

***10th Quality Improvement
Research Day***

Ascension Providence
Rochester Hospital

Office of Graduate Medical Education
Wayne State University
School of Medicine

May 4, 2021



Welcome Message

Since 2012, the Wayne State University Office of Graduate Medical Education (WSUGME) in the School of Medicine and the Internal Medicine, Family Medicine, and Transitional Year residencies at Ascension Providence Rochester Hospital (APRH) in Rochester, Michigan, have jointly administered an annual Quality Improvement (QI) Research Day. Typically held in late spring, this event is attended by residents, faculty, hospital administrators, and WSUGME staff. The QI Research Day is designed to showcase residents' quality improvement and patient safety projects in two formats (posters and oral presentations), both competitively judged by noted faculty and researchers from the Detroit area.

In 2020, the 9th Annual QI Research Day was cancelled since the COVID-19 pandemic rendered a face-to-face event not feasible. In 2021, the event returned as a virtual event held via Zoom; an agenda and a complete recording is available at <https://gme.med.wayne.edu/qiresearchday>.

This booklet provides a brief overview of the QI Research Day, including abstracts/posters of the top winners in Internal Medicine and Family Medicine/Transitional Year and a listing of all presentations and participants. Our judges included *Lisa Dillon*, PhD, Associate DIO and Assistant Vice President for Academic Affairs, Detroit Medical Center; *Robert Klever*, MD, FACEP, Clinical Assistant Professor of Emergency Medicine, WSUSOM; and *Chiedu Chukwuemeka*, MBBS, Infection Preventionist/Quality Management, APRH. Our keynote speaker was *Robert Flora*, MD, MPH, MBA, Chief Academic Officer and Vice President of Academic Affairs at McLaren Health Care. He is Professor and Associate Chair for Education in the Dept. of Obstetrics, Gynecology, and Reproductive Medicine at Michigan State University College of Human Medicine. Many thanks to these individuals for devoting their time to assessing our residents' research, providing them with invaluable feedback, and sharing their expertise in quality improvement initiatives.

We would like to thank the following for their exceptional work as faculty mentors in the administration of the 2020-21 QI projects at APRH: Internal Medicine Residency Program Director *Sarwan Kumar*, MD, IM Associate Program Director *Vesna Tegeltija*, MD, and IM faculty members *Mohammad Fityan*, MD, and *Zain Kulairi*, MD; Family Medicine/Transitional Year Residency Program Director *Pierre Morris*, MD, FM Associate Program Director *Tess McCready*, DO, and FM faculty members *Eleanor King*, MD and *Salieha Zaheer*, MD; and Assistant Professor *Elizabeth Towner*, PhD, faculty in the WSU Department of Family Medicine and Public Health Sciences.

We look forward to another successful QI Research Day in 2022!

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FAMILY MEDICINE/TRANSITIONAL YEAR: Winner

*Indicates a faculty mentor

An Educational Intervention to Reduce Inappropriate Testing for Hospital-Acquired *Clostridium difficile* Infection

Abraham Baidoo, MD, Katrina Siemiesz, MD, Benjamin Maynard, MD, Eleanor King, MD*

Background: *Clostridium difficile* (*C. diff*) is a spore-forming bacterium that can cause a life-threatening infection (CDI). A prior project exploring rates of hospital-acquired CDI (HACDI) at APRH found that inappropriate testing contributed to elevated rates of HACDI. This included testing patients with formed stools and patients who received laxatives. Inappropriate testing wastes resources and causes overdiagnosis of HACDI in patients who are colonized. APRH established a policy that includes parameters to reduce inappropriate testing for CDI. We hypothesized that educating staff on the policy would lower rates of inappropriate testing.

Methods: Baseline data was collected on *C. diff* tests ordered in December 2020. We counted tests ordered on patients on laxatives. We also reviewed tests ordered on patients with formed stool. A 10-minute presentation with video aid on the testing policy was developed and given to nurses and physicians. Three areas were highlighted: (1) Patients receiving laxatives, stool softeners, or enemas within 48 hours should not be tested, (2) patients with formed stool should not be tested, and (3) patients must have clinical indications consistent with active CDI to be tested. Afterwards, data was collected and compared to pre-intervention data.

Results: For the pre-intervention month, 57 orders were designated “inappropriate” by the lab, 9 (15.8%) of which were due to the stool being formed. We reviewed an additional 52 charts of patients taking laxatives, and *C. diff* testing was completed on 6 patients, with 1 positive finding (12%). At post-intervention, 16 of 59 inappropriate tests were due to formed stool (27.1%). There were 8 tests completed in 32 patients (32%) on laxatives with 1 positive finding.

