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| Project Description | A review of the literature pointed to (1) definitions of professionalism; (2) observable and measurable behaviors; and (3) measurement tools that have been used. We used process mapping to investigate our current reporting systems and data repositories to identify how we could report and track physician professionalism concerns and praises. |
| Vision Statement | By March 2015, our team had clearly operationalized components of physician professionalism for residents, fellows, and attending physicians. Partners and existing tools were identified and tweaked. The Physician Commitment to Professionalism was rolled out. We now have the capability to investigate and improve how our ALGH learning environment promotes and measures physician professionalism at the medical staff level. |
| Success Factors | The most successful component of our work was collaboration with multiple partners in Quality, Safety, and Patient Experience as well as medical staff leadership and GME leadership. |
| Barriers | The largest barrier we encountered was the inconsistent and insufficient reporting by and about physicians (both attending and residents) at our hospital. Education and reporting exemplary behavior should improve the volume and variety of reports. A telephone hotline was initiated for physicians and residents/fellows to encourage and facilitate reporting. We have not yet identified a tracking mechanism for residents/fellows that is standardized across programs. |
| Lessons Learned<br>What is the single most important piece of advice for another team embarking on a similar initiative? | Schedule regular (weekly or biweekly) meetings. Keep an open mind about who needs to be at the table and who has the necessary expertise. Make assignments and collaborate to keep them on track. Follow the monthly assignments. Focus on the end goal. |

# Akron General Medical Center, Akron, OH

## Floor-to-Unit Transfers Within 24 Hours of Admission from the ED

**Zachary Robinson, MD; Ankit Anand, MD; Cheryl Goliath, PhD; Titus Sheers, MD; Larry Emmelhainz, PhD**

**Background:** We are a community hospital with approximately 500 beds, 25,000 annual admissions, and 103,000 ED visits at 4 ED sites. The perception among residents was that a high number of patients were being admitted to a medicine floor from the ED but required transfer to a critical care unit within 24 hours of admission. We investigated this transition-of-care question and attempted to answer whether a change occurred in patient status, whether the status change could have been anticipated, and whether the initial admission unit was appropriate.

**Methods:** We performed a medical record audit of 5,302 admissions from January 1, 2014 through March 31, 2014 to identify patients who were transferred to an ICU within 24 hours of admission. Twenty-two patients met the criteria. We manually reviewed these medical records to determine admitting diagnosis, reason for transfer, time to transfer, and final patient disposition. Based on this data and our review of the record, we determined whether the initial placement was appropriate and whether any status change could have been anticipated.

**Results:** No patients died while in the hospital, and 50% were discharged home. The average time to transfer was 11:46 hours. Approximately 27% of transfers were felt to be due to questionable initial placement; however, no clear pattern of cause was identified. Fifty percent of the transfers were due to respiratory decompensation.

**Conclusions:** Reports from residents of unnecessary transfers within 24 hours from admission seemed to be a somewhat pervasive problem, but our study found the opposite: the number of transfers was much lower than expected. Although 50% of transfers were due to respiratory decompensation, without data on the total number of patients admitted for respiratory diagnoses, it is impossible to quantify the risk. In the future, we would like to explore standardized handoffs such as I-PASS to help admitting teams anticipate possible status changes.

**FINAL WORK PLAN – Akron General Medical Center**

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| Team Charter/Objectives | The objective of this project was to create a quality-driven process of standardizing transitions of care for patients from the ED to the inpatient setting. This standardization will improve quality of care and patient safety, as well as decrease length of stay by ensuring appropriate placement of patients at admission. |
| Project Description | Our project focused on the transition of care for patients admitted through the ED to a medical floor who required transfer to a critical care unit within 24 hours of admission. The team conducted a retrospective medical record audit to identify factors related to the transfer and develop a possible intervention to reduce the number of transfers to improve the quality of care, increase patient safety, and reduce costs by admitting the patient to the appropriate unit. |
| Vision Statement | Once the chart audit has been completed (to determine the factors involved in patient transfers from the floor to the critical care units within 24 hours), the project team can identify an appropriate intervention to decrease the number of transfers. |
| Success Factors | The most successful component of our work was working together with the internal medicine and emergency medicine departments that at times approach issues from a different vantage point. Despite early problems with finding a correct reporting mechanism to capture the information needed for the study, we were able to identify a program that produced patient information that we had not been able to obtain previously. |
| Barriers | The most difficult barrier was finding an electronic mechanism to gather the patient information needed. Additionally, several changes of the team membership negatively impacted project momentum, and new members had to be identified. |
| Lessons Learned<br>What is the single most important piece of advice for another team embarking on a similar initiative? | Schedule regular meetings at the beginning of the project for the duration of the initiative to ensure ongoing communication. Scheduling meetings as items came up for discussion made it extremely difficult to get members together. If meetings are scheduled, they can always be canceled if necessary. |

# Atlantic Health System–Goryeb Children's Hospital, Morristown, NJ

## How Simple Technology Can Improve Physician-to-Physician Patient Handoff

**Michael Pollaro, DO; Alan Meltzer, MD, FAAP; Kiley Alpert, C-TAGME**

**Background:** On our institution's pediatric inpatient unit, a number of admissions arrive on the floor without a formal physician-to-physician handoff. Pilot data revealed that handoffs, especially from the pediatric surgical service, were limited. The purpose of our study was to develop a streamlined method of communication between multiple disciplines and the inpatient pediatric admitting resident to increase the handoff rate.

**Methods:** A team was formed of members from the pediatric and general pediatric surgical services. A new portable telephone was introduced that the admitting pediatric resident carried 24 hours a day, 7 days a week. Once the telephone was obtained, verbal and written instructions were provided to all disciplines that admit to the inpatient unit (ie, ED, surgical teams, subspecialists, and outpatient general pediatricians). For a 6-week period, data were collected on the handoff rate for pediatric inpatient admissions. After the initial data collection, results were analyzed, and a second intervention—a feedback session with the general pediatric surgical team—was performed. Data were then collected for an additional 6-week period.

**Results:** During the first 6 weeks after the telephone procedure was implemented, the percentage of completed handoffs was 96% from the ED, 38% from surgery, and 5% from the subspecialties. In the second 6 weeks, after the second