National Priorities Partnership

Convened by the National Quality Forum

SAFETY
CONVENING WORKSHOP
SYNTHESIS REPORT

JULY 2010

NATIONAL PRIORITIES PARTNERSHIP

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Safety Convening Workshop
Synthesis Report

For decades, the nation has focused energy on reducing the risks of injury from care. A recent report by the Department of Health and Human Services (HHS) estimates that 1 in 7 Medicare beneficiaries experienced an adverse event after being discharged from hospitals in October 2008.[1] While much is known about what can be done to provide safe care and prevent healthcare-acquired conditions, and while some gains have been made, more work is needed to effectively implement improvements in the processes and, ultimately, outcomes of care. The Safety Workgroup of the National Priorities Partnership (NPP) convened a workshop to address this very gap and brainstorm strategies for reducing harm from care, with particular focus on the perioperative care environment. Workshop participants (Appendix A) identified high-leverage action steps for NPP Partners and other stakeholder groups to promote shared accountability and stimulate change. Those actions centered on the following demands:

- ensuring patient-informed decisionmaking is incorporated at all stages of care;
- implementing cross-disciplinary team approaches to care;
- building and reinforcing a culture of safety through committed senior leadership;
- aligning payment models and incentives with the demands and need for a safe healthcare system; and
- using health IT to enable change and improvement.

This report provides a synthesis of the workshop discussion with particular focus on these high-leverage action steps. Primary drivers of change and measure gaps are identified, and key areas of action and corresponding stakeholders are offered in detail. It is important to note that while the focus of this workshop was perioperative care safety, the drivers and key areas of change and critical safety measure gaps identified in this report offer broader applicability and relevance to all settings, providers, and recipients of care.

I. Background and Impetus for the Workshop

In its 2008 report, *National Priorities & Goals—Aligning Our Efforts to Transform America's Healthcare*,[2] NPP identified six cross-cutting National Priorities that if addressed would

significantly improve the quality of healthcare delivered to Americans. In an effort to continually reduce the risks of injury from care, NPP identified safety as one of the priorities for national action and created a Safety Workgroup to guide progress on specific goals, detailed below.

NPP Safety Goals

NPP developed three overarching safety goals that help focus improvements in healthcare quality:

- All healthcare organizations and their staff will strive to ensure a culture of safety while driving to lower toward zero the incidence of healthcare-induced harm, disability, or death. They will focus relentlessly on reducing and eliminating all healthcare-associated infections (HAIs) and serious adverse events (SREs).
- All hospitals will reduce preventable and premature hospital-level mortality rates to best in class.[3]
- All hospitals and their community partners will improve 30-day mortality rates following hospitalization for select conditions (acute myocardial infarction, heart failure, and pneumonia) to best in class.

NPP Workgroup and Convening Workshop

With a focus on perioperative care safety, the NPP Safety Workgroup convened a workshop of diverse and multidisciplinary stakeholders on July 27-28, 2010, in Washington, DC. The goal of the workshop was to develop specific actions for NPP Partners and others to consider what would promote the uptake of practices and measures to minimize HAIs, surgical site infections (SSIs), and SREs, with an emphasis on improving the frequency of use and quality of cross-disciplinary team approaches to care.

To support the development of this action plan, the workshop was organized to adhere to the three-part strategy of all NPP workgroups that includes: (1) identifying environmental barriers to achieving the goals and developing a plan to address these barriers through drivers of change; (2) identifying measure gaps and developing a plan for filling high-priority gaps; and (3) addressing implications for health information technology (health IT), including data collection needs, data reporting, and decision support tools.

II. Drivers of Change and Key Areas of Action

Barriers to implementation were addressed within the context of the NPP "drivers" of change, which include, among others: informed consumer decisionmaking, performance-based payment, public reporting, and accreditation and certification. These drivers then provided the mechanism for participants to formulate a set of action steps aimed at aggressively moving toward improved patient safety.