Discussion: We were unable to reduce the number of inappropriately ordered *C. diff* tests but discovered avenues for additional cycles. Hospital data revealed a cyclic pattern of *C. diff* testing with higher rates in the winter months, potentially confounding our results. Additionally, a single educational session may not have been sufficient to communicate to the large group of providers at our hospital. Finally, year-by-year variations in *C. diff* testing likely exist, which means that multiple months and years of data will need to be collected. The *C. diff* antigen testing used by our hospital is \$54.60 per test. This does not include time spent collecting and transporting the sample, and potential reduction in Medicare reimbursement for false positive testing resulting in lower safety metrics. Eliminating 10 inappropriately ordered tests per month would save \$6,552 annually at no cost to the hospital. Further training on this topic should include financial data. We will also consider delegating responsibility to the lab to cancel tests ordered for patients on laxatives.



An Educational Intervention to Reduce Inappropriate Testing for Hospital-Acquired *Clostridium difficile* Infection

Abraham Baidoo MD, Katrina Siemiesz MD, Ben Maynard MD, Eleanor King MD
Wayne State University School of Medicine, Department of Family Medicine & Public Health Sciences

Background

- *Clostridium difficile* (*C. diff*) is a spore-forming bacterium that is transmissible within hospitals and can cause life-threatening *Clostridium difficile* infection (CDI).
- A prior project exploring rates of hospital-acquired CDI (HACDI) at Ascension Providence Rochester Hospital (APRH) found that inappropriate testing contributed to elevated rates of HACDI.
- This included testing patients with formed stools and patients who received laxatives. Inappropriate testing wastes resources and causes overdiagnosis of HACDI in patients who are colonized.
- APRH established a policy that includes parameters to reduce inappropriate testing for CDI. We hypothesized that educating staff on the policy would lower rates of inappropriate testing.

Quality Improvement Objectives

- **Long-term:** educating staff on the testing policy would lower rates of inappropriate tests.
- **Current:** exploring the reasons for continued higher rate of inappropriate testing in order to address confounding factors.

Plan

- Baseline data was collected on *C. diff* tests ordered in December 2020.
- We counted tests that were completed on patients who had taken laxatives as well as tests ordered on patients with formed stool.

Do

A 10-minute presentation with video aid on the testing policy was developed and given to nurses and physicians.

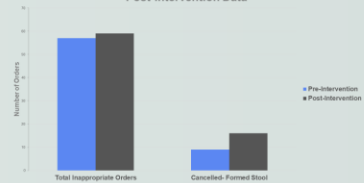
Three areas were highlighted:

- 1) Patients receiving laxatives, stool softeners, or enemas within 48 hours should not be tested,
- 2) Patients with formed stool should not be tested,
- 3) Patients must have clinical indications consistent with active CDI to be tested.

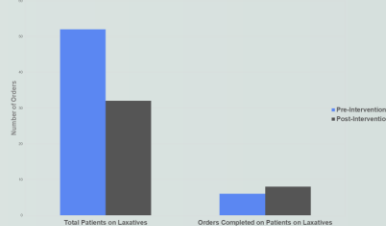
Data was compared to pre-intervention data.

Study

Order Cancellations due to Formed Stool in Pre- and Post-Intervention Data



Orders for *C. diff* Testing on Patients with Laxative Use



Act

- For the pre-intervention month, 57 orders were designated "inappropriate" by the lab and nine of these (15.8%) were due to the stool being formed.
- We reviewed an additional 52 charts of patients taking laxatives, and *C. diff* testing was completed on 6 patients (12%) with 1 positive finding.
- Post-intervention, 16 of 59 inappropriate tests were due to formed stool (27.1%). There were 8 tests completed in 32 patients on laxatives (32%) with 1 positive finding.

Discussion

- Inappropriate testing increased during our study period.
- Data revealed a cyclic pattern of *C. diff* testing with higher rates in the winter months, potentially confounding our results.
- A single educational session may not have been sufficient to communicate to the large group of providers at our hospital.
- Year-by-year variations in *C. diff* testing likely exist, meaning multiple months and years of data will need to be collected.

PUBLIC HEALTH IMPLICATIONS

- *C. diff* tests have financial implications to health-care systems. Materials, time spent collecting and transporting add to costs.
- Further teaching should include financial data and cost estimates.

