CMS 2024 Quality Conference

Resilient and Ready Together

Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

Chartering the Course to Zero Harm

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

Tejal Gandhi, MD, MPH, CPPS

Chief Safety and Transformation Officer

Press Ganey Associates LLC

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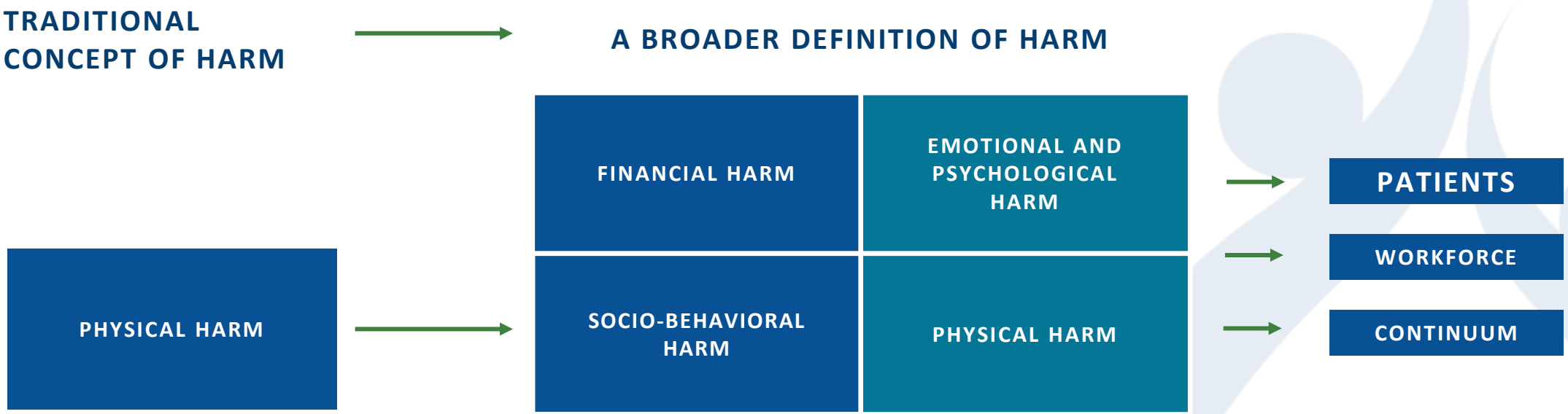
Patient Safety

> “
>
> Patient safety is a public health issue.
> Despite progress, preventable harm remains unacceptably frequent.
>
> Significant mortality and morbidity quality of life implications adversely affects patients in every care setting.
>
> *Gandhi TK et al. NEJM Catalyst 2020*

We See Harm Beyond Physical Safety (1)



The Traditional Conception of Harm and Compared to a Broader Definition of Harm
Dr Tejal Gandhi, NEJM Catalyst

Safety Current State (1)

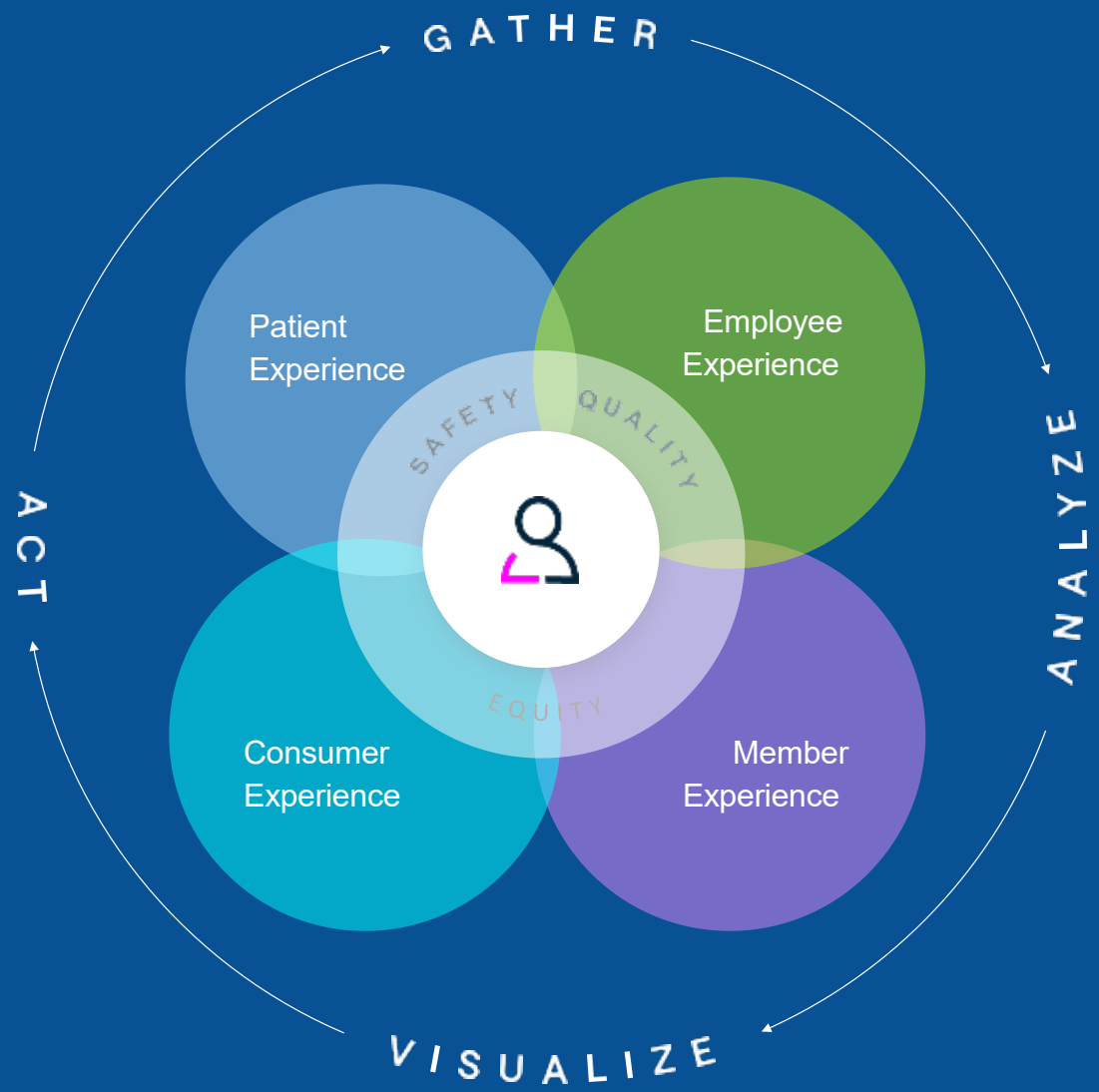
Safety Culture

Press Ganey trends showed worsening nationally but starting to recover

Safety culture is a leading indicator of outcomes

Patient Safety Outcomes

- NDNQI data showed worsening of CLABSI, falls, pressure injuries now with some recovery



Workforce Safety

- Workplace violence increasing
- Reduced engagement and resilience
- Staffing challenges

Safety and Equity

- Inequities in harms for patients and workforce more visible
- Renewed focus on equity nationally

Safety Current State (2)

Safety Culture

Press Ganey trends showed worsening nationally but starting to recover

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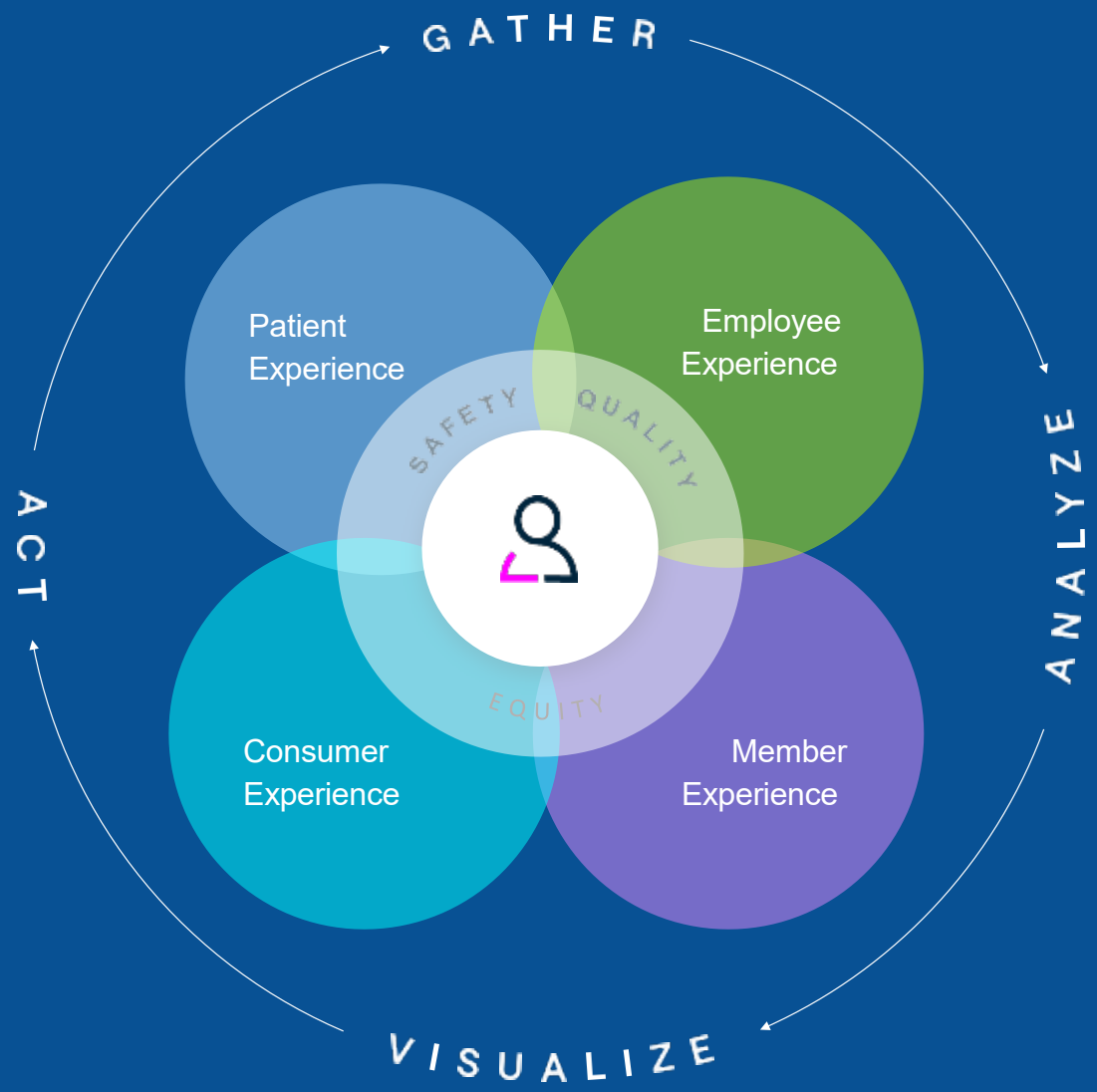

Workforce Safety

- Workplace violence increasing
- Reduced engagement and resilience starting to rebound
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Patient Safety Outcomes

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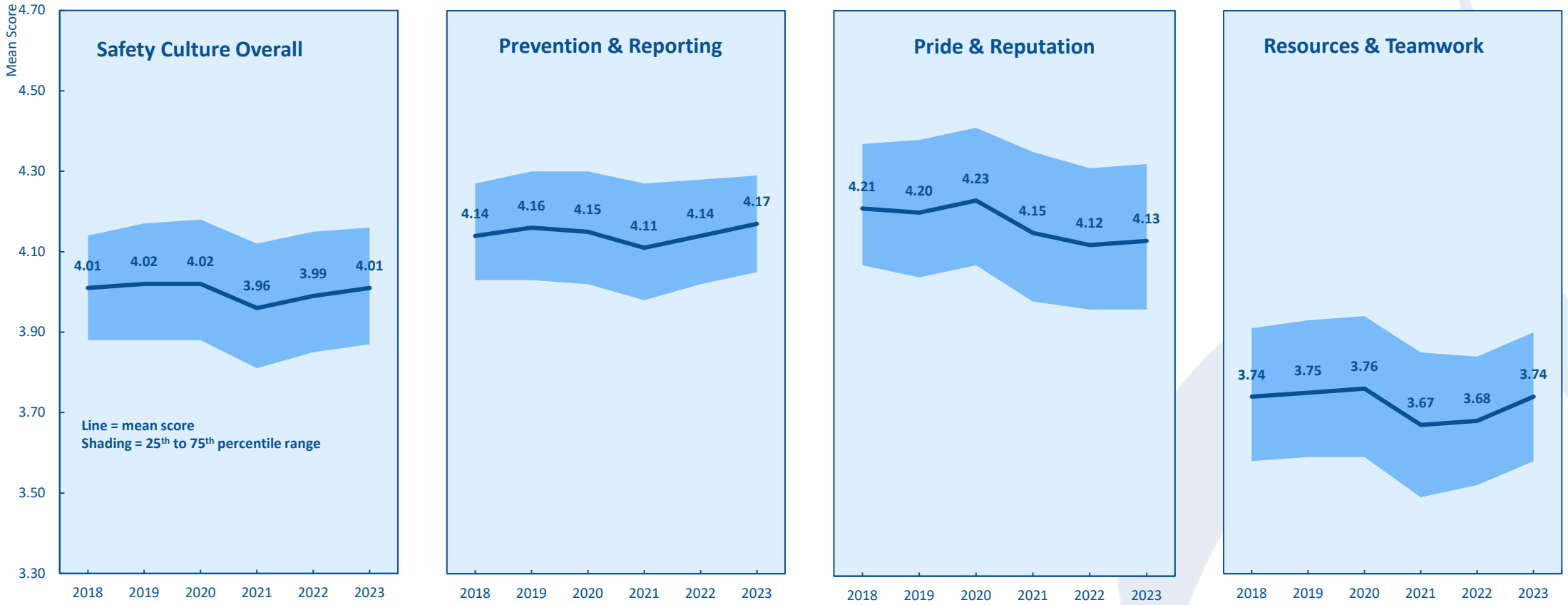
Safety and Equity

- Inequities in harms for patients and workforce more visible
- Renewed focus on equity nationally

Safety Culture is starting to see upward trends

- **After declines in safety culture and its sub-components during the pandemic, we are starting to see organizations rebound, and in some cases return to pre-pandemic levels**

- **Resources & Teamwork remain the lowest sub-component. Prevention & Reporting is starting to surpass pre-pandemic performance**



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Safety Current State (3)

