

# HQIC Community of Practice Call

---

## Connecting Your Hospital Culture of Safety to Patient Harm Reduction

April 13, 2023

This material was prepared by The Bizzell Group (Bizzell), the Data Validation and Administrative (DVA) contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS) specific. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/Bizzell/DVA-1011 03/02/2023



# Introduction

---



Welcome!

**Shaterra Smith**

Social Science Research Analyst  
Division of Quality Improvement Innovation  
Models Testing  
iQuality Improvement and Innovations Group  
Center for Clinical Standards and Quality  
Centers for Medicare & Medicaid Services

# Agenda

---

- Introduction
- Today's topic:
  - Connecting Your Hospital Culture of Safety to Patient Harm Reduction

*Presenter:*

Marie Cleary-Fishman, Vice President of Clinical Quality  
American Hospital Association  
Iowa Healthcare Collaborative

- Open discussion
- Closing remarks

## As You Listen, Ponder...

---

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

## Meet Your Speaker

---



**Marie Cleary-Fishman, BSN, MS,  
MBA, CPPS, CHCQM**

Vice President of Clinical Quality  
American Hospital Association

# Connecting Your Hospital Culture of Safety to Patient Harm Reduction

April 13, 2023

HQIC Community of Practice Call

AHA Funded Partnerships & Performance Improvement

## Agenda

---

- **What is CULTURE?**
- **What is a culture of patient safety and why do errors occur?**
- **2022 - Current Pulse of Patient Safety**
- **Improving Patient Safety and the Quality of Health Care**
- **Role of Leadership**
- **Role of Patients and Families**
- **Role of Teams**

## Supplemental Materials

---

- **Patient Safety Tools**
- **COVID-19 and Patient Safety**
- **Health Equity and Patient Safety**
- **Technology and Patient Safety**



# What is CULTURE?

- a word for the 'way of life' of groups of people, meaning the way they do things

