Commitment to Transparency and Safety: Redesign of Daily Safety Huddle Using HRO Principles

Welcome!

- All lines are muted, so please ask your questions in Chat
- For technical issues, chat to the 'Technical Support' panelist
- Please participate in polling questions that pop up on the lower right-hand side of your screen
- This event is being recorded

We will get started shortly!

Collaborating To Support Your Quality Improvement Efforts

HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

- Healthcentric Advisors
- Qlarant
- Kentucky Hospital Association
- Q3 Health Innovation Partners
- Superior Health Quality Alliance

Learning Objectives

- Describe the five principles of a high reliability organization (HRO)
- Discuss the strategies and tactics of how the Leadership Huddle was redesigned to create a Tier 2 Safety Huddle (T2SH) using HRO principles
- Demonstrate improved patient safety through analysis of the number of event reviews conducted over time

Karen Holtz, MT (ASCP), MS, CPHQ
HQIC Education Lead
Alliant Health Solutions

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

High Reliability Organization (HRO) Principles

1. Sensitivity to operations (i.e., heightened awareness of the state of relevant systems and processes)
2. Reluctance to simplify (i.e., the acceptance that work is complex, with the potential to fail in new and unexpected ways)
3. Preoccupation with failure (i.e., to view near misses as opportunities to improve rather than proof of success)
4. Deference to expertise (i.e., to value insights from staff with the most pertinent safety knowledge over those with greater seniority)
5. Commitment to resilience (i.e., to prioritize emergency training for many unlikely, but possible, system failures)

https://psnet.ahrq.gov/primer/high-reliability

Featured Speakers from Southeast Georgia Health System (SGHS)

Cynthia Gamache, DBA, MA, RN
Chief Nursing Officer/Vice President

Cynde has worked in health care leadership for over 30 years and holds a doctorate in business administration from Northcentral University. She earned her bachelor's degree in nursing from the University of Connecticut and a master's degree in organizational administration from MidAmerica Nazarene University.

Ashley Foster, BSN, RN, CPHRM, CPPS Risk Manager

Ashley started her nursing career at the bedside in 2015 before transitioning to her role as a Risk Manager in 2021. She earned a bachelor's degree in Nursing from the College of Coastal Georgia and holds professional certifications in both Health Care Risk Management and Patient Safety.

Calen Campbell, BSN, RN, CPHQ, CPPS Manager, Patient Safety

Calen began her career as a new graduate nurse at SGHS and currently serves as Patient Safety Manager. She earned a bachelor's degree in Nursing from the College of Coastal Georgia and is a Certified Professional of Healthcare Quality and a Certified Professional of Patient Safety.

Southeast Georgia Health System Overview

- A not-for-profit health system serving the community and surrounding counties since 1888
  - Two hospitals: a 300-bed hospital in Brunswick, GA and a 40-bed hospital in St. Mary's, GA
  - Two long-term care facilities
  - Numerous outpatient practices

- Our main campus is in Georgia's Golden Isles

Brunswick campus
Brunswick, GA

Camden campus
St. Mary's, GA

Agenda

- Brief introduction to our High Reliability Organization journey
- Transition from Daily Huddles to Daily Safety Huddles
- Benchmarking & research for Tiered Safety Huddles
- Logistics and implementation of the Tier 2 and 3 Safety Huddles
- Data supporting transparency and increase in incident reports
- Tier 2 Safety Huddle wins
- Tier 2 Safety Huddle evolution
- Incorporation of Tier 1 Safety Huddle

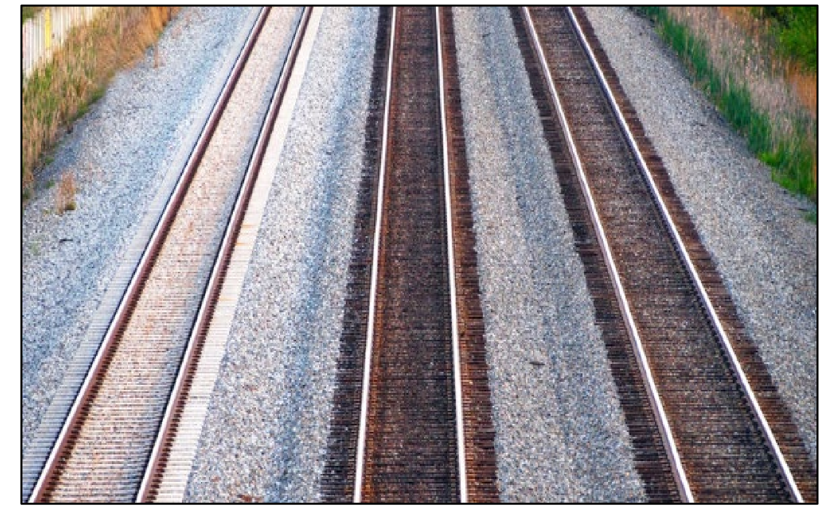
Crossing the Rubicon

- The initial HRO Steering Committee launched shortly after the arrival of our Chief Nursing Officer in May 2022; however, that team quickly grew to include the following:
  - Chief Nursing Officer, VP of Service Excellence, Quality Improvement Director, Risk Management Director, Risk Management Manager, and Patient Safety Manager
  - Currently, the HRO Steering Committee has a total of nine leaders

- We launched our journey and commitment to "No Turning Back" in the Fall of 2022, as we introduced the principles of High Reliability Organizations to our Medical Executive Committees, Board Members, and Leadership team

Purposeful Parallel Tracking

- As the initial education was being completed, additional work was underway to propel our commitment further:
  - Conversion of Daily Huddles to Daily **Safety** Huddles
  - Further sprinkling of concepts to the next level of leadership (i.e., clinical leaders, supervisors, etc.)



