

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY



The National Action Alliance to Advance Patient Safety Summer Webinar Series

Robert Otto Valdez, Ph.D.

Director

Agency for Healthcare Research & Quality

April 25, 2023



AGENCY FOR HEALTHCARE RESEARCH AND QUALITY



Welcome and Thank-You!

Four Goals for Today



- Review the **National Action Alliance to Advance Patient Safety**
- Recount the **urgency** for focusing on patient and workforce safety
- Report what you say about your experiences in an emerging post-pandemic healthcare delivery system and **your needs**.
- Provide an overview of the National Action Plan.
 - ▶ Hear from two organizations using the self-assessment tool to understand better where to place their quality improvement focus and
 - ▶ The importance of organizational governance to maintain a **safety-oriented organizational culture**.

Secretary Becerra's Call to Action

14 November 2022



“If I were to tell you that more than 200 people were going to die today from a medical error, you could say, “That can't be,” but that's exactly what's happening. We're essentially losing an airplane full of Americans pretty much every day from medical errors, but we don't think about it. But is it still the third, fourth leading cause of death in America?”

Join the Action Alliance!

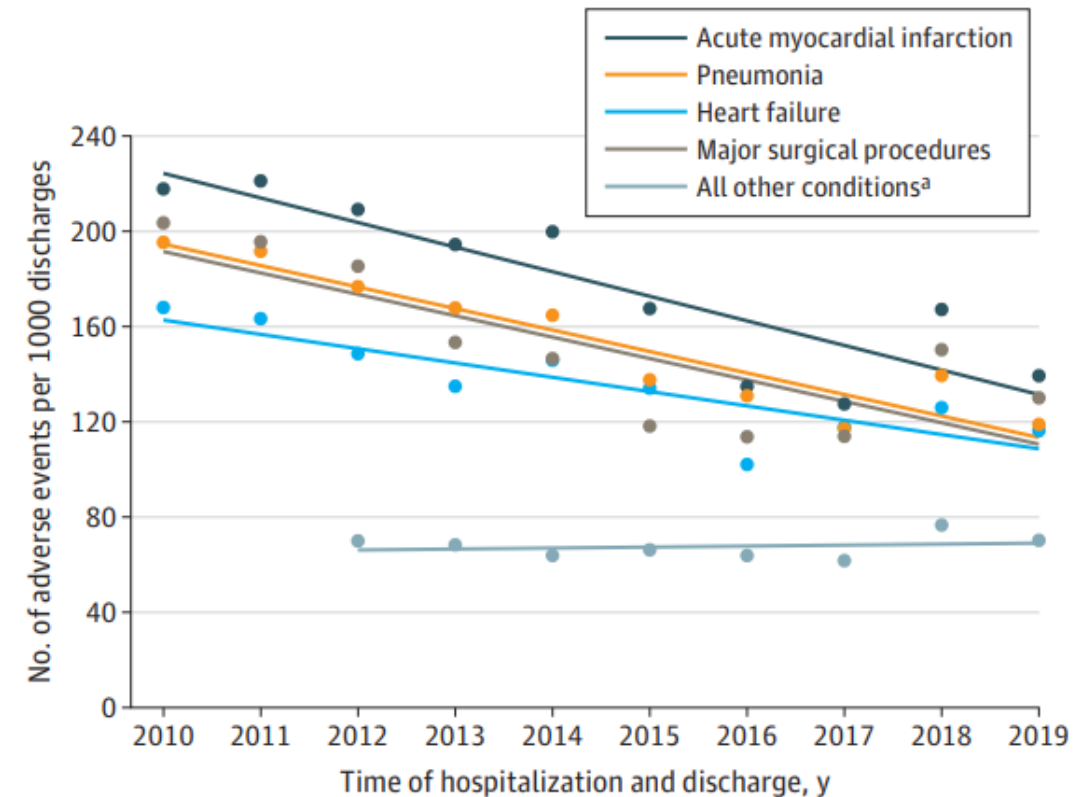
- Healthcare executives, providers, patients and families
- Learning community
 - ▶ Sharing evidence-based best practices, tools, and other approaches
 - ▶ Expert mentorship and peer-to-peer learning.
- www.ahrq.gov/cpi/about/otherwebsites/action-alliance.html
 - ▶ Find best practices, tools and playbooks
 - ▶ Sign up for email updates



Patient Safety Events Declined Prior to COVID-19 Pandemic

- Data from the Medicare Patient Safety Monitoring System from 2010 to 2019
- Adverse events for nearly 300,000 adult patients hospitalized **improved for:**
 - ▶ acute myocardial infarction,
 - ▶ heart failure
 - ▶ pneumonia
 - ▶ major surgical procedures
- But not for:**
 - ▶ **All other conditions (from 2012 through 2019)**

Figure 2. Total Change in the Observed Rates for All 21 Medicare Patient Safety Monitoring System Adverse Events



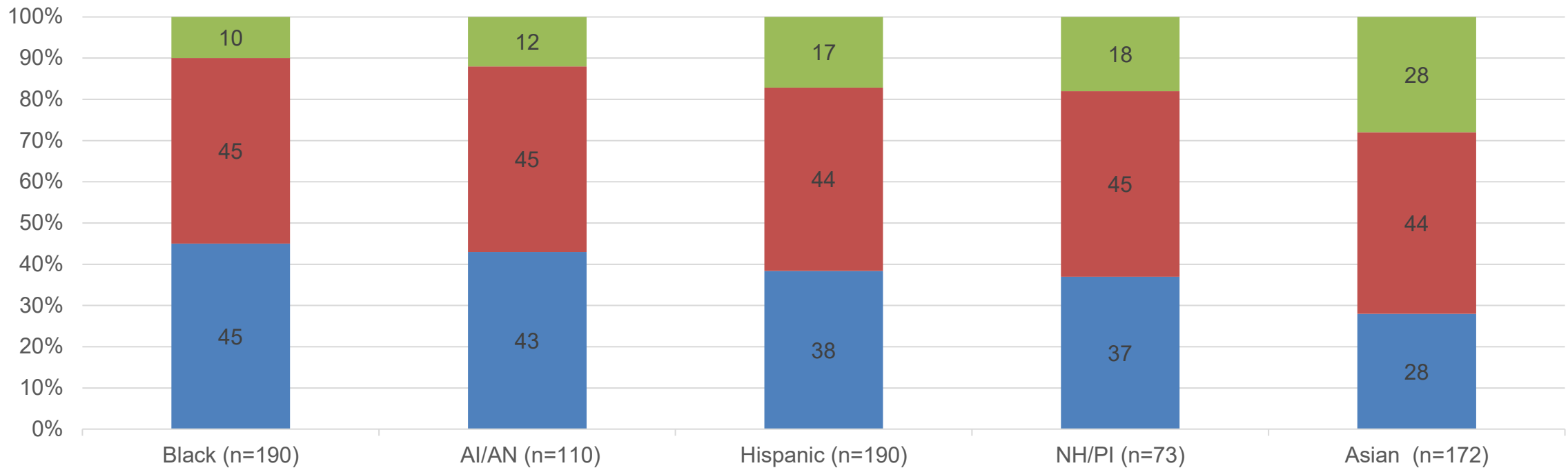
Overcoming Challenges Improving Quality and Safety

- **Despite improvements - Safety Issues persist**
 - ▶ Bates et al. *NEJM*. 2023; 388(2):142-153. Hospitals in Massachusetts in CY2018
 - ▶ **24% admissions with adverse event**
 - ▶ 7% admissions with preventable adverse events
 - ▶ 1% admissions with serious preventable adverse events
- **Pandemic exacerbated issues**
 - ▶ Fleisher et al. *NEJM*. 2022; 386(7): 609-611
 - ▶ Central Line-associated Infections (CLABSI) decreased 31% in 5 years before pandemic
 - ▶ **CLABSI increased 28% in Q2 2020 vs Q2 2019**
- **Challenges**
 - ▶ **workforce burnout and shortage**
 - ▶ **increasing medical specialization**
 - ▶ **increasing patient complexity**
 - ▶ **sharing and implementing best practices for a total systems approach to safety**



Safety Issues are not Equally Distributed

Number and percentage of quality measures for which selected racial or ethnic groups experienced worse, same, or better quality of care compared with White