INTERNAL MEDICINE: Winners

**Indicates a faculty mentor*

Improving the Quality of Outpatient Diabetes

Saad Chaudhry, MD, Mary Dickow, MD, Padmini Giri, MD, Zachary Johnson, MD, Warda Zaidi, MD, Oraib Khan, Zain Kulairi, MD*

Introduction: In US, the prevalence of diabetes continues to increase, and health care spending on this condition is one of the highest compared to other diseases. Diabetes requires regular follow-up with a primary care physician to prevent its progression and complications. According to the American Diabetes Association, clinic efficiency in proper education and follow-up with patients have great impact in reducing complications. Without recommended monitoring and management, various complications can occur. In our academic resident outpatient clinic, there has been an observed lack of comprehensive care for diabetic patients in a timely manner. This project aims to improve diabetic management by educating medical residents on using a template for diabetic follow-up appointments. The template would include all recommended care for diabetic patients and standardize an approach to care.

Methods: The project used a root cause analysis to identify barriers to providing comprehensive diabetic care in the resident clinic. Inconsistency in approach and documentation was noted on different clinic days and with different faculty supervision. Lack of a standardized approach results in residents missing different components of diabetic care. PDSA cycle was used to educate and test change. The clinic team created a template to use in the EMR which would document and standardize diabetic patient management. Residents were educated about the template which includes an "ABCDEF" mnemonic as a reference for easy recall: *A* for most recent hemoglobin A1c, *B* for blood pressure, *C* for cholesterol/lipid panel, *D* for diabetic foot exam, *E* for eye exam, and *F* for a few others (protein/creatinine ratio, kidney function, weight, diet, ASCVD score, and vaccinations).

Results: The study showed increase in overall documentation for each criteria in the study. Hemoglobin A1c was included in all notes after education with 10% increase from prior to education. The diabetic foot exam had 6% increase in notes and the diabetic eye exam had the most significant increase with 24% rise. The overall "ABCDE" increased from 31% to 46% in notes, and 38% of notes included a pre-made diabetic follow-up template. "For other" criteria also had an overall increase for each point in notes. The most significant included documentation of urine protein/creatinine ratio, up 22%. Vaccinations also were noted to have a significant increase, with note of influenza vaccines up 16% and pneumonia vaccines up 19%.

Conclusion: By standardizing an approach to diabetes follow-up visits in the clinic, we hope to improve quality of care and recognize complications early to prevent progression. The next step will be to create intervention plans for complications discovered during this standardized approach and to educate residents. Documenting follow-up and a standardizing approach to complications will allow us to provide quality care and decrease complication costs in the long run.



IMPROVING THE QUALITY OF OUTPATIENT DIABETES

SAAD CHAUDHRY, MD, MARY DICKOW, MD, PADMINI GIRI, MD, ZACHARY JOHNSON, MD, WARDZA ZAIDI, MD, ORAIB KHAN, ZAIN KULAIRI, MD *
WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE - INTERNAL MEDICINE PROGRAM

INTRODUCTION

Diabetes mellitus remains one of the highest costing health care problems in the United States of America. According to American Diabetes Association, efficiency in proper education and following up with patients can reduce the progression and complications of the disease. Monitoring various factors can help with reducing these health issues from occurring including microvascular and macrovascular complications. Various factors must be assessed including blood pressure, eye exam, foot exam, and lab work. By implementing a comprehensive checklist into clinical practice, primary care providers can optimize their care in diabetic follow-up appointments and improve the overall quality of care.

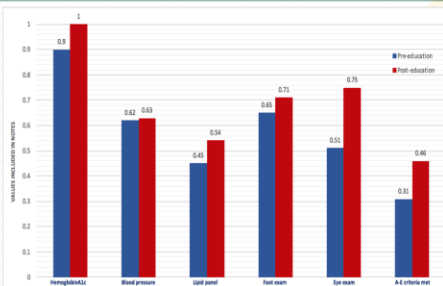
The problem faced at our academic internal medicine clinic includes observed lack of standardized approach in follow up diabetic appointments. This can lead to missing essential components in the care of the patient and can lead to various complications to develop. The aim for the first PDSA cycle includes improving the diabetic management by educating medical residents on using a template for diabetic follow up appointments.

