Boston Children's Hospital
Until every child is well™

# GME ON-CALL

Volume 7 ,Issue 1 Fall 2015

## Message From the Co-Chairs

Alan Woolf, MD, MPH, Debra Boyer, MD

The annual July transition of house-staff at BCH has gone very smoothly. We welcome the new trainees coming from all over the country and the world, as well as those who are returning to the hospital in new roles. In the GME Office, we are focused on a number of very promising developments in medical education at BCH. Dr. Churchwell, the Chief Operating Officer (COO) of the hospital, recently announced that the recommendations of the BCH Task Force on Strategic Planning in Medical Education, first convened by the Hospital's leadership in February of 2014, are being reviewed by both the hospital's Executive Committee and Medical Staff Executive Committee, with some changes in staffing and resources anticipated as soon as later this year. Stay tuned!

**Comings & Goings:**
We want to take this opportunity to extend a warm welcome to **Katelynn Axtman**, our new senior administrative assistant in the Office of GME, Katelynn has previously worked in the department of GI/Nutrition here at BCH and brings a wonderful set of skills and experience to benefit our ongoing GME activities. You can reach her by email at katelynn.axtman@childrens.harvard.edu or by calling 617 355 4372 for any concerns about house-staff issues such as on-call rooms or taxi vouchers. Katelynn will also be our staff person for assisting in the planning of GME-related meetings and for assembling and producing our newsletter.

We'd also like to thank **Simone Guida**, fellowship coordinator for Pediatric Rheumatology, for her contributions to their fellowship program. At the same time we want to welcome **Kimberly Parker**, who takes on new responsibilities as the new coordinator for rheumatology. We want to thank **Gwen Gilmer** who stepped down from her position as fellowship coordinator for the Division of General Pediatrics after many years of outstanding service. We'd like to take this opportunity to congratulate **Adrianne Goncalves**, the previously coordinator for Adolescent Medicine, who has recently promoted to be the Adolescent Medicine Division Manage and we congratulate **Kaytlyn Darling**, who is the new program coordinator for adolescent medicine. We'd also like to welcome **Alaina Carroll**, new program coordinator for Pediatric Sports, and **Karen Granquist**, who assumes her new responsibilities as the manager of anesthesiology training programs.

**Dr. Stuart Goldman** has announced that he is stepping down as a member of our hospital-wide GME Committee. Stuart has been a thought-leader in medical education for many years and we hope that his new part-time status will still afford him the opportunity to give us the benefit of his input on educational matters here and at Harvard Medical School.

Please make a note of these upcoming medical educational events. The **Teaching Academy at HMS** will hold its semi-annual 'Medical Education Day' on **Tuesday October 27th** in the Tosteson Center of the MEC on Longwood Avenue. The **GME Office** will be holding its semi-annual retreat for training program directors, associate program directors, coordinators, and other interested faculty on **Monday, November 2nd** from **12:45-4:45 pm**; the topic of the retreat is "Faculty Development: Teaching Your Faculty". The **Boston Combined Residency Program** will be holding a two-day strategic planning event for the residency on **November 20th and 21st** at the BU Photonics Center.

There are a lot of exciting events this Fall to keep you moving forward towards your goals in GME!

## Inside this issue:

# Strategies for Academic Success

The GME Office again is sponsoring the core curriculum "Strategies for Academic Success (SAS)" during the 2015-16 academic year intended for residents and fellows. This outstanding and innovative hospital-wide trainee development program includes four sessions each academic year and covers curricular content in the areas of leadership and teaching skills, the pursuit of a 'professional development plan', and quality improvement research. Our new GME educators, Drs. Diane Stafford and Ariel Winn, and Debra Boyer, the GME Committee Co-Chair, have been working closely with Dr. Ted Sectish of the BCRP to develop the curricular offerings planned for the 4 sessions that are anticipated over the academic year. The first session of SAS will be offered on Wednesday, October 28th from 12:30-5:30 pm in the Karp Building 7th floor conference room. The second SAS session will be held on Thursday, December 3rd in the Karp Building 8th floor from 1:00-5:30pm. Stay tuned for the dates for 2016!