2022 National Healthcare Quality and Disparities Report

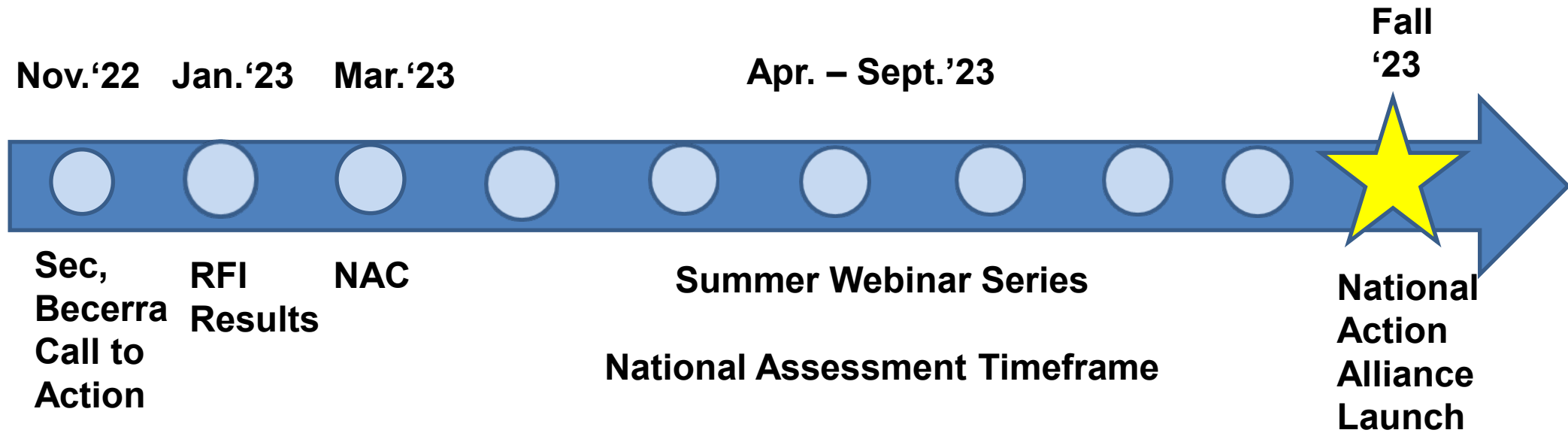
Healthcare is not safe, until it is safe for all

Audience Question



What is your #1 take-a-way from the data and how does that track with your own observations?

National Action Alliance Timeframe



The National Action Alliance to Advance Patient Safety Summer Webinar Series

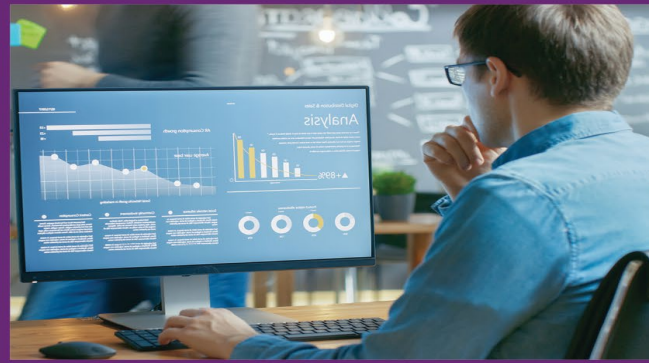


- April 25, 2:00 -3:00 PM ET: AHRQ, Overview of National Action Alliance to Advance Patient Safety <https://cma.ahrq.gov/actionalliance>
- June 27, 2:00 -3:00 PM ET: CDC, Addressing Violence in the Workplace <https://cma.ahrq.gov/actionalliancejune>
- July 25, 2:00 -3:00 PM ET: AHRQ, Involving Patients & Families in Safety <https://cma.ahrq.gov/actionalliancejuly>
- August 22, 2:00 -3:00 PM ET: CMS, Engaging Boards and Executive Leadership in Safety <https://cma.ahrq.gov/actionallianceaugust>

National Action Alliance Website and List Serv



- [The National Action Alliance To Advance Patient Safety](#)
- [Sign up here](#) to learn more and receive regular updates on the National Action Alliance for Patient Safety. Informational list serv already has over 3000 members!!



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National Action Alliance Summary of RFI Comments

**Jade Perdue-Puli, MPA
Acting Deputy Director
Center for Quality Improvement and
Patient Safety**

Request for Information (RFI) Respondents

- Approximately 100 comments from a broad range of stakeholders including:
 - ▶ Healthcare Systems/Providers
 - ▶ Patient-Led Organizations
 - ▶ Membership Organizations (Associations and Societies)
 - ▶ For-Profit Organizations
 - ▶ Colleges and Universities
 - ▶ Non-Profit Organizations
 - ▶ Individuals

RFI Questions

1. What can **HHS bring** to the Action Alliance in terms of **coordination, alignment, tools, training, and other non-financial resources** to support the effectiveness of the Action Alliance in assisting healthcare delivery systems and others in advancing **patient and healthcare worker safety**?

Question 1: Summary

- Clear vision, mission, strategic goals, priorities, governance structure, roles and expectations for the Alliance
- Convening stakeholders and experts to develop solutions for workplace safety challenges
- Providing resources and tools (i.e., training) to ease the workflow burdens faced by healthcare professionals
- Coordinate across federal departments, agencies, and offices that work on patient and workforce safety (e.g. OSHA,PSOs)
- Alliance providing a central repository of lessons learned, best practices, harm events

Question 2

- How can the voluntary Action Alliance **most effectively support healthcare delivery systems and other stakeholders in advancing patient and workforce safety?** Are there **specific priorities for different types of systems or setting of care?** What **stakeholders** should be part of the Action Alliance to make it most effective?

Question 2: Summary

- Need for resources and community educational tools across the continuum of care
- Bring focus on settings beyond inpatient (i.e., SNF, home care)
- Cultivate best practices ('what works') and spread widely
- Bring urgency and coordination among agencies & stakeholders
- Understand the budgetary and financial elements of any advancement to patient care
- Support coordination of care efforts, particularly for patients with behavioral health and developmental disabilities.

Question 3

- What are other national patient and workforce safety initiatives that the Action Alliance should be aware of and how can the Action Alliance best collaborate, coordinate, and avoid duplication with them?

Question 3 Summary

- Leverage resources and expertise from other leading patient safety and specialty organizations (i.e., IHI, Lucian Leap Institute, ASA)
- Coordinate with the National Steering Committee for Patient Safety
- AANA – developed anesthesia resources
- CMS, Quality Improvement Network, Quality Improvement Organizations
- The Office of the National Coordinator for Health Information Technology (ONC) work on Interoperability
- Maternal Morbidity Mortality Work
- PSO's
- The Children's Hospitals' Solutions for Patient Safety Collaboration
- OSHA – collaborate to address workforce safety
- ECRI – safety, device, human factors focus areas
- Workplace Change Collaborative – National Framework on Burnout and Moral Injury in the Health Workforce
- The Joint Commission – National Patient Safety Goals
- CMS initiatives (i.e., Hospital Quality Improvement Contractors)

Question 4

- How can the Action Alliance best **support** healthcare systems in **advancing healthcare equity** within their patient and workforce safety efforts, including through **redesign of care delivery**?

Question 4 Summary

- Define and develop an equity-based scope of work and establish target goals
- Train a diverse healthcare workforce
- Collect standardized data to help identify healthcare disparities
- Review healthcare policies that may serve as barriers to care
- Build knowledge around health equity (e.g. LGBTQ+ specific material to the curriculum of medical, nursing, and pharmacy schools)
- Support efforts to share best practices to advance healthcare equity
- Advocate for incentives for smaller organizations to help them implement equity measures
- Maximize full utilization of healthcare professionals (i.e. pharmacists, nurses)
- Invest in the public health infrastructure & community health programs
- Ensure access to the most advanced, safest technologies for all patients

Question 5

- Are there **specific practices or innovations** that **healthcare delivery systems or others have implemented** during or post-pandemic, including practices focused on **populations that experience health disparities and individuals living in rural communities**, that others could benefit from learning about? Please share any **specific details and sharable outcomes data** regarding innovations if applicable

Question 5: Summary

- Telehealth programs (e.g. COVID, postpartum women for hypertension management, mental health management and coordinated substance use disorder support among others)
- Standardized de-escalation training for all security professionals and a three-tiered workplace violence program
- Institute new healthcare equity standards to help address disparities caused by health-related social needs

Question 6

- What are **the main challenges** healthcare delivery systems and others are facing in meeting their commitments to **advancing patient and healthcare worker safety as they emerge from the pandemic?** Are there **challenges** that are **specific to different types of systems, settings of care, or populations of people?**

Question 6 Summary

Workforce Safety: across all settings

- Physical & psychological (i.e., burnout, mental health)
- Workplace violence/verbal abuse
- Infection control and prevention (HAIs)
- Ergonomic safety
- Staffing turnover and retention
- Staffing reimbursement rates
- Training (i.e., technology, security, de-escalation)
- Availability of equipment and PPE

Question 6 Summary Continued

Technology: across all settings

- Telemedicine: advantages and disadvantages of adoption
- EHRs
- Cybersecurity
- Infrastructure
- Interoperability/ API integration
- Training
- Access
- Sustaining healthcare emergency reimbursement rates
- Artificial Intelligence/Machine Learning (i.e., infection control)
 - Establish standards

Audience Question

“What message would you like to add to what you have just heard?”

Please enter your response in the chat.

