NATIONAL QUALITY FORUM

Meeting Summary

Partnership for Patients 2014 Quarterly Meeting Series

Mobilizing the Health Workforce to Reduce Hospital-Acquired Conditions

January 29, 2014

Introduction

On January 29, 2014, National Quality Forum (NQF) convened the first meeting of the Partnership for Patients (PfP) 2014 Quarterly Meeting Series, "Mobilizing the Health Workforce to Reduce Hospital-Acquired Conditions." Norman Kahn, Meeting Chair, welcomed the group and virtual participants to the meeting, provided an overview of the 2014 National Quality Forum (NQF) Quarterly Meeting Series topics, and reviewed the meeting objectives:

1. Identify the most effective best practices to mobilize the health workforce in meeting the PfP goals.
2. Identify concrete steps for achieving results through these best practices.
3. Enable participants to take immediate action in their organizations and membership bases.

Neal Comstock, Vice President, Member Relations, NQF, offered a short welcome, and gave the attendees a synopsis of NQF's upcoming annual conference on February 13-14, 2014, "Making Sense of Quality Data for Patients, Providers, and Payers."

The Partnership for Patients: Where Are We Now?

Dennis Wagner and Paul McGann, Co-Directors, Partnership for Patients, provided updates on PfP's current activities focused on the two aims of reducing preventable hospital-acquired conditions (HACs) by 40% and reducing 30-day hospital readmissions by 20% through the three PfP engines – federal programs, national partners and Center for Medicare and Medicaid Innovation investments. Among the successes thus far are increased numbers of hospitals meeting patient and family engagement criteria, more than 50% improvement in reductions in early elective deliveries, and almost $1 billion in savings from overall harm reduction. To conclude this session, Norman Kahn challenged the meeting participants to consider the thousands of unknown patients positively affected by the Partnership for Patients and their own efforts to improve patient care.

Embracing the Culture of Safety from Multiple Perspectives

During an interactive exercise, participants broke into small groups to read and discuss two narrative examples of hospital teams struggling to create a culture of safety. Each group reflected on the core elements of an effective culture of safety, and recommended key steps to achieve safety across the board:

- Align the C-suite and leaders from all levels with safety, quality and operations goals
- Move away from a culture of blame and toward a culture of understanding "near misses"

- Implement programs on team building, including communication and shared accountability
- Cultivate a team-based care approach, empowering every member of the care team to speak up and take ownership of the patient
- Engage patients and family as part of the care team as much as possible

Embracing the Culture of Safety: Best Practices for Mobilizing the Workforce

Barbara Pelletreau, Senior Vice President, Patient Safety, Dignity Health and Wendy Kaler, Manager of Infection Prevention, Saint Francis Memorial Hospital presented the first success story from the field, focused on creating culture for excellent patient outcomes. Dignity Health keeps its focus on communities through a strong local leadership, enabling streamlined decision making and greater accountability for outcomes. Their comprehensive approach centers on: (1) structure and leadership engagement; (2) accountability and transparency; and (3) strategies for making change "stick." Their successes on reduced hospital-acquired conditions, cost savings through the "no harm" campaign, and improved patient outcomes reinforce a culture of safety. At Dignity Health, quality care stems from four elements: (1) vision of patient safety goals and strategies, (2) champions to articulate the vision, (3) staff with the proper orientation and the right tools from the beginning, and (4) process that gets measured, reported and improved consistently.

Echoing the previous presentation, Charisse Coulombe, Vice President for Clinical Quality, from Health Research & Educational Trust (HRET), reiterated that culture requires leadership, multiple strategies and measurement to flourish and succeed. Among their best practices at HRET to create culture change are: (1) hospital matchmaking that pairs struggling facilities with successful ones to avoid silos of patient safety practices and encourage sharing of successes and failures, (2) leadership education that involves hospital site visits with specific action planning and follow-up, (3) focus on patient and family engagement activities, and (4) measurement of progress through real-time data reports to leadership and front-line teams. This culture change intervention has resulted in significant harm prevention with a projected total cost savings of over $200 million over two years.

