**ORIGNAL ARTICLES**

**Performance Improvement**

697 Implementation of Choosing Wisely: Promise and Pitfalls

R. Sacha Bhatia; E.A. Kerr

A large-scale Choosing Wisely initiative was implemented across 25 medical clinics. During a three-year period, a multifaceted change management intervention targeted at decreasing unnecessary routine screening tests, age-inappropriate bone density scans, and imaging for uncomplicated headache demonstrated impressive reductions in unnecessary testing. The success was sustained even after the monthly feedback reports stopped. This study's promising results demonstrate that tackling the problem of unnecessary care is possible, but further studies are needed to address methodological limitations and to assess the generalizability of the results.

699 Choosing Wisely in Georgia: A Quality Improvement Initiative in 25 Adult Ambulatory Medicine Offices

S. Pugel; J.L. Stallworth; L.B. Pugh; C. Terrell; Z. Bailey; T. Gramling; H. Ward

A Choosing Wisely campaign was implemented across 25 Kaiser Permanente Georgia medical offices to reduce the use of complete blood counts (CBCs) and electrocardiograms (EKGs) as routine screening tests in physical examination visits, age-inappropriate dual-energy x-ray absorptiometry (DEXA) scans, and imaging for uncomplicated headache. The change management package consisted of guideline selection by clinical leaders, continuing medical education for clinicians, training and education for clinic staff and advice nurses, an internal and external communication plan, and monthly reports. Substantial, statistically significant decreases were seen in nonbeneficial use of all these tests, and improvements were mostly sustained after monthly reports ended.

**Adverse Events**

708 Preventable Anesthesia-Related Adverse Events at a Large Tertiary Care Center: A Nine-Year Retrospective Analysis

C.J. Curatolo; P.J. McCormick; J.B. Hyman; Y. Beilin

Despite improvements, anesthesia-related adverse events continue to occur. A study was conducted to characterize anesthesia-related adverse events within a single large tertiary care institution and to distinguish preventable adverse events from those that are not preventable. In 747 included cases, respiratory complications (n = 245) were the most frequently reported adverse event type. The most common respiratory events included unplanned reintubations, aspirations, and respiratory arrests. A large proportion of the adverse events (42.8%) may have been preventable, particularly respiratory, trauma, and medication adverse events.

**Teamwork and Communication**

719 Developing Standardized “Receiver-Driven” Handoffs Between Referring Providers and the Emergency Department: Results of a Multidisciplinary Needs Assessment

K. Huth; A.M. Stack; G. Chi; R. Shields; M. Jorina; D.C. West; C.P. Landrigan; N.D. Spector; A.J. Starmer

Little is known about best practices for handoffs from referring providers to the emergency department (ED). At a tertiary care children’s hospital with a communication center that receives verbal handoff via telephone from referring providers and provides written summaries to the ED, this study surveyed primary care providers, ED, and communication center staff to understand perceptions of handoff processes and ideal handoff elements. A minority of providers perceived handoff quality between outpatient practices and the ED as “very good” or “excellent”; almost half perceived regular miscommunication. This study identified 10 key elements that should be included in structured outpatient-ED handoffs.

**Information Technology**

731 Using Health IT to Coordinate Care and Improve Quality in Safety-Net Clinics

A.M. Kranz; S. Dalton; C. Damberg; J.W. Timbie

A study was conducted to examine factors associated with the use of health information technology (HIT) capabilities to improve care coordination and quality of care in health centers in the United States. Cross-sectional secondary data from the 2015 Health Resources and Services Administration’s Uniform Data System was used to examine 6 measures of HIT capability related to care coordination and clinical decision support and 16 measures of quality. Many health centers reported using HIT for care coordination activities, and health center size and medical home recognition were associated with significantly greater odds of using HIT for enabling services and engaging patients. These capabilities were associated with higher overall quality and higher rates of 6 process measures and HbA1c control. There may be opportunities to further improve quality of care for vulnerable patients by promoting health centers’ use of these HIT capabilities.
Adaptation and Implementation of a Transitional Care Protocol for Patients Undergoing Complex Abdominal Surgery

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A transitional care protocol was developed to meet the needs of patients discharged to home after major abdominal surgery using an adaptation of the Coordinated-Transitional Care (C-TraC) protocol. The protocol addressed nutrition, fever, ostomy output, dehydration, drain character/output, and wound appearance. Starting in June 2016, a random sample of five patients each month was selected to complete a phone survey. Survey responders reported 100% overall satisfaction with the transitional care program. The adaptable nature of the protocol may allow for low-resource hospitals to use the methodology provided in this study to implement local phone-based transitional care protocols.

An Initiative to Reduce Routine Viral Diagnostic Testing in Pediatric Patients Admitted with Bronchiolitis

B.L. Emerson; C. Tenore; M. Grossman

Current guidelines suggest that routine use of viral diagnostic testing (VDT) for bronchiolitis in pediatric patients is not advisable. A quality improvement project was conducted to reduce the use of routine VDT for patients admitted to a children’s hospital from the pediatric emergency department. Key drivers were identified, and interventions, which included staff education about the cost and use of VDT and dissemination of a simplified cohorting policy aimed to eliminate VDT without medical necessity, were implemented. Between January 2017 and April 2017, VDT use in all non-ICU patients admitted from the PED with bronchiolitis decreased from 63% to 12%. In the same period, patients with VDT sent from the PED fell from 53% to 14%. Further directions for this project include the reduction of routine testing for patients with bronchiolitis who are admitted to the ICU or discharged for outpatient care.