Daily Huddles vs. Daily Safety Huddles

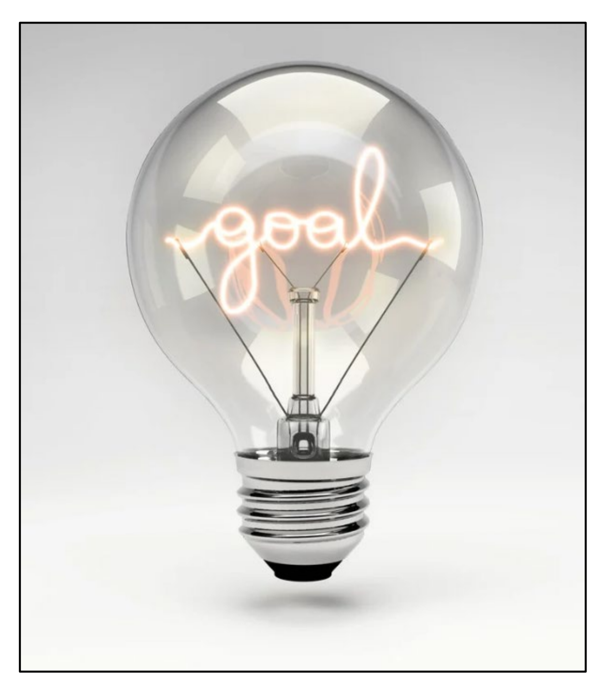
The Curse of "No Report"

- Organizational leaders met at 8:30 a.m. Monday-Friday
- Leaders stood around a room
- Each department was called out
- Each department would share, "No report."
- Actual issues and safety concerns were rarely brought forward

Research and Benchmarking

- Our new CNO had experienced a tiered approach to Safety Huddle at her previous organization and brought the idea to the HRO Steering Committee as the first major step towards moving the organization to high reliability
- Other leaders were brought to the table and joined the Steering Committee in these efforts
- Research into the tiered huddle approach began

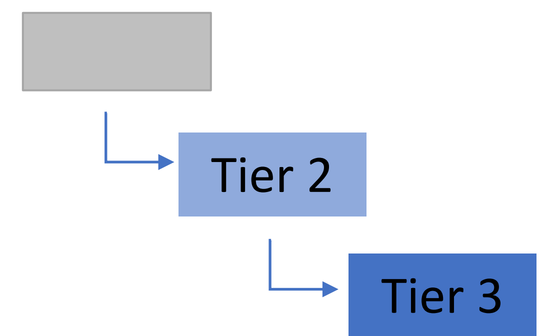
Tiered Daily Safety Huddles and Goals



- To support awareness and transparency
- To drive highly reliable departmental and organizational performance
- To proactively identify and mitigate risk
- To aggressively pursue zero harm in all activities (for team members, customers, community and organization)

Phase 1-Implementation of Tiers 2 and 3

- **Tier 2 Safety Huddle:**
  - Who: Managers, Directors, Executives
  - Time: Monday-Friday at 8:30 AM
  - Location: Large Conference Room with a Zoom Option
  - How: Facilitated by CMO/AOC (administrator on call)
  - Content: Standardized Agenda
- **Tier 3 Safety Huddle:**
  - Who: Executive team
  - Time: Monthly VP/Officer meeting
  - Location: Executive Board Room
  - How: Facilitated by CEO
  - Content: Summaries produced by Quality & Risk



Tier 2 Safety Huddle Methodology

- Redesigned Leadership Huddle to focus specifically on safety
- Created a shared computer drive/folder for the Daily Huddle Dashboard for all leaders to access, achieving full transparency and visibility of events reported
- Developed a tracking spreadsheet/mechanism for follow-up for unresolved issues (T2SH Dashboard SBAR follow-ups from previous huddles)
- Secured a dedicated conference room with capability for virtual access
- Distributed calendar invitations to health system leaders, which included virtual access information
- Appointed CMO as huddle facilitator

Implementation and Team Member Involvement Training

Tier 2 Safety Huddle Data Entry
How to…

Tier 2 Safety Huddle Data Entry
How to…

Please ensure all your information is updated on time within your given window. If there are any issues with updates, please immediately contact Quality/Patient Safety.
Calen Campbell: (912) 552-5610
Lecia Albright: (540) 207-1548

Data Entry Windows:

- Human Resources: End of working day prior to the following Huddle
- House Manager: 6:30 am-7:15 am
- Quality Management: 7:20-7:50 am
- Risk Management: 8:00 am-8:15 am