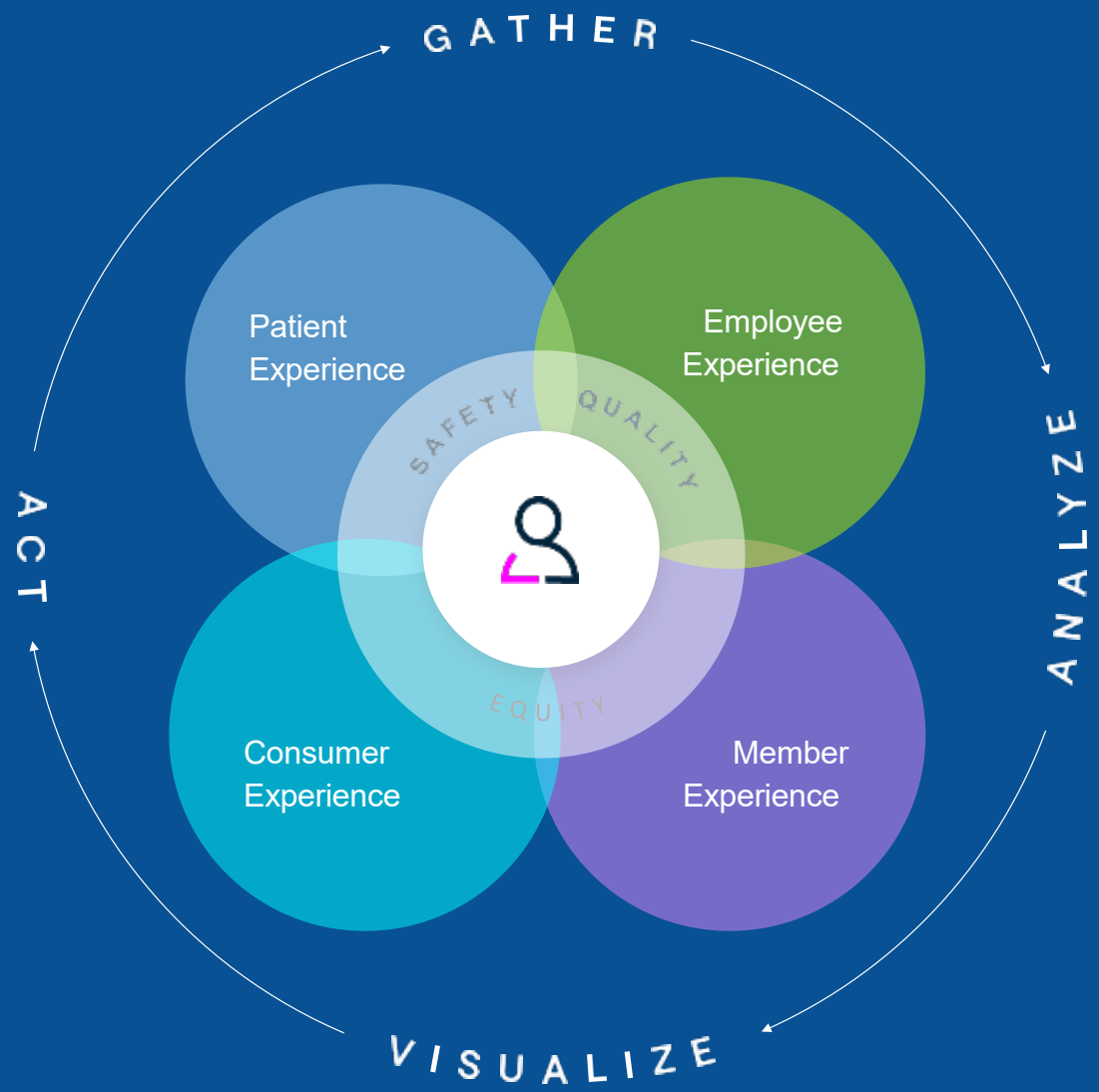
Safety Culture

Press Ganey trends showed worsening nationally but starting to recover

Safety culture is a leading indicator of outcomes

Patient Safety Outcomes

NDNQI data showed worsening of CLABSI, falls, pressure injuries now with some recovery



Workforce Safety

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Safety and Equity

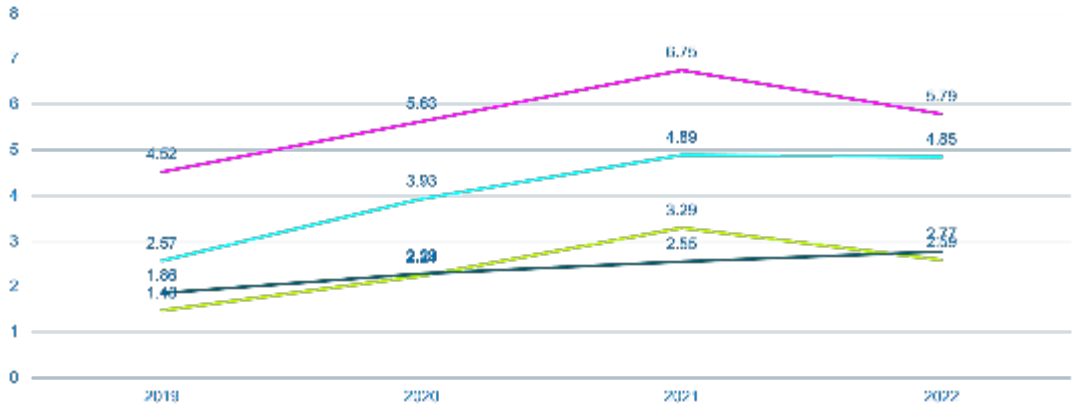
- Inequities in harms for patients and workforce more visible
- Renewed focus on equity nationally

NDNQI Safety Outcome Trends

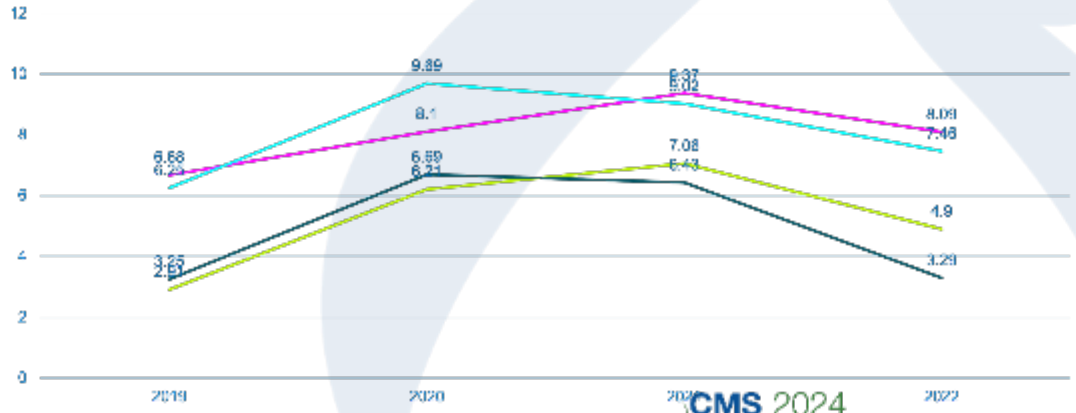
Central line associated blood stream infections (CLABSI) rates by acuity over time

Total fall rates by acuity over time

% Hospital-Acquired Pressure Injury (HAPI) by acuity over time



Ventilator-Associated Events (VAE) rates by acuity over time



Adult Critical Care | Adult High Acuity | Adult Moderate Acuity | Adult Step-Down

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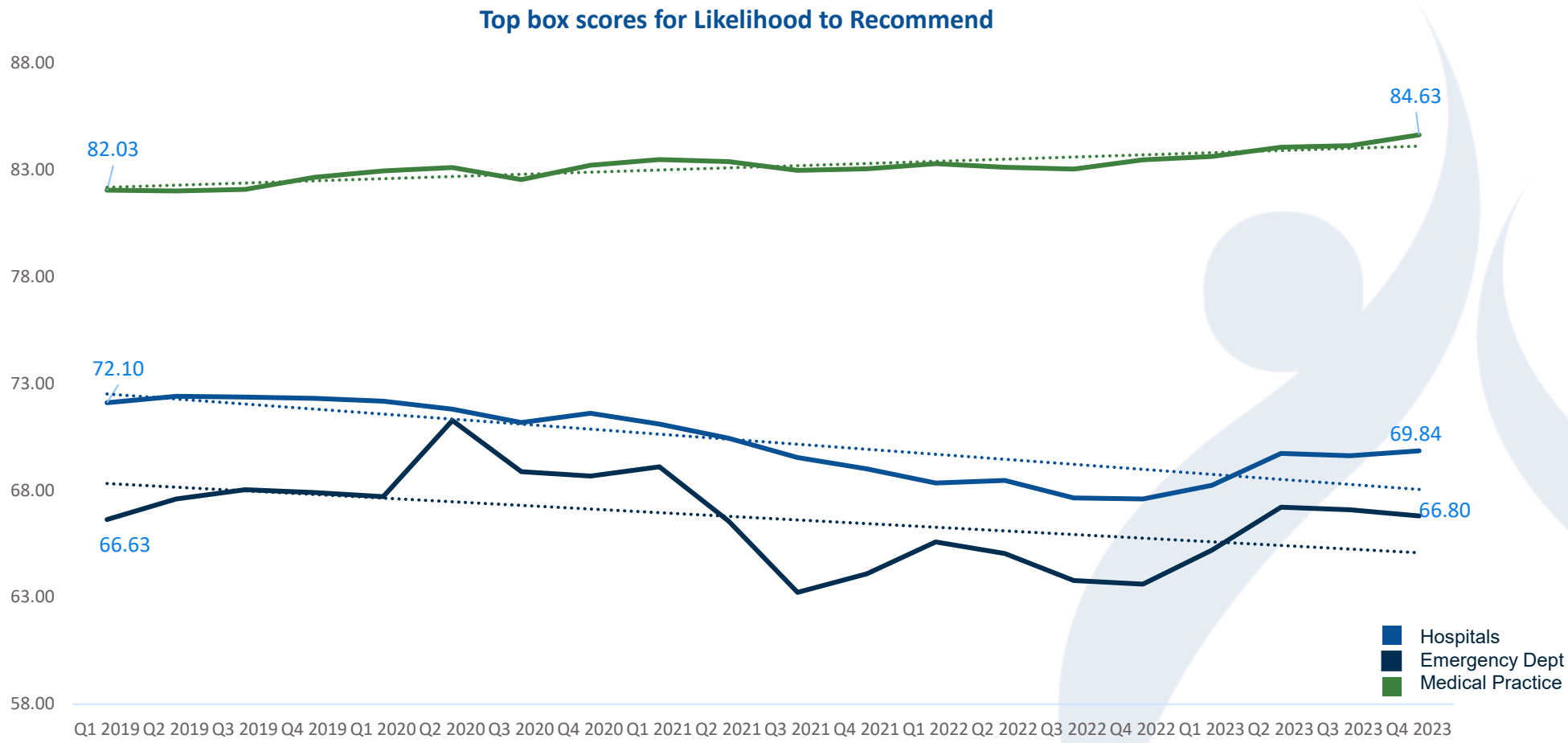
Patient experience rebounds to near pre-pandemic levels



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Safety Current State (4)

Safety Culture

- Press Ganey trends show worsening nationally but starting to recover
- Safety culture is a leading indicator of outcomes

Patient Safety Outcomes

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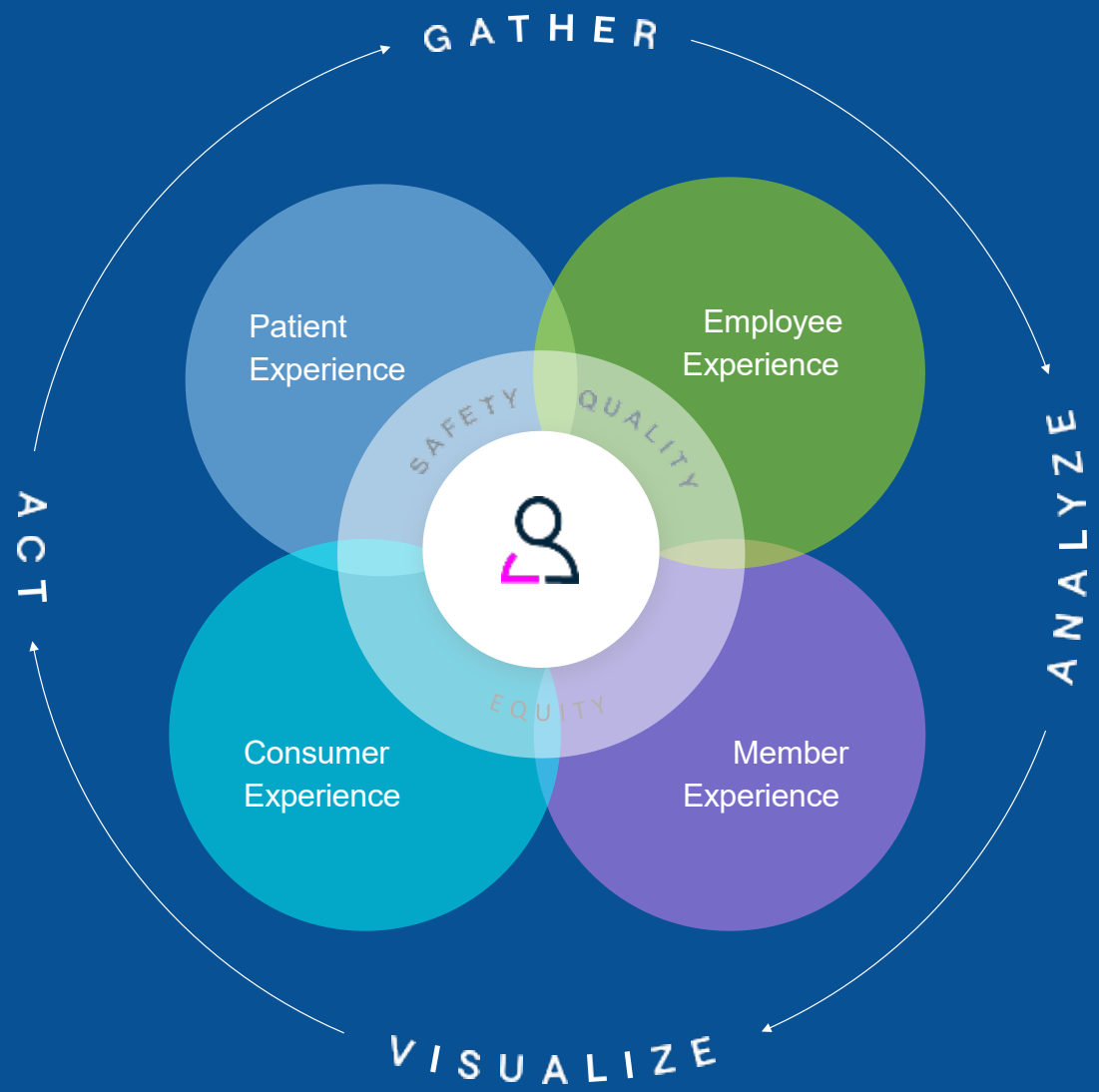


Workforce Safety

Workplace violence increasing

Reduced engagement and resilience starting to rebound

Staffing challenges

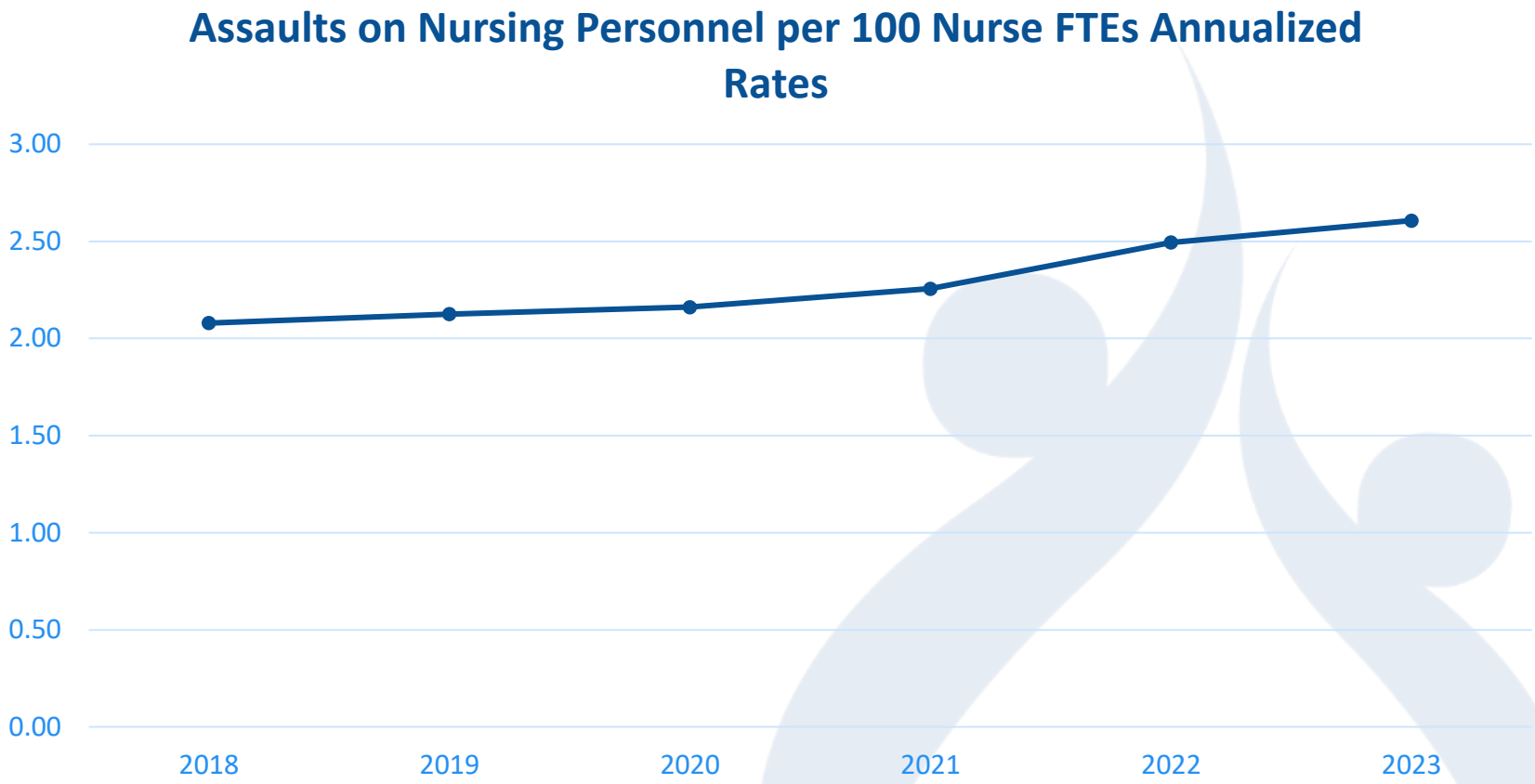
Safety and Equity

- Inequities in harms for patients and workforce more visible
- Renewed focus on equity nationally

