

NATIONAL ACTION ALLIANCE
for Patient and Workforce Safety

Understanding and Operationalizing the National Action Alliance Aim #1: Advance Organizational Safety Strategies Using National Action Plan Foundations

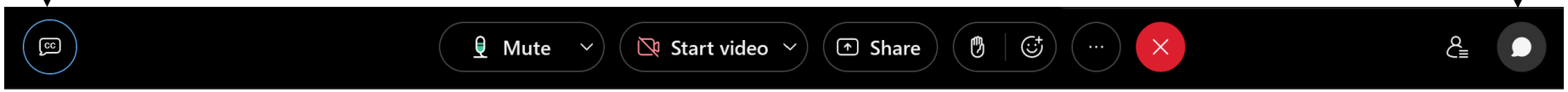
NATIONAL WEBINAR SERIES

May 21, 2024

Housekeeping Instructions

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

- This webinar will be recorded and available for viewing on the NAA website
- Please use the ‘Chat’ function to engage with us throughout to webinar and to ask any questions.
- Closed Captioning (CC) is available.



Questions to Run On

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How can the self-assessment tool help organizations identify and prioritize areas to work on?

How are patient and family representatives best included in the self-assessment process?

***Please submit your response in the chat**

Audience Engagement #1

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How have you assessed safety in your organization?

*Please submit your response in the chat

Overview of IHI's National Action Plan: Self-Assessment Tool to Improve Patient & Workforce Safety

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Patricia McGaffigan
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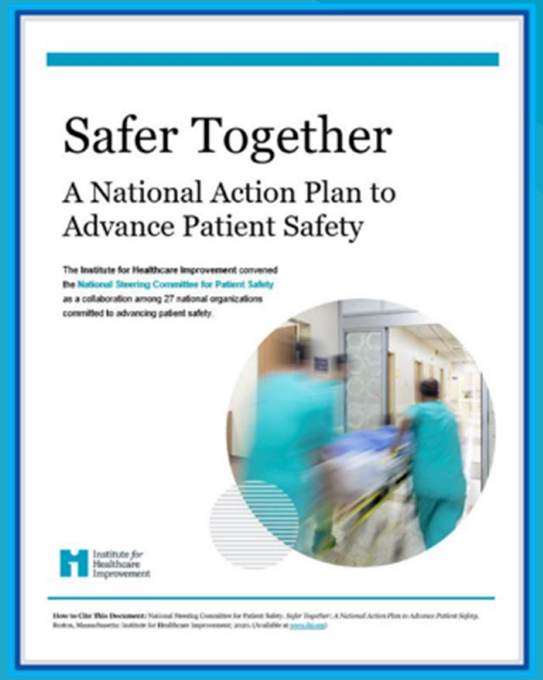
Institute for Healthcare Improvement



The National Action Plan to Advance Patient Safety

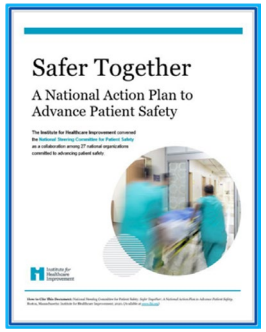
Patricia McGaffigan, MS, RN, CPPS
Vice President Safety, IHI; President, Certification Board for Professionals in Patient Safety
Co-chair, National Steering Committee for Patient Safety
May 21, 2024

Safer Together: National Action Plan to Advance Patient Safety

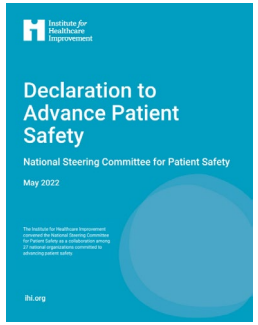
2018 IHI Convenes National Steering Committee for Patient Safety

