Vision Statement	We will identify the specific factors that impact the effective utilization of the Martti device among physicians, obtain insight on how physicians would like to use the Martti device to effectively treat and diagnose their patients, and produce recommendations and improvements to our current language service use guidelines that promote equitable care for all patients.
Success Factors	Once Martti was implemented, residents effectively communicated with the patient. Martti was implemented in a timely fashion, without delay in patient care. Increased awareness regarding other translation services, including "language boxes" and record translation, was achieved through this project.
Barriers	The barriers we encountered were the availability of bilingual simulation patients; the ability of residents to fully participate, given other duties within the 80-hour work week; operating the Martti video remote interpreter device; budgetary support for learning health systems; significant change to executive leadership; and scheduling sessions with residents and leadership.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	The simulation could have been improved by more attention to realistic context (ie, without the Martti device positioned at the bedside). The simulation was limited by a small sample size and should be expanded to include other residents, faculty, and ancillary staff. One of the requested languages was not available with Martti; this challenge could have been circumvented by having multiple language services available for translation, as well as different modalities.

Scott & White Healthcare, Temple, TX

CLER: One Institution's Experience and the Importance of Integrating the C-Suite in Graduate Medical Education

Ravi Kallur, PhD, MPA; Marguerite Peters, MEd; Hania Wehbe–Janek, PhD

Background: With CLER, the entire institution is held accountable, including the C-suite, quality and safety personnel, and the nursing staff. Plans were made to tackle the anticipated CLER visit as an opportunity rather than an accreditation visit. This approach required a team effort consisting of house staff, program coordinators, program directors, faculty members, safety and quality staff, and the C-suite to work collaboratively with the DIO.

Methods: We created handouts for house staff, program directors, faculty, the C-suite, and nursing staff, and we developed a badge holder insert with descriptions of the 6 focus areas: patient safety, professionalism, fatigue management/duty hours, quality improvement, transitions in care, and supervision. Meetings included the CLER advisory group consisting of house staff, coordinators, program directors, faculty, and GME staff. We prepared presentations to nursing executives, the chair caucus, the GMEC board of directors, and the Academic Operations Council. Updates were shared at GMEC meetings.

Results: Excellent team representation contributed to dissemination of information to all concerned. We received timely support and input from the board of directors and C-suite. Program directors, faculty, and house staff led each of the groups in disseminating information and coordinating the team for the actual site visit. We observed a coherent, enthusiastic, and common platform response during the site visit—a proactive approach rather than a reactive one.

Conclusions: Our project paved the way for developing better relationships with house staff and understanding institutional goals, policies, and quality and safety projects. It will be very useful and critical for the success of the GME programs.

Editor's note: The team at Scott & White conducted an extensive preparation for the CLER visit that they detailed in their poster, and that information is presented in the abstract. As a result of the CLER visit, they selected transitions in care for their NI IV project, and that information is presented in the Work Plan.

FINAL WORK PLAN – Scott & White Healthcare

Team Charter/Objectives	We observed a need to standardize the patient handover process throughout the hospital. We aimed to improve the sharing of information and involvement of house staff at the institutional level of the Patient Safety & Quality Council and to improve communication between house staff and senior administration of the institution.
Project Description	To assess the current state of handoffs and transitions of care, we conducted a survey of house staff. We developed a template and made it available in New Innovations, allowing programs/departments to build on the template. The project was an institutional priority, and all departments were expected to buy in to develop a standard process. Each department was allowed to add items as needed so foster ownership of the process rather than a feeling that it was coming from the top.
Vision Statement	We will develop a systemwide transitions-in-care protocol and allow individual departments to add information as needed to meet the departmental requirements.
Success Factors	The most successful component of our work was creating a systemwide transitions-in-care checklist. We were inspired by the work and energy the House Staff Quality Council had previously achieved. After the CLER visit, our program directors took the lead in developing workable solutions in the areas of transitions in care and supervision along with our House Staff Quality Council.
Barriers	The largest barrier we encountered was time. Our team members are nearly all clinicians, and organizing meetings was very challenging with their limited availability. We worked to overcome this challenge by communicating via email and adding the project as a GMEC agenda item when necessary.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Consider the availability of your members and get the house staff involved as early as possible.

Scottsdale Lincoln Health Network, Scottsdale, AZ

CAUTI Prevention Through Education, Continuum of Care, and Systemwide Buy-In

Greg Alaestante, DO, PGY 3; M Moe Bell, MD, MPH; Charles "Chip" Finch, DO

Background: Catheter-associated urinary tract infection (CAUTI) rates were very high, especially in the Scottsdale Health Network Osborn campus ICU. With the aim to decrease CAUTIs, we collaborated with a systemwide CAUTI taskforce and created a resident quality champion position for GME.

Methods: We presented a multidisciplinary CME forum on CAUTI, implemented daily management plans to track catheter use, implemented a urine retention protocol, instituted ED education, and created EMR prompts requiring physicians to enter the reason for a urinary catheter when ordered and to ask physicians if a urinary catheter could be removed or to list the indication for continued use.

Results: The total number of CAUTIs at 3 campuses was reduced from 70 to 52 between 2012 and 2014, and the total number of Foley days was reduced from >16,000 to <13,000 between 2012 and 2014.

Conclusions: As a project team that focused on patient safety and decreasing mortality and morbidity, we were successful. Our hope to completely eliminate CAUTIs in our system was not met. However, many key initiatives will continue and