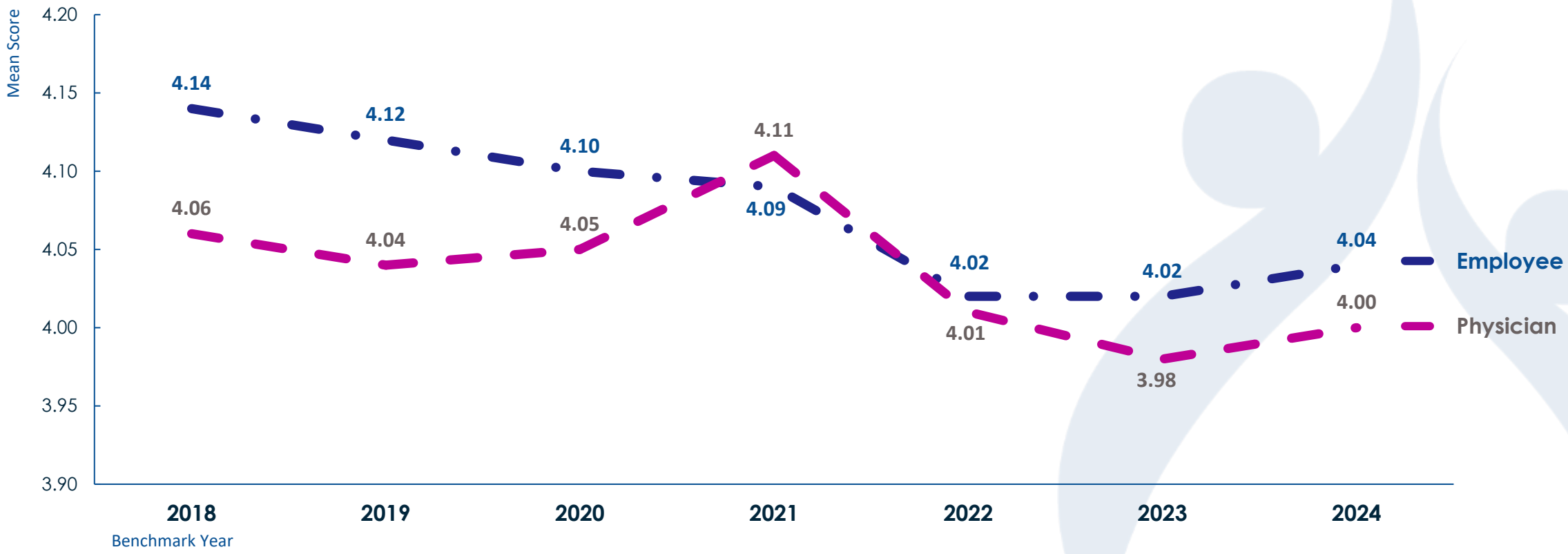
Year Trends Analysis

Overall rate is increasing

2023 has significantly higher annual rates compared to 2018, 2019 and 2020



Engagement stabilizing after years of decline



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Safety Current State (5)

Safety Culture

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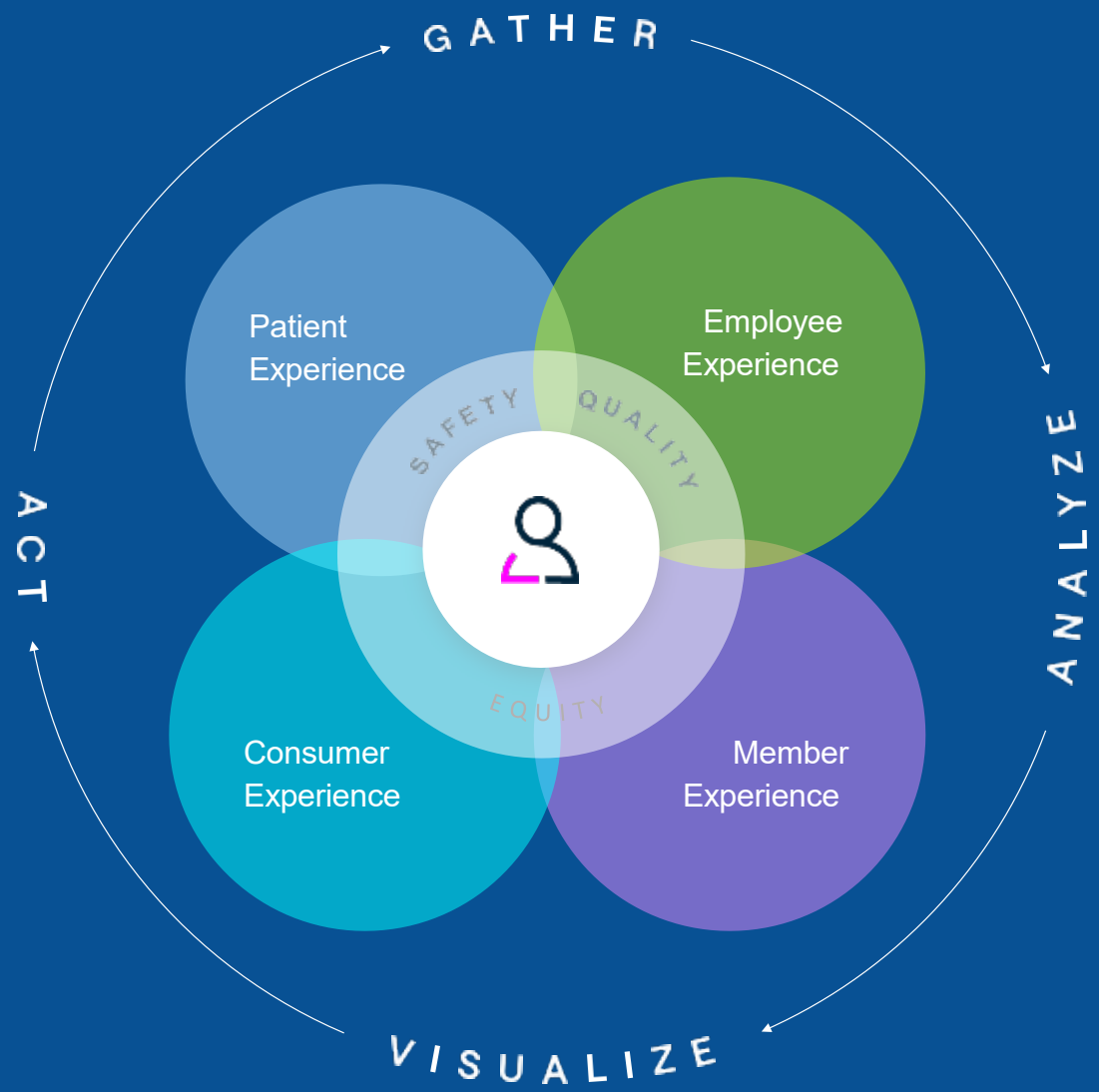
Patient Safety Outcomes

- NDNQI data shows worsening of CLABSI, falls, pressure injuries with some recovery



Workforce Safety

- Workplace violence increasing
- Reduced engagement and resilience
- Staffing challenges

Safety and Equity

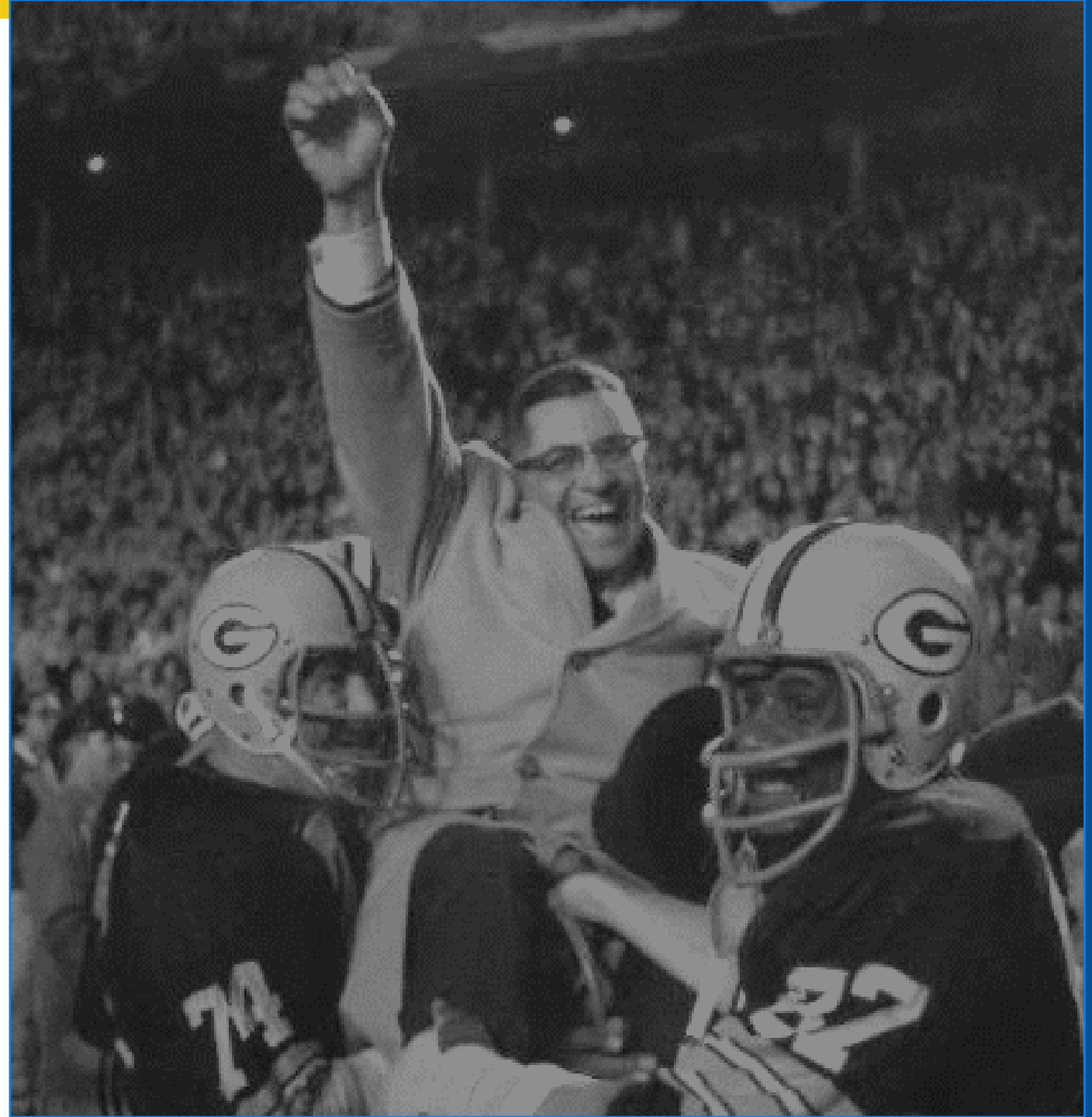
Inequities in harms for patients and workforce more visible

Renewed focus on equity nationally

Inequities Cause Harm

There is no such thing as high-quality, safe care that is inequitable.

Sivashanker K and Gandhi TK. NEJM 2020

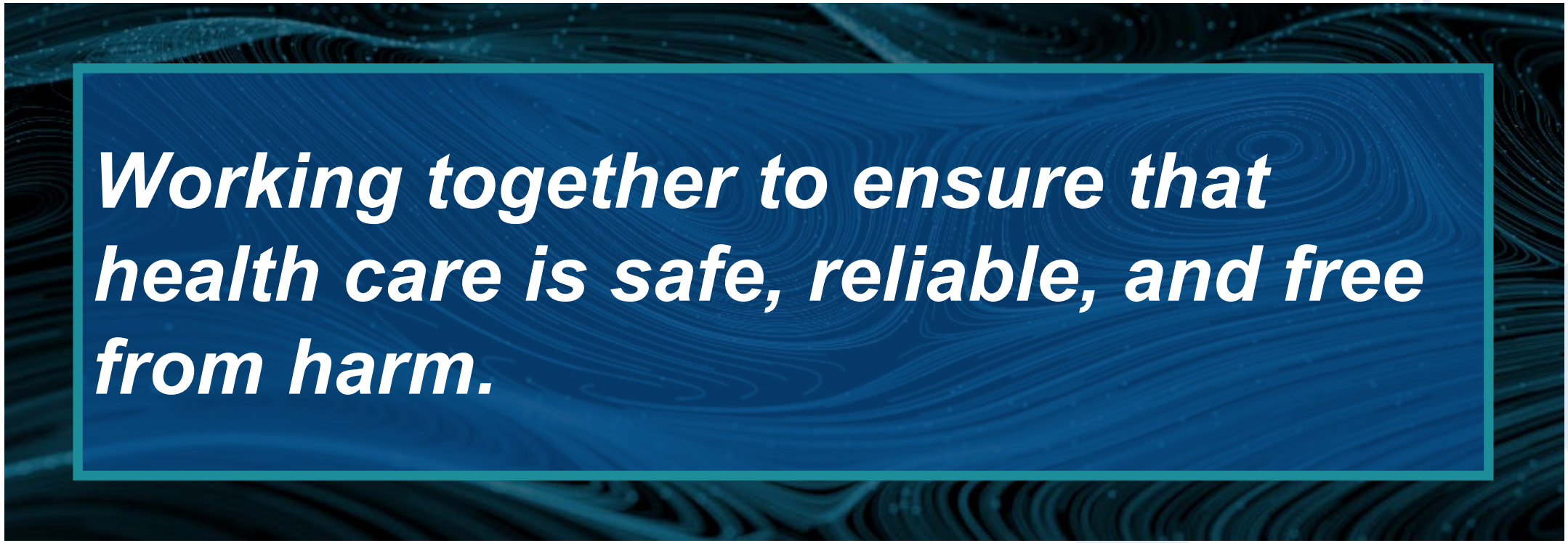


Vince Lombardi, the venerated head coach of the NFL's Green Bay Packers in the 1960s, famously told his players:

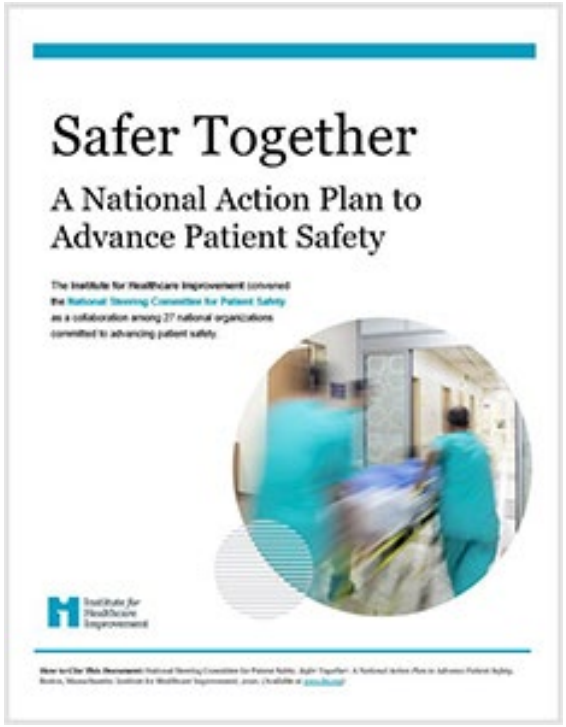
Perfection is not attainable.
But if we chase perfection, we can catch excellence.