METHODS

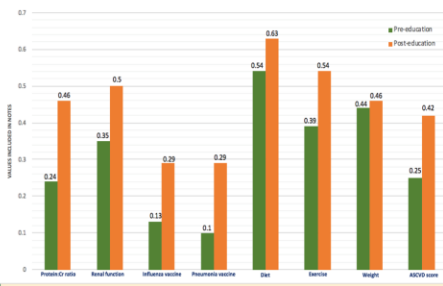
A template was made to standardize care in diabetic follow up appointments at the Ascension Medical Group Academic Internal Medicine in Washington Township, Michigan. The template includes mnemonic "ABCDE" to help enforce what to follow up on during appointments of diabetic patients. The main emphasis was to include A for most recent hemoglobin A1c, B for blood pressure, C for cholesterol/lipid panel, D for diabetic foot exam, and E for eye exam. The secondary goal was for residents to include F "for others" that includes protein:creatinine ratio, renal function, diet, exercise, weight, ASCVD score, and flu and pneumonia vaccinations. Inclusion criteria for the study include patients that are over the age of 18, primarily follow up at the resident clinic for diabetes management, and are not pregnant.

Residents were educated about the project starting in January 2021 and were first sent an e-mail to discuss the goals of the study, what to include in their notes, and a macro template in Athena EMR that included all the desired goals to achieve during a follow up. A PowerPoint presentation was also done to explain the study and reminders were given in clinic to use the template. The study involved analyzing data prior to education, including looking over notes in November 2019 to December 2020 to see if points "ABCDE" were met. The comparison of the study included analyzing notes post-education, that ranged from January 2021 to March 2021. There were a total of 70 notes analyzed prior to education and 25 notes analyzed post education.

IMAGES



Graph 1- The data includes if certain criteria were included in the resident notes on diabetic follow up appointments. These criteria include hemoglobin A1c, blood pressure, lipid panel, diabetic foot exam, and diabetic eye exam. The final bar to the right represents if the data from "ABCDE" were met. The blue bars include results from pre-education and the red bars include results from post-education. The values on top of each bar include the ratio of residents including each data point to their notes.



Graph 2- The data includes "for other" criteria in the diabetic follow up: protein:creatinine ratio, renal function, diet, exercise, weight, ASCVD score, and flu and pneumonia vaccinations. The green bars include results from pre-education and the orange bars include results from post-education. The values on top of each bar include the ratio of residents including each data point to their notes.

RESULTS

The study showed increase in overall documentation for each criteria in the study. Hemoglobin A1c was included in all notes after education with 10% increase from prior to education. Blood pressure had the lowest of only 1% increase in notes, while lipid panel had 9% increase. The diabetic foot exam had 6% increase in notes and the diabetic eye exam had the most significant increase with 24% rise. The overall "ABCDE" went from 31% to 46% in notes. 38% of notes included pre-made diabetic follow template.

"For other" criteria also had an overall increase for each point in notes. The most significant included documentation of Urine protein:creatinine ratio up 22%. Vaccinations also were noted to have a significant increase with note of influenza vaccines up 16% and pneumonia vaccines 19%. Lifestyle modifications including diet went up 9%, exercise 15%, and weight up 2%. Other points including ASCVD went up 17% and renal function 15% in resident notes.

DISCUSSION

The management of diabetes mellitus has greatly shifted to the duties of primary care physicians. The disease can have grave multi-organ complications if not properly managed. Having proper structure in a clinic can help prevent the advancement of the disease. In our resident clinic, diabetic education and pre-set template was used to increase closer follow up of the various aspects of diabetes. The results overall show that education helped increase resident awareness. Hemoglobin A1c was successfully mentioned in each note. Also, other lab work was more recognized to be ordered including lipid panel, protein:creatinine ratio, and creatinine. Vaccinations also had increase in diabetic patients, with residents remembering the importance of yearly influenza vaccine and both PPSV23 and PCV13.

The study overall demonstrates the impact of education and overall reminder that there are various aspects of diabetes that must be remembered to prevent complications from developing. Moreover, keeping a simple template including "ABCDE" can make physicians remember a simple way on what to follow up on during visits of diabetic patients.

