high maternal and neonatal mortality. The Institute of Healthcare Improvement (IHI) is supporting the Ethiopian Federal Ministry of Health in implementing a comprehensive QI initiative focusing on quality planning, building QI/management capability, and designing and testing a scalable district-wide approach for health improvement embedded into the routine system.

Objectives

The aims of this initiative are to 1) introduce a feasible and scalable district-wide improvement approach; 2) improve quality of health services and outcomes in Ethiopia, as measured by selected maternal and newborn health (MNH) priority indicators including three labor and delivery clinical bundles.

Methods

A total of 3,307 and 26,186 medical records were reviewed over the 17-month baseline period and 12-month intervention period respectively. Bundle compliance was plotted using P-charts. Service coverages were calculated using estimated eligible population and U-charts were used to assess improvement.

Results

After the intervention, 84% (110/131) of participating facilities report greater than 90% adherence to at least one labor and delivery bundle, and 67% (88/131) of facilities report greater than 90% adherence to all labor and delivery bundles. The median clinical bundle adherence in the post intervention period is above 80% for all three bundles. 70% (92/131) of facilities reported improvement as determined by run chart rules in at least one service coverage outcome (ANC4, SBA, or PNC within 48 hours).

Conclusions

Findings from this study can be used to strengthen obstetric health service quality throughout Ethiopia and other similar contexts.

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**Pediatric Faculty Workplace Project**

**Key Driver Diagram (KDD)**

**Project Leader(s):** Heather McLean, Jennifer Lawson

**Key Drivers**

- Workload is balanced amongst team
- Workplace is efficient
- Flexibility/control over work
- Work-life integration
- Alignment of individual and organizational values
- Social support at work
- Work is meaningful

**Secondary Drivers**

- Standardize physician workload
- Target high-opportunity work units
- Measure and improve clinical efficiency
- Measure and improve team members working top of scope
- Identify areas faculty can have control over their work
- Provide access to resilience resources
- Acknowledge/assess problem
- Harness power of leadership
- Cultivate community at work

**Interventions**

- Standardize use of patient requests (e.g., in-basket)
- Prioritize and address electronic health record "pain points"
- Improve patient utilization of primary care site/PCP by optimizing panel size
- Improve general inpatient teams by standardizing rounds, adding team members (pharm, CM), piloting MT coordinator
- Revise the comp. plan to minimize at-risk clinical measures
- Support individual wellness thru MOC portfolio projects/Provide wellness toolkit
- Communicate results to faculty and provide opportunity for reflection and action
- Division & faculty appreciation activities
- Division/division collaboration

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**Background**

Physician burnout has a negative effect on the quality of care; however, effective interventions are lacking.

**Objectives**

To identify and impact key drivers of physician workplace satisfaction in an academic pediatric department.

**Methods**

A quality improvement approach was used to impact key drivers of faculty workplace satisfaction. In 2017, 2018, and 2019 faculty completed anonymous surveys that combined the Maslach Burnout Inventory (MBI) and Areas of Worklife Survey (AWS). Interventions included changes to compensation plan, clinical practice, departmental communication, workplace community, individual wellness, and culture. Descriptive statistics and data visualization were performed. Two-sided t-tests and ANOVA regression analysis were used to compare responses.

**Results**

Survey completion rates were: 160/195 (82%) in 2019; 139/180 (77%) in 2018; and 155/171 (91%) in 2017; 101 physicians completed all three surveys. Statistically significant improvements were observed in reward (3.4 vs 3.3; p<0.05) and values (3.6 vs 3.5; p<0.05) domains of the AWS in 2019 and 2018 versus 2017. MBI average scores were similar in all three years, and remained significantly better than the general population in depersonalization (1.0 vs. 1.7; p<0.0001) and personal accomplishment.
domains (5.0 vs. 4.3; p<0.0001). There was no difference in the emotional exhaustion domain. Worse emotional exhaustion scores were reported in women (2.8 vs 2.1; p<0.05) and those working >75% clinical effort (2.8 vs 2.1; p<0.05).

Conclusions Interventions targeting the workplace improved physicians’ experience of reward and values. Risk factors associated with a high emotional exhaustion score included female gender or individuals working >75% clinical effort.
RESOLVING PEDIATRIC POPULATION-LEVEL GAPS: SUCCESS OF AN INREACH MODEL

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Background Primary care settings have implemented processes to resolve population-level care gaps, including patient reminders, health record prompts, and outreach to patients/families. When patients present outside of primary care but still within the larger health system, these primary-care based processes are not applied, and opportunities to resolve care gaps are missed. We hypothesized that we could resolve care gaps outside the primary care setting by creating an ‘inreach’ process within the larger healthcare system.

Objectives Among children 2–66 months of age within our primary care registry, we aimed to identify and resolve care gaps for children admitted to the hospital medicine service. Our goal was to contact the inpatient team for at least 80% of these patients, and to increase the percent of care gaps closed from 30% to 50%.

Methods A multidisciplinary team of physicians, nurses and improvement experts mapped the baseline process. Failure modes were predicted, and a key driver diagram was