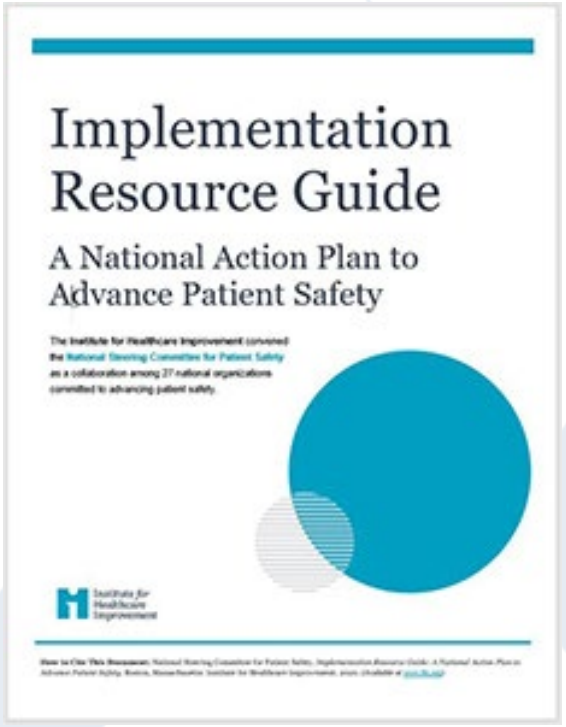
This is exactly what's occurring in ambitious, forward-looking health systems today. By chasing zero, they are achieving excellence.

National Steering Committee Vision



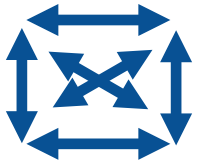
National Action Plan for Safety





National Action Plan Foundational Areas

Culture, Leadership & Governance



Equity

Patient & Family (Person) Engagement

Learning Systems

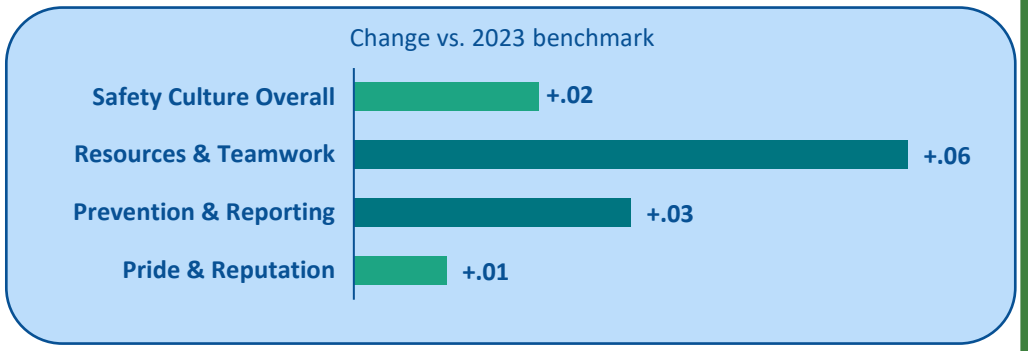
Workforce Safety

Culture, Leadership, and Governance

Culture, Leadership, Governance
Aim: Health care organization governing boards and CEOs across the care continuum establish and sustain a strong culture of safety in a way that is equitable and engaging of patients, families, care partners, and the health care workforce.

Leverage the influence of leadership and governance to commit to safety as a core value of the organization and drive the creation of a strong organizational culture.

Safety Culture



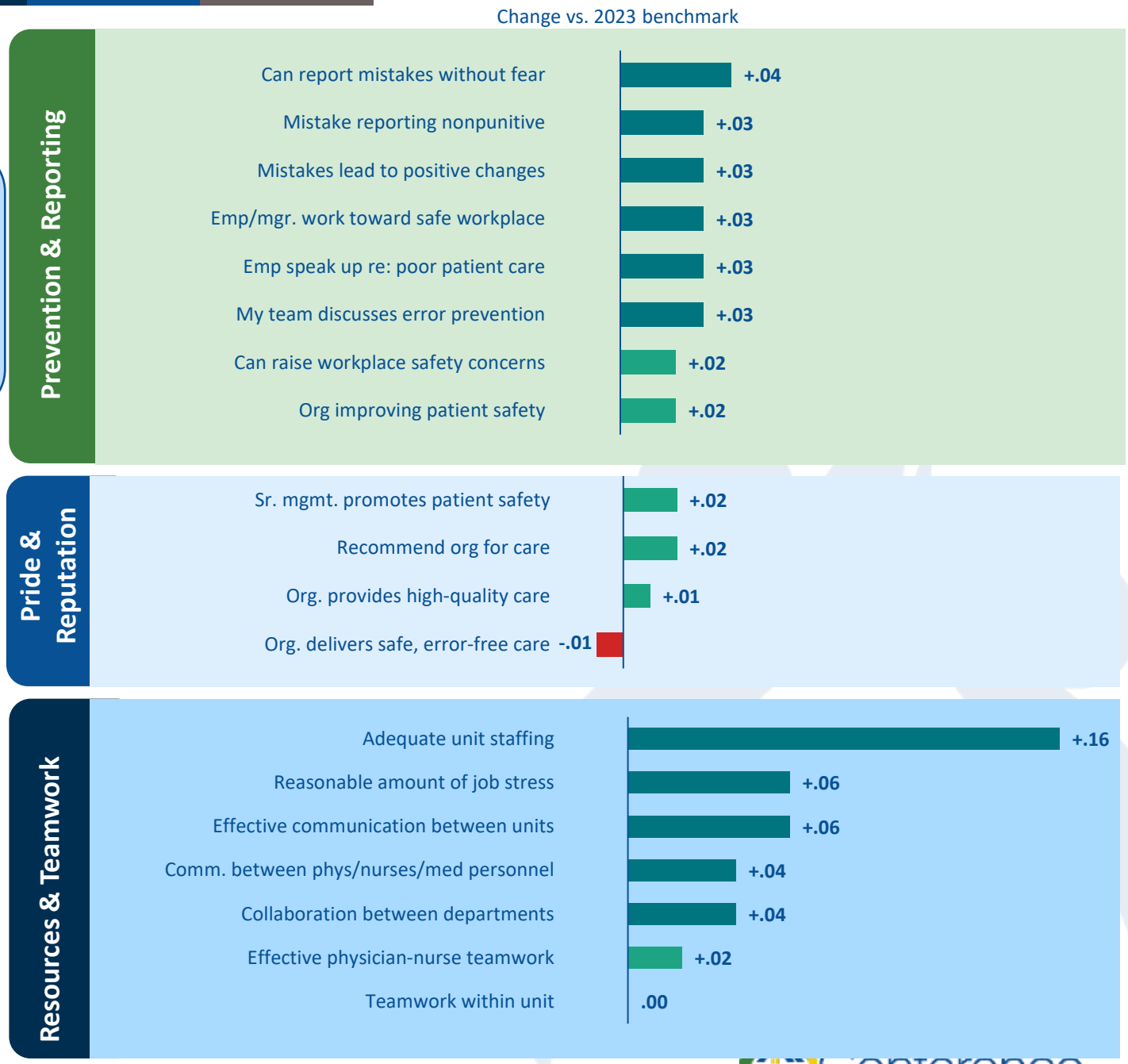
Organizations have made significant improvements in safety culture, with the largest improvements in resources & teamwork.

While staffing continues to be a struggle for most organizations, perceptions of staffing has significantly increased since the 2023 benchmark. Teamwork between groups is also starting to improve.

Prevention & Reporting items have all increased, with many items related to psychological safety as the items with the most improvement, indicating many organizations have put effort into this area over the past year.

Small improvements were made for most of the Pride & Reputation items, with only one item declining for that group of items around the delivery of safe, error-free care.

Data based on 1-year lookback benchmark

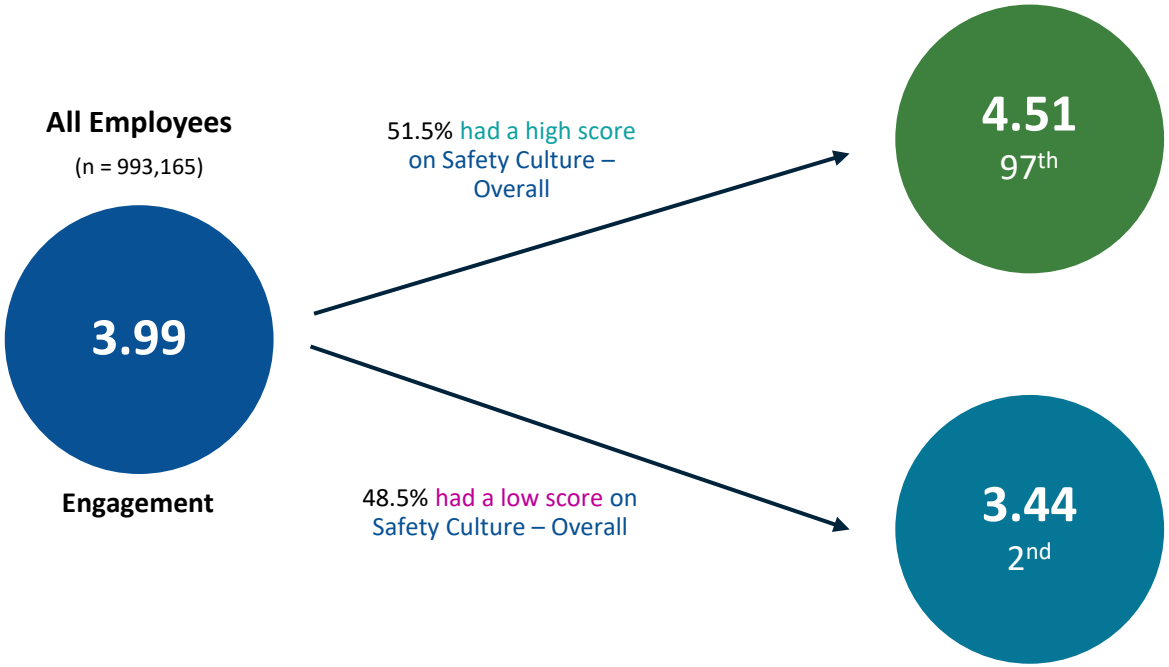


Connections

- Safety Culture is strongly correlated with engagement
- Perceptions of Diversity and Engagement are strongly related
- Perceptions of Diversity are strongly related to Safety Culture

Perception of Safety is Strongly Related to Engagement

Safety Culture – Overall



Data from 2023 EV Projects measuring both Safety Culture and Engagement (complete modules). N = 192 projects, n = 993,165 employees.

- When employees report **high perceptions of safety**, their average Engagement score is **4.51**
- However, when employees **do not report optimal perceptions of safety**, their Engagement mean score **decreases to 3.44**

Safety Culture - Segmented

	Ethnicity vs. Non-Hispanic or Latino	**Race** vs. White or Caucasian						**Sex** vs. Male
	Hispanic or Latino *(n = 12,236)*	American Indian or Alaska Native *(n = 665)*	Asian *(n = 9,035)*	Black or African American *(n = 16,007)*	Native Hawaiian or other Pacific Islander *(n = 383)*	Other *(n = 4,789)*	Two or more races *(n = 3,081)*	Female *(n = 113,660)*
Safety Culture-Prevention & Reporting	-0.01	0.01	**0.05**	**-0.04**	-0.06	**-0.05**	**-0.07**	**-0.05**
Mistakes lead to positive changes	0.01	0.01	**0.07**	**-0.04**	0.00	**-0.03**	**-0.07**	**-0.02**
Org is improving patient safety	0.00	0.01	**0.08**	-0.01	-0.02	**-0.03**	**-0.05**	**-0.03**
Mistake reporting is non-punitive	0.00	-0.02	**0.09**	**-0.08**	-0.04	**-0.05**	**-0.11**	**-0.02**
My team discusses error prevention	0.00	0.04	**0.05**	**-0.03**	-0.05	**-0.04**	**-0.04**	**-0.05**
Emp/Mgr work toward safe workplace	0.00	0.03	**0.09**	**-0.04**	-0.07	**-0.06**	**-0.07**	**-0.05**
Emp speak up re: poor patient care	-0.01	0.00	**0.02**	**-0.03**	-0.04	**-0.06**	**-0.06**	**-0.06**
Can report mistakes without fear	**-0.03**	0.00	-0.01	**-0.06**	**-0.15**	**-0.10**	**-0.08**	**-0.06**
Can raise workplace safety concerns	**-0.03**	-0.03	0.01	**-0.06**	**-0.10**	**-0.09**	**-0.09**	**-0.08**

On average, employees who identify as **Hispanic or Lati** score **0.03 points lower** on **"Can raise workplace safety concerns"** vs. employees who identify as Non-Hispanic or Latino in the same system and job category.

Bold indicates statistically significant difference from comparison group.

Model controls for project. Prefer not to Answer responses excluded.

For a 50th percentile facility:
+ 0.05 = increase of 9-13 percentile ranks
- 0.05 = decrease of 8-10 percentile ranks
(2021 Nat'l Healthcare Avg)

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Safety Culture Transformation

Adopt a goal of Zero Harm and message on safety.
Measure and make harm visible.

Foster a fair and just culture.

Practice daily check-ins for safety (e.g. huddles)

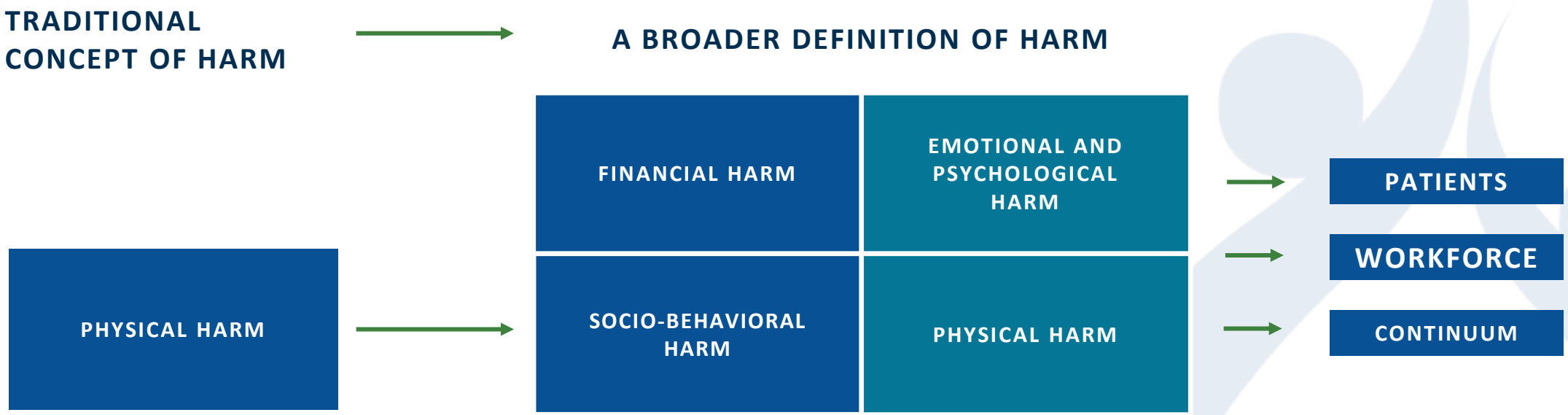
Zero Harm: Fundamentals for Safety Culture Transformation,
Press Ganey 2018

Workforce Safety

Workforce Safety
Aim: Health care organizations across the care continuum implement strategies to measurably and equitably improve safety for health care professionals and all staff in their organizations.