If for any reason, your window for Data Entry has closed and you have been unsuccessful in updating the information, please send an email to the group: ***"Patient Safety Huddle—Tier II"*** *and provide your numbers to be entered into the spreadsheet* ***no later than 8:15 am.***

1. **The file is located in the Share Drive:**
   Share Drive → "Tier 2 Safety Huddle" → Click on the "Tier 2 Safety Huddle" excel spreadsheet

2. **Open the excel sheet, and click on the sheet named, "Data Entry".**

3. **Your responsible sections are color-coded with the legend to the far right.**

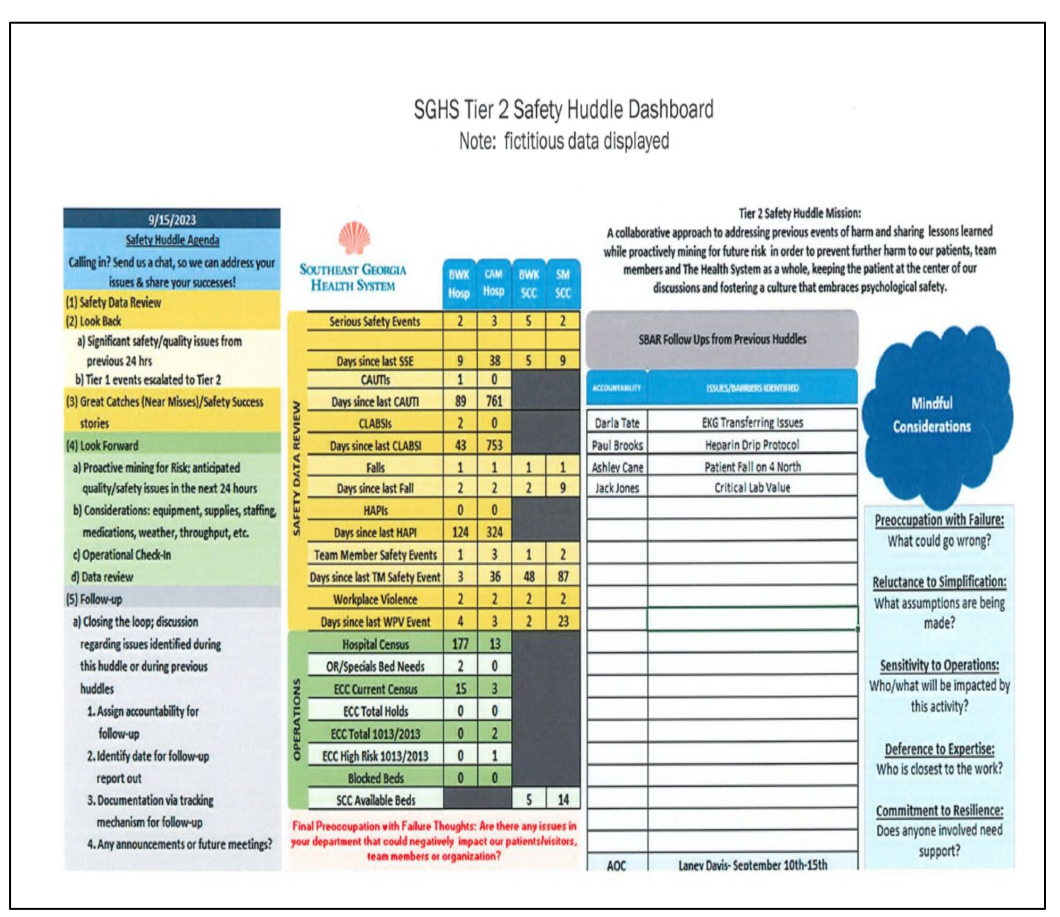
For example: Risk is highlighted red on the legend, and their corresponding data points are also notated in red on the excel sheet.

4. **The only time data needs to be updated is if the information has changed.**
   For example: If Risk has noted a new Serious Safety Event, they would have to update the total number for FYTD

- New format was shared two weeks before the Go-Live, and expectations for reporting were reinforced regularly during the time leading up to the launch
- Leaders were expected to communicate the new process to frontline team members
- The CNO sent a formal communication to the leadership team, outlining expectations for the new format
- Educational "How To" guides were developed to assist participants to successfully engage in the new process
- Created Daily Safety Reports

Tier 2 Safety Huddle Dashboard

- Standardized agenda (left side):
  - Safety data review
  - Safety events over the past 24 hours
  - Great catches/near misses/safety success stories
  - Look forward/operational check-in
  - Follow-up & loop closures
- Key Stakeholders Involvement
  - Risk Management
  - House Supervisors
  - Team Member Health
  - Patient Safety



SGHS Tier 2 Safety Huddle Dashboard

Note: fictitious data displayed

9/15/2023

Safety Huddle Agenda

Calling in? Send us a chat, so we can address your issues & share your successes!