27 Member Organizations; 4 Subcommittees

Sept 2020 *Safer Together* Released



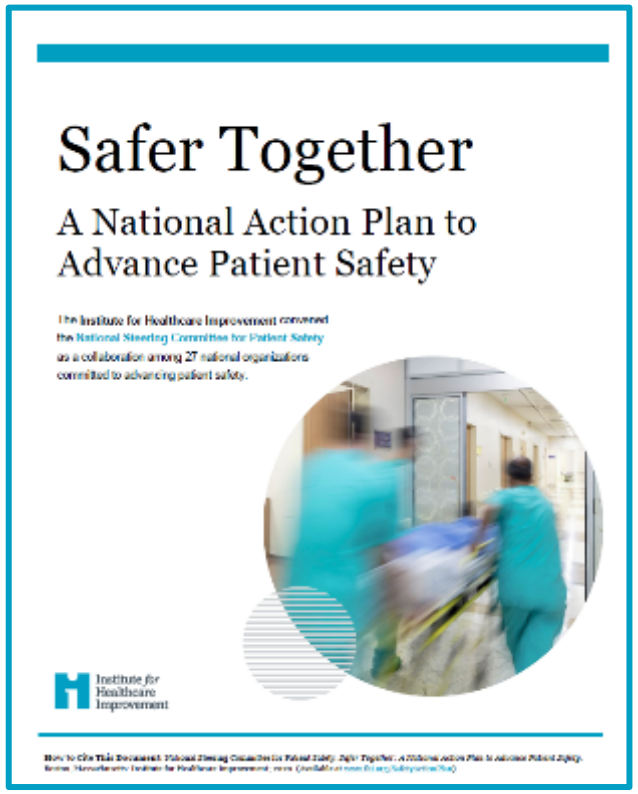
May 2021 Declaration To Advance Safety



2022 Implementation Work Group

2023 HHS National Action Alliance to Advance Patient Safety

Safer Together National Action Plan



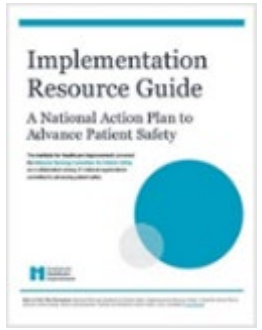
www.ihi.org/SafetyActionPlan

1. Person-Centered Care
2. Care Across the Entire Continuum
3. The Relationship Between Patient Safety & Health Equity

Safer Together in Action

1. REVIEW the 17 recommendations and tactics to advance patient safety in *Safer Together: A National Action Plan for Patient Safety*.

2. IDENTIFY a senior sponsor and core team charged with deploying the *Self-Assessment Tool* to ASSESS your current state in each of the 4 foundational areas.



3. ESTABLISH and ENACT strategies, tactics, and measurement and improvement plans by leveraging the *Implementation Resource Guide*.

www.ihi.org/SafetyActionPlan

Culture, Leadership and Governance

Ensure

- Safety is a demonstrated core value

Assess and commit

- Resources to advance safety

Widely share

- Information about safety to promote transparency

Implement

- Competency-based governance and leadership

Patient and Family Engagement

Establish

- Competencies for all health care professionals-engagement of Pt/F/Care Partner

Engage

- Patients, families, and care partners in the co-production of care

Include

- Pt/F/Care Partners in leadership, governance, and safety and improvement efforts

Ensure

- Equitable engagement for all patients, families, and care partners

Promote

- A culture of trust and respect for patients, families, and care partners

Workforce Safety and Wellbeing

Implement

- A systems approach to safety

Assume

- Accountability for physical and psychological safety and a healthy work environment that fosters the joy of the health care workforce

Develop, resource, execute

- Priority programs that equitably foster workforce safety

Learning System

Facilitate

- Both intra- and inter-organizational learning

Accelerate

- Development of the best possible safety learning networks

Initiate and develop

- Systems to facilitate interprofessional education and training on safety

Develop

- Shared goals for safety across the continuum of care

Expedite

- Industry-wide coordination, collaboration, and cooperation on safety

Average Score by Foundational Area*

	CLG		PFE		WFS		LS	
Just Beginning		7-11		7-11		7-11		6-10
Making Progress	**15.66**	12-17	**13.67**	12-17	**17.28**	12-17	**14.99**	11-15
Significant Impact		18-23		18-23		18-23		16-20
Exemplary Performance		24-28		24-28		24-28		21-24

*N=160 Online Assessments, deidentified (11/2023)

High/low average scores by Foundational Area

Foundational Area	Highest Scoring Element	Lowest Scoring Element
Culture, Leadership, Governance	Harm Events	Annual Reviews for Senior Leaders
Patient & Family Engagement	Communication & resolution of adverse events	PFACs
Workforce Safety	Safety reporting systems	Job Descriptions
Learning System	Safety goals	Engaging patients

*N=160 Online Assessments, deidentified

Proposed CMS Patient Safety Structural Measure (PSSM)

PSSM Domain	NAP Domain	Key PSSM Specifications
Domain 1: Leadership Commitment to Eliminating Preventable Harm	• Culture, Leadership, Governance	• C-suite oversees **safety self-assessment** and resulting plan and metrics
Domain 2: Strategic Planning	• Culture, Leadership, Governance • Workforce Safety & Wellbeing • Learning System	• Strategic plan publicly shares hospital commitment to **"zero preventable harm"** • Safety goals include use of **metrics to identify and address disparities in safety** • Hospital requires **implementation of a patient safety curriculum and competencies for all staff** • Hospital has **action plan for workforce safety**
Domain 3: Culture of Safety & Learning Health System	• Culture, Leadership, Governance • Learning System	• Hospital conducts **hospital-wide culture of safety survey** • Hospital implements: **Team communication training**, Use of **human factors engineering principles in design of devices** • Hospital **participates in large-scale learning network(s) for patient safety**
Domain 4: Accountability & Transparency	• Culture, Leadership, Governance • Patient & Family Engagement • Workforce Safety & Wellbeing • Learning System	• Hospital **reports safety events to AHRQ-listed PSO voluntarily reporting to AHRQ's Network of Patient Safety Databases** • Hospital has a **communication and resolution program**, such as AHRQ's CANDOR toolkit
Domain 5: Patient & Family Engagement	• Patient & Family Engagement	• Hospital has Patient and Family Advisory Council (PFAC) that provides input on safety-related activities • Hospital's PFAC includes patients and caregivers representative of the patient population • Patients have comprehensive access to their own medical records via patient portals • Hospital incorporates patient/caregiver input about patient safety events