Through a facilitated, iterative group process, participants identified specific actions and associated actors or stakeholders that had the potential to "move the needle" toward desired outcomes. Participants also offered prioritization of and further detail on these actions steps through an online survey administered following the workshop (see results in Appendix B). Table 1 and the discussion below detail the five key areas of action that emerged:

- ensuring patient-informed decisionmaking is incorporated at all stages of care;
- implementing cross-disciplinary team approaches to care;
- building and reinforcing a culture of safety through committed senior leadership;
- aligning payment models and incentives with the demands and need for a safe healthcare system; and
- using health IT as an enabler of change and improvement.

Patient-Informed Decisionmaking

The current and potential role of patients and their families or caregivers was central to discussion at the workshop, with the acknowledgment that patients and families are the only "team members" consistently present from start to finish of treatment for a health problem. Participants highlighted the need for patients to be actively informed and engaged in their care, both as recipients of critical information that can assist them in decisionmaking and as key informants on their preferences and experiences in care. Participants suggested full integration of the patient into the care team, with particular sensitivity to cultural influences and health literacy levels that may drive patients' decisions. Building on the model of provider checklists to ensure safety, a patient safety checklist also was suggested as a way to better integrate patients into their own care.

Participants strongly advocated that information on patient outcomes (e.g., HAI and SRE rates) be publicly reported and oversight of mandated reporting improved. Furthermore, it was

stressed that such information be communicated in an understandable format and in a way that is meaningful and useful to consumers. In addition to viewing public reporting as assisting patients and their families in making informed decisions about care settings and providers, participants also saw it as serving as a feedback loop to those settings and providers for the purpose of continuous improvement in patient outcomes of care and assurance of the safest approaches to that care.

Cross-Disciplinary Team Approaches to Care

Workshop participants also desired greater understanding of how care teams are best constructed to include multiple disciplines, how organizational priorities encourage high-functioning teams, and how such teams can improve patient outcomes. First and foremost, participants noted that *forming and supporting* care teams was essential to an organization's functioning and success as defined by better patient outcomes. Such support would help to create a necessary bottom-up culture of safety and encourage leadership at all levels.

Many participants also suggested that education and certification programs offer a viable avenue for ensuring that team-based approaches to care are regarded as a core competency for all healthcare professionals. This suggestion is supported by health reform legislation—Section 3508 of the Affordable Care Act (ACA) allows the Secretary to award grants to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Upstream educational efforts may include medical, nursing, and allied health schools incorporating safe practices and team training into curriculums. Similarly, team training and safe practices can be considered for maintenance of certification and continuing education requirements. Finally, recognizing that specific tools (e.g., simulation training and web-based education) have been successful in providing team training, participants suggested that these and other tools be more widely implemented and used.

Senior Leadership and Achieving a Culture of Safety

Organizations' governing boards and "C-suite" (or senior leadership) play a critical role in building and reinforcing a culture of safety that ensures the delivery of the safest care to and the best outcomes for patients. Specifically, knowledge of and commitment to safety at the

most senior levels in an organization were deemed essential to any effort to improve safety and ultimately patient outcomes. The National Quality Forum's *Safe Practices for Better Healthcare* presents a set of practices that have been demonstrated to be effective in reducing the occurrence of adverse healthcare events across a variety of environments. These practices speak clearly to the role of senior leadership in the delivery of safe care to all patients and suggest guideposts for measuring the culture of safety and continuous improvement through strong leadership and team-based approaches to care.[4]

Participants suggested aligning payment incentives by linking performance and quality care to senior leadership compensation. Others also suggested that "flattening" hierarchy would allow leaders to emerge from all levels and across all disciplines within organizations, including at the level of the healthcare professional. The current use of contracts to require healthcare professionals to meet relevant accreditation standards, for example, also could be employed to explicitly require the provision of safe health services in accordance with a health plan's policy requirements for conditions of participation.