<https://simple.wikipedia.org>



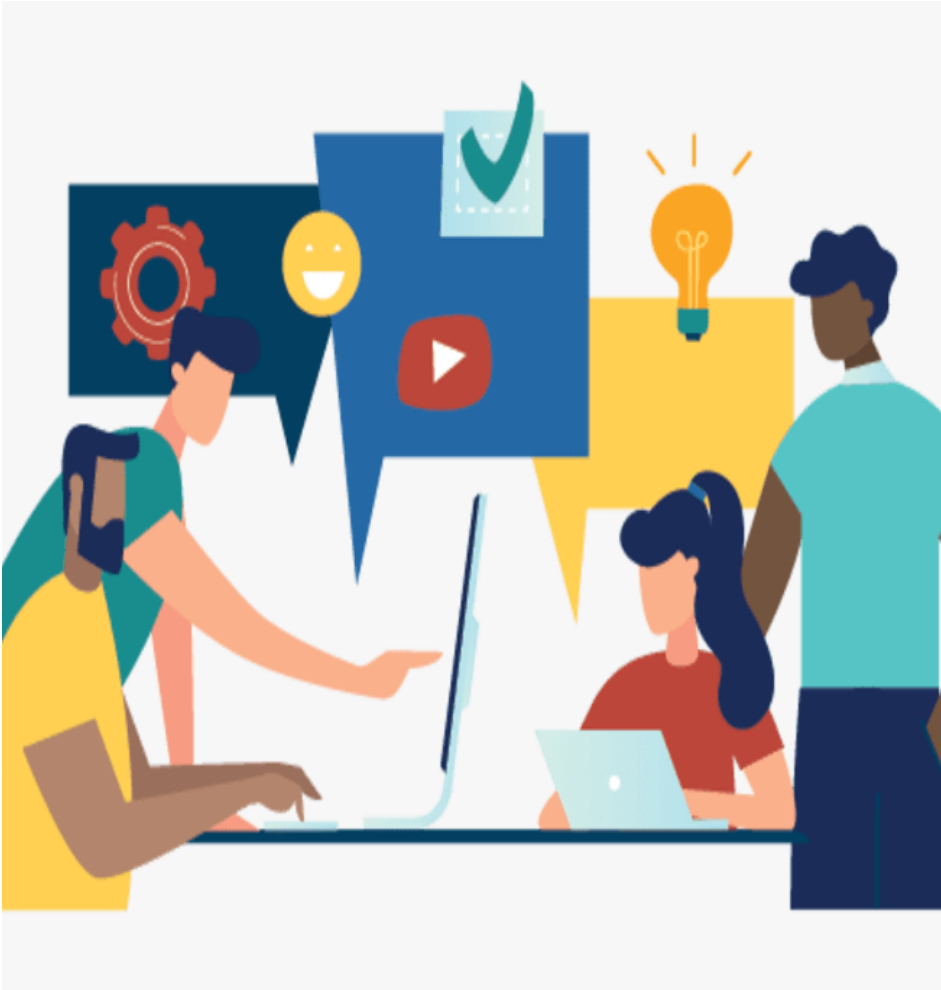


**Think  
about an  
example  
of your  
personal  
Culture**

<https://peachyessay.com/author/peachyessay/>



# My Culture



## Elements of an Organizational Culture

## What is a Culture of Patient Safety?

---

- To Err is Human
- Connecting to Value



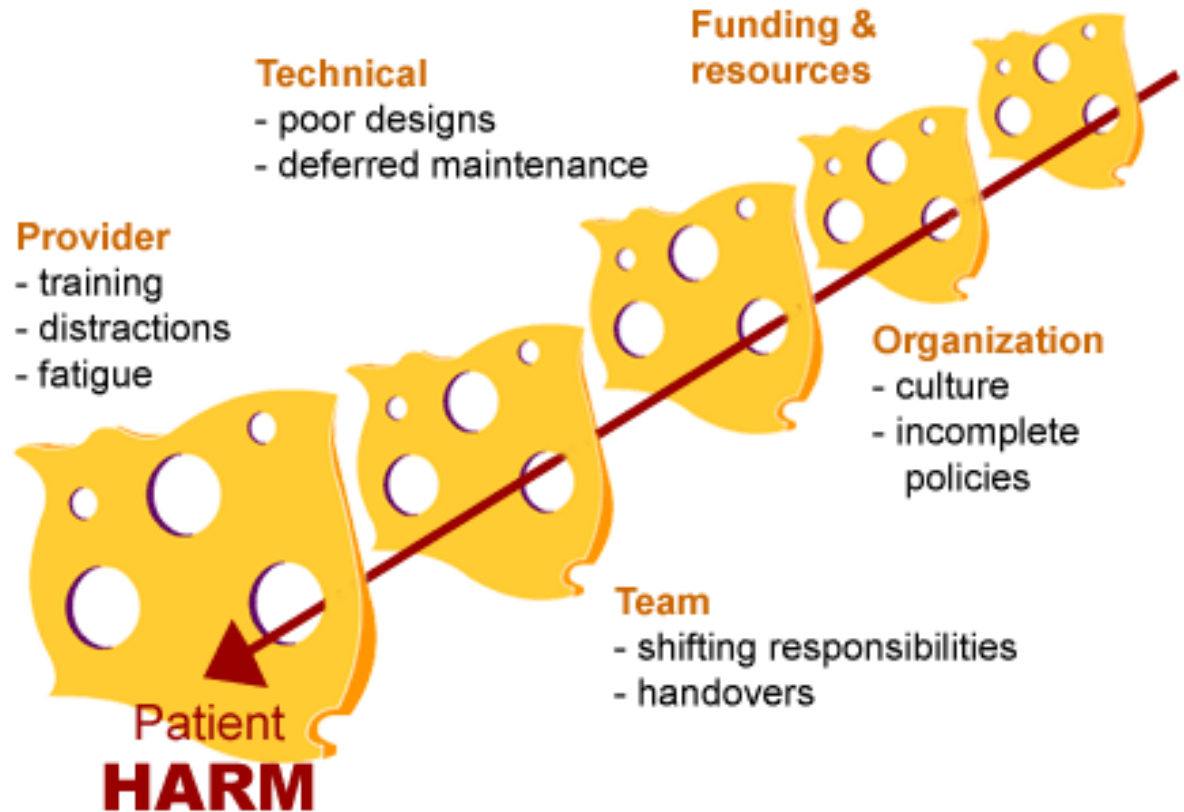


**Structure + Process  
= Outcome**

Donabedian, A., *An Introduction to Quality Assurance in Health Care*, Oxford University Press, 2003.