Key Take-A-Ways

- Wide support for the Action Alliance
- Safety across the board was emphasized (all settings)
- Health equity was important to all and a focus on systems was emphasized
- Workforce safety (physical, psychological and addressing violence) is top of mind and noted as a necessary building block for any future work
- There was a distinct call for transparency and noncompetition on safety

Poignant Quotes

“After more than 20 years of research and policymaking in the field of patient safety, we still do not know the magnitude of harm.”

“By and large, the U.S. does not account for medical care injuries and deaths in our vital statistics as they are often omitted as causes and/or contributing factors on death certificates. This leaves a blank space on the CDC's annual list of leading causes of death. Where it should say 'medical care harm/injuries', it's blank. How can we raise awareness if it's invisible to the public?”

“We don't compete when it comes to safety.”

Today, workforce shortages and increased labor costs, as well as reporting burdens, challenge essential hospitals in meeting their commitment to advancing patient safety. Without additional funding to pay for increased costs associated with new patient safety initiatives, ongoing staff training, care redesign, and process changes, essential hospitals will be disadvantaged in their efforts to revamp patient safety.

“Please remember that equity is not just a matter of skin color, language and national origin, but that there are many other subgroups subjected to bias for medical reasons: the mentally ill, the obese, the addicted, the disabled, the elderly, the impoverished, the female.”

Funding and human capital resources - it takes money, time and effort to train staff on safety protocols and implement quality improvement systems.



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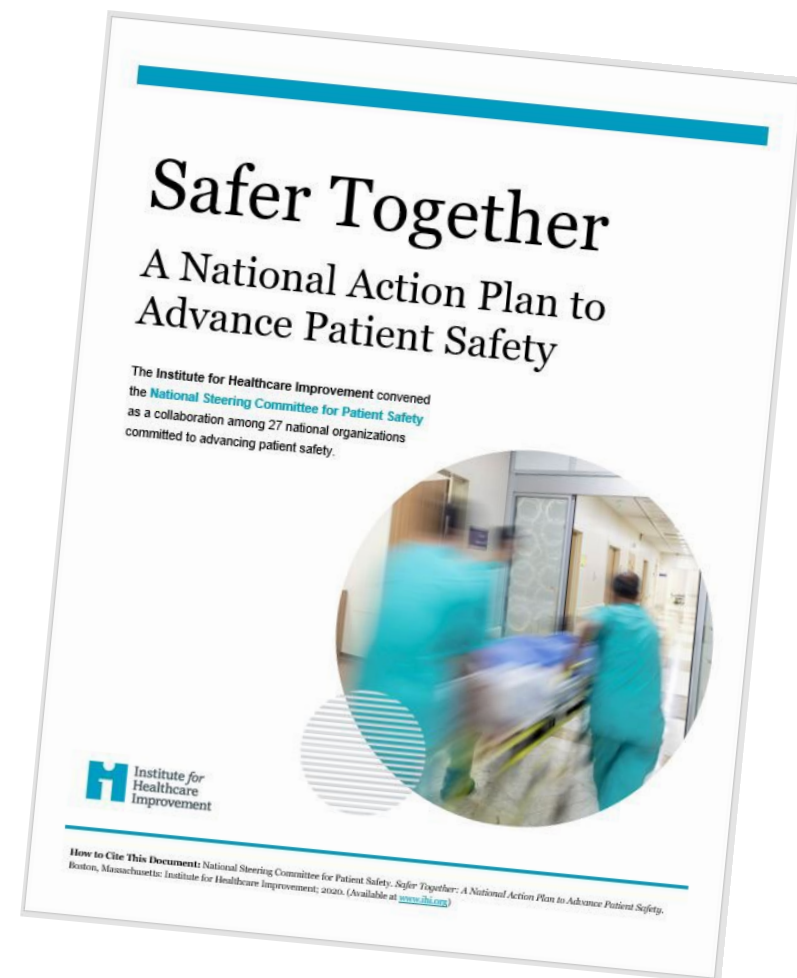
National Action Plan to Advance Patient Safety & Importance of Self-Assessment

**Erin Grace, M.H.A.
Acting Director**

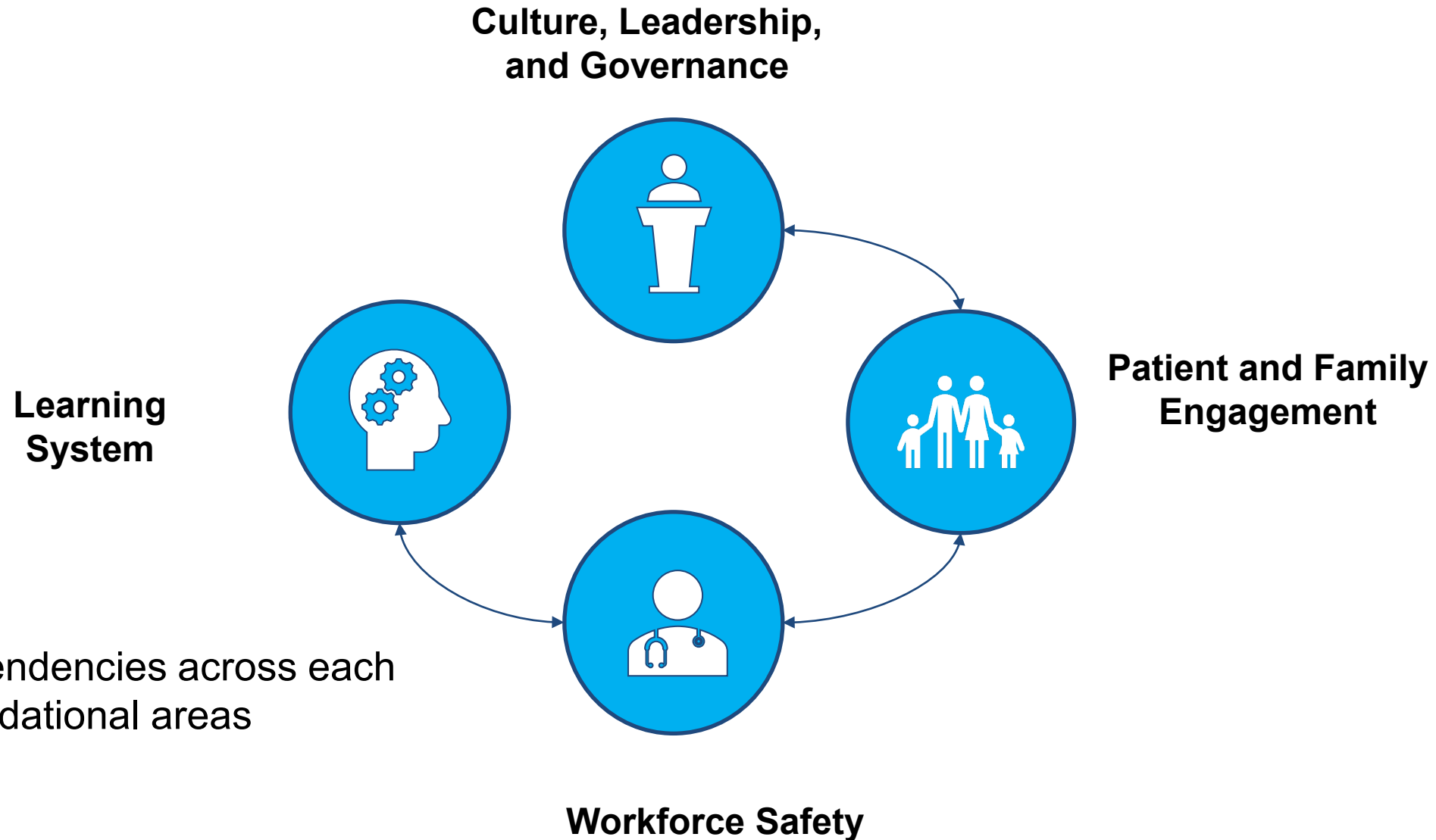
**Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality**

National Action Plan to Advance Patient Safety

- AHRQ co-chaired the [National Steering Committee for Patient Safety](#) (NSC), which was convened by the Institute for Healthcare Improvement
- The NSC comprises 27 leading organizations who are united in their efforts to achieve truly safer care and reduce harm to patients and those who care for them – including AHRQ, CDC, CMS and other government agencies
- The Plan provides clear direction for making significant advances toward safer care and reduced harm across the continuum of care



Four Foundational Areas* of the National Action Plan



* Interdependencies across each of the foundational areas

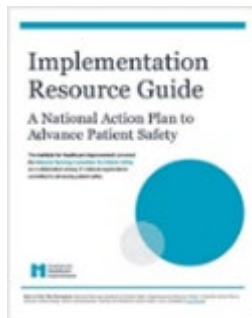
NSC Declaration to Advance Patient Safety



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](#).

