by residents, changes in hospital length of stay, and medication occurrences because these parameters will complement subjective data from observer evaluations and survey results.

FINAL WORK PLAN – Ochsner Clinic Foundation

Team Charter/Objectives	Based on findings from internal and external, formal and informal, and clinical and operational metrics, we have identified a significant need to formalize a process for transitions of care between inpatient care settings: hospital-based and primary care as well as hospital-based and external care providers (ie, skilled nursing facility, rehabilitation, long-term care, and home health). The results of this lack of continuity are found in patient safety metrics (medication and treatment compliance) readmissions, and patients lost to follow-up with unknown outcomes. Based on these findings, transition of care was identified as a primary area of focus for this project.
Project Description	Perform an initial assessment of the tools, practices, and policies currently in use; determine best practices currently in place internally and assess the literature for demonstrated best practices; assess EMR (Epic) functionality that could support defined practice(s); identify metrics (measures of success) and available data sources; identify pilot areas for initial assessment of best practices; review outcomes of pilot/impact on defined metrics; refine metrics and data collection; define accountabilities for implementation; implement an education plan, go live with EMR support, and implement a metric performance reporting process; and develop a plan to spread and sustain.
Vision Statement	By March of 2015, a standardized tool and process for facilitating transitions of care will be in use throughout Ochsner Medical Center in an effort to ensure quality patient care in the safest of environments.
Success Factors	The most successful component of our work was the level of institutional support provided in the form of unlimited assistance/dedication from GME and department heads. Also, we received significant buy-in and support from the health information management team, information technology security and technical staff, Epic developers, and executive administration. We were inspired by our CLER visit and an evident need to formalize a process that has become an instrumental aspect of healthcare.
Barriers	The largest barrier we encountered was getting buy-in from individual residents and overcoming historical perspectives and tendencies. We worked to overcome this challenge by holding interactive sessions describing not only the process but also the research supporting the essential nature of such an endeavor. Additionally, we employed resident and faculty champions to help disseminate the process and drive the change in culture we will need to have continued success.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Plan and anticipate; maintain flexibility in all aspects of the process; be realistic in determining attainable measures and consider the time frame and scope of the project—think small cycles of change; start the project with the end in mind; solicit feedback early in the process from key stakeholders to anticipate problems/issues that can slow implementation/publication; be aware of tools/systems currently in place that can facilitate the process; create an early abstract/draft of the project to serve as a guide and foundation for milestones and final paper publication. Utilization of PDSA cycles throughout implementation can serve as a basis for publications.

OhioHealth Riverside Methodist Hospital, Columbus, OH

Find It, Fix It: Engaging Residents and the C-Suite in Quality Improvement

Sara Sukalich, MD; Miriam Chan, PharmD on behalf of the Find It, Fix It Planning Committee

Background: The ACGME CLER program calls for residents to participate in quality improvement/patient safety initiatives. However, our institutional quality improvement/patient safety initiatives rarely involved trainees and there was little

education/participation in quality improvement/patient safety at the GME level. This gap highlighted an opportunity for engaging residents and the C-suite in a shared quality improvement initiative.

Methods: A planning committee that included residents, faculty members, GME staff, nursing, the vice president of Medical Affairs, and the vice president of Quality was formed in October 2013. The Find It, Fix It quality improvement project was developed using a Kaizen process board approach and kicked off in February 2014. Residents were encouraged to submit idea cards when they identified opportunities for improvement. The C-suite, GME staff, and faculty met weekly to review the central board and help residents fine tune their ideas and facilitate the projects. After residents learned quality improvement in a hands-on fashion by working through PDSA cycles, a survey of knowledge and attitudes based on the Continuous Quality Improvement Questionnaire and Quality Improvement Knowledge Application Tool pretest was administered to academic year 2013-2014 trainees preproject (2/2014), at 4 months (6/2014), and at 12 months (2/2015) and also to incoming academic year 2014-2015 interns (6/2014) and at 7 months (2/2015). Overall metrics and metrics for the individual residency programs were tracked, including the number of idea cards submitted, the number of projects started, the number of projects completed, types of projects, and the number of residents involved.

Results: A total of 124 ideas were submitted by 72 residents, and 71 projects were initiated. Of those 71 projects, 36 were quality improvement/patient safety and patient focused. Thirty-two projects were completed: 10 projects led to improvement in patient care quality, 18 projects led to equipment/storage improvement, 1 project led to improvement in education/training, and 3 projects were accepted for national presentations (as of 2/2015). A total of 97, 106, and 125 residents completed the presurvey, the survey at 4 months, and the 12-month postsurvey, respectively. In the 12 months prior to the project, 40% of residents were involved in at least one quality improvement project, while 87% were involved during the first 12 months of the initiative. A total of 45 residents completed all 3 surveys. Knowledge of quality improvement improved, and lack of knowledge was felt to be less of a barrier. However, interest in quality improvement decreased from baseline to postsurvey, and measures of attitude toward quality improvement did not improve.