## Why Errors Occur

- The impact of human factors and system failures on patient safety



Source: Image adapted from Reason J. Human error: models and management. *BMJ*. 2000;320:768–70. doi: 10.1136/bmj.320.7237.768.

## Current Pulse on Patient Safety

---

### TOP 10 PATIENT SAFETY CONCERNS: 2022

1. **Staffing shortages**
2. **COVID-19 effects on health care workers 'mental health**
3. **Bias and racism in addressing patient safety**
4. **Vaccine coverage gaps and errors**
5. **Cognitive biases and diagnostic error**
6. **Non-ventilator health care-associated pneumonia**
7. **Human factors in operationalizing telehealth**
8. **International supply chain disruptions**
9. **Products subject to emergency use authorization**
10. **Telemetry monitoring**

*Source: "Medicare Shared Savings Program Saves Medicare More Than \$1.6 Billion in 2021 and Continues to Deliver High-quality Care," Department of Health and Human Services, Aug. 30, 2022*



# IMPROVING THE QUALITY OF HEALTH CARE: LESSONS LEARNED DURING THE PANDEMIC

## Improving Patient Safety and the Quality of Healthcare

- ✓ A hospital-wide commitment to providing STEEEP
- ✓ Embed quality into the care journey
- ✓ Foster engagement
- ✓ Promote patient safety
- ✓ Leadership involvement in quality
- ✓ Advance health equity
- ✓ Communi
- ✓ Strengthe
- ✓ Embrace



Source

- IOM STEEEP: dimensions of quality
- Image from IHI, "<https://www.ihl.org/communities/blogs/what-boards-must-do-to-achieve-better-quality-health-care>"

## Role of Leadership

- Strategies health care leaders can use to improve patient safety

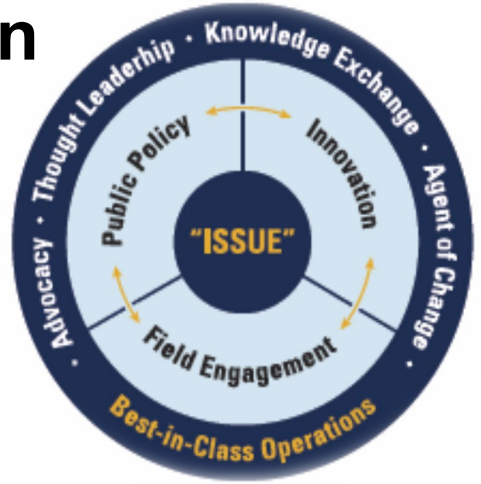
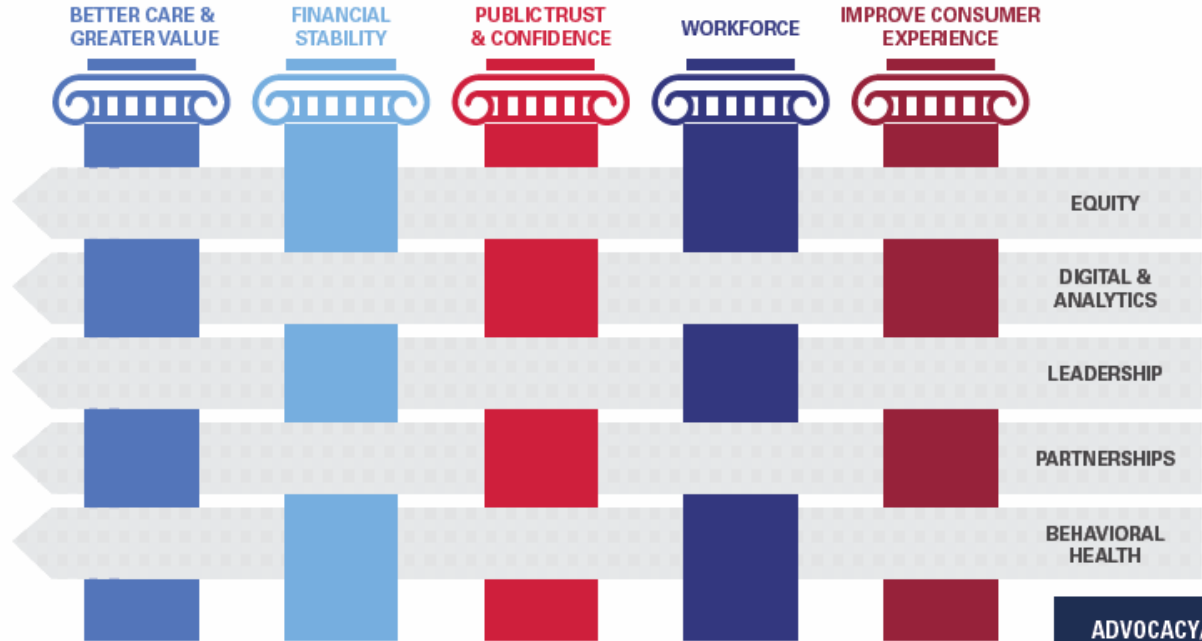
- Organization strategic priorities, culture, and infrastructure
- Engage stakeholders
- Communication
- Aims/goals for improvement
- Align system-wide activities

