FINAL WORK PLAN – Akron General Medical Center

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 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

intervention, ED and the subspecialties had 100% admissions with completed handoffs, whereas surgery decreased to 20%. The percentage of handoffs done using the telephone during the first 6 weeks was 60% from the ED, 50% from surgery, and 0% from the subspecialties. After the second intervention, the ED made 100% of handoffs using the phone, the subspecialties had 11% of handoffs with the phone, and surgery had 22% of handoffs with the phone.

Conclusions: The literature has shown the paramount importance of proper physician-to-physician handoff. One hundred percent of ED and subspecialty admissions now have a formal handoff. Streamlining the process and ensuring that admitting residents are easily accessible should encourage more physicians to hand off their patients when transferring or admitting them to the pediatric floor. Our data indicated an improved number of handoffs from the subspecialists, although the use the new telephone was limited, suggesting a halo effect of the project. The surgical teams did not adopt the process. Future steps will seek to engage the surgeons—more specifically the nonemployed surgical subspecialists—in the handoff process.

FINAL WORK PLAN – Atlantic Health System–Goryeb Children's Hospital

Team Charter/Objectives	A number of admissions arrive on the pediatric inpatient unit without a formal physician-to-physician handoff. Pilot data revealed that handoffs, especially from the pediatric surgical service, were limited. The purpose of this study was to develop a streamlined method of communication between multiple disciplines and the inpatient pediatric admitting resident to increase the handoff rate.
Project Description	A new communication tool—a portable telephone to be carried by the admitting pediatric resident—will be introduced, and verbal and written instructions will be provided to all disciplines that admit to the inpatient unit. Data will be collected and analyzed during 2 consecutive 6-week PDSA cycles. Future PDSA cycles will be planned.
Vision Statement	Our goals are to increase the overall number of handoffs, eliminate the admission pager that leads to delays in communication, see full adoption of the direct line admission telephone, and enhance communication to improve patient safety.
Success Factors	The ED fully adopted the telephone handoff, with 100% of admissions having a formal verbal handoff via the telephone. Although the medical subspecialists did not use the telephone to the extent we desired, the number of handoffs via other methods of communication by the subspecialists reached 100%.
Barriers	The biggest barrier to success was buy-in to the process by the nonemployed surgical subspecialty faculty.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Have frequent meetings with the surgical stakeholders to maintain pressure and focus on the project.

Aurora Health Care, Milwaukee, WI

Creating a Culture of Quality and Safety at Aurora Health Care

Loras Even, DO; Lilia Sen, MD; Indervir Mundh, MD; Deborah Simpson, PhD; Tanya Martinez; Jeffrey A Stearns, MD; Andy Anderson, MD

Background: The aim of this project was to pilot an approach/model that integrates and aligns Aurora Health Care (AHC) priorities (quality and safety), its existing committees/groups (Quality Committee/Council), and metrics with ACGME requirements (CLER, Common Requirements). The Residency Council was engaged in the initiative, and 3 residency programs piloted sustainable, data-driven quality/safety projects.

Methods: The family medicine project was Medication Reconciliation in Primary Care Clinics and involved a fishbone analysis to identify factors contributing to error, a focus on accurate use of the EMR, creation of a medication reconciliation