Ascension Health's Journey Using the National Action Plan Self-Assessment Tool

**Kelly Randall, PhD, LMSW,CPHQ
VP, Patient Safety and Regulatory Clinical
Operations
Ascension**

About Ascension

Size and Scale

ACUTE CARE

19,000

Beds

139

Hospitals

CLINICAL ENTERPRISE

8,300

Employed
Providers

48,000

Nurses

36,000

Affiliated
Providers

AMBULATORY

1,435

Ascension
Medical Group
Locations

73

Ambulatory
Surgery
Centers

6,000

Beds

39

Senior
Living
Facilities

FINANCIAL

185

Imaging
Locations

302

Physical
Therapy
Locations

\$44B

Total Assets

Volumes

\$2.3 Billion

in care of persons living in poverty and other community benefit programs

16.1 million

physician office and
clinic visits

1.1 million

virtual provider
office visits

1.5 million

equivalent discharges

3.0 million

emergency room visits

586,000

surgery visits

527,000

urgent care visits

726,000

discharges

79,000

births

5.9 million

Unique Lives Served

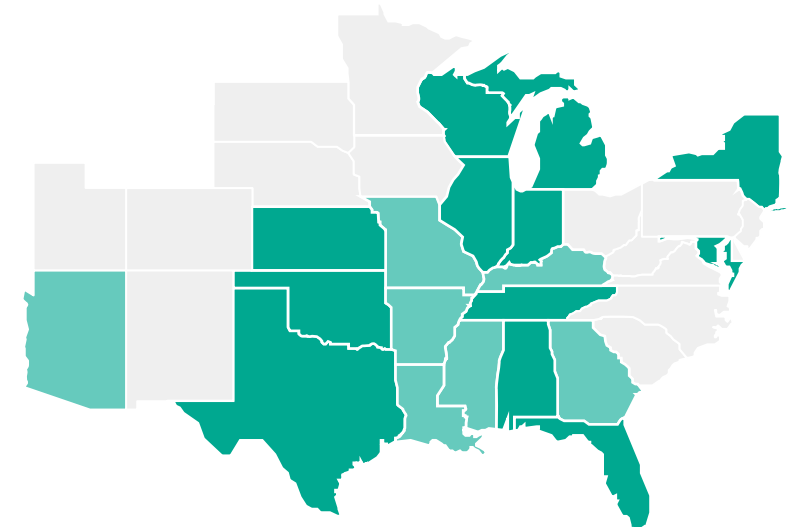
283,000

Observation Days

Geographic Spread

2,600+

sites of care in **19 states** and
the **District of Columbia**



Market

Other Presence

Information as of June 30, 2022

Advancing Patient Safety Assessment

Goal - complete the assessment with 12 ministry markets by March 2023

Who: Market and Hospital Leaders

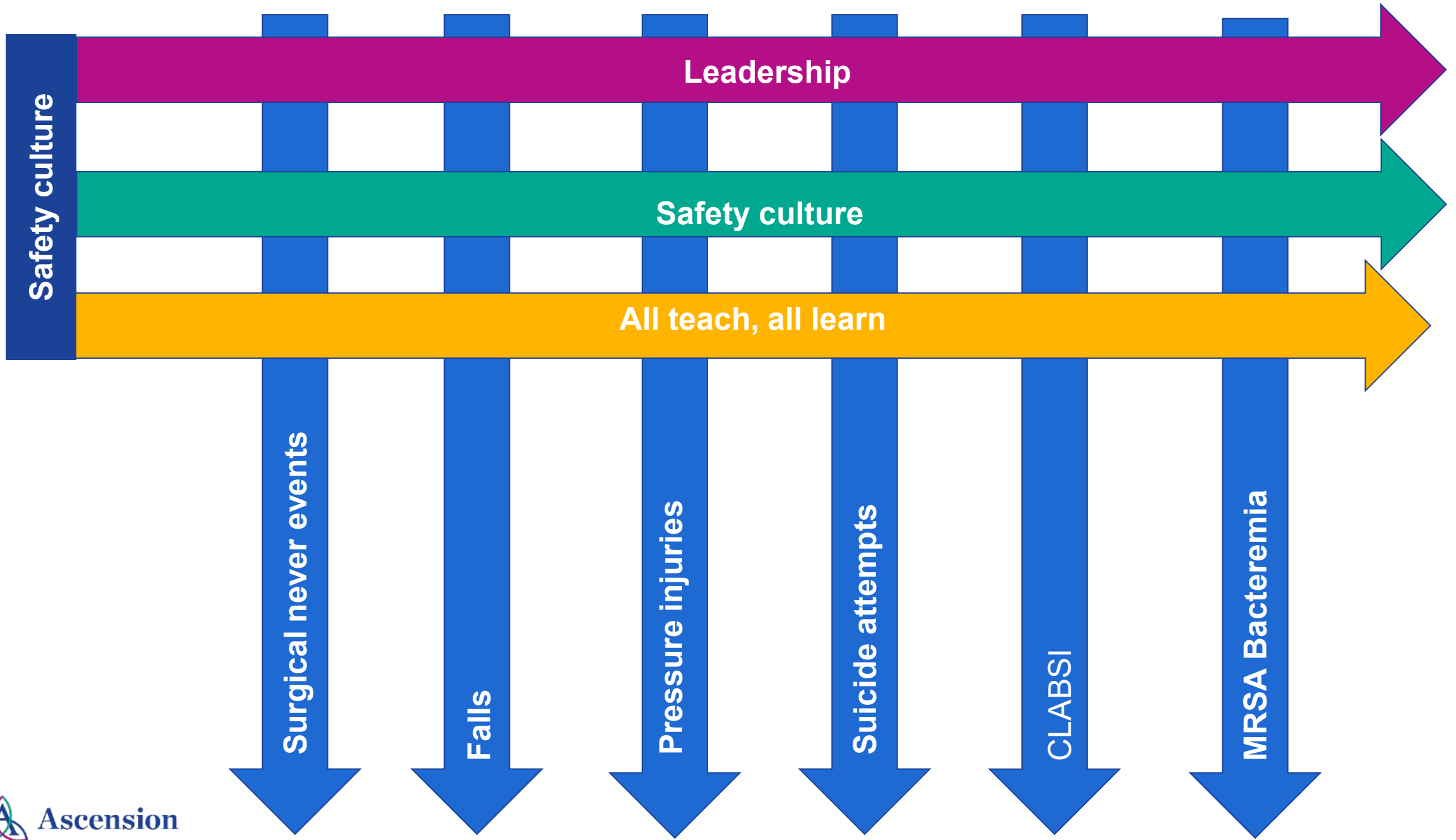
- C-Suite
- Quality and Safety
- Risk Management
- Associate Health
- Physical Safety
- Patient/Family Experience

Logistics

- 1) Hopes and Shared Concerns about Patient Safety current state
- 2) Establish Group Rules - Check your Ego at the Door
- 3) Establish Purpose - All Teach, All Learn
- 4) Level Set with Definitions
- 5) Assess
 - a) Ask probing questions
 - b) Be Challenging
 - c) Consensus
- 6) Close the Loop - Hopes and Fears
- 7) Next steps - Local Action

Improvement

- Leadership must establish safety as the highest priority
 - Structure, Process, Outcome - Don't forget about Accountability and Sustainability
 - Compare structure side by side with the Action Plan
- ## Recommendations
- Be agile
 - Integrate



One story: Leveraging the National Action Plan to Advance Patient Safety to reboot our focus

**Helen Macfie, Pharm.D., FABC, IHI Fellow
Executive in Residence, MemorialCare
COO, MemorialCare Long Beach & Miller
Children's & Women's**

HHS/AHRQ session – 05-25-23



The Action Plan in Action



Where we were in 2022

Omicronmania, succession planning, reconnecting



- Executive Quality Leadership Team was overwhelmed and besieged
- Patient complexity increased, focus diluted
- IHI Fellowship's deep dive with Patricia McGaffigan – a spark!
- Team agreed to do the assessment and see what it would tell us as a way forward
- At that point, didn't have a tool per se so we simply sent out the NAPfAPS and asked leaders to score
- Collected both the range of scores and the Mean which was helpful, and then hosted a discussion

Team approach: Shared definitions matter

Discussing the range, the average, the wording → the plan

Culture, Leadership, and Governance

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
Safety Goals	Safety goals are developed. Some goals are accompanied by an action plan and associated metrics.	<i>Safety goals are clearly articulated in strategic and operational plans. Each goal is accompanied by an action plan and associated metrics.</i>	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.	AVG: 3.1 32% 2s 22% 3s 44% 4s	ID Senior sponsor and action plan for each Bold Goal (done for FY'23)

Segmenting the evaluation

Don't average too soon or you'll miss the rest of the story

This is not about trying to “look good” or make ourselves feel better

It's about finding the pearls for where we can truly improve

Leveraging the NAPfAPS exercise to drilldown and then ask why/why/why

Even where we are “good” we can improve further

This is a journey...