- Track/measure Performance
- Support staff and patients/families
- Redesign systems/ improve reliability





# 2022-2024 AHA Strategic Plan



ADVOCACY/ REPRESENTATION	THOUGHT LEADERSHIP	KNOWLEDGE EXCHANGE	AGENT OF CHANGE
<p>Advancing field priorities in Congress, with the Administration, in courts, in media, in public opinion and beyond.</p>	<p>Highlighting thoughts, data, insights and solutions that are new or do not yet have consensus.</p>	<p>Facilitating the exchange of information and best practices in a way participants can understand and apply it.</p>	<p>Supplying tools and information to empower people to enact change in organizations, systems and communities.</p>

## Role of Patients and Families

---

- Engaging patients and their families in all aspects of their care



## Role of Teams

---

- Teamwork and communication is key!



## Supplemental Materials

---

- **Patient Safety Tools (23-26)**
- **COVID-19 and Patient Safety (27-32)**
- **Health Equity and Patient Safety (33)**
- **Technology and Patient Safety (34-35)**

## Patient Safety Tools

- Patient Safety Assessments

### Hospital Survey on Patient Safety Culture

In 2004, the Agency for Healthcare Research and Quality (AHRQ) released the **Surveys on Patient Safety Culture™ (SOPS®) Hospital Survey** for providers and other staff to assess patient safety culture in their hospitals. An updated version was released in 2019.

#### Topics Covered by the SOPS Hospital Survey 2.0

**Composite Measures:** A composite measure is a grouping of two or more survey items that assess the same area of culture. The 10 composite measures and 32 survey items assessed in the SOPS Hospital Survey 2.0 are:

- Teamwork (3 items)
- Staffing and Work Pace (4 items)
- Organizational Learning – Continuous Improvement (3 items)
- Response to Error (4 items)
- Supervisor, Manager, or Clinical Leader Support for Patient Safety (3 items)
- Communication About Error (3 items)
- Communication Openness (4 items)
- Reporting Patient Safety Events (2 items)
- Hospital Management Support for Patient Safety (3 items)
- Handoffs and Information Exchange (3 items)

**Additional Measures:** In addition to the composite measures, single item measures included assess:

- Number of events reported (1 item)
- Patient safety rating (1 item)
- Background questions (4 items)



Agency for Healthcare  
Research and Quality

## Patient Safety Tools

---

- Patient Safety Assessments (continued)

### Other Assessments Compiled by AHRQ

- Medical Office Survey on Patient Safety Culture
- Nursing Home Survey on Patient Safety Culture
- Pharmacy Survey on Patient Safety Culture