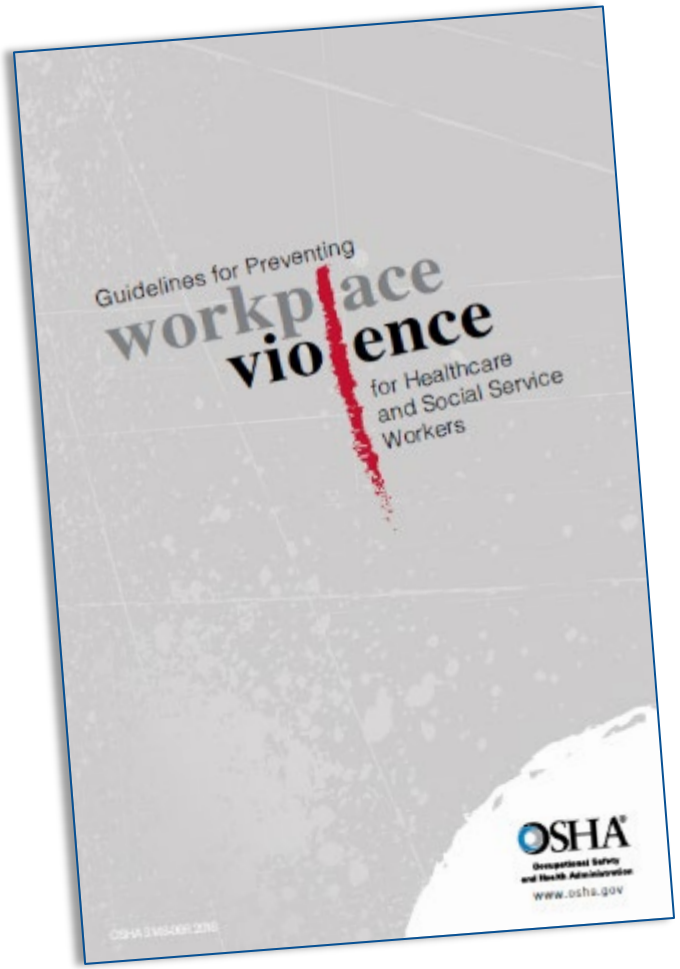
Commit to workforce physical, psychological, and emotional safety and wellness, and full and equitable support of workers.

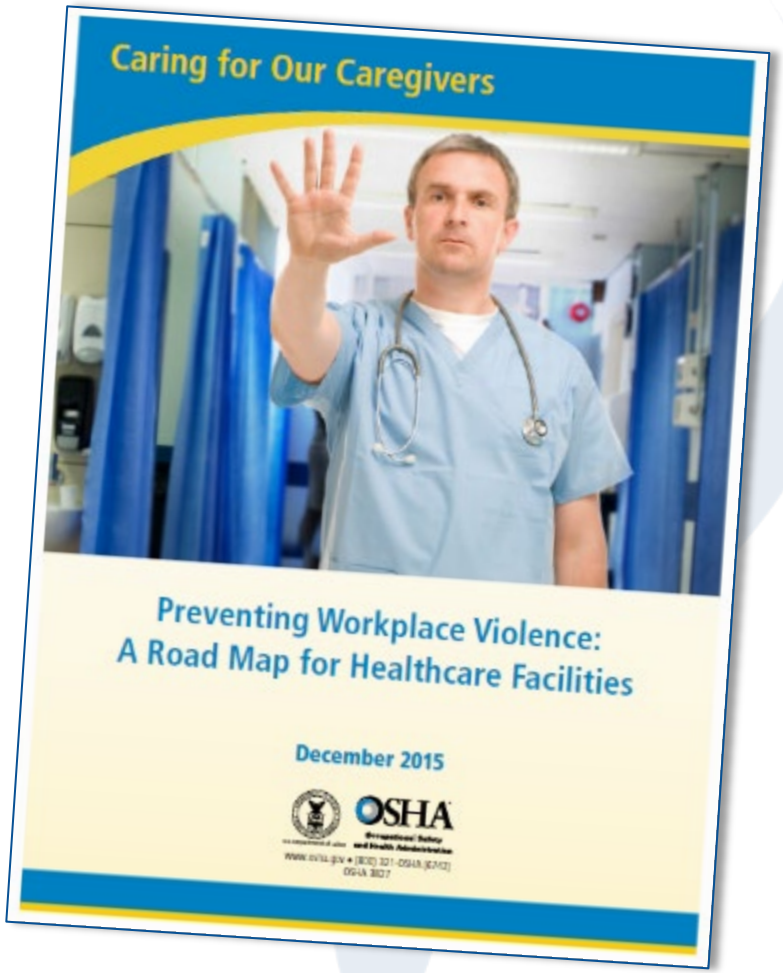
We See Harm Beyond Physical Safety (2)



The Traditional Conception of Harm and Compared to a Broader Definition of Harm
Dr Tejal Gandhi, NEJM Catalyst

Workplace violence prevention tactics





Workplace violence

Joint Commission

January 1, 2022, new and revised workplace violence prevention standards apply to all Joint Commission-accredited hospitals and critical access hospitals

Provide a framework to guide hospitals in developing effective workplace violence prevention systems, including:

- leadership oversight
- policies and procedures
- reporting systems
- data collection and analysis
- post-incident strategies
- training, and education to decrease workplace violence

Improving Engagement and Resilience

- Rounding, Listening
- Workflow, Operational Efficiency
- Job Do-ability

- Psychological Safety
- Development & Training
- Coaching & Mentoring
- Build community

- Pro-active peer support outreach
- De-stigmatize MH support & make it easy to access
- Financial support where needed

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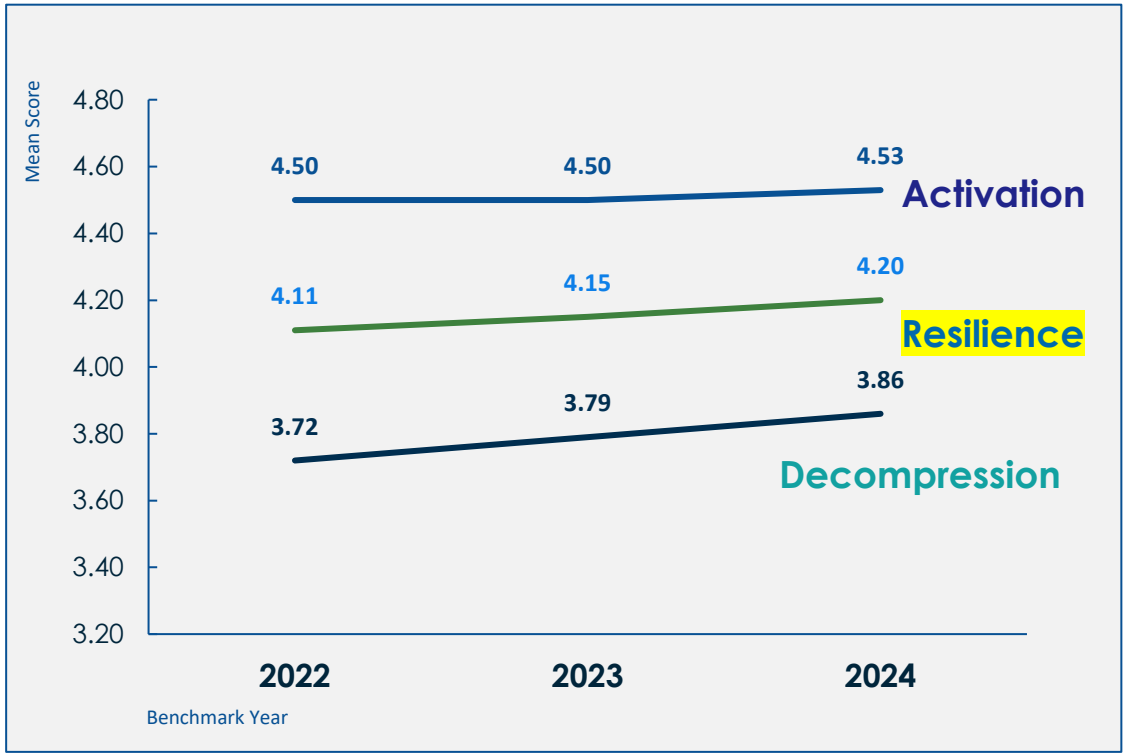
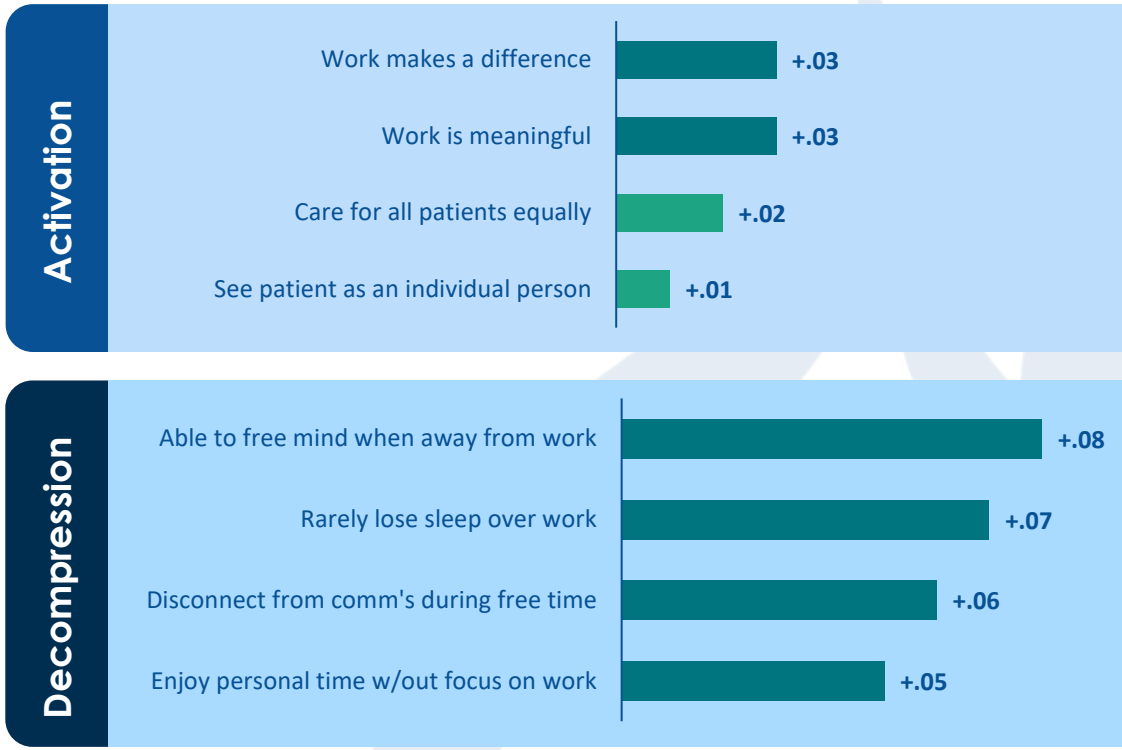
Gaining ground in resilience

3-year trending



Item-level change vs. 2023 benchmark



Data based on 1-year lookback benchmark

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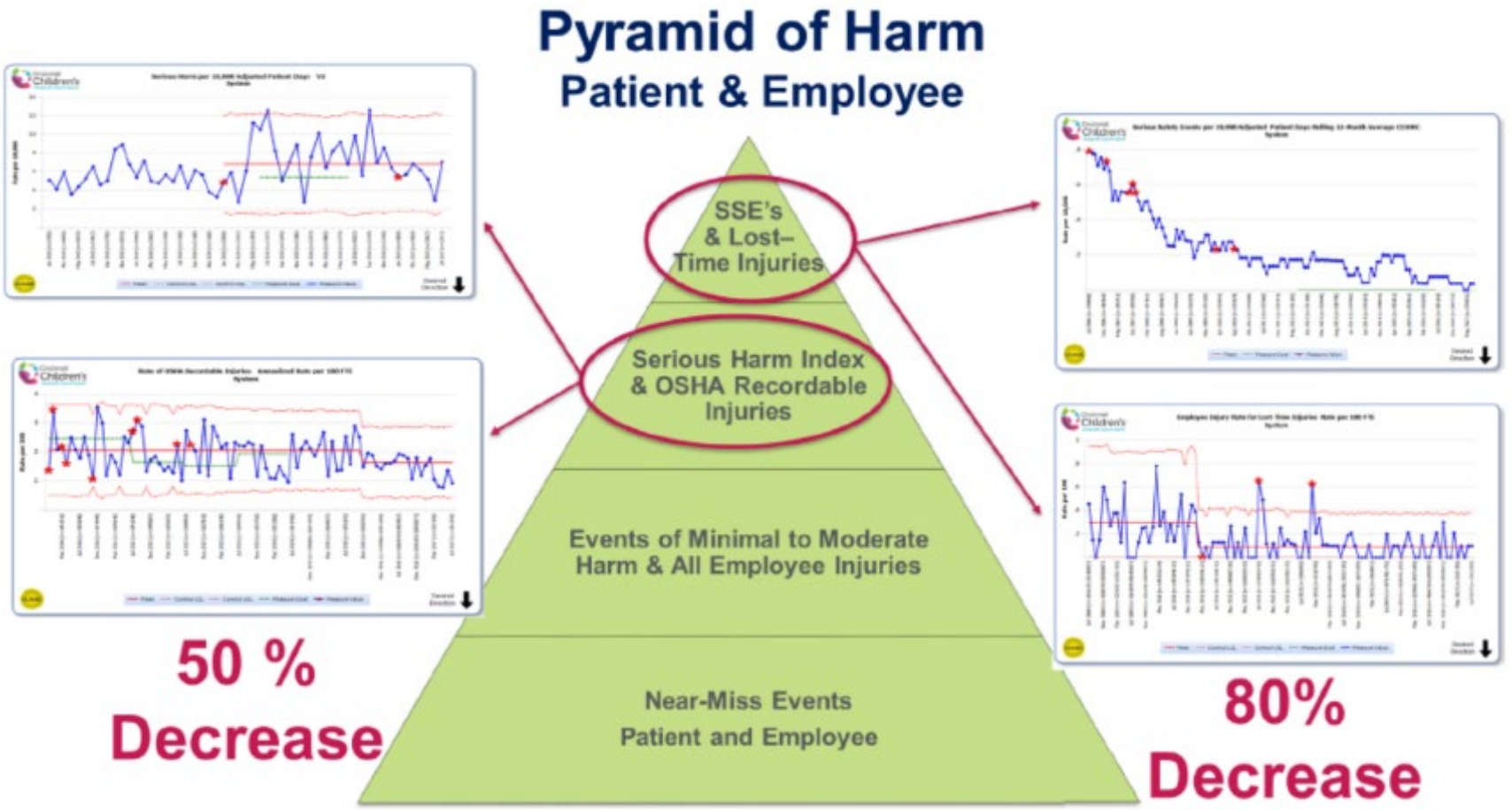
Pyramid of Harm



Slide courtesy of Dr. Steve Muething, Cincinnati Children's

Patient and Family Engagement

Patient and Family Engagement
Aim: Health care organizations institute strategies to improve safety, as defined by patients, families, care partners, and the workforce, in all settings across the care continuum.

Commit to the goal of fully engaging patients, families, and care partners in all aspects of care at all levels.