Section Assessments	Teams' Score (Mean)	NPAfAPS Summary & Range
Culture, Leadership & Governance	20	Significant Impact (18-23)
Patient & Family Engagement	16.3	Making Progress (12-17)
Workforce Safety	20.3	Significant Impact (18-23)
Learning System	21	“Exemplary Performance” (21-24)

Culture, Leadership, and Governance

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
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.	AVG: 3.1 32% 2s 22% 3s 44% 4s	ID Senior sponsor and action plan for each Bold Goal (done for FY'23)
Job Descriptions	Job descriptions for senior leaders reference responsibility for quality and safety.	Job descriptions for senior leaders specify explicit responsibility for quality and safety.	Job descriptions for senior leaders and trustees specify explicit responsibility for quality and safety.	Job descriptions for senior leaders and trustees specify explicit responsibility for quality and safety. Performance reviews for senior leaders include safety and culture metrics.	AVG:2.0 22% 0s 11% 1s 33% 2s 33% 4s	Review with CHRO and CLO. Tie into JD & LEAD remodel
Annual Reviews	Annual reviews of some leaders include a focus on safety.	Annual reviews for all senior leaders incorporate review of organization-wide safety and culture metrics.	Annual reviews for all senior leaders and trustees incorporate review of organization-wide safety and culture metrics, safety competency assessments, and development plans for education and training in safety and improvement methods.	Annual reviews for all senior leaders and trustees incorporate review of organization-wide safety and culture metrics, including equity and diversity, safety competency assessments, and development plans for education and training in safety and improvement methods. Senior leaders and/or trustees are sponsors for patient safety improvement initiatives.	AVG: 2.5 56% 2s 32% 3s 11% 4s	Review with CHRO and CLO. Tie into JD & LEAD remodel
Just Culture and Transparency	The organization has a written policy establishing just culture and transparency practices.	The organization has a written policy establishing just culture and transparency practices that has been adopted in some but not all areas of the organization.	The organization has a written policy establishing just culture and transparency practices. This policy is adopted by all areas of the organization and training is provided to all clinicians and staff.	The organization has a written policy establishing just culture and transparency practices. This policy is understood by all clinicians and staff and includes an audit and reporting program to ensure equal deployment across all areas and levels of the organization.	AVG: 2.8 11% 0s 11% 2s 55% 3s 22% 4s	Clarify P&P status as likely awareness issue (we had one before...) and also update prn for 2022 Best Practice
Harm Events	Harm events and reported near misses are reviewed periodically, but not consistently.	All harm events and reported near misses are reviewed and evaluated in a timely manner. The CEO is notified within 24 hours of a serious adverse event.	All harm events and reported near misses are reviewed and evaluated in a timely manner. The CEO and Board Chair are notified within 24 hours of a serious adverse event.	All harm events and reported near misses are reviewed and evaluated in a timely manner. The CEO and Board Chair are notified within 24 hours of a serious adverse event. Patient and family communication is completed in accordance with best practices.	AVG: 2.9 55% 2s 44% 4s	Clarify CEO and Board Chair timing, varies by entity/campus
Meeting Agendas	Safety is not on all leadership and board meeting agendas.	Safety is a topic included on all leadership and board meeting agendas.	At least 20% of all leadership and board meeting agendas are dedicated to review and discussion of safety.	At least 20% of all leadership and board meeting agendas are dedicated to review and discussion of safety. There is follow-up on action plans.	AVG: 3.1 33% 2s 22% 3s 44% 4s	Clarified with IHI – can include Q Council/Close / Committee time

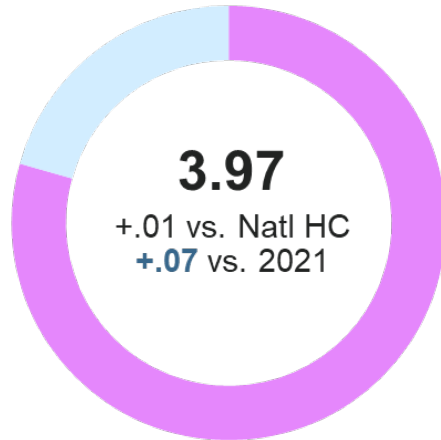
Culture, Leadership, and Governance

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
Safety Culture Surveys	No or some units/departments conduct patient safety culture surveys.	An <i>organization-wide</i> 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. <i>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.</i>	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. <i>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.</i>	AVG: 3.7 33% 3s 66% 4s	Continue – survey Oct'22; update heat maps and sync to action planning per department and overall
TOTAL SCORE:					AVG: 20	
Culture, Leadership, and Governance						
SIGNIFICANT IMPACT 18-23						

Safety Culture & Resilience Results Overview

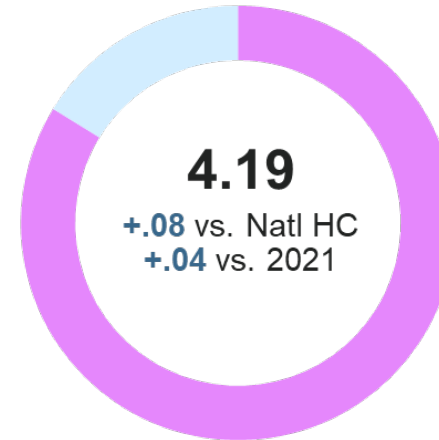
Safety Culture**

Evaluation of attitudes and behaviors impacting patient and workplace safety



Resilience

Ability to recover and bounce back from adversity—early warning system for burnout



	2022	vs. Natl HC	vs. 2021
Prevention & Reporting	4.11	.00	+.07
Resources & Teamwork	3.70	+.03	+.09
Pride & Reputation	4.17	+.01	+.05

	2022	vs. Natl HC	vs. 2021
Decompression	3.90	+.17	+.09
Activation	4.48	-.02	-.01

**Safety Culture module administered to employees who spend 50% or more of their time in direct patient care.



Interpreting the Total Score: Culture, Leadership, and Governance

For more information on the recommended actions and related resources, please refer to the Implementation Resource Guide.

Total Score	Current State Description	Recommended Actions
7–11	Just Beginning	<ul style="list-style-type: none"> • Create an action plan for and use improvement science methods to begin improvement in lowest scoring area(s). • Add patient safety improvement to the responsibilities of all leaders. • Create an explicit plan for the entire organization to practice transparency in sharing data and communications. • Add a patient story to start each board and executive meeting, with examples of what has gone well and what can be improved.
12–17	Making Progress	<ul style="list-style-type: none"> • Assign each senior leader responsibility to lead specific patient safety improvement initiatives, meeting with the team regularly and supporting all efforts. • Develop a plan to ensure that all senior leaders are trained and understand the principles of patient safety. • Create a written just culture policy that clearly applies to all levels and staff in the organization. • Escalate all serious events to the senior level and chairman of the board within 24 hours of occurrence. • Dedicate a portion of every meeting agenda to the discussion of patient safety issues.
18–23	Significant Impact	<ul style="list-style-type: none"> • Senior leaders, with support and advice from staff, set the goals and strategic plan for the organization. • Incorporate patient safety goals into the strategic plan. Each goal should have a clear aim, interventions to be tested, and associated measures to assess progress toward aims. • Assess all leaders, at all levels of the organization, for progress in fostering a culture of safety and work toward patient and workforce safety goals, with the purpose of reflection and recalibration as needed. • Develop a clear aim and action plan to address all safety issues and defects discussed during meetings.
24–28	Exemplary Performance	<ul style="list-style-type: none"> • Move from proactive to generative in the approach to patient safety, clarifying that safety is not a project but a way of working. • Ensure all leaders and staff at every level of the organization feel clear ownership for patient safety. • Implement an adverse event review process that begins with and focuses on a review of systems. • Clearly identify the role of the board and senior executives in reviewing and overseeing patient outcomes. • Communicate with staff about their individual roles in improving patient safety, including working as a team to improve the system and ensuring reliable processes that support evidence-based care.