Ascension: Utilization and Impact of the Self-Assessment Tool

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Kelly Randall
Vice President, Patient Safety and Compliance,
Clinical Operations, Ascension
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Ascension National Action Plan Journey

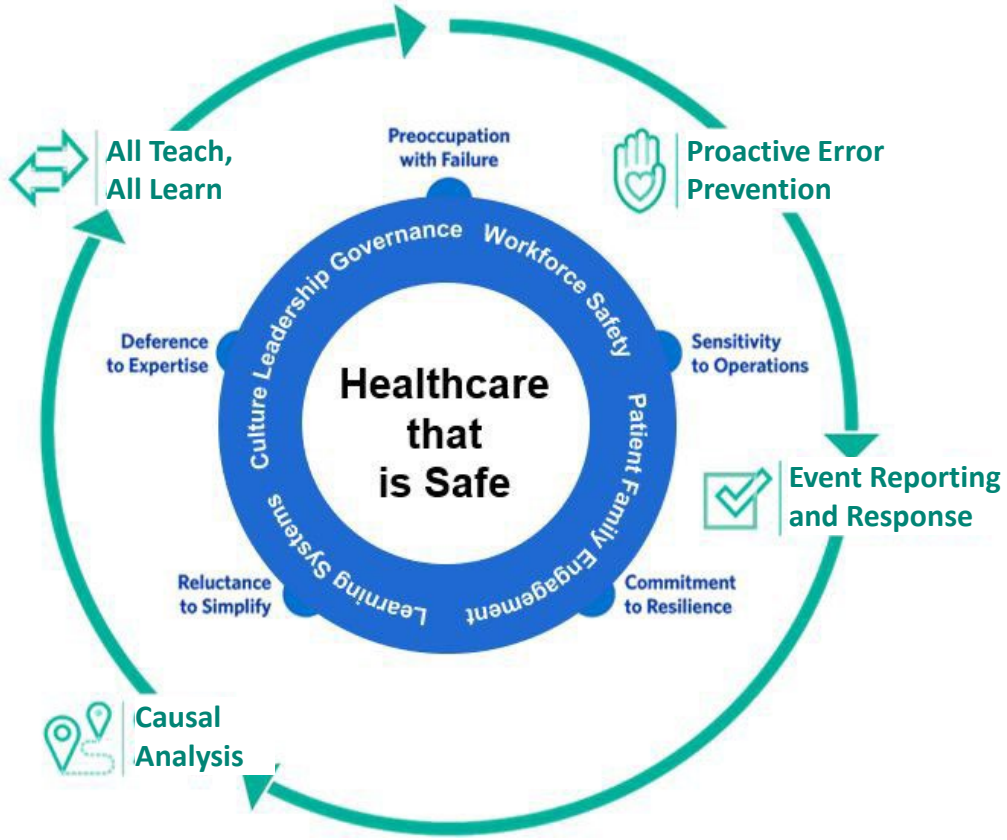
Ascension

Listening to you, caring for you.®

Amplification of the Journey to “Heal without Harm”

- Complacency with safety program – struggling with reconnecting on safety culture at the front lines
- Massive disruption in the care environment
- Focused on Reactive Safety and Amplifying High Reliability Practices
- Needed to evaluate Structure – Insert NAP –a framework with tactical operational recommendations for improvement
- Assessment with each Ministry market – establish baseline

Align and Integrate



- This is **NOT** another initiative
- Additional goals and priorities can be overwhelming in the current environment
- Using this to transform who we are and how we work

Aligning our Strategies

Healing without Harm: Zero Preventable Harm

HIGH RELIABILITY ORGANIZATION

- Preoccupation with failure
- Deference to expertise
- Sensitivity to operations
- Reluctance to simplify
- Commitment to resilience

- Culture leadership and governance
- Learning systems
- Patient family engagement
- Workforce safety

- Escalation of events to leadership
- Leadership safety rounds
- Great catch recognition and storytelling in meetings
- Safety Coach Program
- Safety behavior training and application
- Safe tables
- PFAC committees
- Safety huddles
- Causal analysis
- Just Culture algorithm

Initiation of the Assessment

- Self Assessment Conducted as Group discussion – Ground rules were important to establish focus on learning
- Established consensus – Facilitation was key to maintaining psychological safety
- Pay attention to the variation and **take time to understand** the perceptions that contribute