(1) Safety Data Review

(2) Look Back

a) Significant safety/quality issues from previous 24 hrs

b) Tier 1 events escalated to Tier 2

(3) Great Catches (Near Misses)/Safety Success stories

(4) Look Forward

a) Proactive mining for Risk; anticipated quality/safety issues in the next 24 hours

b) Considerations: equipment, supplies, staffing, medications, weather, throughput, etc.

c) Operational Check-In

d) Data review

(5) Follow-up

a) Closing the loop; discussion regarding issues identified during this huddle or during previous huddles

1. Assign accountability for follow-up
2. Identify date for follow-up report out
3. Documentation via tracking mechanism for follow-up
4. Any announcements or future meetings?

Southeast Georgia Health System

		BWK Hosp	CAM Hosp	BWK SCC	SM SCC
SAFETY DATA REVIEW	Serious Safety Events	2	3	5	2
	Days since last SSE	9	38	5	9
	CAUTIs	1	0		
	Days since last CAUTI	89	761		
	CLABSIs	2	0		
	Days since last CLABSI	43	753		
	Falls	1	1	1	1
	Days since last Fall	2	2	2	9
	HAPIs	0	0		
	Days since last HAPI	124	324		
	Team Member Safety Events	1	3	1	2
	Days since last TM Safety Event	3	36	48	87
	Workplace Violence	2	2	2	2
	Days since last WPV Event	4	3	2	23
OPERATIONS	Hospital Census	177	13		
	OR/Specials Bed Needs	2	0		
	ECC Current Census	15	3		
	ECC Total Holds	0	0		
	ECC Total 1013/2013	0	2		
	ECC High Risk 1013/2013	0	1		
	Blocked Beds	0	0		
	SCC Available Beds			5	14

Final Preoccupation with Failure Thoughts: Are there any issues in your department that could negatively impact our patients/visitors, team members or organization?

Tier 2 Safety Huddle Mission:

A collaborative approach to addressing previous events of harm and sharing lessons learned while proactively mining for future risk in order to prevent further harm to our patients, team members and The Health System as a whole, keeping the patient at the center of our discussions and fostering a culture that embraces psychological safety.

SBAR Follow Ups from Previous Huddles

ACCOUNTABILITY	ISSUES/BARRIERS IDENTIFIED
Darla Tate	EKG Transferring Issues
Paul Brooks	Heparin Drip Protocol
Ashley Cane	Patient Fall on 4 North
Jack Jones	Critical Lab Value
AOC	Laney Davis- September 10th-15th

Mindful Considerations

Preoccupation with Failure: What could go wrong?

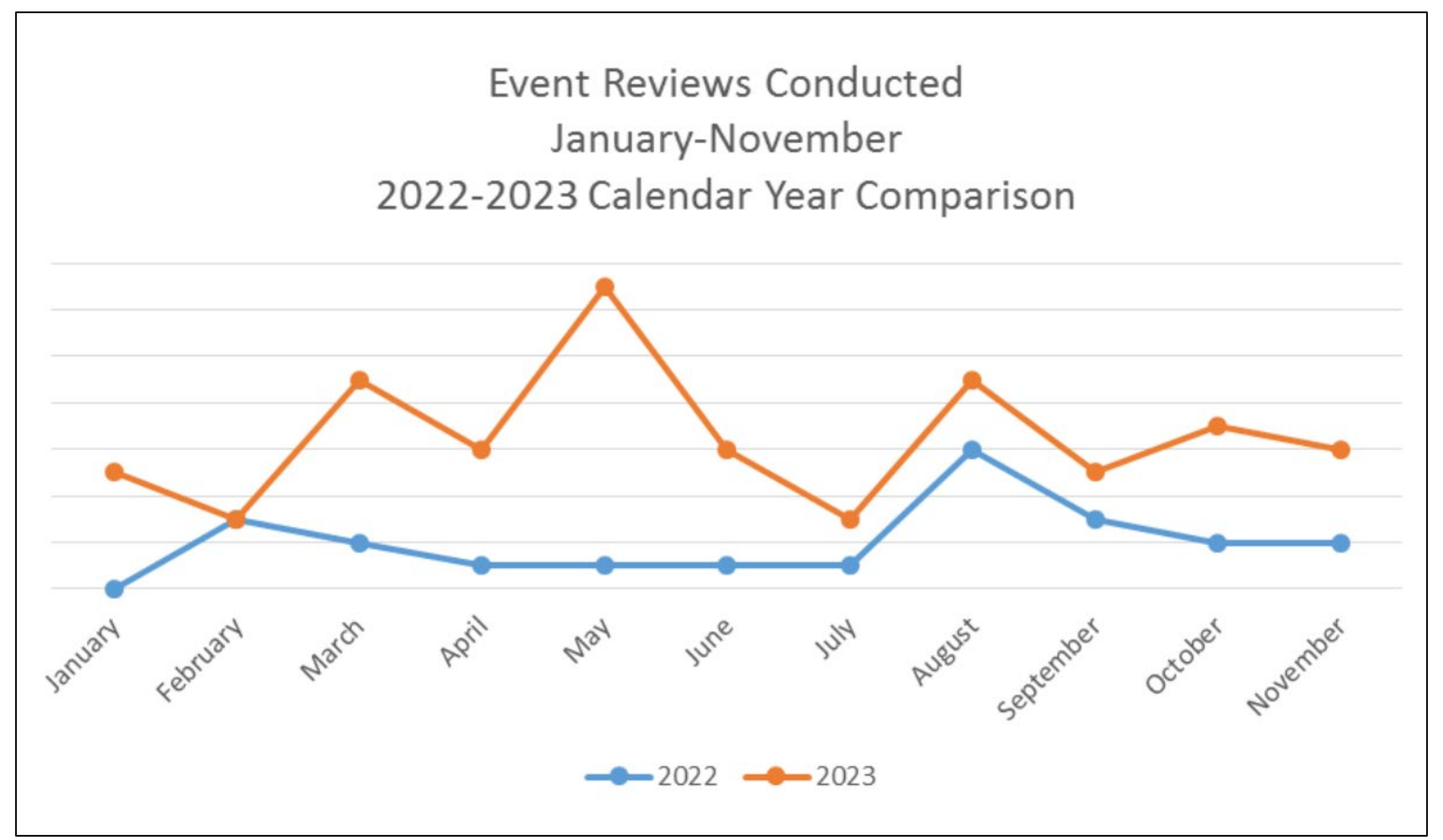
Reluctance to Simplification: What assumptions are being made?