# AAP Studies Early Career Pediatricians

## Alan Woolf, MD, MPH

In 2012 the American Academy of Pediatrics launched a new longitudinal study of recent graduates of pediatric residencies aimed at defining better the experiences and needs of physicians early in their careers. Currently collecting the fourth year of data, the Pediatrician Life And Career Experience Study (PLACES) will give invaluable insights on emerging trends in the workforce. Two cohorts of residency graduates: 2002-04 and 2009-11, with 900 participants in each cohort, have agreed to be surveyed twice annually regarding professional and personal facets of their lives. Some early profiles of the n=1,804 participants in 2012 included:

Women: 60% in 2002-04 and 70% in 2009-11
Mean Age: 40 in 2002-04 and 33 in 2009-11
Married/partnered: 89% in 2002-04 and 78% in 2009-11
White: 72% in 2002-04 and 66% in 2009-11
Asian: 20% in 2002-04 and 23% in 2009-11
Black: 5.3% in 2002-04 and 6.7% in 2009-11
Hispanic or Latino: 10% in 2002-04 and 8% in 2009-11
Parents: 84% in 2002-04 and 51.6% in 2009-11
Board-Certified in Pediatrics: 90% on 2002-04 and 85% of 2009-11
Specialty-Certified: 39.5% in 2002-04 and 5% in 2009-11
Work part-time: 24% of 2002-04 and 17% of 2009-11
Employees, not owners: 73% in 2002-04 and 88% in 2009-11
42% are generalists
41% are specialists or in fellowships
9% are hospitalists
64% still have educational debt
only 50% are satisfied with the time they have to spend with their children

For more information on the PLACES study, see Frintner MP et al. Pediatrics 2015; 136: 370-80.

# Data Data Data – Who is Asking For All of This and Why?

## Tery Noseworthy, C-TAGME

Under the Next Accreditation System (NAS), the ACGME eliminated the Program Information Form (PIF) and changed site visits from every three to five years to every ten years. Sounds great, right? The ACGME didn't really decide to leave you alone for those ten years, though; they just transitioned to a system where information is collected and reviewed annually. They also transferred some responsibility for overseeing compliance at the program level to the institution.

## Upcoming Events

Strategies for Academic Success

**Session 1: Career Development**

10.28.15
1:00-5:00pm

**Session 2: Teaching, Leading and Learning**

12.3.15
1:00-5:00pm

**Session 3: Professionalism, Humanism, and Ethics**

1.25.15
1:00-5:00pm

**Session 4: TBD**

**Session 5: TBD**

Volume 7 ,Issue 1 Fall 2015

## By the Numbers

**ACGME**

**9,600**
Residency and fellowship programs

**120,000**
Residents and fellows

**700**
Sponsoring Institutions

**28**
Specialty-specific review committees

**99**
ACGME-international programs

**WEB-ADS:** The ACGME provides accreditation for your training program and allows your trainees to be board-eligible. As such, it expects that you report a fair amount of data to them on an annual basis - questions about compliance with their requirements, board pass rates, evaluation methods, block schedule and scholarly activity as well as a response to any citations and notification of any major program changes. Log into the ACGME's Web Accreditation System (WebAds), selecting "Annual Update Status" from the menu on the right. Due dates for the Annual WebAds Update vary by specialty but are generally completed between August and November.

**TRAINEE SURVEY**: The ACGME collects additional data by surveying residents/fellows from every program they accredit between January and April annually, with results available to programs in late June. Programs with four or more trainees can log into Web-Ads to see the results, trends in their program for the past three years and national averages for their specialty. Programs with three or fewer residents/fellows cannot see their results, but ACGME will release a summary survey of their data once they have 3 years of results.

**FACULTY SURVEY:** In 2013 the ACGME began surveying faculty as well. Faculty survey results are also available to programs with four or more core faculty.

The specialty-specific Residency Review Committees (RRC) of the ACGME review all of the above information annually and then send you a letter regarding your accreditation status. This letter identifies areas of concern and might ask for a progress report. If there are multiple (or severe) concerns, you may be notified that the ACGME is coming for a focused site visit to review your program in person.

**CCC:** The ACGME also collects milestones evaluation data for trainees, based on the work of your Clinical Competency Committee (CCC). It is not yet clear what they will do with this information.