Ascension Overall Aggregated Scores – Baseline	
Culture, Leadership Governance	Making Progress
Patient Family Engagement	Making Progress
Workforce Safety	Making Progress
Learning Systems	Making Progress

Prioritize

Strengths	Weaknesses	Opportunities	Threats
Incident Reporting / Improvement in Culture	Safety 2 - Proactive / Preventative	Patient Safety Standard Work	Workforce Stability
SERT / RCA Guidelines	Individual vs. System Focus	Just Culture - consistent understanding and application	Financial Stability
PSO All Teach, All Learn	Lack voice of the patient/family in safety processes	Expand the shared mental model for patient safety	Patient Safety Resources
			Regulatory Pressures
			Challenges to the PSO protections

Culture Leadership and Governance

- Intentional Communication and Messaging
- Board Education
- Senior Leader Accountability for Safety Goals
- AIM Calls, Leadership Safety Rounds

Workforce Safety

Opportunities and Focus:

- **Safety Strategy**
  - Organizing Operations to Support Associate Safety
- **Priority Safety Programs - Aligning with STEEEP***
  - Non-Healthcare Targets
  - Ascension Associate Safety Top 5 Committee
  - Action Oriented Committee - Micro, Meso, Macro
- **Safety Events**
  - Aligned with Patient Safety Event Response
  - Trained Associate Health in Causal Analysis
  - Integration with Safety Causal Analysis database to facilitate Common Cause Analysis
  - All Teach All Learn inclusion

NAP Assessment	2022	2024 Projection
Workforce Safety	Just Beginning	Exemplary Performance

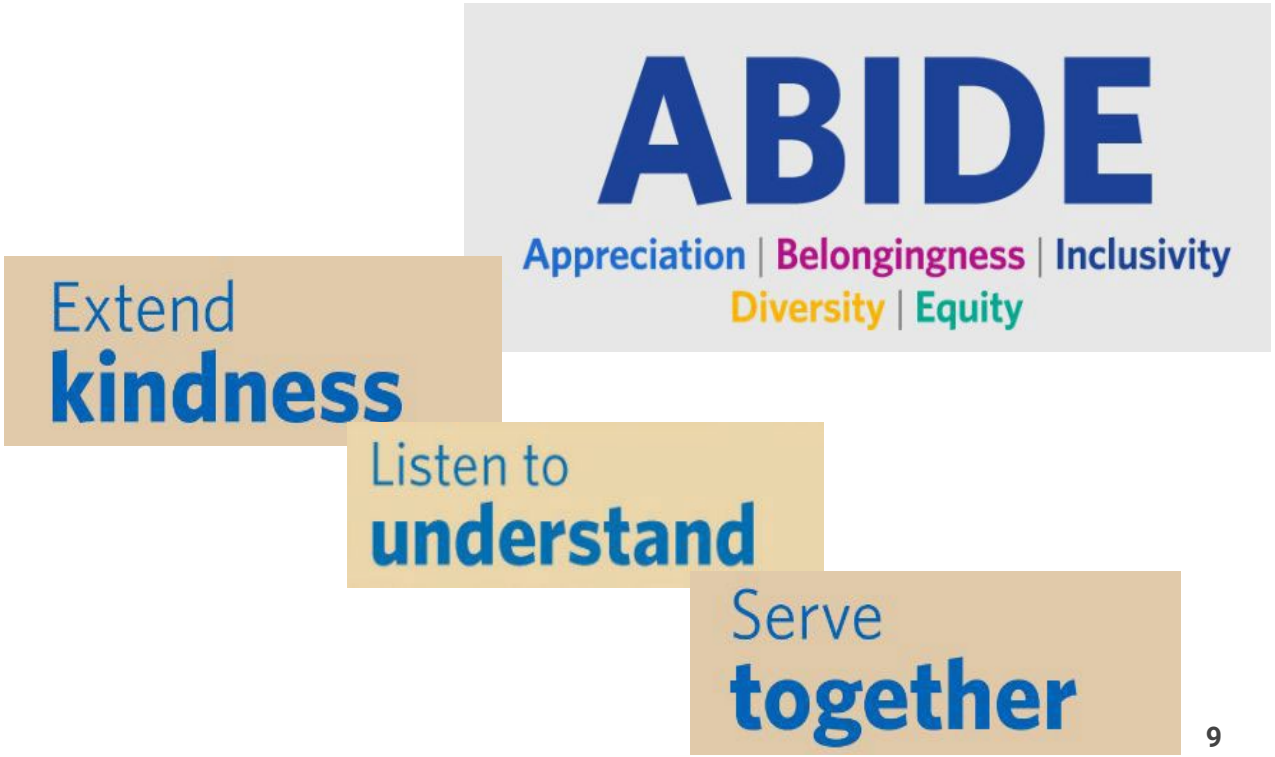
Patient and Family Engagement

Opportunities and Focus:

Ascension Service Commitments

- **Patient Family Advisory Councils**
  - Patient and Family Digital Panels
- **Equity**
  - Focus on the Community – 600 CHNA
  - Equity Reports by Market by Zip Code
  - Stratification of Quality and Safety data and Equity related goals
- **Patient Portals**
  - Ascension ONE
- **Communication and Resolution Programs**
  CORE – Communicate Openly Resolve Early

NAP Assessment	2022	2024 Projection
Patient and Family Engagement	Just Beginning	Significant Impact



*Specific, Timely, Effective, Efficient, Equitable, Patient-centered

Learning System

Leverage Use of the Ascension PSO

- Safe Tables
- Standardized Communications - including All Teach All Learn Safety Stories
- Everyday Hero Program
- High Reliability Spotlight Series
- Annual Virtual Patient Safety Summit
- External engagements

Focus leads to Results

- Intentional Communication all the way to the front line
- Amplification of High Reliability and Safety
    - “We’ve Got Your Back”
- Focus on Structure and Accountability

Improvement in 5 Areas of Safety Culture in 2022

Voluntary reporting of near misses and no-harm events has rebounded

Decrease in Serious Safety

Events 13% decrease in mortality

20% reduction in HAIs

20% Increase in Medicare Annual Wellness Visits overall with a 16.5% increase in the Black/African American Population

Milestones of the Journey

- Walk – don't run
- Anticipate the bumps – change management
- If we are going to transform – we can't forget about
- Structure, Process, Outcome, ACCOUNTABILITY AND SUSTAINABILITY

Goal	
In FY24, Increase by a minimum Of 1 point in Each Foundational Area	•High Reliability Practice Amplification - inclusive of recommendations in the NAP •Identifying and responding to current structure for patient safety in each market •Escalation pathways for Serious Safety Events •Segmentation of patient safety data to identify inequities •Increasing All Teach, All Learn Activities facilitated by the AHPSO •Increased participation in External Learning Networks

Anticipated Results
Culture Leadership and Governance
Pt and Family Engagement
Workforce Safety
Learning Systems

UnitedHealth: Utilization and Impact of the Self-Assessment Tool

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Melinda Sawyer
Vice President and Chief Quality and Patient Safety Officer
UnitedHealth Group

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Safety Together National Action Plan: Driving System Level Transformation

Melinda Sawyer, DrPH, CNS-BC, RN, FAAN
Chief Quality and Patient Safety Officer
UnitedHealth Group

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UHG Journey Toward High Reliability

Goal: Eliminate harm and achieve optimal clinical quality

Governance Leadership & Accountability

Focused oversight for quality and patient safety across all levels of the organization.

Learning Systems

Anticipate and mitigate risks before they occur.

Capacity & Infrastructure

Develop and support an engaged, accountable, and continuously improving workforce.

Teamwork & Communication

Foster open dialogue among leaders, staff, patients, members and families.

Innovation & Insights

Embrace new techniques to eliminate harm and achieve optimal clinical quality

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Safer Together National Action Plan (NAP)

- NAP created by the National Steering Committee for Patient Safety included:
  - 27 national organizations
  - 5 federal agencies
  - Several patient advocacy groups
- UHG Plan:
  - Assess our current state
  - Leverage our best practices
  - Prioritize areas of focus with evidenced-based recommended action to improve
  - Measure and monitor improvement
  - Repeat every 24 months

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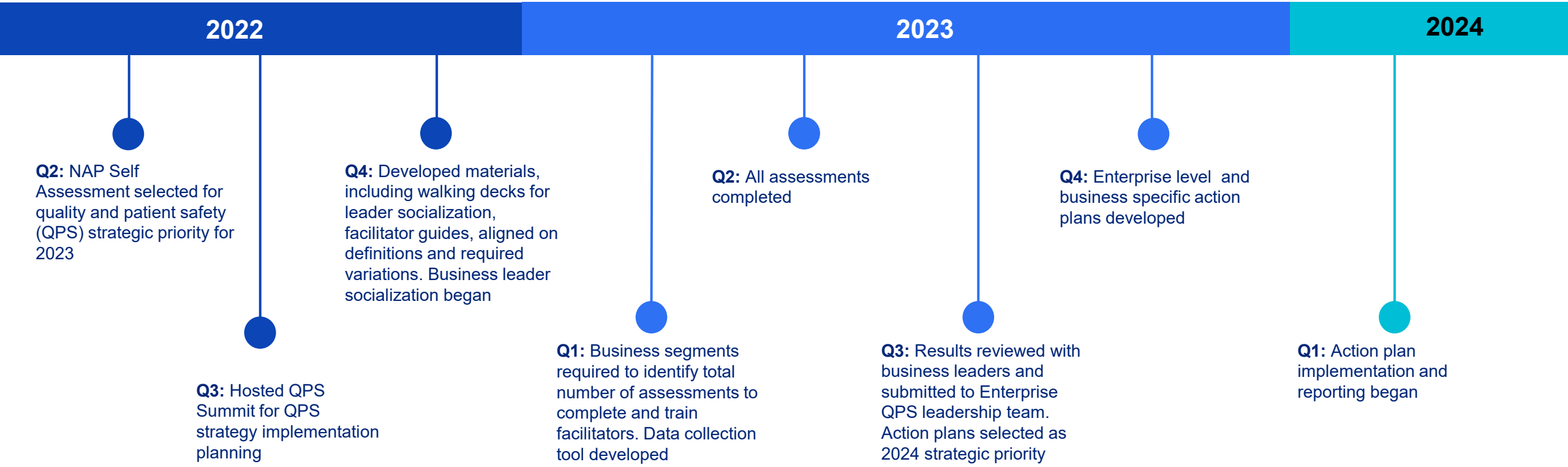
NAP Self Assessment: Planning, Implementation and Intervention Timeline