Conclusions: Find It, Fix It was a successful initiative to engage residents and the C-suite in quality improvement. The Kaizen approach allowed widespread exposure to and involvement in quality improvement. Sustainability of this large project will require significant time and effort for faculty. A GME-led quality initiative can spur culture change around quality improvement within residency programs and create opportunities to showcase medical education at the institutional and organizational level.

FINAL WORK PLAN – OhioHealth Riverside Methodist Hospital

Team Charter/Objectives	The Find It, Fix It initiative was designed to engage residents to work closely with hospital administration on quality improvement projects and to actively participate in improving their clinical learning environment. The following ideas guided the project: (1) quality improvement should be a part of daily life and is not just the job of nurses/administration, and (2) residents should be empowered to report/identify areas for improvement and should drive change with the support of an engaged C-suite and the GME staff.
Project Description	Find It, Fix It used a Kaizen approach with process boards and idea cards located centrally to visually show progress and track completed issues. PDSA cycles were used to address issues raised on idea cards. Both residents and the C-suite were engaged to identify issues, actively work to provide solutions, and close the feedback loop. Outcome measures included pre/post surveys of residents, project success rates, engagement of the C-suite, success of the CLER visit, and national presentations.
Vision Statement	The Find It, Fix It project will engage residents and the C-suite in quality improvement and will ultimately lead to a cultural shift in which residents actively participate in quality improvement on a daily basis.
Success Factors	The project engaged residents from all programs and increased quality improvement knowledge. C-suite and GME collaboration led to successful completion of projects, improved access to resources, and better alignment with ongoing hospital quality improvement work. Providing residents protected time increased their involvement in quality improvement. An unexpected win was that the project was showcased at our successful CLER visit.

Barriers	The scope of the project required significant project management (time, effort, and expertise); the engagement of residents was variable and challenging; and while knowledge improved during the year, attitudes toward quality improvement did not.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	The success of this type of project requires early engagement of all stakeholders (faculty, program directors) and ensuring that sufficient time is available for active participation. Expectations should be realistic; goals/metrics should be carefully considered at the start. Continuous evaluation and improvement of the project are important. Recognize and manage project fatigue early.

Orlando Health, Orlando, FL

Hand Hygiene Compliance at Orlando Health

Malisa Agard, MD; Martha Toms, MD; Caroline Nguyen-Min, MD; Kwabena Ayesu, MD

Background: Proper hand hygiene can help reduce healthcare-acquired infections (HAIs). HAIs prolong hospital stay, increase the resistance of microorganisms to antimicrobials, and result in additional financial burden and excess deaths. The director of Infection Prevention and Control at Orlando Health showed that only 72% of individuals entering a *Clostridium difficile* isolation room wore gowns, and only 45% of them washed their hands after exiting the room. These startling numbers made the need improve the overall hand hygiene compliance rate self-evident.

Methods: We performed a baseline analysis of hand hygiene among internal medicine physicians and residents. We developed succinct PowerPoint presentations lasting no longer than 5 minutes to teach about hand hygiene importance and techniques that we administered to residents in the internal medicine residency program. We then reevaluated hand hygiene compliance within the internal medicine program, including attending physicians, residents, and medical students.

Results: Baseline results showed that 80% of hand-washing opportunities were missed; attending physicians performed proper hand hygiene 8% of the time, and residents (interns and seniors) performed proper hand hygiene 12% of the time. Postintervention, the enter room/exit room hand-washing rates improved: internal medicine attending physicians, 81%/100%; seniors, 93%/100%; interns, 100%/100%; medical students, 100%/100%; and fellows, 88%/83%. Compliance among PGY 2-3 residents (seniors) showed improvement compared to their 4% rate reported in the baseline analysis.

Conclusion: Hand hygiene is the single most effective measure to prevent HAIs. Our study revealed that compliance improved after education with succinct PowerPoint presentations to promote awareness and hand-washing demonstrations. Although compliance has improved, the patient must be included in the practice to optimize safety.

FINAL WORK PLAN – Orlando Health

Team Charter/Objectives	Our goal was to evaluate hand hygiene compliance at Orlando Health after education and demonstration of proper hand hygiene.
Project Description	Our aim was to develop an innovative and feasible approach to impact hand hygiene that would help align the GME and institutional goals (to in turn help reduce HAIs) and to reevaluate hand hygiene compliance after education and demonstration of proper technique. We collected data on the opportunities for hand washing from internal medicine residency program teams via secret selected members of the team, in this case, medical students. We approached the Infection Prevention and Control Department for secret observers to evaluate all GME programs.
Vision Statement	We will improve hand hygiene compliance to 50% compared to baseline for the internal medicine program (attending physicians, residents, and medical students) in 6 months and then distribute effective strategies to all GME programs.