Vision Statement	The My Health Care Team pictorial will provide a more positive patient experience by aiding in the identification of providers and coordination of care. As the project continues, we plan to obtain additional data, including randomization of patients, and expand the project to other departments.
Success Factors	The creation of a user-friendly team pictorial and subsequent distribution system to the hospital wards is achievable with the right support system. All patients reported positive impressions of the pictorial. Allied providers also anecdotally agreed that the pictorial is a helpful tool. We observed a trend toward improved name recall, patient satisfaction, and care plan understanding.
Barriers	The largest barriers we encountered were the distribution process and points of contact and a lack of compliance in pictorial distribution by the ward teams. Another barrier was data collection; we would like to have more patients and more data to achieve statistical significance. Other barriers included patients were selected retrospectively and not randomized, official data from other members of the care team have yet to be gathered, and the project's scope was likely too narrow. The plan is to include other programs in the future. As a jointly sponsored residency program (Marshfield Clinic and Ministry Saint Joseph's Hospital), we do not have a seamless approach to project management because both institutions, while merged as a training program, operate independently from one another.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Ensure a good support system and a project team that can fulfill all roles as defined by the project. Education of all team members is important, and identification of key contacts is critical.

Monmouth Medical Center, Long Branch, NJ
A Hospital Public Health Response to CLER

Beth Baratz, MS, MPH, CCLS; Alex Puma, BA; Joseph Jaeger, DrPH, MPH

Background: Our ACGME CLER site visit revealed issues with patient safety, quality, and health disparities, so a core curriculum team consisting of members of the Office of Academic Affairs and an MPH candidate was formed to develop a public health curriculum for residency programs. Desired outcomes included the identification and reduction of public health–related knowledge gaps.

Methods: A literature search, a needs assessment of program directors and residents, curricular audit, presentation, and peer review were conducted to design a public health curriculum that addresses patient safety, healthcare improvement, error reporting, and health disparities. Success depended upon the approval of the Monmouth Medical Center GMEC.

Results: The "Public Health Curriculum for Graduate Medical Education Program at Monmouth Medical Center" was completed on time and within the project budget. The GMEC approved the curriculum, and the program directors adopted it. The program-specific curriculum was found to be responsive to the needs of 7 residency programs.

Conclusions: Educators and trainees now have access to a complete set of concepts, terms, and activities that make up the public health domain. This access has increased awareness regarding public health, disparities, and inequities and has also led to greater awareness of patient safety and error reporting.

FINAL WORK PLAN – Monmouth Medical Center

Team Charter/Objectives	The ACGME CLER site visit revealed issues with patient safety, quality, and health disparities. Our team's goal was to infuse the clinical learning environment with public health principles and practices.
Project Description	The Office of Academic Affairs and an MPH candidate developed a comprehensive public health curriculum for GME designed to improve patient safety reporting and education, performance and quality improvement practices, health disparities interventions, and cultural competency. The project identified and addressed barriers to patient safety reporting.

Vision Statement	Monmouth Medical Center will provide its medical staff and students with a clinical learning environment that prioritizes quality-driven, safe, and responsive healthcare services. Future efforts should target the translation of knowledge to physician strategy, physician performance, and improved patient outcomes.
Success Factors	A needs assessment helped staff and students recognize opportunities for learning. A dedicated person searched for and provided resources for learning. Peer review encouraged staff and students to provide feedback on translational potential.
Barriers	The largest barrier we encountered was challenging the institutional and program culture: "the way we do things."
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Engage learners in the full scope of curriculum development.

Ochsner Clinic Foundation, New Orleans, LA

Implementing a Standardized and Sustainable Resident Sign-Out Process at Ochsner Clinic Foundation: An AIAMC National Initiative IV Project

Jacob Breaux, MD; Roneisha McLendon, MD; Robin Stedman, MD; Navita Gupta, MD; Kelly Shum, MD; Mannan Khan, MD; Elizabeth Ellent, MD; Ronald Amedee, MD; Janice Piazza, MSN, MBA; Robert Wolterman, MHA

Background: Duty-hour restrictions imposed on training physicians have led to increased patient handoffs and the potential for discontinuity in patient care. We identified a significant need to formalize a process for transitions of care between inpatient settings.

Methods: We distributed surveys to residents and faculty to assess current perceptions and practices surrounding transitions of care. We met with program directors and residents from multiple specialties to review the importance of sign-out standardization and our goals at the institutional level. We designed a written sign-out template, using elements from the pneumonic ANTICipate. We programmed the written document within the EMR, and we piloted it as a standardized and up-to-date sign-out tool accessible via computers and iPads. We defined a verbal sign-out modeled after the pneumonic I-PASS, developed at Boston Children's Hospital. We printed tables for both the written and verbal handoff processes on note cards and distributed them to all staff and residents. We held interactive didactic sessions introducing the documents and training participants in their use. We facilitated feedback and discussion surrounding specialty-specific requirements and considerations for the handoff process. We repeated the survey to quantify improvement; we plan a later survey to evaluate sustainability. We identified stakeholders to ensure sustainability of the project and continued improvement.

Results: Repeat survey results were obtained from 45 faculty members and 63 residents representing multiple specialties. Comparing the initial results to the repeat survey, there remained variability in process perception. Seventy-two percent of faculty reported at least once identifying a patient safety issue occurring as a result of the handoff process consistent with the initial survey results. Faculty reporting supervision of the handoff process increased from 82% to 86%. In the initial survey, 80% of residents reported sometimes or never receiving feedback on their handoffs, and that number decreased to 70% in the repeat survey. The percentage of residents reporting the use of a standardized process for handoffs also increased.

Conclusions: Results indicate a modest increase in feedback with respect to and supervision of handoffs. As we progress with systemwide implementation, we plan to incorporate objective metrics such as numbers of laboratory tests ordered