**APE**: For the GME Office you complete the Annual Program Evaluation (APE), which is reviewed by the GME Executive Committee. The ACGME requires that the GME leadership review compliance with ACGME requirements at least annually. You can see what information we are reviewing by logging onto New Innovations and going to Administration - Program - APE. Our goal is to identify potential issues before they reach the notice of the ACGME and to be sure any issues already identified by the ACGME are being addressed. The APE may result in a letter from the GME Office noting areas that could be improved. You might also be asked to provide a progress report on how you are addressing areas of concern. You might also be asked to participate in a special review, during which member of the GME Committee will meet with your trainees and your faculty to review areas out of compliance. This is an internal process; results of the AP, progress reports and special reviews are not shared with the ACGME.

**AAMC:** Outside of the accreditation process, the American Association of Medical Colleges (AAMC) also surveys all ACGME-accredited training programs each fall, asking questions about current trainees, your program's structure and polices, and information on salary, benefits and time off. Aggregate information is used by the AAMC to track trends in GME; program-specific information is made available to medical students and residents via the American Medical Association's Fellowship and Residency Electronic Interactive Database Access (FREIDA).

# Attending Physician Mandatory Notification

Alan Woolf, MD, MPH

The ACGME has clear expectations for training programs to achieve an optimal balance in their supervision of trainees' clinical activities. Programs must give evidence of providing for progressive levels of responsibility over the course of a resident's or fellow's training towards their independence as signified by Entrustable Professional Activities (EPA). At the same time, the ACGME mandates that attending physicians be available to supervise all trainee activity consistent with the highest standards of patient medical care and patient safety. The ACGME's Common Program Requirements specify:

*"The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident- delivered care with feedback as to*

*the appropriateness of that care. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:*

- Direct Supervision – the supervising physician is physically present with the resident and patient.
- Indirect Supervision:

  *<u>with direct supervision immediately available</u> – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.*

  *<u>with direct supervision available</u> – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.*

*Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence."*

**Standard**

- The attending physician has the ultimate responsibility for all medical decisions regarding his/her patients.
- The attending physician is responsible for providing oversight and supervision of all care provided by trainees.
- Attending physicians are expected to behave in a professional manner at all times in regard to trainee supervision and are expected to encourage each trainee to seek guidance from the attending physician at any time the trainee believes it to be helpful in the care of patients. The attending physician is to make clear to each trainee that it is only the failure to seek guidance that is considered to be problematic.

**Hospital-wide attending notification events**

The attending physician communicates clearly to each trainee involved in the care of the patient when the attending physician expects to be contacted by the trainee. At a minimum, trainees are told to notify the attending physician of significant changes in the patient's condition, regardless of the time of day or day of week. Significant changes may include, but are not limited to the following:

- Admission to hospital
- Transfer of patient to ICU
- Transfer to Complex Care Service (CCS)
- Need for intubation or ventilatory support
- Cardiac arrest or significant change in hemodynamic status
- Development of significant neurological changes
- Development of major wound complications
- Medication errors requiring clinical intervention
- Any significant clinical problem that requires an invasive procedure or operation
- ICU/ICP Consult
- Delay in transfer to higher level of care after an ICU/ICP consult has been obtained
- A patient to be transferred to CCS Service with concerning clinical condition
- New arrhythmia
- Lack of response from clinical team
- Lack of reassuring response/concern not being addressed by clinical team

## By the Numbers

**193**
Newly-accredited programs in AY201

**25**
ACGME sponsoring institutions in MA

**415**
ACGME-accredited programs in MA

**4.3%**
of all training programs nationwide are in MA

Volume 7 ,Issue 1 Fall 2015

**By the Numbers**

## GME AT BCH

39
ACGME and ADA-accredited programs

33
Non-accredited programs

479
Residents and clinical fellows

118
Programs at other institutions whose residents/fellows rotate to BCH

900+
Rotating Residents/Fellows

- Vital signs not at baseline norm and concerning to staff
- Marked change in fluid balance
- Significant increase in O2 requirement
- Uncontrollable pain despite pain meds
- Increased parental concerns
- Panic Lab Values/new positive blood culture
- Need for patient care huddle
- Anuria or change in urinary quality
- Red CHEWS Score > 5
- Access issues
- Increased nursing concerns
- Any criteria determined by attending physicians during morning or evening rounds

It is a continuing challenge to our mentorship as faculty within the environment of a teaching hospital to strike the appropriate balance between supervision of trainees while directing patient management and nurturing the trainee's sense of responsibility for decision-making and ownership of patient care. (reprinted from GME On-Call 2014 newsletter vol 5 number 3)