REFERENCES

American Diabetes Association. Standards of medical care in diabetes—2007. *Diabetes Care* 2007; 30(Suppl 1): S4– S41.
Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2020. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2020.
Maureen I Harris, Ronald Klein, Tim A Welborn, Matthew W Knudsen; *Diabetes Care* Jul 1992, 15 (7) 815-819; DOI: 10.2337/diacare.15.7.815

Decreasing Inappropriate Vancomycin Use

George-Joseph Nahal, MD, Monica Dhawan, MD, Mohamad Abu, MD, Sarwan Kumar, MD,
Vesna Tegeltija, MD*

Introduction: Vancomycin has become a frequently prescribed antibiotic in the hospital as empiric treatment for variety of infections. The CDC developed criteria for appropriate use of Vancomycin, but despite this intervention, inappropriate vancomycin use is reported to be between 20% and 70%. Although this is an excellent antibiotic in specific, indicated situations, it does carry many side effects, including nephrotoxicity, neutropenia, and thrombocytopenia. Further, since it is given via parenteral route, it requires close monitoring to assure therapeutic effect. Lastly, overusing vancomycin increases risk for resistant infection. Our community hospital was noted to have one of the highest vancomycin usages compared to other healthcare systems. Our QI project aims to reduce inappropriate prescribing of vancomycin by 20% within a year, which would result in decreased cost and increased patient safety.

Methods: The IHI model was used to guide and format this project. A Plan-Do-Study-Act (PDSA) cycle was used to test change. A multidisciplinary team including the antimicrobial stewardship committee and the pharmacy provided monitoring results and data. During root cause analysis, the team noted that vancomycin is frequently prescribed to treat lower respiratory infections without evidence of MRSA infection. As a result, an interdisciplinary team developed a policy addressing appropriate vancomycin use criteria for treating pneumonia. The policy was introduced to the medical staff and resident physicians.

Results: Prior to implementing our vancomycin use policy, from September 2019 through December 2019 30-40% of total vancomycin ordered in our hospital was used for the treatment of pneumonia. Our team implemented a new policy to decrease vancomycin use by requesting testing for MRSA using a nasopharyngeal swab in cases where vancomycin is ordered to treat pneumonia. As this test has high negative predictive value, vancomycin should be stopped if this test is negative. We implemented the intervention and educated resident physicians starting in January 2020. Following implementation of a system-based intervention, 77 cases were reviewed, of which 55 cases ordered nasopharyngeal swabs when vancomycin was initiated. For patients with a nasopharyngeal swab, average length of stay was 12 days, in contrast to patients treated with vancomycin without a swab, whose average length of stay was 15.3 days. Duration of vancomycin treatment was also affected; those without a nasopharyngeal swab received treatment for an average of 5.7 days, in contrast to those with a swab received treatment for an average of 4.9 days with vancomycin.

Conclusion: Decreasing inappropriate vancomycin use results in decreased cost, length of stay, potential for adverse effects, and resistance, thus improving overall safety and quality of care. Implementing a policy that requires MRSA screening in order to continue vancomycin therapy results in appropriate treatment of patients and elimination of unnecessary use of vancomycin when treating pneumonia. With these promising results, next steps include (1) implementing reflex MSRA swabs as soon as vancomycin is initiated for empiric treatment of pneumonia and (2) instituting a “pop-up” alert box which reiterates the risk factors for high-risk MRSA patients.

Decreasing Inappropriate Vancomycin Use

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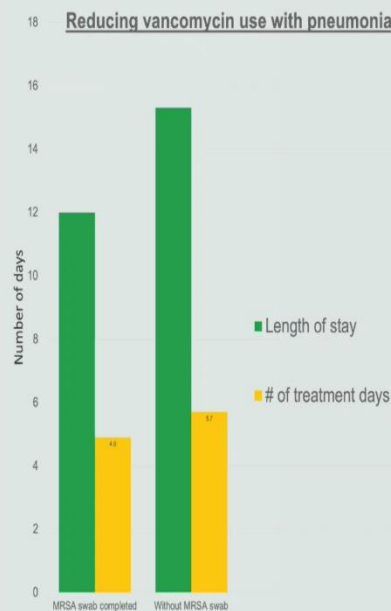
INTRODUCTION

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METHODS

The IHF model was used to guide and format this project. Plan-Do-Study-Act (PDSA) Cycle was used to test change. A multidisciplinary team including the antimicrobial stewardship committee and pharmacy provided monitoring results and data. During root cause analysis, the team noted that Vancomycin is frequently prescribed to treat lower respiratory infections without evidence of MRSA infection. As a result, an interdisciplinary team developed a policy addressing appropriate Vancomycin use criteria for treating pneumonia. The policy was introduced to the medical staff and resident physicians.