Patient and Family Engagement

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
Patient and Family Advisory Council (PFAC)	The organization does not have a Patient and Family Advisory Council or the role of the PFAC is very limited.	The organization has a Patient and Family Advisory Council. The organization does not have a mechanism to measure the impact of this work.	The organization has an <i>actively engaged</i> Patient and Family Advisory Council. <i>Senior leaders ensure the PFAC informs an organization- or system-wide strategy and measurement plan for patient engagement.</i>	The organization has an actively engaged Patient and Family Advisory Council. Senior leaders ensure the PFAC informs an organization- or system-wide strategy and measurement plan for patient engagement <i>that includes patient and community representation on all boards and committees, event review processes, and improvement initiatives.</i>	AVG:2.7 33% 2s 66% 3s	Reactivating routine PFACs post-COVID (some were canceled, in progress plus in person again)
Co-Design Care with Patients	Some clinicians fully involve patients in their care.	Some clinicians involve patients in their care, including use of "What matters to you?" questions, checklists, and shared decision-making tools. <i>Some clinicians complete huddles and shift changes at the bedside.</i>	<i>All clinicians are trained to involve patients in their care, including use of "What matters to you?" questions, checklists, and shared decision-making tools. The organization recommends completing all huddles and shift changes at the bedside.</i>	<i>All clinicians fully involve patients in their care, including use of "What matters to you?" questions, checklists, and shared decision-making tools. All huddles and shift changes are completed at the bedside.</i>	AVG:2.1 11% 1s 66% 2s 22% 3s	Add focus on What Matters to You – opportunity for IP and OP/AMB. It is built into Epic for IP but not hard-wired into Nursing Bundle/rounds
Training and Resources	The organization does not provide safety and patient-provider communication training and resources to patients, clinicians, and staff.	There is <i>limited</i> safety and patient-provider communication training. <i>Resources are available to all patients, clinicians, and staff. These educational materials are available in some of the preferred languages of patients.</i>	<i>The organization provides safety and patient-provider communication training and resources to all patients, clinicians, and staff. These educational materials are available in the preferred language of each patient.</i>	The organization provides safety and patient-provider communication training and resources to all patients, clinicians, and staff. These educational materials are available in the preferred language <i>and appropriate literacy level for each patient.</i>	AVG:2.4 66% 2s 22% 3s 11% 4s	TBD for ALL pts/clinicians and staff. Needs focused review (EQL team)
Patient Portals	Patients do not have timely and full access to medical records and visit notes.	Patients <i>have</i> access to their medical records through an online portal. There is not an organizational program to ensure that all patients know about and are able to access their records.	Patients have access to their medical records through an online portal. <i>There is an organization-wide program to raise awareness about patient ability to access their medical records and advisors are available to assist patients as needed.</i>	Patients have <i>timely and full</i> access to medical records <i>and visit notes</i> through a <i>user-friendly</i> online portal. There is an organization-wide program to raise awareness about patient ability to access their medical records and advisors are available to assist patients as needed. <i>The organization monitors patient activity on this platform to understand use and usability, and fosters increasing use by all patients.</i>	AVG:3.0 11% 1s 11% 2s 44% 3s 33% 4s	Continue progress on Open Notes and CURES ACT requirements (Physician Society/CTS team)

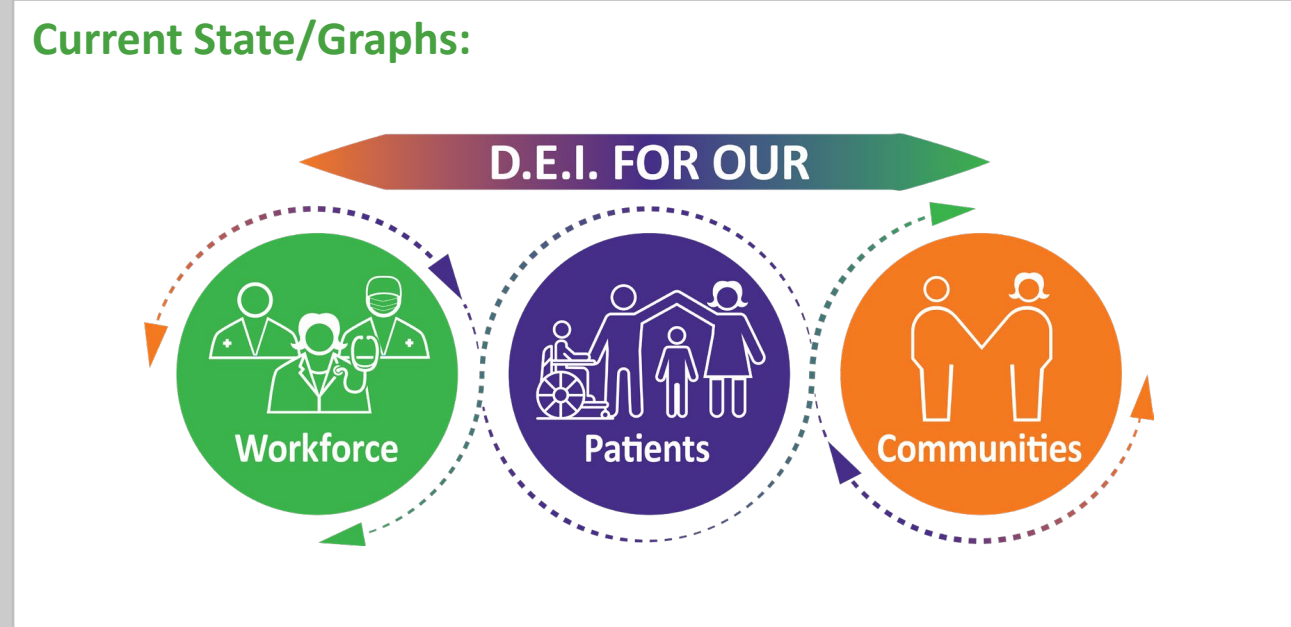
Patient and Family Engagement

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
Equity	The organization does not segment and review adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income.	The organization <i>understands the need</i> to segment and address adverse event data and patient experience by different patient segments and <i>has begun to identify the data necessary for this review.</i>	The organization <i>segments and reviews</i> all adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income. <i>Senior leaders regularly review identified gaps, and action plans to address health inequities are developed and executed.</i>	The organization segments and reviews all adverse event data and patient experience feedback by characteristics such as race, ethnicity, sexual orientation, gender, age, disability, and income. Senior leaders regularly review identified gaps, and action plans to address health inequities are developed and executed. <i>All leaders, clinicians, and staff receive training in health equity and unconscious bias.</i>	AVG:2.2 22% 1s 33% 2s 44% 3s	Segmenting pt sat but not AE data – create plan to do so and then review findings for OFIs (CRM team) Rolling out training on HE and UB to leaders and select clinicians (done) plus adding to YouLearn LMS system for all.
Communication and Resolution for Adverse Events	The organization does not have a communication and resolution program (CRP) to respond to adverse events.	The organization <i>has made a commitment</i> to a communication and resolution program (CRP) to respond to adverse events, but has not made it organizational policy.	The organization <i>has a communication and resolution program (CRP)</i> to respond to adverse events. <i>All staff are trained in appropriate response to adverse events.</i>	The organization has a communication and resolution program (CRP) and a staff training plan in place to respond to adverse events. <i>Support programs are available for patients and families, clinicians, and staff who are impacted by these events. The program is regularly reviewed by senior leaders and the board.</i>	AVG: 2.9 33% 2s 55% 3s 11% 4s	Have CRM but opportunity to do further staff training and hardwire use of WISE and SWIT for all. Also augment review by senior leaders/Board at some entities
Escalation Pathways for Safety Events	There is no mechanism for patients and families to report safety events outside of the complaint system.	<i>Patients have the ability to report safety events into a patient safety database,</i> though the system may be variable across the organization.	Patients have the ability to report safety events into a patient safety database, and there is a <i>structured system for patients and families to escalate concerns about their care through the use of a rapid response team or other structured response mechanism.</i>	Patients have the ability to report safety events into a patient safety database, and there is a structured system for patients and families to escalate concerns about their care through the use of a rapid response team or other structured response mechanism. <i>The organization regularly reviews and responds to safety events that have been raised by patients and families.</i>	AVG: 1.4 55% 1s 44% 2s	Needs further discussion. Patients can report through complaint system but not outside. Research best practices and bring back
TOTAL SCORE:					AVG:16.3	
Patient and Family Engagement						
MAKING PROGRESS (12-17)						


System-Wide Strategic Visibility Board
Target: ACTIVATE D.E.I. Roadmap, Year 2
Focus: Achieve meaningful impact on the DEI needs of our communities & workforce




Updated:
December 2022
 (By: S. Kaneshiro, Cadavona)



- Key Analysis and Activities:**
- Prior focus with IHI Leadership Alliance
 - Strategic Pyramid created, Jul'21 PG Intensive for FY'22-23
 - Steering Committee created and launched Nov'21, meeting routinely to review progress on initiatives
 - Selected Paradigm as key strategic partner for insights and education
 - Designed overall focus on D.E.I. for our workforce, for our patients, and for our communities. Logo designed and adopted.
 - **Launched Unconscious Bias training for all leaders**



Presented at IHI Virtual Forum 12/13

VW20: Diversity, Equity, and Inclusion: Removing Inequities in Health Systems Policies: For our Workforce, Patients and Communities

Sheila Kaneshiro, MBA, NEA-BC, FACHE. MemorialCare Chief Clinical Transformation Officer

Helen Macfie, PharmD, FABC, IHI Fellow (2022). MemorialCare Executive in Residence and COO Long Beach Medical Center and Miller Children's and Women's Hospital

What We're Working On, Will See Next:

Initiative/ Tactic	Who	Target	Action/Status
Community Health Needs	K. Pugh	2FQ'23	• Community grant recipients selected, announced; \$50K/hospital to distribute through grants
Skills and Training	S. Kaneshiro L. Cadavona	2FQ'23	• Scheduled to launch education, starting with microlearning library for enterprise in Jan • Share 2023 DEI calendar in Jan
Paradigm Consulting	D.E.I. Steering	1FQ'23	• Focus on internal/external communication, refresh intranet • Consult re: ERGs in CY'23
Communication	R. Steele	2/3FQ'23	• Release 2nd Webcast (Dec), 3 rd planned in Jan
People & Culture	M. Leahy	2&3FQ'23	• Auto-escalate retirement plan for those <10% • Conducting financial education classes; Vanguard 1:1 phone consultations in English/Spanish • Completed 1 st phase succession planning; dev plans to be completed Jan 2023 • Press Ganey employee survey result release/action planning Jan

Manager and Board training launched in Unconscious Bias

Participation highly encouraged

- Provided 2.5hour workshops for all managers, expert facilitator
- What we heard back:
 - 95% completed. Now required for all new leaders.
 - Very good content and discussion, engaging facilitator
 - Better clarity between equality and equity
 - More detailed questions to answer. Would like coaching resources, group discussions, on-demand tools and further learning opportunities
- Next steps:
 - Micro-learnings, on-line tools
 - Discussion and affinity groups



Great training day. Pleasantly surprised :)

Hope this mandatory for all managers and directors

Seeing it demonstrated by leadership and being part of our day to day culture.