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NAP Assessments Completed

Each business needed to identify how many assessments to complete:

- Determined by how much variability vs consistency existed within each business on the 4 domains
- Wanted to detect where there were differences in scores within each business without being redundant

	Assessments Completed	Businesses represented
Optum	64	Optum RX – 18, Optum Health – 42, Optum Insights - 4
UHC	57	US – 3, Global - 54
UHG Total	121	

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NAP Results: Enterprise Priority Areas of Focus

Domain	Item
Culture, Leadership and Governance	Safety culture survey
Culture, Leadership and Governance and Learning Systems	Safety goals
Culture, Leadership and Governance and Workforce Safety	Job descriptions
Workforce Safety	Safety strategy
Workforce Safety	Occupational safety
Learning Systems	Education and Competencies

Safety Culture Survey

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Safety Culture Surveys	No or some units/departments conduct patient safety culture surveys.	An *organization-wide* patient safety culture survey occurs *at least every 2 years using a validated survey tool*.	An organization-wide patient safety culture survey occurs at least every 2 years using a validated survey tool. *Survey data is tracked and trended with the ability to drill down to the unit/department level. Action plans are put in place on an inconsistent basis.*	An organization-wide patient safety culture survey occurs at least every 2 years using a validated survey tool. Survey data is tracked and trended with the ability to drill down to the unit/department level. *Action plans are put in place as a result of the data and progress is monitored and evaluated for improvement. Data and actions are shared at all organization levels.*	

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Safety Culture Survey

Measurement

- First enterprise-wide safety culture survey completed in Oct 2023.
- 5 surveys used:
    - AHRQ SOPS surveys where applicable
    - Input provided by AHRQ, Westat, internal organizational psychologists on measuring outside of currently available SOPS survey types (ex. Home and community, mail order pharmacy, pharmacy benefits manager, payers)
- 61% response rate, 409,000 employees surveyed
- Plan for every 2-year measurement

Analysis, Debriefing, Action Planning

- Analysis:
    - Data tracked and trended with drill down at every level of organization down to individual teams
    - Domains and items trend analysis
    - Race/ethnicity, gender – to complete LGBTQ+ analysis next
    - Qualitative - latest AI and NLP techniques for topic modeling, sentiment analysis and risk review for over 65,000 comments
    - Identification of hot spots, warm spots and bright spots for quantitative and qualitative results
- Debriefing and Action Planning:
    - Debriefing and Action planning tool developed. Action planning built into survey platform allowing for action plans to be viewed by all managers ***and*** AHRQ evidenced-based recommendations pre-populated for ease.
    - Business level action plans submitted with updates q6 months

Safety Goals

Culture, Leadership and Governance

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Safety Goals	Safety goals are developed. Some goals are accompanied by an action plan and associated metrics.	Safety *goals are clearly articulated in strategic and operational plans*. *Each goal* is accompanied by an action plan and associated metrics.	Safety goals are clearly articulated in strategic and operational plans *for all care settings*. Each goal is accompanied by an action plan and associated metrics.	Safety goals are clearly articulated in strategic and operational plans for all settings of care. Each goal *has a dedicated senior sponsor* and is accompanied by an action plan and associated metrics.	

Learning Systems

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Safety Goals	The organization's goals are vague and do not specify patient safety.	The organization's goals *include specific patient safety goals*, but targets are not bold. There is no formal process to collect best practices, but rather a reliance on staff willingness to report back from meetings and other outside sources.	The organization has *specific patient safety goals, shares learning, and incorporates evolving evidence-based best practices* with the aim of eliminating specific types of harm and improving safety.	The organization *adopts bold national goals*, shares learning, and incorporates evolving evidence-based best practices with the aim of eliminating specific types of harm and improving safety	

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Quality and Safety Goals

October 2023

- Launched quality belief and new, aligned definition of quality and safety
- Incorporation of quality into our values
- Stop the clock week to connect

December 2023

- Launched revised clinical quality and patient safety dashboard to drive toward high reliability.
    - Includes completion of NAP self-assessment
- Issued bold, specific, target setting guidance for all dashboard measures

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Quality and Safety Goals

January 2024

- Quality and safety goal requirement for all business areas with measurement by objectives (MBOs) to measure progress
- Launched quality and safety goal in annual performance review for all employees

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OUR SHARED QUALITY BELIEF

Quality connects us.