# TeamSTEPPs

## Patient Safety Tools

- TeamSTEPPs
- CUSP



© 2018 American Hospital Association

## CUSP

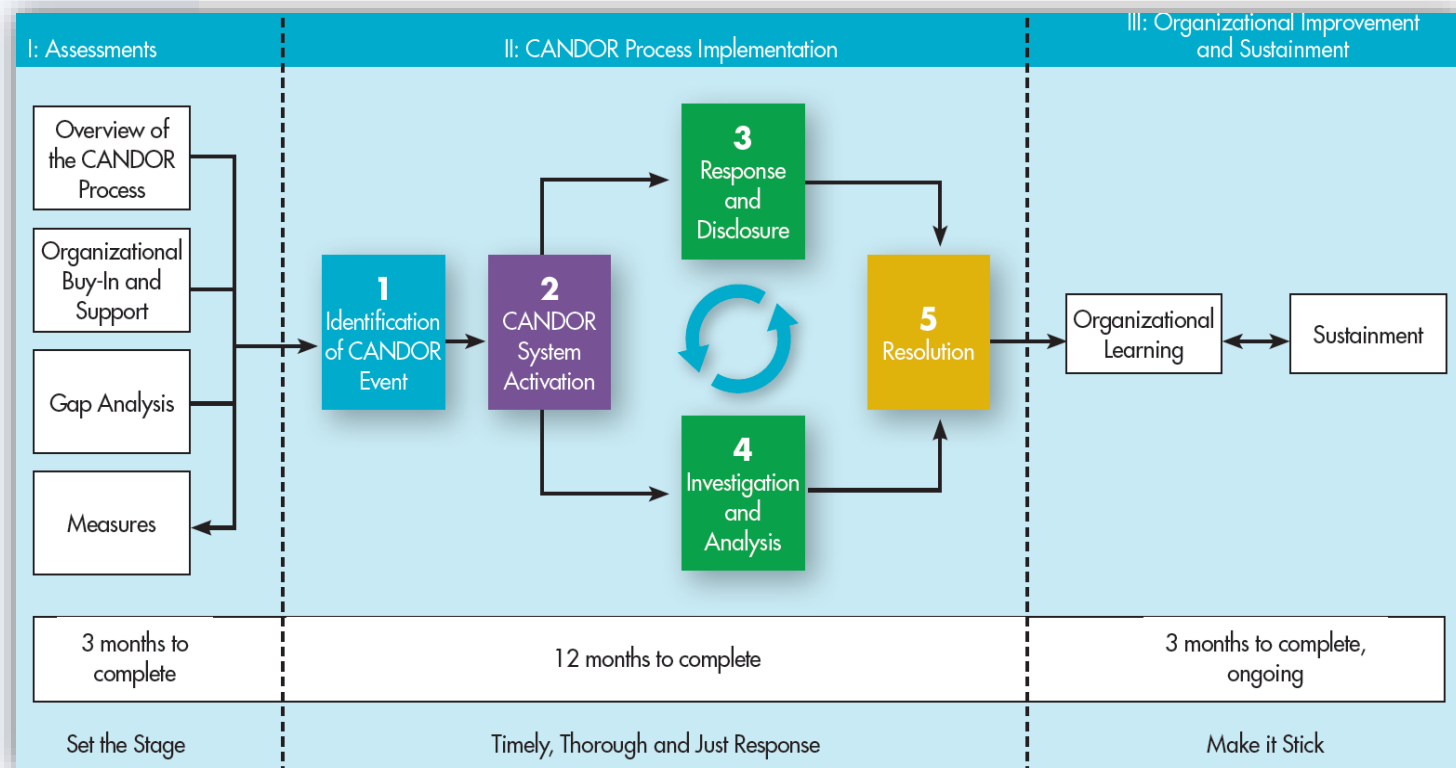


Agency for Healthcare Research and Quality  
Advancing Excellence in Health Care • [www.ahrq.gov](http://www.ahrq.gov)



# Patient Safety Culture

## CANDOR - Communication and Optimal Resolution



Source: *Communication and Optimal Resolution (CANDOR) Toolkit*. Content last reviewed September 2017. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/patient-safety/capacity/candor/modules.html>

# CANDOR Toolkit

---

- Module 1: An Overview of the CANDOR Process
- Module 2: Obtaining Organizational Buy-in and Support
- Module 3: Preparing for Implementation: Gap Analysis
- Module 4: Event Reporting, Event Investigation and Analysis
- Module 5: Response and Disclosure
- Module 6: Care for the Caregiver
- Module 7: Resolution
  - Adverse Event—Reasonable Care
  - Adverse Event—Unreasonable Care
- Module 8: Organizational Learning and Sustainability