Alignment of Payment Incentives for Safe Care

Across the board, the action steps proposed significantly rely on payment models and incentives that can align to best support providers and settings in delivering the safest care possible to patients and communities. Alignment of payment incentives with provider performance and patient outcomes was suggested to help drive positive behavior change and encourage progress toward a safer healthcare system. Specifically, as new payment models gain traction through health reform implementation efforts, piloting efforts for medical home models, transitional care models, and Accountable Care Organizations, for example, should embed measures of safety and promote shared accountability for the purpose of improving patient outcomes and ultimately community health.

Payers and purchasers play an integral role in moving this effort forward, and federal efforts are already in motion to consider financial incentives for safer care. Specifically, ACA contains language to incentivize hospitals to reduce hospital-acquired conditions by imposing a 1 percent penalty on payments that would otherwise apply with respect to such discharges occurring in fiscal year 2015 or thereafter; the section also establishes public reporting requirements for such information (Section 3008[a]). ACA also asks the Secretary of

HHS to explore expansion of similar payment reform to care settings other than hospitals (Section 3008[b][1]).

Health IT as an Enabler

Many of the action steps workshop participants recommended rely on health IT—at both the micro and macro levels—to enable practice and reporting tools that can enhance or improve processes and practice of care. An important discussion point was the need to ensure that more robust safety measures are included in Meaningful Use 2013 and 2015 guidelines as required under the American Recovery and Reinvestment Act of 2009 and that the field be ready to implement these guidelines. Others suggested that the pre- and post-event employment of surveillance, prevention alerts, reminders, and other tools would allow providers to anticipate and respond better to patient needs and possible events. The collection and aggregation of data—and incentives to ensure compatibility across settings and providers—was deemed necessary to facilitate quality improvement, encourage and enable value-based purchasing, and serve as an accountability mechanism for consumers.

III. Critical Safety Measure Gaps

Workshop content and discussion allowed participants to identify specific measure gap areas that will need to be addressed to monitor and assess progress toward reducing the risk and incidence of injury from care. Furthermore, by appreciating the cross-cutting nature of the NPP safety priority with the other NPP Priorities, particularly patient and family engagement, the most significant barriers to change begin to present themselves as potential facilitators for improvements in care and ultimately patient outcomes.

Specific areas highlighted at the workshop in which more robust measures are needed include:

- the degree to which patients and families are kept central to all care and their experience of care is considered a primary determinant of quality;
- the extent to which high-quality care is ultimately focused on patient outcomes;
- the effectiveness of care teams and using team members at all levels to inform processes; and
- the safety of care provided across all care settings, including beyond the traditional inpatient “hospital walls” and into outpatient and ambulatory care settings.

Workshop participants stressed the need for measures that speak to patient preference and indicate shared decisionmaking as a component of safe and appropriate surgical procedures and care. A systematic approach to capturing patient and family experience of care data and providing that data to providers is needed to drive the system toward patient-informed decisionmaking that is congruent with patient and family preferences. In all, care often is seen to exclude patients and their families/caregivers, thereby removing critical sources of information before, during, and after care. Emphasis was placed on using measures of patient outcomes to assess the quality and effectiveness of care—for example, by linking outcomes outside of the surgical unit's walls (e.g., post-operative infection rates) to improvements in the quality of care delivered through a full surgical procedure.

Workshop participants also explicitly desired increased focus on the use and success of care teams and a multidisciplinary approach to care. With a significant focus on promoting cross-disciplinary team approaches to care and with evidence supporting such approaches, workshop participants specifically called for structural and process measures of "teamness" to be significantly more widespread, both to examine whether providers are offering care in the most supportive environment possible and according to proven processes that they know will benefit patients.

