Barriers	The largest barrier we encountered was the tension between "today's work" and culture change process. We worked to overcome this by imbedding training and reinforcement into regularly scheduled activities. We plan continuation at existing sites, selection of next sites, and secession planning (resident champions/other staff transition to new roles).
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Involve key stakeholders from day one (C-suite, management, faculty, residents, and office staff). Be patient yet persistent with timelines.

Bassett Medical Center, Cooperstown, NY
Creating a Core Faculty in Quality and Safety

James Dalton, MD; Kelly Currie, MD; Edward Bischof, MD; Charlotte Hoag

Background: We aimed to create an educated and enthusiastic core faculty of senior and resident physicians and administrators who would take ownership of the curriculum in quality and safety for all residents. Most physician faculty across all disciplines have not been engaged in and have had little or no formal training concerning the process of quality and safety. With new ACGME requirements, residents need to be actively involved in quality and safety activities. We planned to establish a curriculum in quality and safety for all postgraduate trainees that is highly valued by the residents and is sustained by a dedicated faculty skilled in the science of quality and safety.

Method: We identified core faculty by surveying residents and faculty for interest in developing a quality and safety program. The core faculty held monthly meetings to discuss quality and safety issues with residents and create a learning curriculum. Residents attended a house staff quality council meeting. The core group held monthly teleconferences with NI III colleagues, establishing relationships and common ground.

Results: We have developed a lecture series and are in the process of executing it. Cultural obstacles have become apparent to both core faculty and residents. Participants' collaboration fostered courage, creativity, and resident empowerment, and the teleconferences resulted in a collaborative research project with an outside partner. We recognized the tension concerning securing time to teach and develop as a faculty, and the implementation of an electronic health record program was an additional time concern. The project is still ongoing and long-term effects are not yet discernible.

Conclusions: The outcome of the program remains to be seen, but we have found the process invaluable. Our experience also demonstrated the need to collaborate among residency programs for common curricular goals and the importance of administrative support.

FINAL WORK PLAN – Bassett Medical Center

Overall Goal for NI III/Elevator Speech	Our team's goal was to develop a core faculty in quality and safety that would support a curriculum in quality and safety across all of our residency programs.
Needs Statement	This goal was important because the needs of our patients and the requirements of the ACGME mandate training in quality and safety for all physicians in training. We have a deficit in faculty trained in the science of quality and safety. Residents respond better to curricular goals when they see the goals as important to their faculty role models.
Vision Statement	In March 2013, we hoped to see the outcomes of our success by having a faculty trained in the science of quality and safety that is actively involved in the delivery of curriculum for all residents.
Measures	Our intervention is incomplete. The didactic curriculum for the faculty is outlined and we are partway through delivery. Our plan is to measure attitudes and knowledge regarding the science of quality and safety among the core faculty pre- and postintervention and to survey program directors and residents regarding involvement of the core faculty in delivery of the curriculum.

Success Factors	This program has not been successful so far, but we have hope. The most successful component of our work was the spinoff work done within one of the residency programs by 2 of the core faculty. We were inspired by the dedication of some of the members of the group.
Barriers	The largest barrier we encountered was an institutional mismatch of priorities. Two specific issues were barriers. The implementation of an electronic medical record system—a huge drain on human resources—occurred during the middle of the project, rendering several core faculty members unable to participate in the project during that time period. Also, several core faculty members had personal commitment to the project but did not have support of their clinical chief of service. These faculty members were from departments that do not have residency programs, so the chief did not appreciate the value.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Don't simply get endorsement up front for the project by the CEO, CMO, and clinical chiefs—have them actively involved in the process so anticipated conflicts can be better determined and the time spent on the project is truly valued by the participants' leaders.

Baystate Medical Center, Springfield, MA
Development of an Interdisciplinary, Interprofessional Resident Quality Council

Reham Shaaban, DO; Adrianne Seiler, MD; Melody Brewer, MD; Kevin Hinchey, MD

Background: House staff play a key role in patient care but are not optimally involved in efforts to improve care. Current assessment procedures do not always include resident input, which can lead to lack of engagement. To help meet ACGME requirements, we planned to develop an interdisciplinary, interprofessional resident quality council (RQC) to engage residents in QI culture, teach them about QI, and enhance communication with administrators.

Methods: We initiated the RQC in 2012 and selected the chiefs of all 10 residency programs in the hospital as the first class. Our primary focus was teaching the teacher through monthly didactic sessions, allowing us to disseminate information and knowledge about QI science to all residencies. The secondary focus was to form parallel quality tracks in all residencies to perform at least 1 quality project per year, as well as to develop participation criteria and interest for the RQC.

Results: We saw significant improvement and comfort with interdisciplinary communication among the 10 participants. We were able to identify QI champion attendings within each program to support the council and connected the psychiatry chief resident to a psychiatry attending to develop a QI track. Participants also generated multiple interdisciplinary project ideas for the future. Residents were chosen to participate without gauging their level of interest, which led to lack of engagement. Residents also had a variety of responsibilities, so scheduling time for the RQC meetings was difficult. The initiative lacked a strong emphasis on the main goal of RQC participation.

Conclusions: Although the RQC did not reach all of the initial goals, it successfully formed interdisciplinary working relationships and gauged the house staff's interest in and knowledge of QI. Moving forward, the council will consist of residents who have applied and have shown interest in QI as recognized by their programs.

FINAL WORK PLAN – Baystate Medical Center

Overall Goal for NI III/Elevator Speech	To develop an interdisciplinary, interprofessional RQC to improve patient care and safety by engaging residents in a culture of QI, teaching them about QI, and enhancing communication between hospital administrators and residents.
Needs Statement	House staff play a key role in patient care at academic medical centers. They have unique insights into problems that occur within a hospital, yet they are not optimally involved in efforts to improve care.