Sensitivity to Operations: Who/what will be impacted by this activity?

Deference to Expertise: Who is closest to the work?

Commitment to Resilience: Does anyone involved need support?

Tier 2 Safety Huddle Launch and Year Overview



Tier 2 Safety Huddle Wins

- Our leaders appreciated the shift to safety
- Leaders have become more comfortable speaking up
- Leaders brought frontline team members to Tier 2
- Reporting increased
- Positive feedback when HRO principles were applied

How We Evolved

- CMO and Risk Management stopped prompting leaders
- Situation Background Assessment Recommendation (SBAR) Report requirement for loop closures
- Adoption of the Safety Assessment Code Matrix (SAC) Scoring Methodology
- Formatting changes to Tier 2 Safety Huddle Template:
  - Incorporation of HRO principles & mindful consideration questions
  - Changed the format to enhance communication

Tier 2 Safety Huddle Follow Up SBAR Template

Tier 2 Safety Huddle Follow Up SBAR Template

Directions: *Please feel free to type out your report within the word document to prepare for the scheduled Tier 2 Safety Huddle Follow-Up Report on your designated date. Completion of this template is not a requirement; however, it may assist you with delivering a concise SBAR report.*

Please refrain from utilizing any protected health information such as patient/employee identifiers.

Situation- A concise statement of the problem

Example: A patient arrived to the inpatient unit from the Cath Lab with an armband that was taped back together after being cut off.

Background- Pertinent and brief information related to the situation

Example: Armbands are commonly removed from patients due to the preferred operative site for radial access. Events like this have happened previously, and patients requiring emergent catheterizations are more vulnerable to potential failure with patient identification.

Assessment- What you found/think

Example: After performing a process flow, it was determined our current process is high risk with potential failure points throughout. We partnered with Quality/Patient Safety & Risk and performed a Failure Modes Effects Analysis (FMEA) on a newly redesigned process to address the failure points in order to mitigate risks and lessen the chances for this type of incident to occur again.

