pictorials to patients admitted to their service, ideally within 24 hours of admission. The pictorials were referenced by the patient, nurses, and consultants for coordination of care. The project leader performed a cohort study of patients to determine effectiveness.