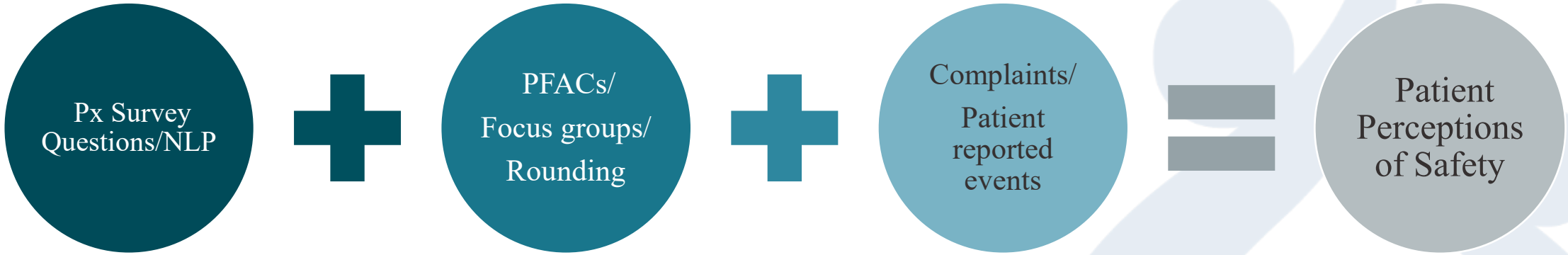
Partner With Patients and Families for the Safest Care

- “Nothing about me without me”
- “What Matters to You”
- Patients and families need to be actively engaged at all levels of health care
- Patient involvement needs to be authentic
- Studies link patient engagement with
  - Patient satisfaction
  - Safer care
  - Improved work experience for caregivers
  - Better health outcomes

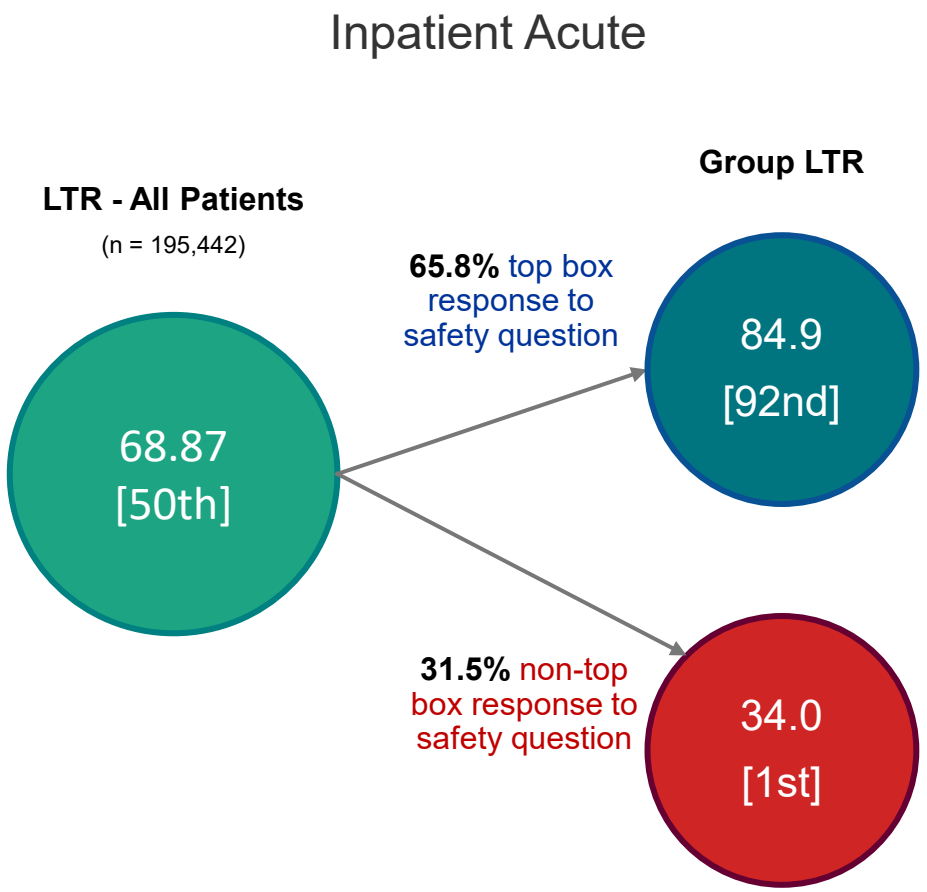
The Four Levels of Engagement

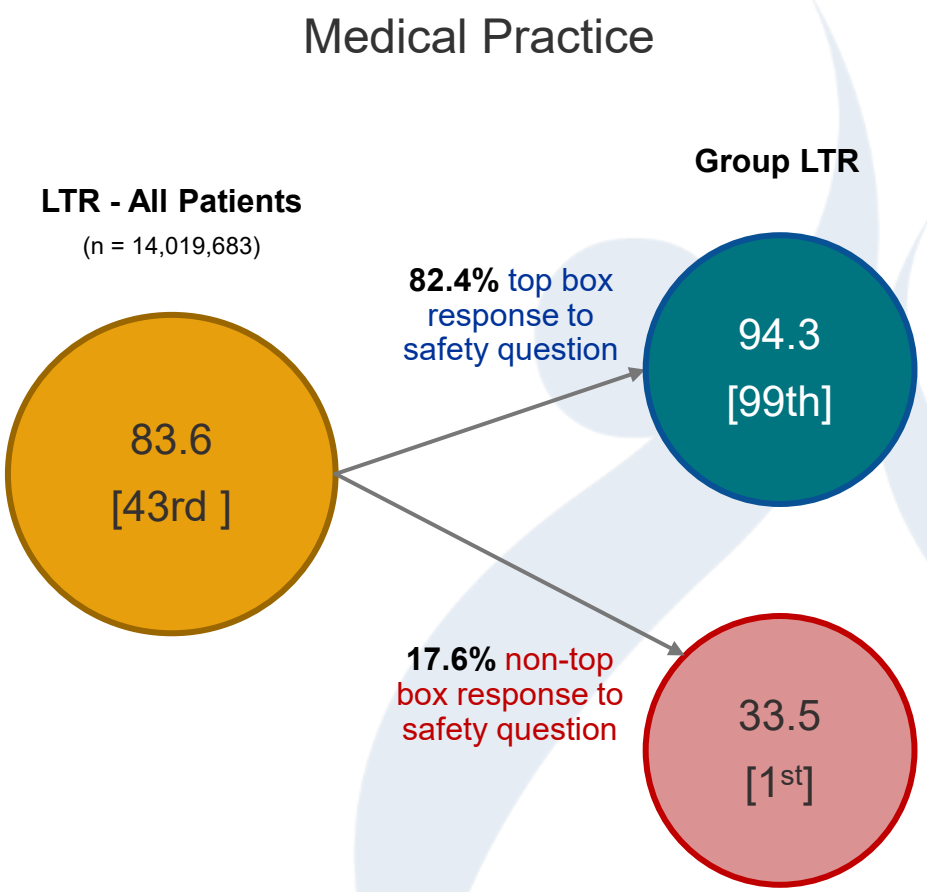
The framework/declaration was originally developed for the World Innovation Summit for Health (WISH) 2013, an initiative of Qatar Foundation. See WISH Patient Engagement Report (available at www.wish-qatar.org/reports/2013-reports).

Listening Everywhere for Safety



Patients who feel unsafe are 2.5-3x less likely to recommend





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ORIGINAL RESEARCH

How do hospital inpatients conceptualise patient safety? A qualitative interview study using constructivist grounded theory

Emily Barrow,[1] Rachael A Lear,[1,2,3] Abigail Morbi,[2] Susannah Long,[1,3] Ara Darzi,[1,2] Erik Mayer ,[1,2,3] Stephanie Archer [1,2,4,5]

This study aimed to understand how hospital inpatients across three different specialties conceptualise patient safety and develop a conceptual model that reflects their perspectives.

This study adds to the growing body of evidence that suggests patients predominantly conceptualise patient safety in the context of what makes them **'feel safe',** which is distinct from clinical and academic definitions of safety.

BMJ Quality & Safety Published Online First: 05 October 2022. doi: 10.1136/bmjqs-2022-014695

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Type Of Action	Definition and Examples
Performed Actions	Actions performed by patients themselves (e.g. reporting safety concerns)
Received Actions	Actions performed by others, but received by patients (e.g. receiving medication or treatment from hospital staff)
Shared Actions	Actions undertaken by patients and others (e.g. monitoring and checking care)
Observed Actions	Actions that are directly observed by patients (e.g. cleaning/staff undertaking clinical tasks)
Interaction	The model acknowledges that the quality of interaction between patients and others (hospital staff, and friends, family or carers) is important in shaping patients' feelings of safety.

BMJ Quality & Safety Published Online First: 05 October 2022. doi: 10.1136/bmjqs-2022-014695

What Patients Say About Safety Should Drive Improvements in Safety

- With artificial intelligence (AI), we are now able to see trends and gain insights from large volumes of patients' comments, where patients describe their experiences with all aspects of their care, including safety.

- Qualitative study themes:
  - Comfort with safety of their care
  - Cleanliness
  - Courtesy and respect

President's Council of Advisors on Science and Technology to the President

Recommendation 3B: Improve Data and Transparency to Reduce Disparities

- CMS should incentivize healthcare facilities to collect self-reported patient race/ethnicity information as part of their safety improvement efforts.
- AHRQ should encourage patient safety organizations (PSOs) to collect, analyze, and disseminate information on racial and ethnic disparities in patient safety.
- AHRQ to lead the development and validation of new questions focused on racial/ethnic bias and patient safety in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, allowing CMS to require collection of patient perceptions of racial/ethnic bias and patient safety through existing surveys.

The Joint Commission Journal on Quality and Patient Safety 2023; 000:1–2

COMMENTARY

Now Is the Time to Routinely Ask Patients About Safety

Tejal K Gandhi, MD, MPH, CPPS

Engaging with patients and families in their care has long been advanced as a foundational strategy for achieving patient safety. One essential component of engagement is a better understanding of patient perceptions of safety. Patients and families are reliable observers of medical error, and patient reports of safety concerns often identify issues that are not documented in the chart and of which clinicians and organizations may not even be aware.[1–3] Common themes from patient reports of safety concerns relate to communication issues, staffing, environment of care, and provider behavioral issues, which can lead to physical harm, emotional harm, or both. Asking patients about safety broadens the approach to safety issue identification beyond safety event reporting and can capture concerns that are important to patients but overlooked by clinical reporting systems.[3] This additional lens is essential because safety reporting does not provide a truly comprehensive picture due to known underreporting and bias.[4]

Despite these benefits, directly and routinely asking patients about patient safety issues has not been a standard part of how health systems engage. Why? Paternalism is one reason—the belief that we in health care understand safety better and know what the issues are. Another barrier has been fear about our ability to appropriately respond to what patients identify, and potential litigation risks. Another common concern is that patients may not understand what we mean by "safety." Often safety can be confused with security—because these concepts are sometimes combined in a single question, though their meanings differ substantially. Another barrier is fear of unintended consequences—we don't want to ask about safety issues because of worry we might make patients afraid. However, the COVID-19 pandemic has changed the narrative. Patients have had to live daily with pandemic-related safety fears and fears of getting sick in health care environments. We should not underestimate patients' ability to identify safety concerns, and we need to value and act on the information. The benefits of asking about these issues to help identify solutions far outweigh the relatively low risk of worsening patient fears.

What are the best ways to ask patients about safety issues? Health systems have created patient and family advisory councils (PFACs) that often discuss safety problems or strategies for improvement with patients. PFACS, however, have a relatively small number of participants and often are challenged to include patients of diverse backgrounds. Patient complaints are another source of potential safety issues, and organizations should ensure that complaints are reviewed with that lens in mind. However, complaints also tend to come from a very small subset of patients.

Asking *all* patients about their experiences with safety is essential to really understanding patients' perceptions of safety concerns and then addressing them. One approach that has been explored is creating patient reporting systems where patients can report concerns about safety, but numbers of reports have been low.[5] A more impactful approach would be to leverage patient experience surveys. Required patient experience surveys (for example, Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS]) ask questions related to specific issues that could affect safety, such as explanations from clinical staff, communication about medications, or communication about discharge planning. However, these surveys currently do not routinely ask about safety explicitly.

When questions about safety are included in patient experience surveys, often as custom questions, valuable information can be obtained not only about safety but also about other related dimensions of quality. For example, a nationally used medical practice patient experience survey asks "how well the staff protected your safety (by washing hands, wearing ID, etc.)" and asks about patients' "likelihood to recommend [LTR] the practice." Analysis of more than 12 million survey responses found that patient perception of safe care had a strong association with LTR.[6] Therefore, efforts to improve both safety and patient experience must also include a robust understanding of safety perceptions of patients. There is also an untapped opportunity to analyze free-text comments in patient experience surveys or online consumer reviews using artificial intelligence to identify safety-related themes and better understand the context of why patients feel unsafe.

Therefore, the current patient experience survey approach should be modified to routinely include broader questions about patients' perceptions of safety, as well as questions related to specific safety issues such as medication errors, fall concerns, infection, or misdiagnosis. These kinds of questions could be incorporated into HCAHPS

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ORIGINAL RESEARCH

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Family Input for Quality and Safety (FIQS): Using mobile technology for in-hospital reporting from families and patients

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Abstract

Objective: Despite three decades of effort, ensuring inpatient safety remains elusive. Patients and family members are a potential source of safety observations, but systems gathering these are limited. Our goal was to test a system to gather safety observations from hospitalized patients and their family members via a real-time mobile health tool.

Methods: We developed a mobile-responsive website for reporting safety

ORIGINAL ARTICLE

Engaging Patients in the Use of Real-Time Electronic Clinical Data to Improve the Safety and Reliability of Their Own Care

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Objectives: There is considerable evidence that providing patients with access to their health information is beneficial, but there is limited evidence regarding the effect of providing real-time patient safety–related information on health outcomes. The aim of this study was to evaluate the association between use of an electronic patient safety dashboard (Safety Advisor) and health outcomes.

Methods: The Safety Advisor was implemented in 6 adult medicine units at one hospital in the United States. Study participants were asked to use the Safety Advisor, which provides real-time patient safety–related information through a Web-based portal. The primary outcome was the association between the application usage and health outcomes (readmission rate and mortality rate) per 3 different usage groups, and the secondary outcome was the association of Patient Activation Measure (PAM) scores with use.

Results: One hundred eighty-one participants were included for the data analysis. Approximately 92% of users accessed the application during the first 4 days of enrollment. 51.6% of users only accessed it on 1 day, whereas 5.8% used it more than 3 days. Patients who used the application more had lower 30-day readmission rates ($P = 0.01$) compared with the lower-usage group. The PAM scores for users of Safety Advisor (71.8) were higher than the nonpatient portal users (60.8, $P < 0.0001$).

Conclusions: We found an association between the use of Safety Advisor and health outcomes. Differences in PAM scores between groups were statistically significant. A larger-scale randomized control trial is warranted to evaluate the impact on patient outcomes among a high-risk patient population.

Key Words: patient safety, patient experience, patient engagement, adverse events

(*J Patient Saf* 2021;00:00–00)

Throughout the past few decades, patient safety has been in the forefront of health care research and improvement models.[1–5] Technology is advancing, and awareness of the importance of patient safety is increasing; thus, interventions to improve safety have proliferated. However, serious safety problems and risks still persist.[6–8] This is due in part to the challenges in detecting adverse events and other safety problems during hospitalization.[1,10–14] Previously, we have explored one avenue to combat this problem with the utilization of electronic health record (EHR) data.[15,16] Our prior work on a patient safety active management system has demonstrated that real-time detection and prediction of adverse events can be achieved.[17] Because this was a provider Web-based application, it left the door open to exploring possibilities of improving patient safety using a patient-centered application.

Because of the rapid changes in the condition of hospitalized patients, providing real-time information is invaluable for facilitating patient engagement and improving patient safety.[18–20] Having access to up-to-date data regarding their condition keeps patients properly informed and may proactively prevent adverse events, such as reducing medication errors and other safety outcomes.[21,23–25] In recognizing this need for up-to-date information, providing patients with access to a patient portal has become increasingly common.[21,22]

Previous studies have demonstrated limited results on the impact of patient portals on patient safety,[26,28] although more research is needed to draw more definitive conclusions.