Finally, given that care today crosses numerous settings and that a large percentage of care from diagnosis to rehabilitation is delivered outside of the hospital setting, many noted the critical need for measures of safe care within ambulatory care settings. These and other measure gaps must be addressed to capture patient outcomes, to best understand and improve patients' and families' involvement in their care across all settings and providers, and to improve care coordination across these settings and providers. Participants felt strongly that the ultimate goal of ensuring the best possible outcomes of care for patients must remain central to all efforts.

IV. The Path Forward

Since the workshop, a great deal of activity in health reform has made these suggested action steps increasingly relevant and timely. As the HHS Secretary finalizes the National Quality Strategy, NPP's Priorities and Goals work to bolster the three parts of this strategy: better

care, affordable care, and healthy people/communities. The safety priority and goals in particular offer several opportunities to support the National Quality Strategy:

- *Better Care:* driving the prevention and elimination of healthcare-associated infections, surgical site infections, and the occurrence of SREs; improving patient safety through the use of interdisciplinary care teams
- *Affordable Care:* driving out unsafe practices to eliminate associated and avoidable costs (e.g., longer hospital stays and increased number of tests), particularly for patients, families, their employers and communities, and the healthcare system
- *Health People/Communities:* reducing harm from care that reaches beyond hospital walls and into ambulatory and broader community settings (e.g., Methicillin-Resistant Staphylococcus Aureus [MRSA])

As mentioned earlier, ACA supports efforts to reduce harm from care, including providing incentives for reductions in healthcare settings and for that information to be publicly reported. Furthermore, specific elements of ACA support the integration of quality improvement and patient safety in the clinical education of health professionals.

In all, the key drivers and associated actions presented in this report—and supported by the direction of the National Quality Strategy and ACA—serve as a starting point for all stakeholder groups when evaluating their potential to contribute to progress on NPP's safety goals. The path forward includes focusing further on the specific steps that need to be taken and by whom, as well as identifying those organizations in public and private sectors that are already leading by example—both individually and in partnership—to realize the defined action plan.

Table 1
Safety Action Plan Summary

*Actions are not listed in any particular order

	Key Areas of Action				
	Patient-Informed Decisionmaking	***Cross-Disciplinary Team Approach***	***Senior Leadership and Culture of Safety***	***Payment Models and Incentives***	***Health IT as an Enabler***
Actions	Develop a safety checklist for patients and their families/caregivers. Include patients and their families/ caregivers as part of the care team. Promote patient-provider shared decisionmaking practices and tools to reach care approaches and decisions that best fit the needs of patients. Standardize shared decisionmaking and engage the legal community early on in the care process. Ensure care delivered exercises components of cultural competency, including an understanding of the health literacy levels of patients and their families/caregivers. Create awareness in the public at large with consistent, understandable reporting and use that data to help consumers make informed decisions on providers and settings of care.	Ensure the formation and support of multidisciplinary teams for patient care. Implement leadership and team training through upstream and downstream accreditation and certification initiatives: • Include team training as part of curriculum core competencies for all disciplines • Include knowledge and practices of team approach in Maintenance of Certification and continuing education programs • License providers as team-trained Empower providers at all levels to inform safe processes of care and improvements to patient care. Support widespread use of and education on tools: • Simulation training • Web-based learning • Briefs and debriefs	Increase boardroom knowledge and awareness of safety matters and make the impact tangible to encourage a culture of safety. Link performance and quality care to credentialing requirements and payment, including senior leadership compensation. Employ contracts (e.g., conditions of participation) to ensure commitment to safe care across all disciplines and levels within an organization. "Flatten" organizational hierarchy to support team approach to care and allow leadership to emerge from within. Have all disciplines and levels inform regular safety assessments. Create an open, fair, "just culture" that encourages consistent behavior management, ongoing monitoring and evaluation, and systems of accountability.	Align payment incentives with quality safety care (e.g., Accountable Care Organizations [ACOs], bundled payment, global fees, transitional care models, medical home). Link performance and quality care to credentialing requirements and payment, including senior leadership compensation. Ensure funding for the formation and support of multidisciplinary teams for patient care.	Ensure readiness of safety-specific measures for Meaningful Use 2013 and 2015. Use HIT tools to anticipate and respond to pre-event surveillance, prevention alerts and reminders, and early detection and intervention. Encourage patients to provide and use data on their care (PHRs; web-based applications; shared decisionmaking). Encourage further adoption of EHRs, particularly those with clinical decision support tools. Aggregate data across providers, settings, and health plans (e.g., Beacon communities): • Set standards to ensure compatibility through incentives • Allow patients to cross providers and settings seamlessly
Implementors	• Consumer groups • Healthcare professionals and providers • Health plans • Legal community • Public and private purchasers • Quality alliances	• Accreditation and certification bodies • Healthcare professionals and providers • Professional societies • Public and private purchasers • Schools and continuing education providers • State licensing boards	• Credentialing bodies • Healthcare professionals and providers • Health plans • Policymakers • Professional societies • Public and private purchasers	• Healthcare professionals and providers • Health plans • Policymakers • Public and private purchasers	• Consumer groups • Healthcare professionals and providers • Health plans • HIT vendors • Policymakers • Public and private purchasers