Quality means we strive for excellence in everything we do.

Every service delivered. Every home visited. Every pill dispensed. Every document created, product developed and phone call answered. Every moment – and decision – is an opportunity to put Quality first.

Quality is...
Caring about people *and* performance.
Making connections *and* building trust.
Taking individual ownership *and* building trust.
Getting it right the first time *and* continuing to improve.

Because when we focus on our Mission and live our Values, we consistently deliver Quality – to each other and every person we serve.

When we follow our Mission and live our Values, we deliver Quality

Quality is reflected in all the ways we work, and infused across our Values

Our Mission is our *why.*

Helping people live healthier lives and helping make the health system work better for everyone.

Our Values unite us around *how* we deliver Quality.

Integrity

We do the right thing and follow through on our shared commitment to quality.

Compassion

We listen, advocate and act with urgency for those we serve and our colleagues.

Inclusion

We welcome, value, and hear all voices and diverse points of view.

Relationships

We work together to deepen connections and collaboration for better outcomes.

Innovation

We invent a better future by learning from the past.

Performance

We strive for high quality results in everything we do.

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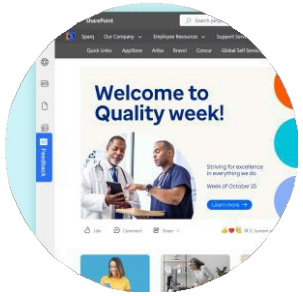
Stop the Clock: UHG Quality Week during National Healthcare Quality Week



Monday 10/16

Knowledge

- Digital & physical takeover
- Leaders deployed to key sites
- Fireside Chat
- People Leaders activate toolkit
- Passport, Bravo, Social

Tuesday 10/17

Discussion

- Listening Sessions with Leaders
- UHC & Optum Town Halls
- Photo sharing opens: #QualityConnectsUs
- LinkedIn Learning
- Manager Development Conference

Wednesday 10/18

Discussion

- Leader Listening Sessions & discussions
- Team meetings & commitments
- Manager Development Conference

Thursday 10/19

Thank You

- “Thank You Thursday”
- Teams & leaders recognize Quality
- Immersive story sharing
- Leader social posts
- All employees recognize & thank each other

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Education and Competencies

Learning Systems

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE
Education and Competencies	There is no clearly defined strategy for patient safety competencies or education within the organization.	*Select staff members* in select departments receive basic patient safety education as a part of their role within the organization.	The organization's *documented human resources strategy includes a defined patient safety curriculum and competencies for clinical roles* and evaluations to assess these competencies. *Action plans for continuing education are limited to leaders and clinicians*.	The organization's documented human resources strategy includes a defined patient safety curriculum and competencies for *all* roles, regular evaluations to assess these competencies, and action plans for continuing education of *all leaders, clinicians, and staff*.	

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Quality Academy

April 2024

- Quality Academy launched
- 1st course – Quality in Action –101 level course for ***all*** current employees and new hires

Late 2024

- Launch core problem solving courses for all employees – 201 level
- Launch 201 level courses for clinically facing employees

NAP Self-Assessment Lessons Learned

Phase	Strengths	Improvements for the future
Planning & Pre-work	• Planning, planning, planning • Facilitator guide for alignment of language and necessary variation. • Dry runs with facilitators • Walking decks to support communication	• Host a facilitator kick off, encourage best practice sharing among facilitators • Additional facilitator training and oversight to ensure interrater reliability
Implementation	• Developed standard data collection tool. • Key definitions from facilitator guide imbedded in data collection tool. • Implementation timeline of March – June was right given size of organization	• More work to align language and consistency in non-care delivery settings. • Improve data collection tool to save and return – took 1-2 meetings to complete tool.
Reporting & Analysis	• Used the IHI reporting tool with imbedded action plan recommendation for individual reports. Great design for each assessment. • We created rollup reports for larger businesses to summarize their results.	• Summarizing enterprise score. Businesses were so different in size it made it impossible to roll up scores. Better guidance on rolling up scores, if at all.
Action Planning & Implementation	• Both enterprise and business specific action plans were critical. • Incorporated into strategic planning process • Tracking of action plan completion is done quarterly as part of quarterly QPS data reporting cycle.	• We will see --- May 2024: Started planning for reassessment in 2025

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Summary

- The Safer Together National Action Plan (NAP) is a critical tool for our organization to:
  - Assess our current state
  - Leverage best practices
  - Prioritize areas of focus with evidenced-based recommended action to improve
  - Measure and monitor improvement
- It was successfully used across all areas of our organization to drive our quality and safety strategy – including hospitals, ambulatory clinics, behavioral health, urgent care, pharmacies, pharmacy benefits, and payer.