In addition, providing clinical information through patient portals may have an impact on patient activation and health-related outcomes.[24,25,29,30] Furthermore, another possible benefit is the potential to transform the patient-physician relationship and help patients become more active in their own disease management.[25] A strong patient-physician relationship has been shown to improve patient satisfaction and their ability to comprehend their health issues, increase adherence with medical treatments, and decrease overall health care costs.[31–34] One means to improve this relationship is to encourage patients to ask more questions about their care. However, patients do not always remember questions they may want to ask, or they may not know which questions are *right* to ask. Recently, the Agency for Healthcare Research and Quality developed an application for patients to use that allows patients to compile appropriate questions to ask their health care provider before their visit to improve this problem.[35]

In this study, we developed and implemented a patient-centered real-time patient safety dashboard (Safety Advisor) that includes patient safety–related information as well as a list of corrective or preventive actions for adverse events and questions to ask the health care team. This system was co-designed with patients and their caregivers.[25] We evaluated the feasibility and acceptability of sharing real-time patient safety information with patients and care partners in the inpatient environment for a 3-month intervention period. We hypothesized that through the use of Safety Advisor, providing patients with real-time patient safety–related information

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Dr Blake consults for EarlySense, which makes patient safety monitoring systems. He receives consulting compensation from CDO (Negev), Ltd, which is a not-for-profit incubator for health IT startups. He receives equity from ValueHealth, which makes software to help patients with chronic diseases. He receives equity from Clew, which makes software to support critical decision making in intensive care. He receives equity from MDClone, which takes clinical data and produces deidentified versions of it. Dr. Bates' financial interests have been reviewed by Brigham and Women's Hospital and Partners HealthCare in accordance with their institutional policies. Other authors disclose no conflict of interest.

Contributors: All authors have contributed sufficiently and meaningfully to the conception, design, and conduct of the study; data acquisition, analysis, and interpretation; and/or drafting, editing, and revising the manuscript.

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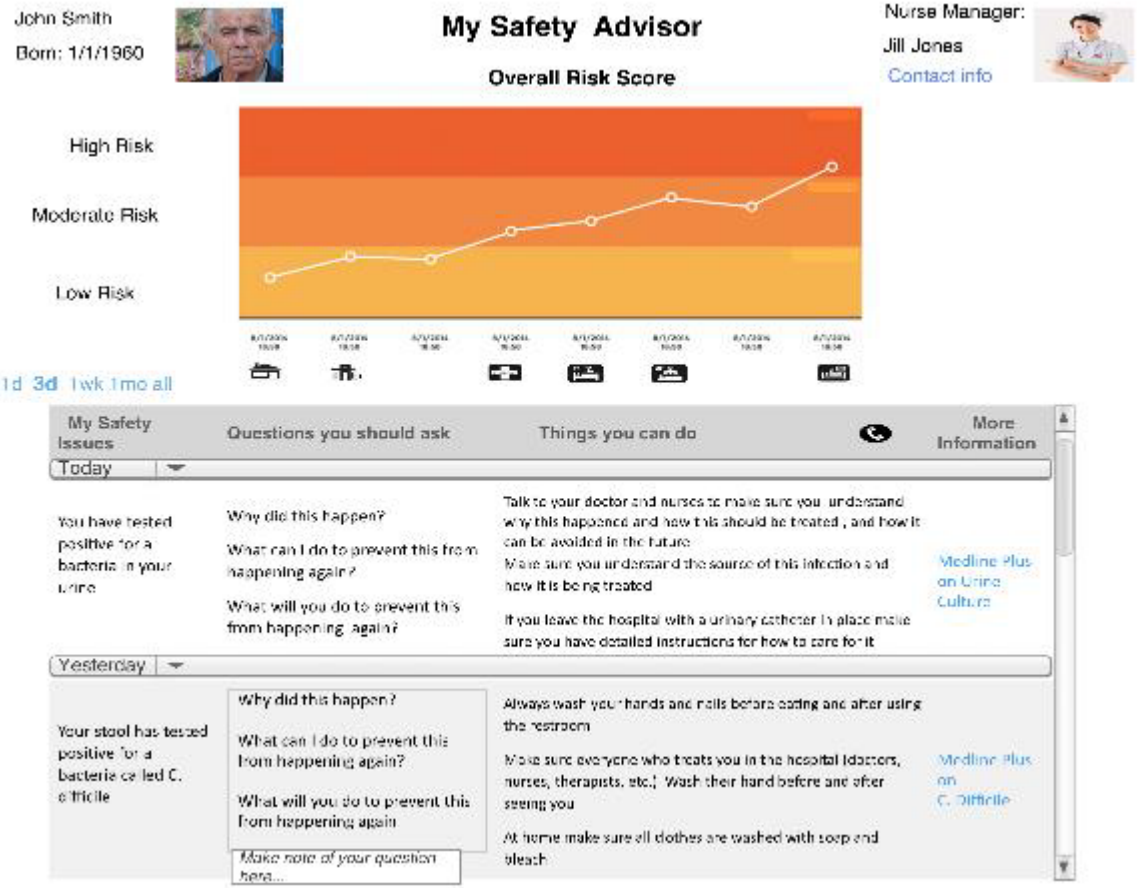

Higher activation, no increase in fear

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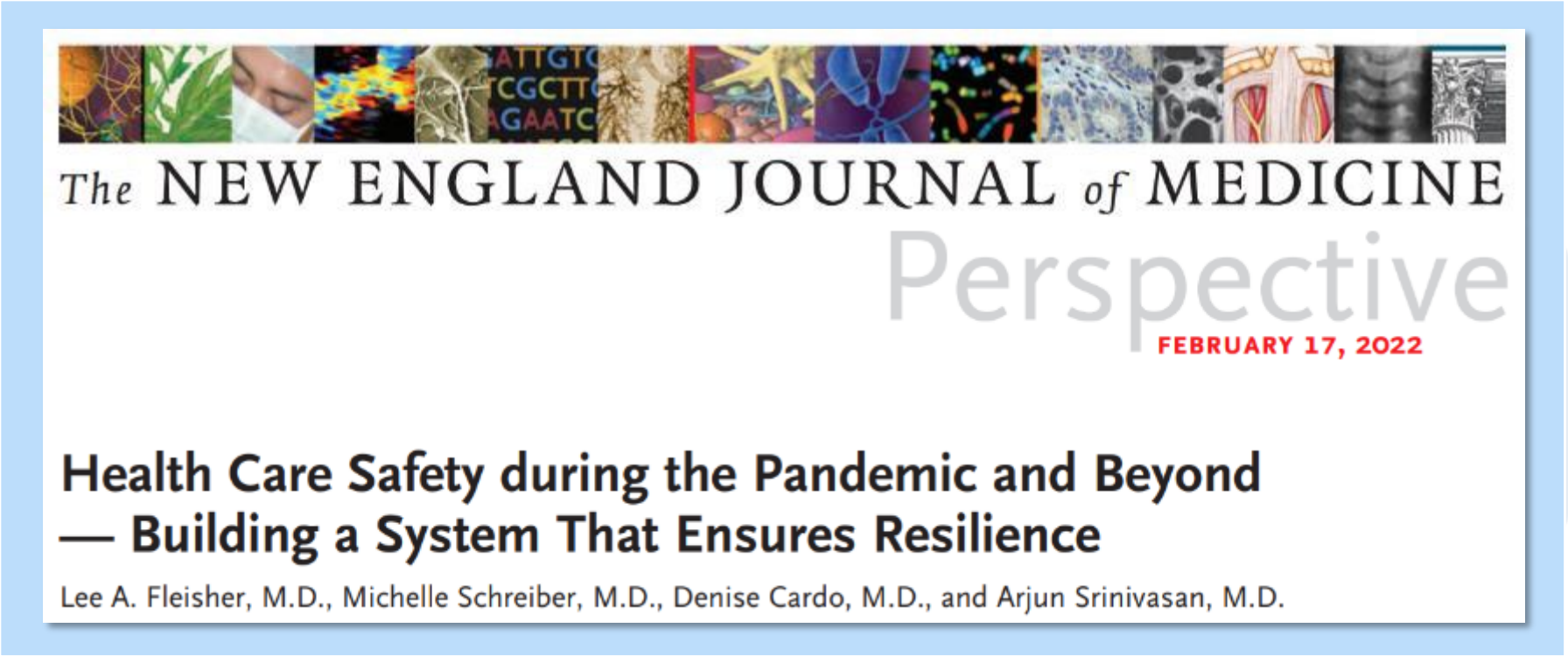
Learning Systems

Learning System
Aim: Health care organizations and other stakeholders across the care continuum implement reliable learning systems. These learning systems actively engage with local, regional, state, or national learning systems to develop a national learning network of existing and future learning systems.

Commit to continuous learning within organizations by creating and strengthening internal processes that promote transparency and reliability, and through sharing as part of an integrated learning system and networks.



"The health care sector owes it to both patients and its own workforce to respond now to the pandemic-induced falloff in safety by redesigning our current processes and developing new approaches that will permit the delivery of safe and equitable care across the health care continuum during both normal and extraordinary times. We cannot afford to wait until the pandemic ends."

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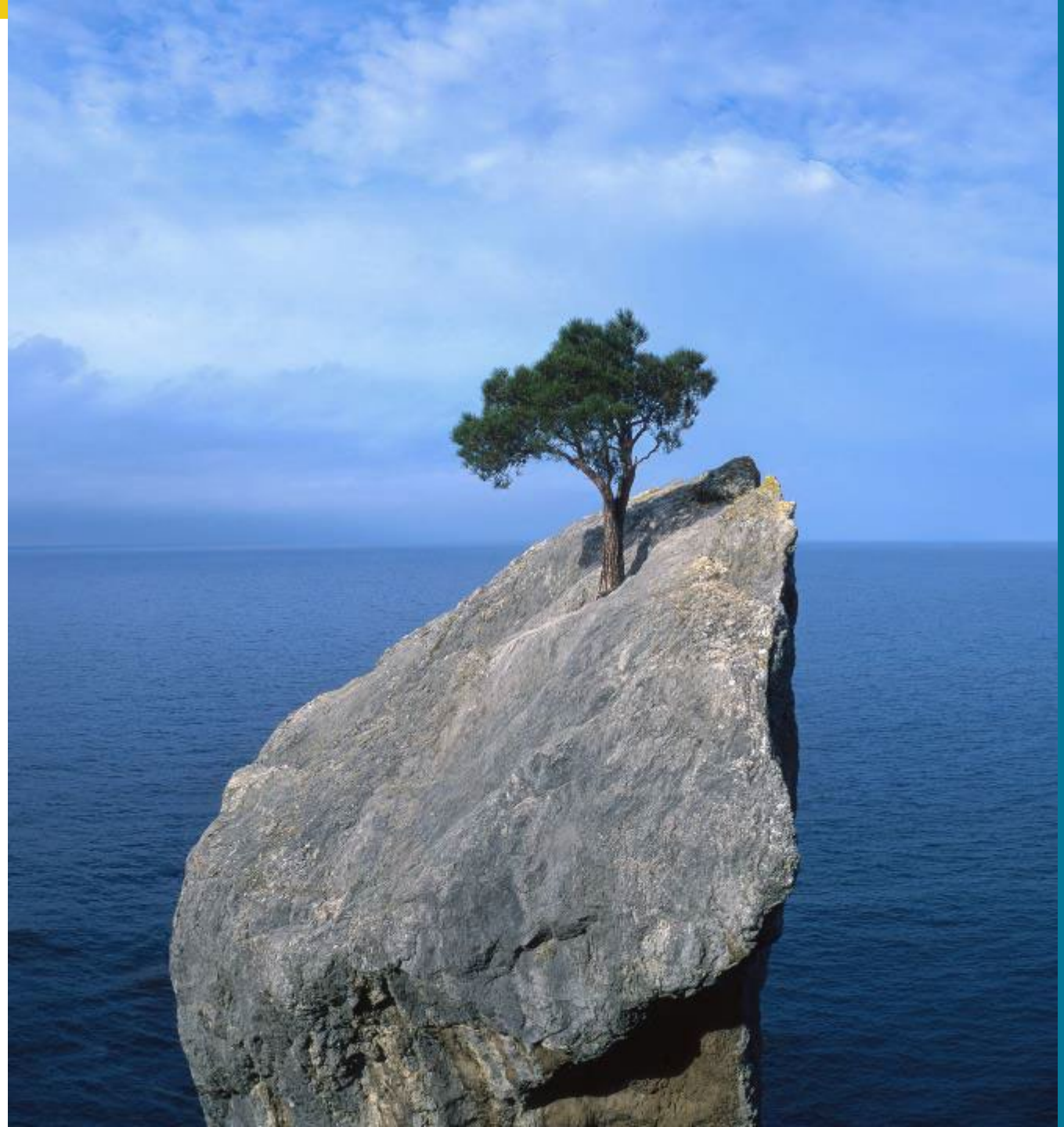
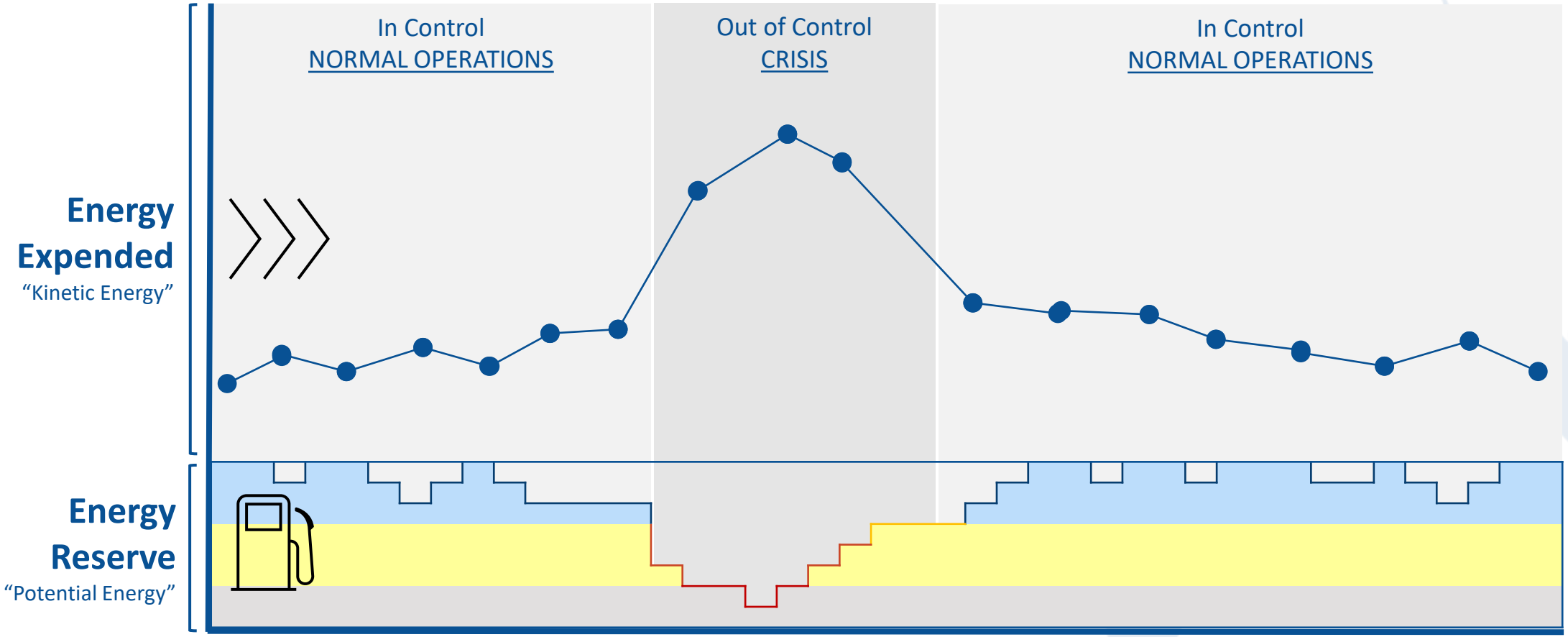


Resilience

An ability to recover from or adjust easily to misfortune or change.