Notes

1. U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries.* November 2010. Report No. OEI-06-09-00090. Available at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf. Last accessed December 2010.
2. National Priorities Partnership, *National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare*, Washington, DC: National Quality Forum; 2008.
3. "Best in class" may be determined by using an accepted methodology, such as Achievable Benchmarks in Care (ABC)™, available at http://main.uab.edu/show.asp?durki=14527. Last accessed August 2010.
4. National Quality Forum (NQF), *Safe Practices for Better Healthcare–2010 Update: A Consensus Report*, Washington, DC: NQF; 2010.

APPENDIX A
NATIONAL PRIORITIES PARTNERSHIP

SAFETY
CONVENING WORKSHOP ATTENDEES
JULY 2010

NATIONAL PRIORITIES PARTNERSHIP
Convened by the National Quality Forum

SAFETY CONVENING WORKSHOP

INVITED PARTICIPANTS

Steven Findlay (Co-Chair)
Consumers Union, Washington, DC

Frank Opelka (Co-Chair)
Louisiana State University, New Orleans, LA

Sherri Alexander
Association of Surgical Technologists, Littleton, CO

James Bagian
Veterans Administration National Center for Patient Safety, Ann Arbor, MI

Richard Bankowitz
Premier, Inc., Philadelphia, PA

Mara Bollini
St. Louis Children's Hospital, Saint Louis, MO

Patrick Brennan
University of Pennsylvania Health System, Philadelphia, PA

Richard Brilli
Nationwide Children's Hospital, Columbus, OH

Clair Callan
American College of Physician Executives, Lake Forest, IL

Marjory Cannon
Centers for Medicare & Medicaid Services, Baltimore, MD

John Clarke
Patient Safety Authority/ECRI Institute, Plymouth Meeting, PA

David Classen
University of Utah, Salt Lake City, UT

Curtis Collins
The University of Michigan Health System, Ypsilanti, MI

Helen Darling
National Business Group on Health, Washington, DC

NATIONAL PRIORITIES PARTNERSHIP
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E. Patchen Dellinger
University of Washington School of Medicine, Seattle, WA

Richard Dutton
Anesthesia Quality Institute, Park Ridge, IL

Frank Federico
Institute for Healthcare Improvement, Reading, MA

Beth Feldpush
American Hospital Association, Washington, DC

Timothy Ferris
Massachusetts General Hospital/Institute for Health Policy, Boston, MA

