OSHE for a 91% participation rate. Faculty champions hosted a didactic session on transitions of care, secured resident availability, scored the written handoff, and provided resident feedback. Senior residents scored the verbal handoff and gave feedback.

Results: Survey results indicated resident confidence in picking up a new service significantly increased (t=2.12, [63], $P<0.05$.), along with improved ability to make contingency plans (t=2.00, [63], $P<0.06$), to perform a read-back (t=2.08, [63], $P<0.05$), and to know when to perform a read-back (t=2.78, [63], $P<0.01$). Written template scores varied by program.

Conclusions: Institutional educational interventions accomplish several objectives simultaneously. Such interventions are a demonstration of GME engagement and permit policy monitoring that does not detract from the educational focus. The OSHE is a simple but effective tool for sampling how faculty and residents deliver handoffs and provides an ongoing opportunity to refine handoff education.

FINAL WORK PLAN – Wayne State University and Crittenton Hospital Medical Center

Team Charter/Objectives	The goal of this project was to standardize resident-to-resident handoffs across all aspects of patient transfer within the hospital, services, outpatient, and discharge.
Project Description	We identified that follow-up appointments are critical in reducing readmission for COPD and CHF, and these served as the topics for the template. We used the OSHE to evaluate resident-to-resident handoffs and make recommendations. We analyzed qualitative data to identify transition-of-care gaps for each aspect of care and to evaluate the fit/utility of the template.
Vision Statement	We were able to demonstrate that institutionwide transition-of-care educational interventions were possible and sustainable while accounting for specialty variability.
Success Factors	Faculty engagement from all programs through an institutional task force that provided a platform for OSHE implementation was a key to success. The OSHE has become an annual monitoring tool for program compliance with the institutional transition-of-care policy.
Barriers	Senior residents reported difficulty in giving feedback to a fellow resident. As a result, feedback expectations were added to the didactic component.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Collaborate with the simulation center early to establish a standardized procedure. Link OSHE performance to direct observation of handoffs. Track and compare resident performance over time. Shape cases over time to accommodate changing program needs.

Florida Hospital, Orlando, FL

Advancing Patient Safety Education Through a Systematic Mortality Learning Program

Victor Herrera, MD; Joseph Portoghese, MD

Background: A need to improve the teaching of patient safety in GME exists. Traditional formats such as lectures have not been effective in engaging residents in a patient safety culture. Case-based and experiential learning have demonstrated the capacity to advance skills and change behaviors.

Methods: We developed a structured curriculum employing case-based exercises and interactive delivery of content using the Florida Hospital Mortality Review Program as a framework. Residents assigned to plan a mortality and morbidity presentation participated in 2 phases of training under faculty supervision, with emphasis on patient safety education and learning of the IHI Global Trigger Tool for Measuring Adverse Events methodology as it relates to mortality reviews.

Results: A structured, evidence-based methodology based on the hospital mortality review program provided an effective framework to teach patient safety. Resident engagement was facilitated by using real morbidity and mortality cases.

Conclusions: Mortality review programs offer an opportunity to train residents on principles of patient safety and high reliability. A clinical triggers methodology that measures and tracks adverse events provides a framework to deliver the content using a case-based and interactive format.

FINAL WORK PLAN – Florida Hospital

Team Charter/Objectives	In a collaboration between the GME and the Performance Improvement departments, the main focus of our project was to develop an effective patient safety curriculum for faculty and residents using a comprehensive mortality learning program for the hospital as a framework.
Project Description	The curriculum was divided into 4 phases: (1) 3 modules on the study of medical errors, the science of human error, and principles of high reliability; (2) review of training charts using a clinical triggers methodology; (3) review of the real case using the tools and format of the Florida Hospital Mortality Review Program; and (4) a mortality and morbidity presentation to the resident group.
Vision Statement	Residents at Florida Hospital will acquire the skills, knowledge, and attitudes necessary to become leaders in the development and implementation of initiatives that mitigate patient harm and advance a culture of high reliability in healthcare.
Success Factors	The most successful component of our work was engaging faculty and residents in a patient safety curriculum. We were inspired by institutional commitment to advancing a culture of patient safety and high reliability.
Barriers	The largest barrier we encountered was a lack of familiarity with the implications of patient safety for the medical profession. We worked to overcome this lack of knowledge by discussing the implications of patient safety for not only the patient but also for the healthcare system and for the individual doctor's practice.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Institutional support and getting buy-in from residents and faculty are critically important.

Regions Hospital[1]/HealthPartners Institute for Education and Research,[2] St. Paul, MN

"Good Catch" Safety Event Reporting

Josh Peltier, MD;[1] Julie Cole, MPP;[2] Kelly Frisch, MD;[2] Felix Ankel, MD[1,2]

Background: One of the 6 focus areas of the CLER program is patient safety, specifically patient error reporting. Teaching institutions need to ensure that residents have the opportunity to report errors, unsafe conditions, and near misses and then participate in safety event analysis, action plan development, and follow-up. Unfortunately, early reports from ACGME CLER visits have shown that many institutions fail to engage residents in this process. At the same time, residents may not be aware of why or how to report patient care errors. Even if they are aware, they may be hesitant to report errors for fear of retribution or because of time constraints.

Methods: We created a multidisciplinary work group involving key Regions Hospital leaders in nursing, quality improvement, patient safety, finance, informatics, GME, and residency programs. We integrated an event reporting system into our EMR. We presurveyed residents to obtain baseline levels of awareness, ease, and comfort with safety event