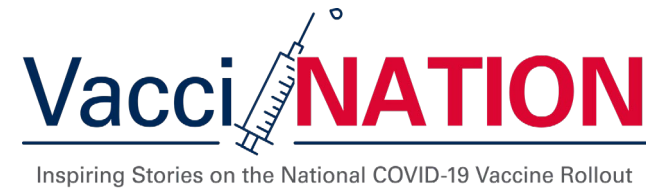
# COVID-19 and Patient Safety

---



Examples of AHA patient safety support during the pandemic and beyond:

- Project Firstline
- Living Learning Network
- Vaccinate with Confidence
- Strengthening the Workforce





## COVID-19 and Patient Safety

---

- **Project Firstline** – Infection Prevention and Control resources and training

### ENHANCING TEAMWORK

Clinical and non-clinical staff training on communications and teamwork.

### ENVIRONMENTAL SERVICES

IPC interactive tools and guidance for EVS workers.

### HEALTH CARE FACILITIES

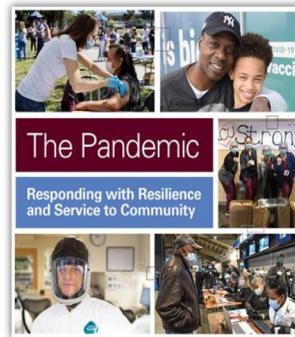
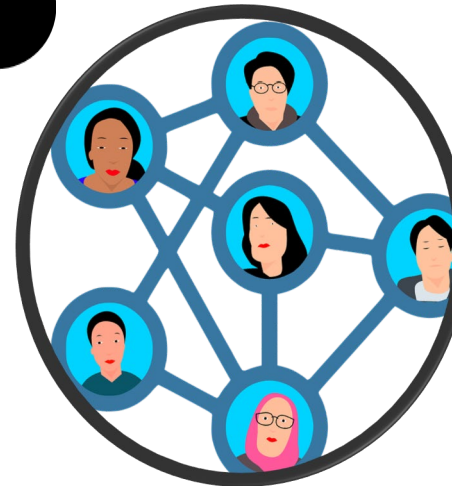
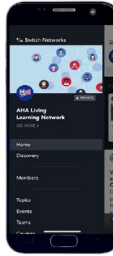
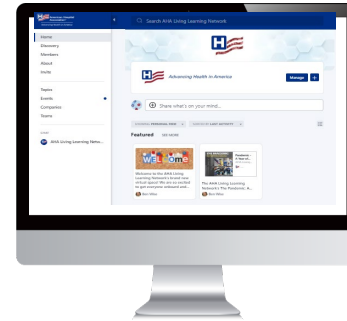
Risk assessment checklists and training on proper ventilation and safety for building engineers.

### INFECTION CONTROL TRAINING

Strategies & methods toolkit for IPC facilitators  
Education resources for front-line workers






# COVID-19 and Patient Safety

Living Learning Network— virtual network of health care professionals across the nation



### What We Learned About Palliative Care During the Pandemic – And Why These Lessons Matter for Patients and Workforce as We Rebuild

**PRESENTERS**

				
<b>Michelle Hood</b> American Hospital Association	<b>Brynn Bowman</b> Center to Advance Palliative Care	<b>Marie Cleary-Fishman</b> American Hospital Association	<b>Dr. Danielle Noreika</b> Virginia Commonwealth University	<b>Dr. Sean Morrison</b> Icahn School of Medicine at Mount Sinai

**Protect yourself and your baby from COVID-19. Get vaccinated.**

[cdc.gov/coronavirus](https://cdc.gov/coronavirus)