I loved it! Much needed and very much appreciated as a new board member and seeing existing board trained on this very important and timely topic

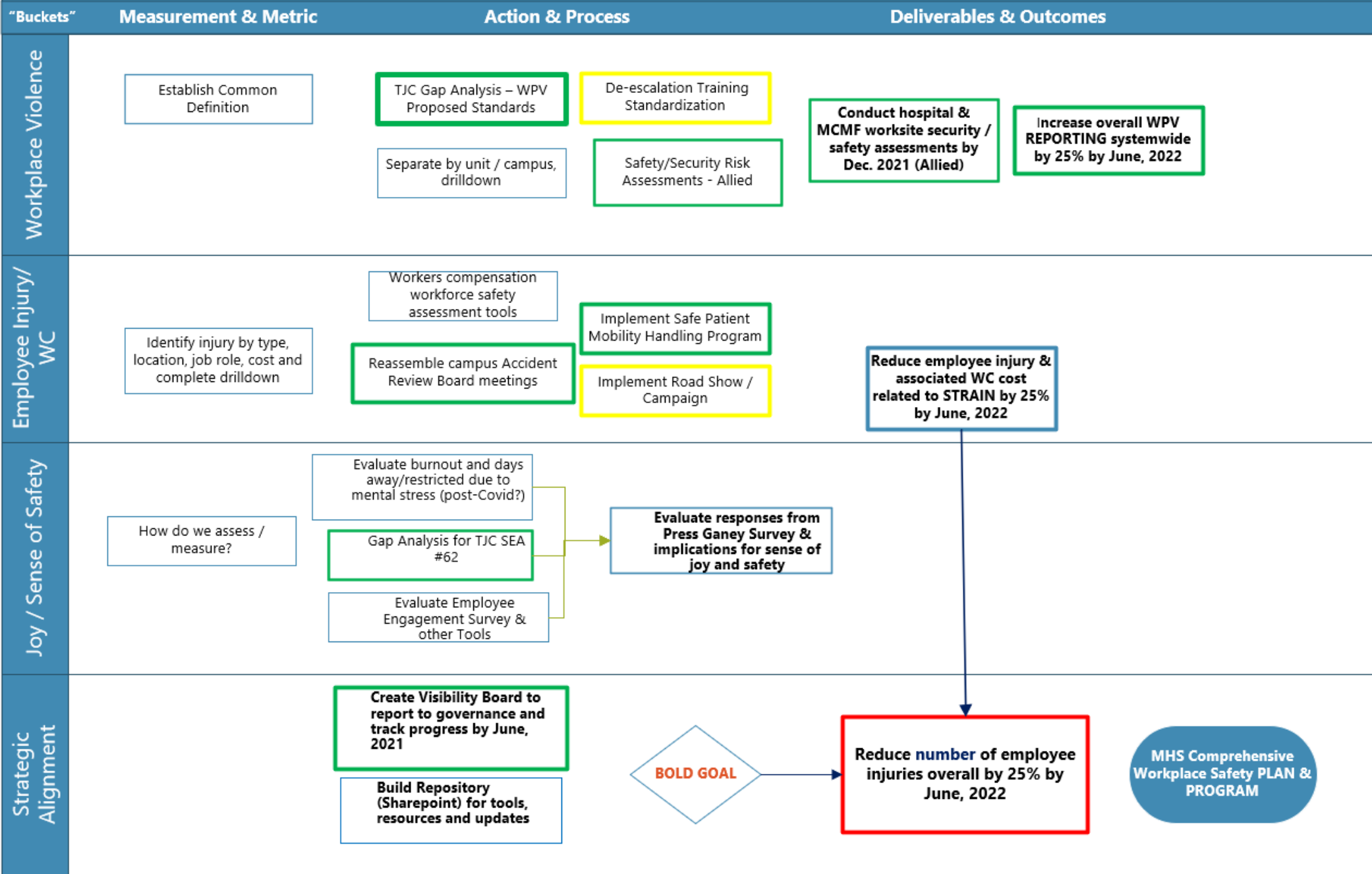
Workforce Safety

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
Job Descriptions	Job descriptions and Performance expectations for leaders do not reflect accountability for workforce safety.	Job descriptions and performance expectations <i>for some leaders reflect accountability for workforce safety.</i>	Job descriptions and performance expectations <i>for all leaders</i> reflect accountability for workforce safety.	Job descriptions and performance expectations for all leaders reflect accountability for workforce safety. <i>In addition, the organization has appointed designated leaders to champion and drive improvement in workforce safety.</i>	AVG:2.7 22% 1s 22% 2s 22% 3s 33% 4s	Review with CHRO and CLO. Tie into JD & LEAD remodel
Safety Strategy	The organization does not yet have an explicit workforce safety strategy.	The organization <i>has an explicit workforce safety strategy</i> , but it is not aligned with the mission and patient safety strategy.	The organization has an explicit workforce safety strategy <i>that is aligned with the mission and patient safety strategy.</i>	The organization has an explicit workforce safety strategy that is aligned with the mission and patient safety strategy. <i>This strategy includes a multi-year work plan, metrics, and a well-understood reporting protocol.</i>	AVG: 3.4 55% 3s 44% 4s	Continue focus with WPS VAT and Strategic Action Plan
Occupational Safety	The organization does not consult with occupational safety experts and does not have a system to capture and control job hazards by position.	The organization <i>periodically consults</i> with occupational safety experts and is <i>working to ensure the development</i> of a system to capture and control job hazards by position.	The organization <i>regularly consults</i> with occupational safety experts to ensure the development of a system to capture and control job hazards by position.	The organization <i>employs and fully integrates</i> occupational safety experts to ensure the development <i>and use of a system to capture and control job hazards by position.</i>	AVG: 2.6 22% 1s 11% 2s 55% 3s 11% 4s	Expand on Judy T's and Erin's role for site reviews
Budgeting	Organizational and department budgets are not designed to address resources for staff safety, including equipment, systems, and personnel.	Organizational and department budgets <i>reflect adequate resources for staff safety, including equipment, systems, and personnel.</i>	Organizational and department budgets reflect adequate resources for staff safety, including equipment, systems, and personnel. <i>These budgets are reviewed by senior leaders.</i>	Organizational and department budgets reflect adequate resources for staff safety, including equipment, systems, and personnel. These budgets are reviewed <i>and championed</i> by senior leaders.	AVG: 2.6 22% 2s 55% 3s 22% 4s	Review with WPS VAT. We do budget for resources, but are they used?
Safety Reporting System	The organization does not have a workforce safety reporting system.	The organization <i>has a workforce safety reporting system</i> to identify physical harm.	The organization has a workforce safety reporting system <i>that allows for anonymous reporting by employees and staff, physical and psychological harm, and captures (control) job hazards by position.</i>	The organization has <i>an integrated patient and workforce safety system</i> that allows for reporting of <i>physical and psychological events of harm and anonymous reporting by all employees/staff and patients and families. The system includes stratification of sociodemographic data, evaluation of and plans to identify inequities, and monitoring and evaluation to foster meaningful action to address inequities.</i>	AVG: 3.1 11% 2s 66% 3s 22% 4s	Work with W/C and internal system to stratify data by SE factors with a view to workforce equity