GRAPH



RESULTS

Prior to implementing our Vancomycin use policy, from September 2019 through December 2019, 30-40% of total Vancomycin ordered in our hospital was used for the treatment of pneumonia. Our team implemented a new policy to decrease Vancomycin use by requesting testing for MRSA using a nasopharyngeal swab in cases where Vancomycin is ordered to treat pneumonia. As this test has high negative predictive value, Vancomycin should be stopped if this test is negative. We implemented the intervention and educated resident physicians in Jan 2020. Following implementation of a system-based intervention, 77 cases were reviewed, of which 55 cases ordered nasopharyngeal swabs when vancomycin was initiated. For patients with a nasopharyngeal swab, average length of stay was 12 days, versus patients treated with vancomycin without a swab average length of stay was 15.3 days. Duration of vancomycin treatment was also affected where those without a nasopharyngeal swab received treatment for an average of 5.7 days vs those with a swab were treated for an average of 4.9 days with vancomycin.

CONCLUSIONS

Decreasing inappropriate Vancomycin use results in decreased cost, length of stay, potential for adverse effects and resistance thus improving overall safety and quality of care. Implementing a policy which requires MRSA screening in order to continue Vancomycin therapy results in appropriate treatment of patients and elimination of unnecessary use of Vancomycin when treating pneumonia. With these promising results, next steps include implementing reflex MRSA swabs as soon as vancomycin is initiated for empiric treatment of pneumonia. As well as instituting a "pop-up" alert box which reiterates the risk factors for high risk MRSA patients.

Family Medicine/Transitional Year presentations

Poster #1: *Improving Fall Rates at Ascension Providence Rochester*

Presenter: Martin Dukaj

Co-authors: Oneil Doha, Martin Dukaj, Ashley Aragona, Andrea Milne, Elizabeth Towner

Poster #2: *Improving Resident Wellness Through a Formal Wellness Curriculum*

Presenter: Roshan Patel

Co-authors: Ashley Aragona, Roshan Patel, Tess McCready, Elizabeth Towner

Poster #3: *Educational Intervention to Reduce Inappropriate Testing for C. difficile Infection*

Presenter: Ben Maynard

Co-authors: Abraham Baidoo, Katrina Siemiesz, Ben Maynard, Eleanor King

Poster #4: *Impact of a Redesigned Patient Whiteboard on the Incidence of Delirium in Hospitalized Patients*

Presenters: Subha Hanif and Bennett Osantowski

Co-authors: Bennett Osantowski, Subha Sanif, Steven Townsend, Andrew Yan, Pierre Morris, Elizabeth Towner, Deborah King

Poster #5: *Observation Status Patient Discharge Optimization in the Setting of an Academic Residency Program*

Presenter: Robert Richards

Co-authors: Peter Ly, Robert Richards, Salieha Zaheer, Elizabeth Towner

Internal Medicine presentations

Poster #1: *Improving ICU Transition of Care, a QI Initiative*

Presenter: Bernadette Schmidt

Co-authors: Bernadette Schmidt, Victoria Gonzalez, Danyal Taheri, Zain Kulairi, Sarwan Kumar

Poster #2: *Addressing Healthcare Disparities in Internal Medicine Residents*

Presenter: Jurgena Tusha

Co-authors: Jurgena Tusha, Danyal Taheri, Yashar Eshman, Mohammad Fityan, Vesna Tegeltija, Sarwan Kumar

Poster #3: *Standardize Treatment of Inpatient Asymptomatic Hypertension*

Presenter: Bernadette Schmidt

Co-authors: Trishya Reddy, Bernadette Schmidt, Aldin Jerome, FNU Sourabh, Vesna Tegeltija, Sarwan Kumar

Poster #4: *Improving Resident Error Reporting*

Presenter: Verisha Khanam

Co-authors: Padmini Giri, Verisha Khanam, Vesna Tegeltija

Poster #5: *Decreasing Inappropriate Vancomycin Use*

Presenter: George-Joseph Nahal

Co-authors: Monica Dhawan, George-Joseph Nahal, Mohamad Albu, Sarwan Kumar, Vesna Tegeltija

Poster #6: *Improving Sepsis Care in a Community Hospital: A QI Initiative*

Presenter: Michael Meehan

Co-authors: Jurgena Tusha, Manishkumar Patel, Kishan Adusumilli, Michael Meehan, Ahmed Zaki, Mohammad Fityan, Sarwan Kumar, Vesna Tegeltija

Poster #7: *Improving the Quality of Outpatient Diabetes*

Presenter: Saad Chaudhry

Co-authors: Saad Chaudhry, Mary Dickow, Padmini Giri, Zachary Johnson, Warda Zaidi, Zain Kulairi

Poster #8: *Establishment of an Internal Medicine Wellness Committee*

Presenter: Victoria Gonzalez

Co-authors: Victoria Gonzalez, Bernadette Schmidt, Mohammad Fityan

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