# Online Social Media: Do's & Don'ts

Do you use social media on-line while you are working at Boston Children's Hospital? Of course you do! Navigating sites such as Facebook, CarePages, LinkedIn, Netflix, YouTube, Instagram, Blogspot, WordPress, and Twitter is now a part of daily life for many of us. And BCH itself sponsors popular websites. The Hospital has adopted some commonsense rules for using social media responsibly and professionally while on the job, and both trainees and faculty should make sure they are following them. Here are a few examples:

**Responsible Social Media Use**

Ensure that time spent on-line does not distract from patient care

Maintain appropriate professional and personal boundaries

Follow intellectual property rules

Exercise professional judgment and mutual respect

Use social media for research only with prior IRB review and approval

Comply with applicable BCH policies on professional behavior, therapeutic relationships, code of conduct, protected health information (PHI) (confidentiality and release of information), sexual harassment and discrimination, and violence prevention

**Prohibited Social Media Use**

Use of social media for personal purposes while providing patient care

Sharing or posting patient, family, employee, or organizational information (e.g. PHI, personal identifier information, or photos or other images unless prior written permission has been obtained in accordance with BCH policies)

Sharing or posting confidential BCH information (e.g. confidential financial or business information)

Engaging in conduct that is an invasion of another person's privacy

Communicating in a manner that is disruptive, threatening, harassing, bullying, embarrassing, defamatory, libelous, obscene, demeaning, racially or ethnically offensive, or discriminatory

Using a BCH email address when using social networking sites for personal reasons

Initiating contact with a patient or family through social media sites

Trainees and faculty using social networking sites during work time are subject to monitoring to ensure compliance with BCH policies. Unauthorized use or excessive personal use of on-line social networking is not acceptable and will result in a full range of disciplinary actions under Hospital policy.

For more information, consult the BCH 'Use of Social Media' policy at:
http://web2.tch.harvard.edu/marcomm/mainpageS2627P63.html

Questions can also be directed to the hospital's Social Media Specialist, Lily Albin, at
lillian.albin@childrens.harvard.edu

# Coordinator's Corner – Education Committee

## Catherine Bartolomucci, Pediatric Otolaryngology

Prior to our ACGME accreditation in February 2014 (effective retroactively to July 2013), our Department had always highlighted the importance of education and considered the Fellowship Program an integral part of our service. To enhance this focus, an "Education Committee" was formulated. This committee met on a monthly basis to discuss the fellows' academic progression, areas for improvement, general feedback regarding their training and the quality and growth of our program. This working group consisted of eight full-time attending physicians including the Fellowship Program Director, Otolaryngologist-in-Chief and Residency Rotation Director. To accommodate multiple schedules, each initial meeting took place one hour before our monthly Department Faculty Meeting.

Once our program received ACGME accreditation approval, we decided to turn this committee into two separate working agencies. Each month of the academic year (aside from June), the Education Committee is now identified as the Clinical Competency Committee (CCC). Recurrent agenda topics for the CCC include each fellow's Milestones evaluation, their individual development thus far and innovative ways for them to advance in each area. For the June meeting, we invite all four of our clinical fellows to attend. We then utilize this session as our "Program Evaluation Committee" (PEC) meeting. Our PEC agenda entails evaluating the curriculum, implementing new educational activities, reviewing and revising of goals as well as our fellow and faculty assessment of the overall program. We have found that this particular discussion is crucial for our development. Therefore, our plan for this current academic year is to facilitate a PEC meeting every three months.

Our Program Director gathers all input from these meetings and incorporates these discussions in a weekly catch-up session with the fellows. These sessions occur every Monday evening after our Department's Multi-Disciplinary Airway Conference. Each Friday of the week prior, our Program Director contacts the current Chief of Service (COS), the weekly ORL physician appointed to supervise the inpatient service. The COS is asked to comment on his/her observations regarding the performance and interaction with the fellows that week. Along with the CCC and PEC feedback, our Program Director considers the weekly COS annotations to be an essential element in the fortification of our fellows didactic training.

As indicated by a broad overview, our team effort of close and constant communication is a significant contributing factor in the achievement of our annual goal for a rigorous and refining clinical fellowship.

