Measures	We determined the success of meeting our goal by measuring attendance at training (residents and PDs), number of training activities given, number of active projects, and initiation of PI and PS curriculum.
Success Factors	The most successful component of our work was the initial program with interns and new residents during orientation. We were inspired by new resident interest and promotion of projects to faculty and other residents.
Barriers	The largest barriers we encountered were the time requirements and conflicts due to clinical schedules. We worked to overcome this using electronic notes and correspondence but did not find a way to solve all issues.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Time management and time conflicts are an expected barrier. We learned that residents are very much interested in improving quality and PS and would like to have a larger involvement. Faculty could be motivated through resident involvement. We also learned that new methods of teaching are needed that include both face-to-face and alternative avenues to get information to learners.

MedStar Health, Baltimore, MD, and Washington, DC

MedStar Health Handoff Initiative

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Background: The goal of the initiative was to create and implement a comprehensive handoff curriculum across all training programs in accordance with Joint Commission priorities and ACGME requirements for patient safety and continuity of care. This study investigated the current state of resident handoffs throughout MedStar hospitals and the efficacy of a new resident handoff workshop.

Methods: The study was conducted at 4 teaching hospitals in MedStar Health. To establish a baseline, an anonymous survey was distributed among residents. Researchers developed a standardized handoff workshop employing the S-T-I-R model (Summary, To Do, If-Then, Readback/Feedback) and offered it to internal medicine, general surgery, and obstetrics/gynecology. Workshop sessions included didactics and simulation with audience interaction. The quality of resident handoffs was evaluated both before and 3-4 months after the workshop by direct observation.

Results: Residents from levels PGY1-5 completed 206 preliminary surveys. At baseline, a significant portion of residents across various disciplines lacked handoff protocols (26%) and training (47%); 75% of PGY1 residents said they received no formal training on handoffs in medical school. The postintervention survey was completed by 119 residents. Postworkshop observations found that interns who had received the intervention were significantly more likely to report To Do and If-Then statements, along with facilitating receiver Readback.

Conclusions: A handoff workshop led to sustained improvement in handoff quality. Next steps include (1) establishing a handoff workshop with emphasis on the S-T-I-R model at the start of each academic year for all residents and (2) using the handoff checklist to evaluate progress in transitions-of-care milestones and to provide formative feedback on protocol implementation.

FINAL WORK PLAN – MedStar Health

Overall Goal for NI III/Elevator Speech	Our team's goal was to create a comprehensive handoff curriculum to be implemented across all training programs within MedStar Health. The curriculum involved a training-the-trainer approach to promote a consistent handoff process that ultimately will be promoted by the residents themselves.
Needs Statement	This goal was important because several studies have noted inadequacies and wrong information conveyed through handoffs among residents. One study found that key information was not passed to the oncoming resident 60% of the time. Two prior surveys found that the majority of programs in internal medicine (60%) and emergency medicine (74.4%) do not have handoff curricula in place.

Vision Statement	In March 2013, we will see the outcomes of our success by instituting a resident handoff curriculum throughout all MedStar Health that improves the knowledge, skills, and attitudes of incoming and current residents and interns.
Measures	We determined the success of meeting our goal through surveys. Of incoming interns who completed a survey prior to the handoff workshop, 75% said they received no formal training on handoffs in medical school. After the interns received training, they were observed performing handoffs. A checklist was used to assess whether or not they were complying with the crucial components of an adequate handoff: face-to-face interaction, uninterrupted handoff, a written component, a succinct statement of the problem, addressing a To-Do list, If-Then plans, and acknowledgement of recipient understanding. Our comparison of pre and post direct observation encounters demonstrated statistically significant improvement after 3 months.
Success Factors	The most successful component of our work was implementation of a standardized curriculum for resident handoff education. Also, we worked towards developing a reproducible and reliable tool to assess resident skills and knowledge in performing handoffs. We were inspired by the positive responses we received from the residents regarding the handoff curriculum.
Barriers	The largest barrier we encountered was working across different hospitals at different locations. We worked to overcome this by frequent telephone conference meetings, liberal use of group emails, and help from the AIAMC.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Ensure a good simple study design that utilizes a simple tool to assess resident knowledge and skills that is both reproducible and reliable. "The process of conducting a multicenter, multispecialty study across two cities with a large team was a 'learning experience' in itself." —Dr Dick Williams

MedStar Georgetown University Hospital / MedStar National Rehabilitation Hospital, Washington, DC

Experiential Process Improvement Curriculum (EPIC)

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Background: We recognized the need for a comprehensive, sustainable experiential PI curriculum (EPIC) for our residency program that enables multiple quality projects. Our team's goal was to create an interactive QI curriculum that matches residents with attending physicians needing to complete a PI project for maintenance of certification (MOC). Curriculum projects will satisfy ABPMR MOC-4 for attending physicians, as well as ACGME Residency Review Committee requirements.

Methods: The team distributed a needs assessment survey to all inpatient attending physicians. Each physician who participated in our pilot curriculum was matched with a group of residents. Together they were to be led through an interactive online QI curriculum using Moodle, group meetings, and the PDSA framework.

Results: Per the initial needs assessment, 75% of respondents had not completed the MOC-4 requirement because they were not sure what to do with regard to PI methodology, 50% were not sure what to do with regard to MOC-4 requirements, and 37.5% were not able to find time in their schedules to complete the requirement. Although we saw clear interest in the project from both attending physicians and residents, we encountered a barrier to curriculum implementation in coordinating participant schedules and organizing the curriculum. Positive unintended consequences included increased awareness of the need for QI and its requirement for MOC.

Conclusions: We plan to fulfill our goals in the next few months after implementation of our online curriculum. We believe that enabling attending physicians to complete their required MOC PI project via this course will help sustain this initiative. As the participating groups complete the stages of EPIC, we expect to see a number of PI projects completed and several needed adjustments to our facility.