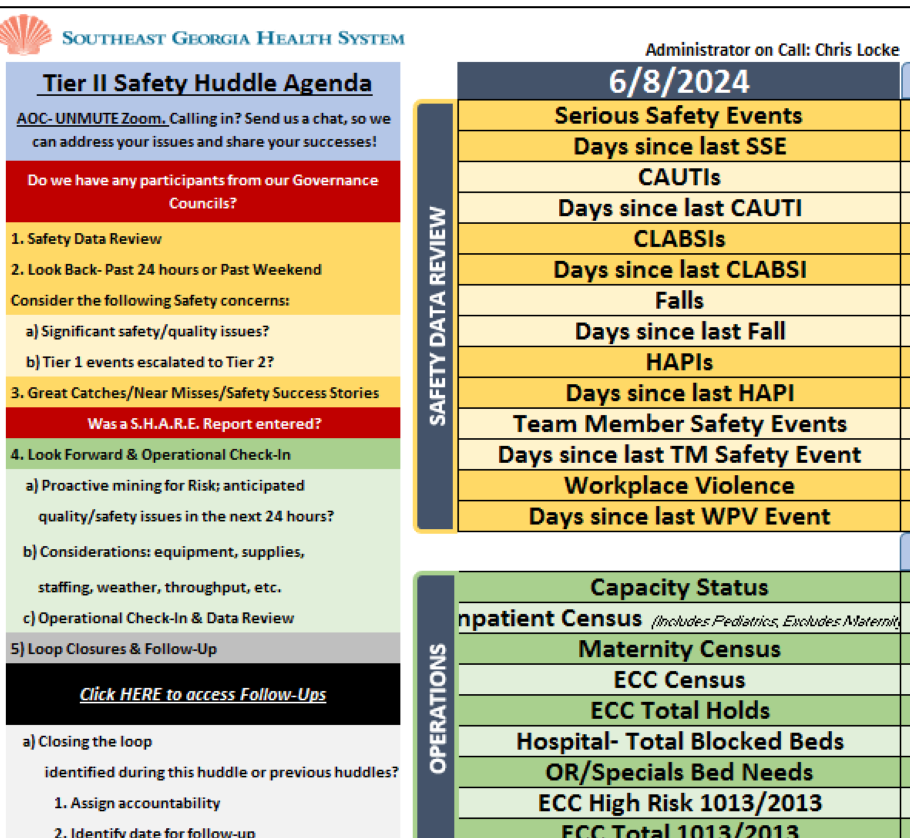
Recommendation- What you want

Example: The FMEA conducted on the new process showed the steps where marked improvements were made in our efforts to mitigate future risk. The new process permits the Cath Lab to have the ability to print our own armbands in our department, which will eliminate errors like this in the future.

Mindful Considerations to consider when creating an action plan to follow-up on the issue/event:

Preoccupation with Failure	Sensitivity to Operations
• What could go wrong? • What should we be most concerned about? • Where are we most vulnerable? • What is the worst case scenario? • Where could this fail? • What problems are we not considering?	• Who/what will be impacted by this activity? • What is the collateral impact? • What is the bigger picture? • Where are the experts who best understand this activity? • Who has the relevant skill/skills knowledge to consider this?
Reluctance to Simplify • What assumptions are being made? • Is there data to disconfirm the assumptions? • Are there other assumptions we could make? • What are potential alternatives? • What is the easiest/quickest solution or approach? • What would a differing opinion be? • What tough questions are we not considering?	**Deference to Expertise** • Who is closest to the work? • What does the evidence/experience say? • How will this perspective be obtained? • What barriers exist that impact our ability to draw upon the appropriate expertise?
Commitment to Resilience • How do we know we need to stop and discuss or debrief? • What went well and can it be replicated? • What went wrong and how can it be avoided in the future?	**Feel free to utilize this space to answer 1 or more questions from each HRO concept above.**

Tier 2 Safety Huddle Safety Data Review



SOUTHEAST GEORGIA HEALTH SYSTEM

Tier II Safety Huddle Agenda

AOC- UNMUTE Zoom. Calling in? Send us a chat, so we can address your issues and share your successes!

Do we have any participants from our Governance Councils?

1. Safety Data Review
2. Look Back- Past 24 hours or Past Weekend

Consider the following Safety concerns:

a) Significant safety/quality issues?

b) Tier 1 events escalated to Tier 2?

3. Great Catches/Near Misses/Safety Success Stories

Was a S.H.A.R.E. Report entered?

4. Look Forward & Operational Check-In

a) Proactive mining for Risk; anticipated quality/safety issues in the next 24 hours?

b) Considerations: equipment, supplies, staffing, weather, throughput, etc.

c) Operational Check-In & Data Review

5) Loop Closures & Follow-Up

Click HERE to access Follow-Ups

a) Closing the loop identified during this huddle or previous huddles?

1. Assign accountability
2. Identify date for follow-up
3. Documentation of follow-up
4. Any announcements or meetings?

Administrator on Call: Chris Locke

SAFETY DATA REVIEW

6/8/2024	BWK	CAM
Serious Safety Events	1	0
Days since last SSE	16	24
CAUTIs	0	0
Days since last CAUTI	36	24
CLABSIs	0	0
Days since last CLABSI	79	1020
Falls	3	1
Days since last Fall	7	6
HAPIs	0	0
Days since last HAPI	16	591
Team Member Safety Events	1	1
Days since last TM Safety Event	18	33
Workplace Violence	2	1
Days since last WPV Event	2	5

OPERATIONS

	BWK	CAM
Capacity Status	N/A	N/A
npatient Census *(Includes Pediatrics, Excludes Maternity*	181	6
Maternity Census	8	2
ECC Census	22	2
ECC Total Holds	0	0
Hospital- Total Blocked Beds	0	0
OR/Specials Bed Needs	0	0
ECC High Risk 1013/2013	1	1
ECC Total 1013/2013	4	0

Tier II Safety Huddle Mission:

A collaborative approach to address previous events of harm, and share lessons learned, while proactively mining for future risk to prevent further harm to our patients, team members, and the health system as a whole; while keeping the patient at the center of our discussions and fostering a culture that embraces psycological safety.

Scan the QR code to view the mindful consideratio

Monthly Great Catches/Near Misses/Safety Success Stories

Team Member's Name	Department	Stories
Chad Roberson	MRI	Discovered Anes. Cart left behind in MRI
Ja'Cory Atkinson	Transporter	Observed non verbal cues from pt.
Regina Hendrix	Monitor Tech	observe visitor giving contraband to pt.
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Preoccupation with Failure: What could go wrong?

Deference to Expertise: Who is closest to the work?

Commitment to Resilience: Does anyone involved need support?

Reluctance to Simplify: What assumptions are being made?

Sensitvity to Operations: Who/what will be impacted by this activity?