Mary Reich Cooper, Chief Quality Officer, from Connecticut Hospital Association (CHA) started her presentation with a patient safety story (which is routine practice at CHA meetings). Ensuring patient safety while delivering the highest quality of care is the number one priority at all CHA facilities. Through their high-reliability efforts, such as leadership engagement that models the safety culture, endorsing hospital behaviors, conducting site visits, and using media outlets, CHA has observed dramatic drops in catheter associated urinary tract infections (CAUTI) as well as significant cost savings.

These success stories demonstrate that data is a necessary driver for change towards a culture of safety, along with engagement at all levels of the organization including patients and families, and sharing of successes and barriers with other hospitals and health care facilities.

Moving to Action: How Will You Create Safety across the Board at Your Organization?

After being reoriented to the PfP goals, hearing success stories from the frontline, and discussing how a culture of safety is taking shape within health care teams, meeting participants ended the day by identifying action steps to mobilize the health workforce to improve patient safety across the board.

Meeting participants identified the following four high priority action areas and corresponding tactics to accelerate success:

1. Patient and Family Engagement
   - Spread the imperatives of engaging patients and families within hospitals and other health care facilities
   - Stay patient-centered
   - Develop a patient advocate social media database
   - Create groups that can mentor patient advocates
2. Hospital Safety
   - Maintain a checklist for patient safety, quality and patient results
   - Promote data transparency, openness, and connect areas of opportunities with success stories
   - Formalize specific strategies and tools to further promote team concept as a step in reducing HACs
   - Develop quality indicators focused on best practices in HAC prevention
   - Disseminate free resources
   - Engage front-line staff in local safety efforts
   - Encourage date sharing to inspire progress
3. Health Workforce Engagement
   - Create updated health workforce competencies to reduce patient harm
   - Support an effective health workforce in carrying out care coordination and prevention
   - Align with medical societies, patient-safety groups and measure developers to further collaborate on quality improvement initiatives
4. Preventative measures
   - Re-engage HENs to increase reporting on progress in reducing adverse drug events (ADEs)
   - Roll-out protocols on ADEs, CAUTI, sepsis, medication and radiation dose management

Participants concluded the meeting by committing to take action on at least one of these tactics, working within their organizations or in collaboration with others.

Next Steps

The 2014 Partnership for Patients Quarterly Meeting Series will continue to bring together individuals and organizations working in collaboration to advance patient safety. Additional meetings in the series will focus on engaging purchasers and payers, leveraging accreditation efforts, and taking action in person-centered care to accelerate the PfP aims of reducing hospital-acquired conditions and readmissions. This meeting's agenda, slides, summary and recording are all available on National Quality Forum's website.

Appendix: Roster of Attendees

Organization	Name
American Nurses Association	Maureen Dailey
American Society of Health-System Pharmacists	Shekhar Mehta
The National Content Developer	Debra Reed-Gillette
American College of Surgeons	Frank Opelka
American Hospital Association	Charisse Coulombe
American Medical Association	Sandra Fryhofer
America's Essential Hospitals	Sarah Callahan
Association for Professionals in Infection Control and Epidemiology	Carole Van Antwerpen
Association of periOperative Registered Nurses	Linda Groah
Association of Women's Health, Obstetric & Neonatal Nurses	Debra Bingham
Connecticut Hospital Association	Mary Cooper
Council of Medical Specialty Societies, Meeting Chair	Norman Kahn
Dignity Health	Barbara Pelleatreau
Infectious Diseases Society of America	Thomas Kim
Mathematica Policy Research	Maureen Higgins
National Association for Healthcare Quality	Jan Orton
Partnership for Patients, CMMI	Sharon Andres
Partnership for Patients, CMMI	Jacqueline Kreinik
Partnership for Patients, CMMI	Paul McGann
Partnership for Patients, CMMI	CDR Ed Poindexter
Partnership for Patients, CMMI	Dennis Wagner
Patient Representative	Chrissie Blackburn
Patient Representative	Alicia Cole
Patient Representative	Lisa Ann Morrise
Powell Tate DC	Michelle Baker
Saint Francis Memorial Hospital, Dignity Health Member	Wendy Kaler
School of Nursing, University of Kansas Medical Center	Danielle Olds
Service Employees International Union	Howard Berliner
University of Minnesota/National Coordinating Center for Intraprofessional Education and Collaborative Practice	Brian Isetts