Workforce Safety

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
Priority Safety Programs	The organization tracks several or all of the following priority programs: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, and violence prevention.	The organization tracks the following priority programs: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, and violence prevention. <i>The organization has developed an action plan to respond when an injury occurs.</i>	<i>Action plans for workforce safety include metrics and are developed for some departments.</i> The organization tracks the following priority programs: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, and <i>psychological safety.</i>	Action plans for workforce safety include metrics and are developed and implemented <i>for all departments.</i> At a minimum, these plans include the following priority programs: slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, and psychological safety.	AVG: 2.7 55% 2s 22% 3s 22% 4s	Refer to WPS VAT and Action plan for these items (do sync up with our KPIs)
Safety Events	Workforce safety is discussed only when there is a serious safety event.	The organization <i>engages in intermittent communication with staff</i> about workforce safety hazards, incident rates, safety stories, and actions taken to improve workforce safety.	The organization engages in <i>frequent communication</i> with staff about workforce safety hazards, incident rates, safety stories, and actions taken to improve workforce safety.	The organization is <i>fully transparent</i> about and engages in <i>regular communication with staff</i> about workforce safety hazards, incident rates, safety stories, and actions taken to improve workforce safety.	AVG: 3.0 33% 2s 33% 3s 33% 4s	Ongoing. Refer to WPS VAT
TOTAL SCORE:					AVG: 20.3	
Workforce Safety						
SIGNIFICANT IMPACT (18-23)						

Workplace Safety Program Roadmap



Learning System

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
Harm Events	Harm events and reported near misses are reviewed periodically, but not consistently. Voluntary and anonymous reporting is sporadic.	The organization follows up on serious harm events, but lessons learned are not shared with the entire organization.	The organization has clear processes in place in some areas to evaluate and learn from near misses and safety events, including voluntary and anonymous reporting systems available to all staff and defined event review processes	The organization has clear processes in place to evaluate and learn from near misses and safety events across the organization, including voluntary and anonymous reporting systems available to all staff, defined event review processes, and audit systems.	AVG: 3.7 11% 2s 11% 3s 77% 4s	Continue
Patient Engagement	There is no process to engage patients and families and/or their involvement in learning systems is discouraged.	Less than one quarter of the areas of the organization engage patients and families in learning systems and feedback processes.	The organization includes patient and family representatives in at least half of all learning systems and feedback processes.	The organization includes patient and family representatives in all learning systems and feedback processes.	AVG: 2.2 77% 2s 22% 3s	Reinstitute pts/fam in Lean teams, re-up PFACs
Event Review	Organizational leaders are not involved in event investigations. Information is not shared and transparency is discouraged.	Clinical leaders are involved in event investigations. Information is shared in the involved department/service only.	Clinical leaders are involved in event investigations. Information is shared in the involved department/service and learnings are communicated to staff. There are some examples of improvement spurred by reported events.	Clinical leaders are involved in event investigations. Information is shared in the involved department/service and learnings are regularly communicated to all staff. All team members can share examples of improvements spurred by reported events.	AVG: 3.7 33% 3s 66% 4s	Continue
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.	AVG: 3.3 33% 2s 22% 3s 44% 4s	Continue, review patient safety curriculum for 2022 update needs
Learning Networks	The organization does not participate in learning networks.	Although the organization is a member of a learning network, participation is limited.	The organization has started actively participating in a system-wide and/or external learning network that shares data and established best practices. The organization has developed a plan to integrate this learning.	The organization actively participates in a system-wide and/or external learning network that shares data and established best practices. The organization integrates this learning in an ongoing way.	AVG: 3.8 22% 3s 77% 4s	Continue – IHI, internal (BPTs, VAT), other

Learning System

	SCORE: 1	SCORE: 2	SCORE: 3	SCORE: 4	ROW SCORE	ACTION PLAN
Safety Goals	The organization's goals are vague and do not specify patient safety.	The organization's goals <i>include specific patient safety goals</i> , 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 <i>specific patient safety goals, shares learning, and incorporates evolving evidence-based best practices</i> with the aim of eliminating specific types of harm and improving safety.	The organization <i>adopts bold national goals</i> , shares learning, and incorporates evolving evidence-based best practices with the aim of eliminating specific types of harm and improving safety.	AVG: 4.0 100% 4s	Bold Goals!
TOTAL SCORE:					AVG:21	
Learning System						
					EXEMPLARY PERFORMANCE (21-24)	

“Harm Across The Board”, Bold Goals make a difference

Original: Partnership for Patients

Bold Goals: From the Board to front lines

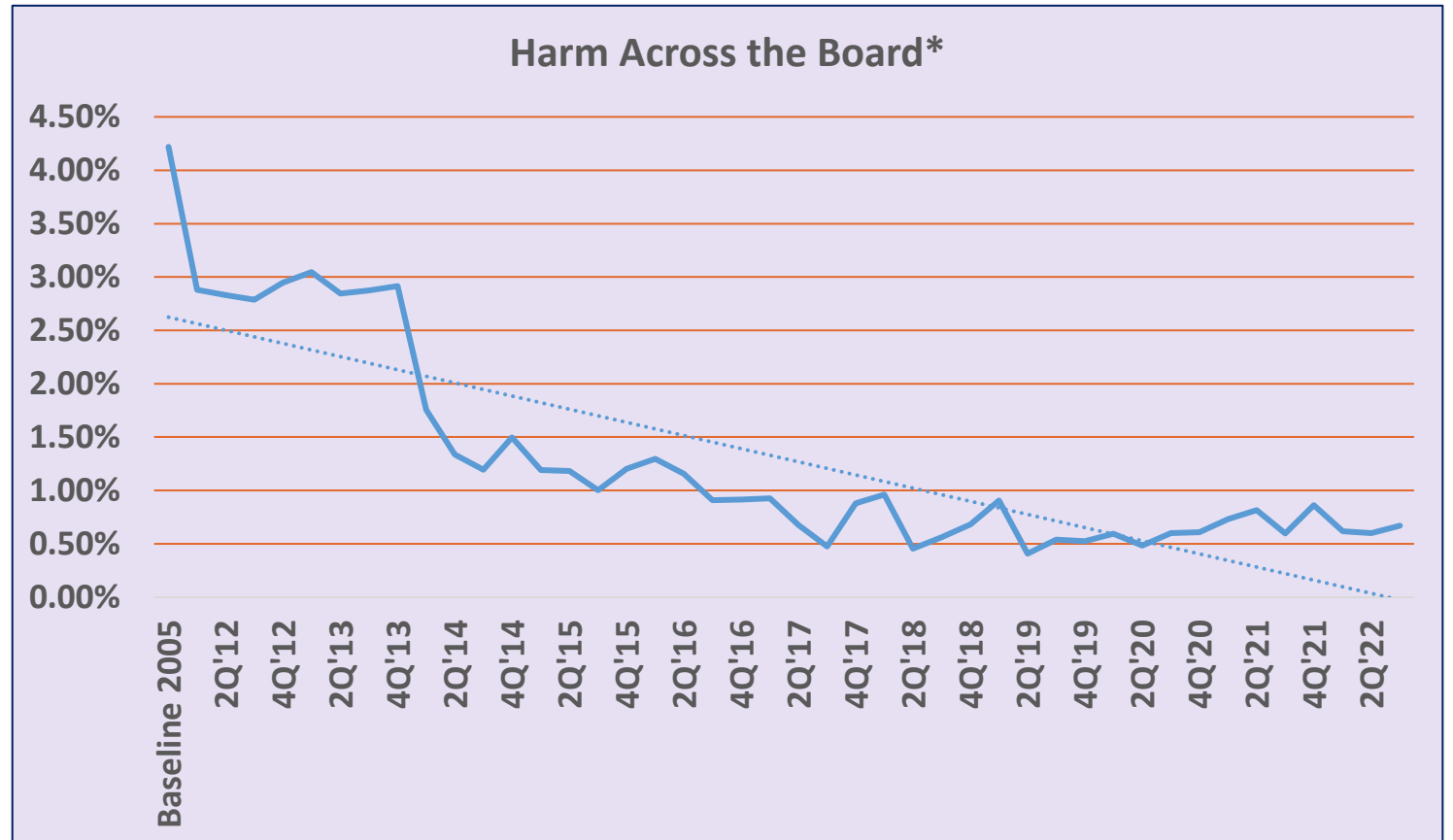
84% reduction, sustained

Reliability

And more to do...

p.s. There is no such thing as surge ... our new normal

***Healthcare Acquired Infections, Early Elective Deliveries, Falls with Injury, Healthcare Acquired Pressure Injuries, NTSV C-Section patients to get to WHO Goal, Sepsis Mortality reduction, pediatrics**



Where we are now in 2023

Leveraging the National Action Plan to refocus



- Created an action plan for each item
- Discussed with MC Quality Close and Committee
- Activated/ing key ideas and solutions
- Executive Quality Leaders monitoring for gap closure
- Updating and discussing progress with our governance members, clinicians, teams

Synergy with Joy at Work



Question



What is your #1 key take-a-way from these presentations?

The National Action Alliance to Advance Patient Safety Summer Webinar Series



- June 27, 2:00 -3:00 PM ET: CDC, Addressing Violence in the Workplace <https://cma.ahrq.gov/actionalliancejune>
- July 25, 2:00 -3:00 PM ET: AHRQ, Involving Patients & Families in Safety <https://cma.ahrq.gov/actionalliancejuly>
- August 22, 2:00 -3:00 PM ET: CMS, Engaging Boards and Executive Leadership in Safety <https://cma.ahrq.gov/actionallianceaugust>

THANK YOU!