This information is protected and confidential. Peer review information is not subject to discovery pursuant to the State Protection Act. This information will be used by professional healthcare providers for purposes which include evaluaiton of the quality and performed by other healthcare providers, including the acmpliance of hospital facility

Tier 2 Safety Huddle Safety Follow Up

Tier II Safety Huddle Agenda

AOC- UNMUTE Zoom. Calling in? Send us a chat, so we can address your issues and share your successes!

Do we have any participants from our Governance Councils?

Click HERE to access Safety & Operational Data

1. Safety Data Review
2. Look Back- Past 24 hours or Past Weekend

Consider the following Safety concerns:

- a) Significant safety/quality issues?
- b) Tier 1 events escalated to Tier 2?

3. Great Catches/Near Misses/Safety Success Stories

Was a S.H.A.R.E. Report entered?

4. Look Forward & Operational Check-In

- a) Proactive mining for Risk; anticipated quality/safety issues in the next 24 hours?
- b) Considerations: equipment, supplies, medications staffing, weather, throughput, etc.
- c) Operational Check-In & Data Review

5) Loop Closures & Follow Up

- a) Closing the loop; discussion regarding issues identified during this huddle or previous huddles?
  1. Assign accountability for follow-up
  2. Identify date for follow-up & report out
  3. Documentation of follow-up & report out
  4. Any announcements or meetings?

Administrator on Call: Chris Locke

6/8/2024

FOLLOW-UPS FOR TODAY

T1SH	Accountability	Issue
Yes	Jane Doe	Code White
.	Jack Frost	Ceiling Tile
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UPCOMING FOLLOW-UPS

T1SH	Follow-Up Date	Accountability	Issue
.	June 13, 2024	Ron Lee	Straw Cover on Patient Cups
.	June 10, 2024	LJ Turner	New Process for Overhead Pages
.	June 9, 2024	Jill Knox	Serious Safety Event from June 8th
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Tier II Safety Huddle Mission:

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Scan the QR code to view the mindful consideration questions!

COMPLETED LOOP CLOSURES

T1SH	Date of Loop Closure	Accountability	Issue
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.	Friday, June 7, 2024	William Keene	Snake Issue
.	Friday, June 7, 2024	Tina Turner	Instruments processing
Yes	Friday, June 7, 2024	Calli Page	2 Incidents
.	Wednesday, June 5, 2024	Sandra Shaske	New Orders placed during pre-op
Yes	Wednesday, June 5, 2024	Norah Jane	Med Error (ECC)
.	Tuesday, June 4, 2024	Joe Lee	Prisoner Entry & Route

TIER III

Tier III Escalation Date	Accountability	Issue
June 9, 2024	Chris Farmer	Capital Expense for Equipment
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Preoccupation w Failure: What could wrong?

Deference to Expertise: Who is closes the work?

Commitment t Resilience: Does anyon involved need sup

Reluctance to Sim What assumpt are being made

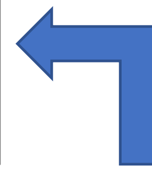
Sensitivity to Operations: Who/what wi impacted by th activity?

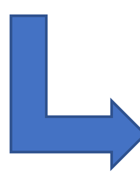
Phase 2: Tier 1 Safety Huddle

- A pilot program of department-based Governance Councils launched in January 2024
- This pilot program consists of eight departments representing both clinical and non-clinical areas
- The first assignment for our Department Governance Councils has been to implement a Tier 1 Safety Huddle Process
- The expectation is the Tier 1 Safety Huddle will occur routinely and before the Tier 2 Safety Huddle to provide leaders with a current state overview from frontline team members regarding safety and risk issues

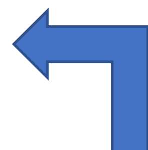
Tiered Patient Safety Huddles

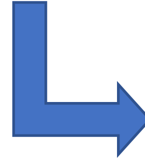
Tier 1: Department-based Governance Councils meet before Tier 2 (time flexible)





Tier 2: Managers, Directors, and Executives meet M-F at 8:30 a.m.





Tier 3: Executive Team meets monthly and ad hoc

References & Questions

1. “NAHQ Next 2022” Conference
   - “Tiered Safety Huddle: Strengthening Human Connections, Communication, and High Reliability” by Leslie Russell MBA, MS, BSN, BS, CPHQ and Jane Braaten RN, PhD, CPPS, CPHQ
2. HPI SSE and SSER Patient Safety Measurement System for Healthcare
3. IHI’s White Paper on RCA2 SAC Scoring Methodology – see link to download https://www.ihi.org/resources/tools/rca2-improving-root-cause-analyses-and-actions-prevent-harm

What is an RCA2?
Watch video on YouTube

Alliant HRO Coaching Package

Evidence-based interventions and links to resources

HQIC website and scroll to Coaching Packages

https://quality.allianthealth.org/wp-content/uploads/2023/12/2023-Coaching-Package-High-Reliability-FINAL_508.pdf