***Residency and Fellowship Coordinators' Meetings are held the 2nd Wednesday of every month from 12 p.m.—1 p.m. in Gamble Reading Room, Hospital Library. All residency/fellowship coordinators and administrators involved in graduate medical education are encouraged to attend.***

# Welcome to the Fall Edition of the Housestaff Council for Patient Safety and Quality Improvement (HCPSQI) Newsletter!

This is the first of four intended newsletters throughout the year. Why do we care about Patient Safety and Quality Improvement (PSQI)? Because we believe that our patients should get the best care possible. At Boston Children's Hospital, the commitment to improve child health and the way we deliver healthcare permeates our institution - the best when you need it most. Our patient and family-centered QI efforts involve everyone from frontline staff to hospital leaders with the goal of narrowing the existing gaps between the care we provide and the optimal care we strive to provide. As trainees, we are surrounded by and engaged in PSQI initiatives - from our everyday IPASS use for handoffs to improve the safety of transitions of care and the utilization of the Safety Event Reporting System (SERS) to the activation of new initiatives to improve awareness and communication around the timely delivery of care in patients with sepsis or concern for stroke, whether or not we realize the thoughtful process measures behind such applications.

*Want to learn more?* We will keep you posted on the ongoing PSQI initiatives, grants and training opportunities, how to get involved and more… Cheers to quality, safety and innovation!

## By the Numbers

### NRMP

**27,293**
PGY1 positions listed in 2015

**26,678**
PGY1 positions listed in 2014

**18,447**
PGY1 applicants in 2015

**17,767**
PGY1 applicants in 2015

Volume 7 ,Issue 1 Fall 2015

**Alphabet Soup**

**AAMC**
American Association of Medical Colleges

**ACCME**
Accreditation Council for Continuing Medical Education

**ACGME**
Accreditation Council for Graduate Medical Education

**ERAS**
Electronic Residency Application Service

**NRMP**
National Residency Matching Program

# Housestaff Council for Patient Safety and Quality: Who We Are

The Boston Children's Hospital Housestaff Council for Patient Safety and Quality Improvement (HCPSQI), a subcommittee of the Graduate Medical Education Committee, was created in the fall of 2014. The mission of the HCPSQI is to ensure meaningful involvement of BCH housestaff as frontline providers in the existing patient safety and quality initiatives of the hospital. HCPSQI is an avenue by which housestaff can openly express concerns or ask questions about patient safety and quality of care, as well as present ideas for modifications to clinical workflow and system practices to senior staff members and hospital administration who can help to implement reasonable changes. HCPSQI also works to educate housestaff about the quality improvement opportunities throughout the hospital.

Senior staff across BCH have openly welcomed this effort and embraced the opportunity to work with the Council. They are eager to aid in identifying areas in need of improvement in order to eventually facilitate system-wide change. The hope is that communication of the HCPSQI initiatives to the Senior Clinical Leadership Quality Committee at Boston Children's Hospital will ensure meaningful and lasting change in the hospital.

The first application cycle of the HCPSQI was completed in October 2014 and involved review of a tremendous number of applications by the selection committee, after which 20 core members were selected. Involvement in HCPSQI entails attendance of monthly meetings to address key patient safety and quality improvement issues, to discuss strategies with leaders in the field, and to learn about available resources for housestaff QI projects.
To better serve its purpose, the Council established 3 subcommittees, the aims of which are summarized below:

**Newsletter Committee:** Responsible for issuing a quarterly Newsletter that distributes information about ongoing PSQI-related opportunities for Housestaff at BCH and the greater Boston area and highlights impactful QI initiatives already in place. Another goal of this subcommittee is to increase awareness and participation of housestaff in QI and patient safety projects throughout the BCH network.

**Database Committee:** Responsible for developing a central location/repository to find and explore ongoing QI projects throughout the BCH network.

**Education Committee:** Responsible for supporting and communicating additional PSQI educational resources and opportunities to housestaff in the BCH network.

**Interested in joining HCPSCI?** Applications for this year have already closed; watch for new applications next summer. Residents and fellows from across all hospital departments with a strong interest in patient safety and quality are strongly encouraged to apply!

# PSQI Spotlight: The Heart Center

The Heart Center at Boston Children's Hospital is an interdisciplinary group comprised of the Departments/Divisions of Cardiology, Cardiac Surgery, Cardiac Anesthesia, and Cardiovascular Nursing. A Heart Center Quality Committee sits at the executive level of the Center, is comprised of clinical and administrative leaders from across the Heart Center and sets the quality agenda for the Heart Center. Within each department/division, there is a triad structure of quality improvement consultants, physicians, and nurses who report to the departmental chief. The members of these triads also belong to the Heart Center Quality Committee. The Committee is tasked to merge the Quality Improvement and Safety Program with the clinical and academic practices of the Center. Additionally, specific goals are tailored to align with the Strategic Plan of the larger PPSQ of the hospital.