## COVID-19 and Patient Safety

---

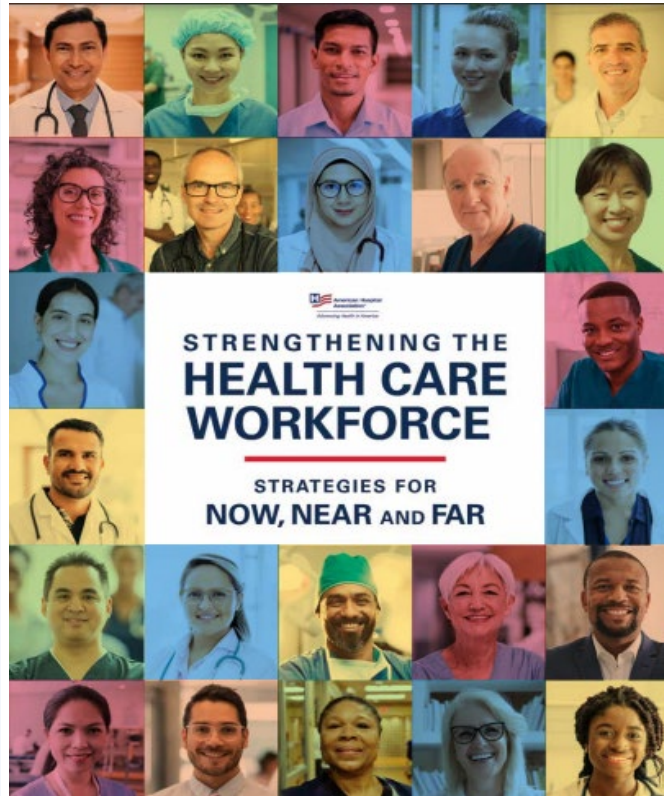
- **Vaccinate with Confidence** – resources to help the health care field support COVID-19 vaccinations



## COVID-19 and Patient Safety

---

- Caring and strengthening the health care workforce is a vital component to patient safety!



## SUPPORTING THE TEAM

- Addressing Well-Being
- Supporting Behavioral Health
- Workplace Violence Prevention

## DATA AND TECHNOLOGY TO SUPPORT THE WORKFORCE

- Data and Analytics
- Technological Supports

## BUILDING THE TEAM

- Recruitment and Retention Strategies
- Diversity and Inclusion
- Creative Staffing Models



## Health Equity and Patient Safety

---

- Addressing health care disparities to improve health outcomes



# VALUE OF DIGITAL TRANSFORMATION TO HEALTH CARE QUALITY INITIATIVES

## Technology and Patient Safety

---

- Applying proven quality disciplines to new, digital and disruptive technologies.
- New technology should always be introduced with a clear articulation of the desired benefits it will deliver.

Value propositions include:

- ✓ Improving upon human intelligence.
- ✓ Increasing the speed and quality of decision-making.
- ✓ Improving transparency, traceability and auditability.



# Technology and Patient Safety

---



- ✓ **Anticipating changes, reveal biases and adapt to new circumstances and knowledge.**
- ✓ **Evolving relationships, organizational boundaries and concept of trust to reveal opportunities for continuous improvement and new business models.**
- ✓ **Learning how to learn by cultivating self-awareness and other awareness as skills.**

## Patient Safety Tools and Resources

---

- [AHA Team Training](#)
- [AHRQ Hospital Survey on Patient Safety Culture](#)
- [AHRQ The CUSP Method](#)
- [AHRQ CANDOR Toolkit](#)
- [AHA Health Equity Roadmap](#)



## COVID-19 and Patient Safety Resources

---

- [AHA Project Firstline](#)
- [AHA Living Learning Network](#)
- [AHA Vaccinate with Confidence](#)
- [AHA Workforce](#)



# Thank You for Helping Us To Achieve Our Highest Potential for Health

---



## Discussion

---

- What impactful actions can you take as a result of the information shared today?
- How are you able to increase engagement within your facilities to ensure a true change in patient safety?
- Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next 30, 60 or 90 days?

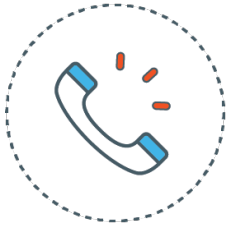
# Final Thoughts

---



# Join Us for the Next Community of Practice Call!

---



Join us for the next  
Community of Practice Call on May 11, 2023  
from 1:00 – 2:00 p.m. ET

We invite you to register at the following link:

[https://zoom.us/webinar/register/WN\\_ASI\\_I3p\\_TEyX\\_VY\\_YYFFeA](https://zoom.us/webinar/register/WN_ASI_I3p_TEyX_VY_YYFFeA)

*You will receive a confirmation email with login details.*

# Thank You!

---



*Your opinion is valuable to us. Please take 4 minutes to complete the [post assessment](#).*

*We will use the information you provide to improve future events.*