Category	Best Practices/Interventions	Links to Resources and Toolkits
Process Improvement Tools	A Look at Six Sigma's Role in Improving Healthcare	https://www.villanovau.com/articles/six-sigma/six-sigma-improving-healthcare/
	Fishbone (Cause and Effect) Diagram (Alliant HQIC)	https://quality.allianthealth.org/wp-content/uploads/2021/07/Fishbone-Diagram-Worksheet_AHSHQIC-TO3H-21-871_11.5.21_508.pdf
	Patient Safety Essent Download these nine guide your organizat patient safety and de care. Tools include Fl cause analysis, daily	
	RCA2: Improving Roo and Actions to Preve	
	Failure Mode and Eff	
	What is Six Sigma?	
	What is LEAN? Problem-Solving Ten	
	PDSA Worksheet	
Staff Education and Training	High Reliability Train Includes costs. (Joint Resources)	
	Leadership Engagem Multidisciplinary Tea Building	
Case Studies	Becoming a High Re	
	Leadership Support i Pressure Injury Preve	

Other/Professional Association Websi
1. Three Misconceptions About High Re https://premierinc.com/newsroom/blog
2. Survey Findings: Barriers to Achievin https://offers.premierinc.com/WC_QR_l dium=&utm_content=whitepaper&utm
3. Age-Friendly Health Systems https://www.ihi.org/initiatives/age-frien
4. Integrating Clinical and Cultural Dat

HIGH RELIABILITY ORGANIZATION (HRO) COACHING PACKAGE

Purpose: Use the evidence-based best practices and resources below to create quality improvement action plans.

Category	Best Practices/Interventions	Links to Resources and Toolkits
Culture Assessment	Agency for Healthcare Research and Quality (AHRQ) Survey on Patient Safety Culture (SOPS™)	https://www.ahrq.gov/sops/surveys/hospital/index.html
Leadership	Leading a Culture of Safety: A Blueprint for Success	https://www.ihi.org/resources/publications/leading-culture-safety-blueprint-success#downloads (download)
	The Benefits of High-Reliability in a Value-Based Payment Environment (Premier, 2018)	https://premierinc.com/downloads/Premier-Inc_The-Benefits-of-High-Reliability-in-VBP_HealthLeaders.pdf
	Five Ways to Sustain the Gains from High Reliability (blog) (Premier, 2019)	https://premierinc.com/newsroom/blog/five-ways-to-sustain-the-gains-from-high-reliability
	Leading in Tough Times: A Resilience Playbook (Cynosure, 2023)	https://app.box.com/s/viwvnq35xv5fpmzaiuwgldm55yxdkxmc/file/1331570382741
Just Culture and Always Events	What is Just Culture? Changing the way we think about errors to improve safety and staff satisfaction	https://www.brighamandwomensfaulkner.org/about-bwfh/news/what-is-just-culture-changing-the-way-we-think-about-errors-to-improve-patient-safety-and-staff-satisfaction
	The Promise and Practice of a Just Culture	https://healthcareexecutive.org/archives/march-april-2020/the-promise-and-practice-of-a-just-culture
	Always Events: A Toolkit	https://www.ihi.org/resources/tools/always-events-tool-kit#downloads (download)
	Always Events: Make the Patient the Focus	https://www.patientsafety.com/en/blog/always-events-make-the-patient-the-focus
HRO Framework	The Framework for High-Reliability Healthcare	https://www.vizientinc.com/our-solutions/care-delivery-excellence/reliable-care-delivery (download the white paper)
	A Framework for Safe, Reliable, and Effective Care	https://www.ihi.org/resources/white-papers/framework-safe-reliable-and-effective-care#downloads (download)
	Reliability Culture Implementation Guide	https://www.mha.org/Portals/0/Documents/MHA%20Keystone%20Center/Tools/reliability-culture-implementation-guide.pdf
Learning Systems	Adverse Events, Near Misses, and Errors (AHRQ, 2019)	https://psnet.ahrq.gov/primer/adverse-events-near-misses-and-errors
	AHRQ Learning from Defects	https://www.ahrq.gov/hai/cusp/toolkit/learn-defects.html

Upcoming Events

Rural and Critical Access Hospital Strategies for Successfully Implementing Hospital Patient and Family Engagement Best Practices

Tues., July 23, 2024

1 p.m. ET

- Webinar Registration - Zoom
- https://telligen.zoom.us/webinar/register/WN_-hpzoYVpTq65OQTntR70lA#/registration

Q&A/Wrap Up

- Please type questions and comments in Chat

Thank you for attending!

Complete the Post-Event Assessment to Receive Credit

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Contact Us

Alliant HQIC Team

Karen Holtz, MT (ASCP), MS, CPHQ
Alliant Health Solutions
Karen.holtz@allianthealth.org

View our Website

Compass HQIC Team

Charisse Coulombe, MS, MBA, CPHQ, CPPS
Director, Hospital Quality Initiatives
coulombec@ihconline.org

Melissa Perry, MSW, LCSW
perrym@ihconline.org

View our Website

IPRO HQIC Team

Rebecca Van Vorst, MSPH, CPHQ
HQIC Project Manager
RVanVorst@ipro.org

Lynda Martin, MPA, BSN, RN, CPHQ
martinl@qlarant.com

View our Website

Telligen HQIC Team

Meg Nugent, MHA, RN
HQIC Program Manager
mnugent@telligen.com

View our Website

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

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How did we do today?

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