Audience Engagement #2

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Based on what you heard today,

what will be the one action that you take in the next week?

***Please submit your response in the chat**

Upcoming Event of Interest

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Webcast: Using AHRQ's SOPS® Hospital Survey and Workplace Safety Item Set: Experiences from a State Hospital Association

May 23, 2024 (3:30-4:30 p.m. ET)

Registration and event details can be found on AHRQ website

This webcast will highlight how the Indiana Hospital Association (IHA) used AHRQ's Surveys on Patient Safety Culture® (SOPS®) Hospital Survey and Workplace Safety Supplemental Item Set to assess patient safety culture and workplace safety in 41 Indiana hospitals. Speakers will discuss their member organizations' survey results, how SOPS resources were used, and their focus on initiatives to address workplace safety, including burnout. The webcast will also showcase recent research about the relationship between hospital workplace safety culture and patient safety culture, job satisfaction, and intent to leave.

Thank You!

Announcing the Next NAA Monthly National Webinar

Empowering Patient Voice in Safety Strategies: Understanding and Operationalizing the National Action Alliance Aim#2

June 18, 2024

Noon- 1:00 PM ET

Registration is open and can be found on the NAA website

https://cma.ahrq.gov/actionalliancejune

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Appendix

History

- **May-September 2018**: NSC reviews best available evidence and identify four areas to of focus
    - Criteria: substantial, wide-ranging influence on many aspects of patient safety; relevant across boundaries of specialization, settings, organizational characteristics, and populations; interdependent
- **Dec 2018**: Subcommittees convene, comprised of diverse subject matter experts and patient/family representation.
- **Dec 2018-Feb 2020**: Biweekly-monthly meetings to establish aims, key recommendations, tactics, online assessment tool, and Implementation Resource Guide. Co-chairs join NSC meetings for feedback and to ensure coordination across focus areas.
- **March-July 2020**: NSC & Subcommittees review Plan for relevance given COVID-19 pandemic
- **Sept 2020**: National Action Plan Released

National Steering Committee Members

- **Chair - Craig Umscheid -** Agency for Healthcare Research and Quality (AHRQ)
- **Co-Chair - Patricia McGaffigan** –Institute for Healthcare Improvement
- **NSC Leadership - Erin Grace** – Agency for Healthcare Research and Quality (AHRQ)
- **NSC Leadership - Tejal Gandhi** –Press Ganey
- **Akin Demehin –** American Hospital Association
- **Amy Gibson –** American Board of Medical Specialties (ABMS)
- **Andrew Furman** –USC
- **Anne Marie Pizzi -** DNV
- **Arjun Srinivasan** – Centers for Disease Control and Prevention (CDC)
- **Cheryl Peterson** – American Nurses Association (ANA) / Nurses Alliance for Quality Care (NAQC)
- **Chris DeRienzo** - American Hospital Association (AHA)
- **Danielle Harris**– US Food and Drug Administration (FDA)
- **Daisy Smith** – American College of Physicians (ACP)
- **David Bartholomew** – American College of Healthcare Executives (ACHE)
- **Gary Kaplan –** IHI Lucian Leape Institute
- **Gerard Cox** – VA National Center for Patient Safety, Veterans Health Administration (VA)
- **Helen Haskell** – Mothers Against Medical Error
- **Helen Macfie –** Memorial Care
- **Jade Perdue-Puli** –AHRQ
- **Jeff Brady** –Highmark Health
- **Mallika Mundkur** – US Food and Drug Administration (FDA)
- **Marijin VanOort –** American College of Healthcare Executives
- **Martin Hatlie** – Project Patient Care
- **Michelle Schreiber** – Centers for Medicare and Medicaid Services (CMS)
- **Minda G. Nieblas** - Occupational Safety and Health Administration (OSHA)
- **Missy Danforth –** Leapfrog Group
- **Paul Abramowitz** – American Society of Health-System Pharmacists (ASHP)
- **Rita Jew** – Institute for Safe Medication Practices (ISMP)
- **Robyn Begley** – American Hospital Association (AHA) / American Organization for Nursing Leadership (AONL)
- **Ron Wyatt** – Society to Improve Diagnosis in Medicine (SIDM)
- **Shannon Davila** –ECRI
- **Stephanie Mercado** – National Association for Healthcare Quality (NAHQ)
- **Stephen Muething** – Children's Hospitals' Solutions for Patient Safety (SPS)
- **Steve Littlejohn –** Patient Family Representative
- **Susan Edgman-Levitan** – MGH, IHI Lucian Leape Institute
- **Susan Reinhard** – AARP
- **Suz Schrandt –** Chief Patient Advocate
- **Terry Fairbanks** –MedStar Health
- **Thomas Granatir** –
- **Troy McCann** – DNV