The Heart Center is quite active in quality and safety projects. According to the 2014 Quality Management Report, there were greater than 130 quality measures tracked by the Committee. There were 35 externally benchmarked measures, 22 internal benchmarks, 16 quality assurance measures, 42 other initiatives, and 17 SCAMPS (Standardized Clinical Assessment & Management Plans). In 2014, there were 51 publications, 42 presentations, 22 posters, and 5 grants related to quality improvement and patient safety.

## GME ON-CALL

Recent and notable Quality Improvement projects organized in conjunction with the Heart Center Quality Committee:

Structural and process changes were implemented to the eighth floor to maximize bed utilization. With input from a consulting MIT professor, a predictive scheduling model was designed to allow for dynamic surgical scheduling. Additionally, analysis prompted expansion of the cardiac ICU by two beds taken from the 8E step-down unit, an Admissions Group was formed to meet daily to discuss upcoming bottlenecks, and an Access Manager was hired to assist with international and out-of-state patients coming for surgical repair. This process has optimized daily census, particularly on the weekends, and dramatically reduced the number of canceled cases due to lack of ICU space.

The Cardiac RESTORE protocol is a nurse-implemented goal-directed sedation management algorithm for use after cardiac surgery in the CICU. The protocol was designed to decrease ventilator days, medication-related adverse events, and prolonged sedation weans. Since the program was implemented, ventilator days have not changed, but total length of stay was reduced by 15% and the number of children exposed to methadone and discharged from the hospital on methadone weans have fallen significantly.

The Red Zone @Home. The Red Zone Medication Safety Initiative was introduced in 2009 within the BCH ICU's and has been successful in reducing, on average, the number of reported medication errors/events by 25% among all inpatient cardiovascular and critical care areas. This initiative has been expanded into a pilot program run by the nursing staff of the Electrophysiology division, whose patients routinely use highly specialized and dose-dependent medications. Using similar principles of distraction-free time for preparing and giving medications, standardized teaching protocols, consistent labeling and syringe sizes, and coordinating medication schedules, this pilot program looks to reduce the number of home-based medication errors.

Congenital Cardiac Cath Pediatric Outcomes – Quality Improvement. C3PO-QI is a 15-institution collaboration that began in 2013. The collaborative is improving patient care practices by expanding basic benchmarks through quality improvement initiatives. These initiatives work to reduce radiation exposure and risk-adjusted adverse events, as well as track efficacy outcomes for six specific cardiac lesion types.

In the past, fellows have been involved in a variety of projects, most notably a Single Ventricle Passport program, improved data transfer between cardiology software applications, and a multidisciplinary effort with Neurology on stroke rates in cardiac patients. Fellows are required to be involved in at least one QI project prior to graduation. 0A Fellows and Nurses QI Lecture Series was put into place in 2011 to improve the awareness of department QI efforts and to encourage collaborative efforts towards QI and patient safety projects.

Have a QI project that needs a little funding to get off the ground?

The Office of Graduate Medical Education (GME) and the Program for Patient Safety and Quality (PPSQ) are pleased to invite medical students, residents, and clinical fellows to submit proposals for projects on patient safety and quality improvement. The aim of this award is to support quality improvement projects that could otherwise not move forward without financial assistance. The maximum award is $8,000, but most awards are expected to be $2,000-$5,000. The project proposal should be no longer than 3 pages and include a 1-2 page budget. The next round of applications are due on February 15th, 2016 and June 15th, 2016.

For more information and details, download the application at:
http://web2.tch.harvard.edu/gme/Documents/Trainee%20QI%20Grants%20RFP%20and%20Face%20Sheet%202015-OCT.docx

Trainees seeking funding for research on quality improvement or patient safety are encouraged to apply to the Patient Safety and Quality (PPSQ) Grants Program; PPSQ makes grants available for employees to conduct research addressing patient safety and quality, establish a best practice and then
inform the broader hospital community. There are two applications cycles ; submission deadlines are October 1 and April 1 each year.

Please refer to the PPSQ website for information at: http://web2.tch.harvard.edu/ppsq/mainpageS2718P3.html