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

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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

by residents, changes in hospital length of stay, and medication occurrences because these parameters will complement subjective data from observer evaluations and survey results.

FINAL WORK PLAN – Ochsner Clinic Foundation

Team Charter/Objectives	Based on findings from internal and external, formal and informal, and clinical and operational metrics, we have identified a significant need to formalize a process for transitions of care between inpatient care settings: hospital-based and primary care as well as hospital-based and external care providers (ie, skilled nursing facility, rehabilitation, long-term care, and home health). The results of this lack of continuity are found in patient safety metrics (medication and treatment compliance) readmissions, and patients lost to follow-up with unknown outcomes. Based on these findings, transition of care was identified as a primary area of focus for this project.
Project Description	Perform an initial assessment of the tools, practices, and policies currently in use; determine best practices currently in place internally and assess the literature for demonstrated best practices; assess EMR (Epic) functionality that could support defined practice(s); identify metrics (measures of success) and available data sources; identify pilot areas for initial assessment of best practices; review outcomes of pilot/impact on defined metrics; refine metrics and data collection; define accountabilities for implementation; implement an education plan, go live with EMR support, and implement a metric performance reporting process; and develop a plan to spread and sustain.
Vision Statement	By March of 2015, a standardized tool and process for facilitating transitions of care will be in use throughout Ochsner Medical Center in an effort to ensure quality patient care in the safest of environments.
Success Factors	The most successful component of our work was the level of institutional support provided in the form of unlimited assistance/dedication from GME and department heads. Also, we received significant buy-in and support from the health information management team, information technology security and technical staff, Epic developers, and executive administration. We were inspired by our CLER visit and an evident need to formalize a process that has become an instrumental aspect of healthcare.
Barriers	The largest barrier we encountered was getting buy-in from individual residents and overcoming historical perspectives and tendencies. We worked to overcome this challenge by holding interactive sessions describing not only the process but also the research supporting the essential nature of such an endeavor. Additionally, we employed resident and faculty champions to help disseminate the process and drive the change in culture we will need to have continued success.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Plan and anticipate; maintain flexibility in all aspects of the process; be realistic in determining attainable measures and consider the time frame and scope of the project—think small cycles of change; start the project with the end in mind; solicit feedback early in the process from key stakeholders to anticipate problems/issues that can slow implementation/publication; be aware of tools/systems currently in place that can facilitate the process; create an early abstract/draft of the project to serve as a guide and foundation for milestones and final paper publication. Utilization of PDSA cycles throughout implementation can serve as a basis for publications.

OhioHealth Riverside Methodist Hospital, Columbus, OH

Find It, Fix It: Engaging Residents and the C-Suite in Quality Improvement

Sara Sukalich, MD; Miriam Chan, PharmD on behalf of the Find It, Fix It Planning Committee

Background: The ACGME CLER program calls for residents to participate in quality improvement/patient safety initiatives. However, our institutional quality improvement/patient safety initiatives rarely involved trainees and there was little