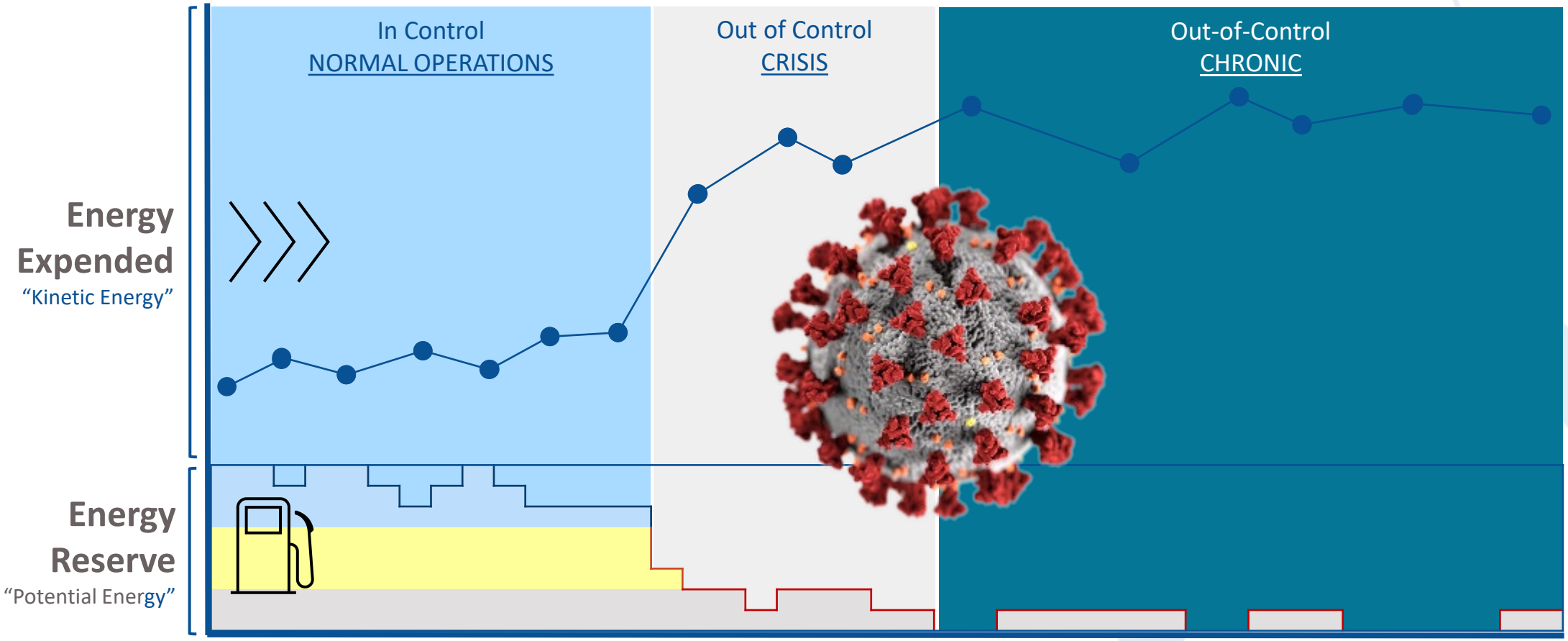
Energy Balance Under Short-Term Stress

Total Energy = Energy Expended (“Kinetic Energy”) + Energy Reserve (“Potential Energy”)



Energy Balance Under Long-Term Stress

Total Energy = Energy Expended (“Kinetic Energy”) + Energy Reserve (“Potential Energy”)



Reliability

The capability to perform to the highest standard, consistently and without failure over time.

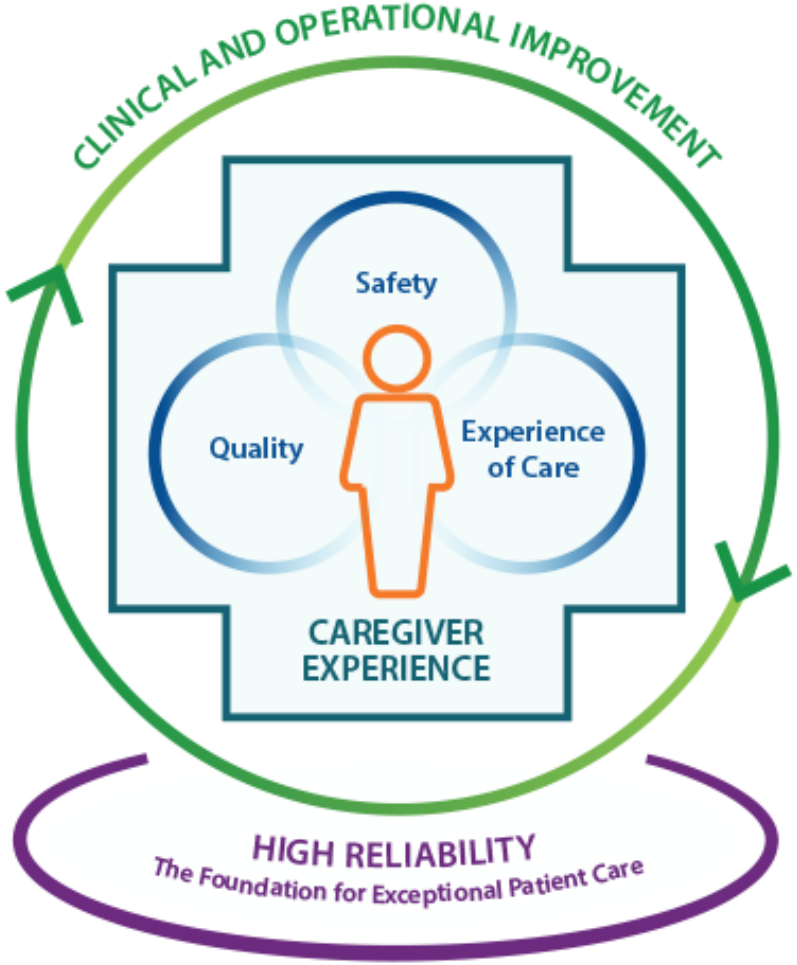
Reliability + Resilience Connection

Reliability:

- The pathway to Resilience
- The muscle for managing when in crisis and when in knowledge-based situations
- A battle-ready starting point
- A moderator of the negative impact that crisis and prolonged stress has on organizational performance in safety, quality, experience, engagement

RELIABLY IMPLEMENT

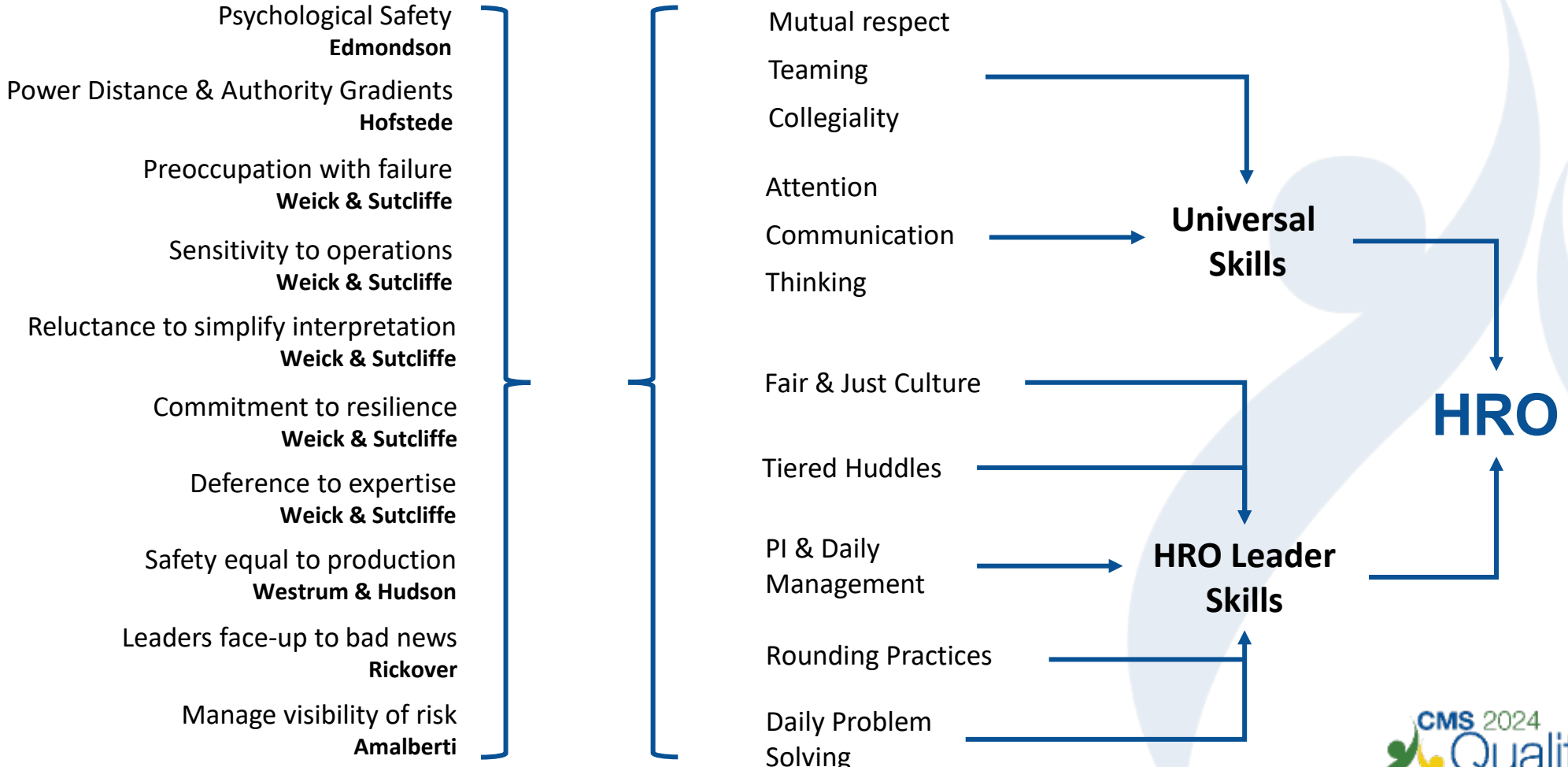
Systems Solutions To Reduce Harm



High Reliability Can Improve All Types of Performance

HRO Transformation Driver Diagram

Turning HRO Principles into Practices for Leaders, Staff and Physicians



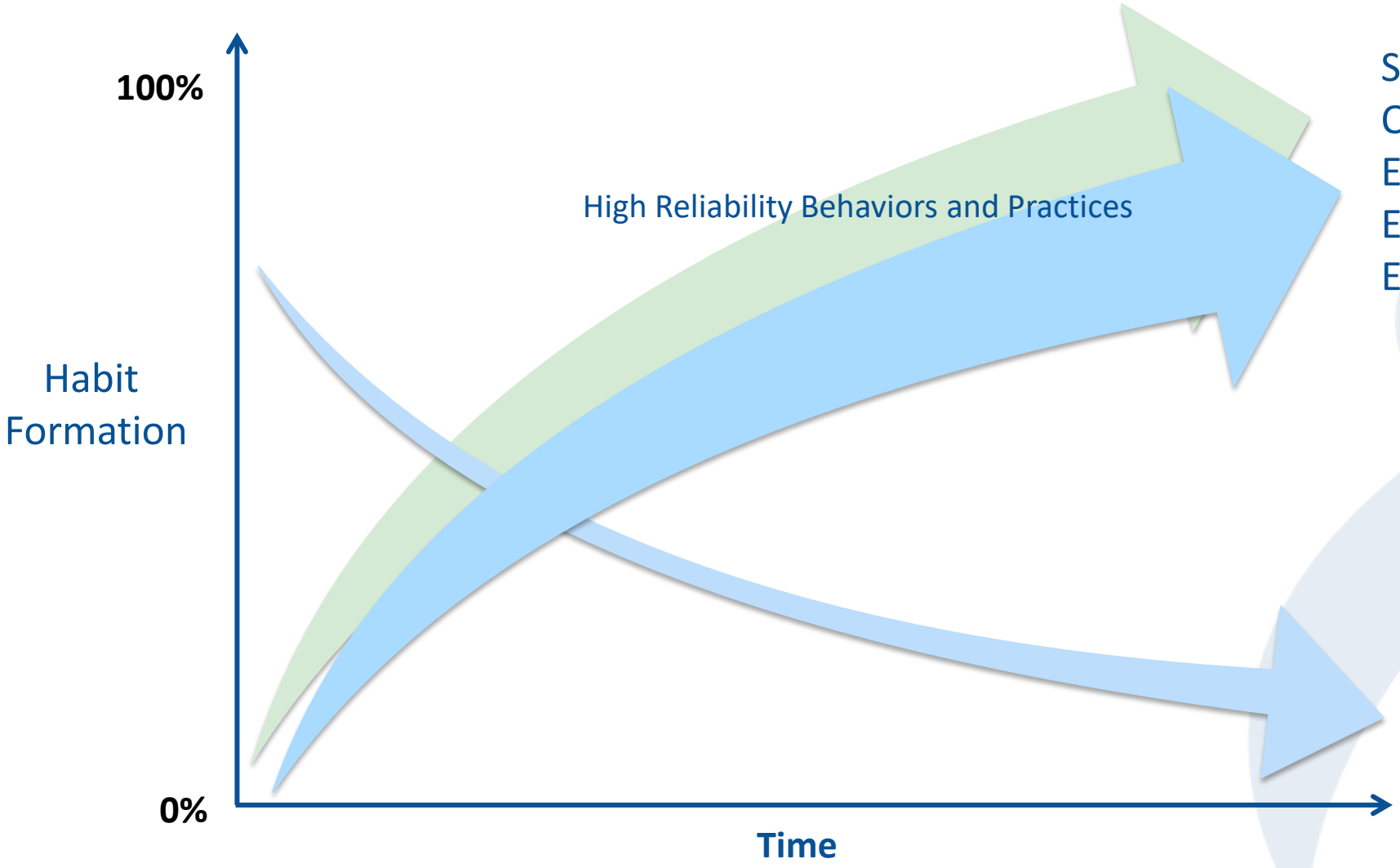
Reliably Embed Equity into Safety Infrastructure

- Stratifying data enables health care institutions to identify, study, and address previously hidden inequities and identify systems solutions
  - Data can be stratified by patient race, ethnic group, language, sex, gender identity, disability status, and other key social determinants of health
  - Ensure accurate and reliable capture of this information and then integration
- Apply equity lens to foundational safety areas
  - Culture, Leadership, and Governance (Safety culture, Workforce Safety)
  - Learning System (Safety reporting, Cause Analysis)
  - Patient and Family Engagement (PFACs, co-design)

Using Standard Tactics Broadly and Reliably

BEST PRACTICE	QUALITY & SAFETY	PATIENT CENTEREDNESS & EXPERIENCE OF CARE	WORKFORCE ENGAGEMENT
CARE (HOURLY) ROUNDING	X	X	
HUDDLES	X	X	X
EXECUTIVE & LEADER ROUNDING	X	X	X
PATIENT & FAMILY ADVISORY COUNCIL	X	X	

“Habitual Excellence”



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In Conclusion

- We need to transform our organizations to an integrated approach to quality, safety, patient centeredness to drive patient experience.
  - ***We must lead with safety and engagement***
  - ***High reliability can be the chassis***
- In safety, much has improved but we have a long way to go.
  - ***Need to make substantial, measurable, system-wide strides in improving patient safety***
  - ***Patients must be at the center of all we do***
- We must accelerate efforts to create a world where patients and those who care for them are free from harm, which will ensure that we then can deliver the best experience of care possible.