Linda Greene
Association for Professionals in Infection, Rochester, NY

Harry Greenspun
Dell | Dell Services, Austin, TX

Linda Groah
Association of Perioperative Registered Nurses, Denver, CO

Dale Harvey
Virginia Commonwealth University Health System, Richmond, VA

Helen Haskell
Mothers Against Medical Error, Columbia, SC

LuAnn Heinen
National Business Group on Health, Washington, DC

Janet Izlar
American Association of Nurse Anesthetists, Savannah, GA

Richard Johannes
CareFusion, Marlborough, MA

Donald Kennerly
Baylor Health Care System, Dallas, TX

Linda Kenney
Medically Induced Trauma Support Services, Chestnut Hill, MA

Carol Koeble
North Carolina Center for Hospital Quality and Patient Safety, Cary, NC

NATIONAL PRIORITIES PARTNERSHIP
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Patricia Kurtz
The Joint Commission, Oakbrook Terrace, IL

Paul Larson
Radiology Associates of the Fox Valley, Neenah, WI

Alan Levine
Consumers Advancing Patient Safety, Alexandria, VA

Jerod Loeb
The Joint Commission, Oakbrook Terrace, IL

Martin Makary
Bloomberg School of Public Health, Baltimore, MD

Francis Margolin
The Leapfrog Group, Washington, DC

Lisa McGiffert
Consumers Union, Austin, TX

Matt Moore
Ethicon Endo-Surgery, Cincinnati, OH

William Munier
Agency for Healthcare Research and Quality, Rockville, MD

Lena Napolitano
American College of Surgeons, Washington, DC

James Poyer
Centers for Medicare & Medicaid Services, Baltimore, MD

Peter Pronovost
Johns Hopkins University School of Medicine, Baltimore, MD

Jean Rexford
Connecticut Center for Patient Safety, Redding, CT

Jay Schukman
Anthem Blue Cross and Blue Shield, Richmond, VA

Jason Slagle
Vanderbilt University School of Medicine, Nashville, TN

Donna Slosburg
Ambulatory Surgery Center Quality Collaboration, St. Petersburg, FL

NATIONAL PRIORITIES PARTNERSHIP
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Thoralf Sundt
Mayo Clinic Rochester, Rochester, MN

Margaret Van Amringe
The Joint Commission, Oakbrook Terrace, IL

Sam Watson
Michigan Health & Hospital Association, Lansing, MI

Pamela Windle
American Society of PeriAnesthesia Nurses, Houston, TX

Deborah Yokoe
Society for Healthcare Epidemiology of America, Arlington, VA

PROJECT STAFF

Tom Valuck
Senior Vice President, Strategic Partnerships

Karen Adams
Vice President, National Priorities Partnership

Peter Angood
Senior Advisor, Patient Safety

Wendy Vernon
Senior Director, National Priorities Partnership

Bonnie L. Zell
Senior Director, Population Health

Anisha Dharshi
Senior Program Director, National Priorities Partnership

Christy Olenik
Evaluation Methodologist

Lindsay Lang
Program Director, Strategic Partnerships

Nadine Allen
Research Analyst, Strategic Partnerships

Eric Colchamiro
Research Analyst, Performance Measures

Lindsey Tighe
Research Analyst, Performance Measures

APPENDIX B
NATIONAL PRIORITIES PARTNERSHIP

PRIORITIZED ACTION STEPS FOR PERIOPERATIVE CARE SAFETY

SUMMARY OF SURVEY RESULTS

Prioritized Action Steps for Perioperative Care Safety
Summary of Survey Results

Following the National Priorities Partnership (NPP) Safety Convening Workshop, participants were requested through an online survey to provide more in-depth feedback on the action steps discussed at the workshop. The intent of the survey was to use their responses to fine-tune the action steps offered for the creation of a comprehensive action plan for perioperative care safety to bring forth to NPP and for use by their respective stakeholder groups.

The survey was organized around the workshop's three breakout group topic areas: (1) healthcare-associated infections (HAIs) and surgical site infections (SSIs); (2) serious reportable events (SREs); and (3) cross-disciplinary team approaches to care. Recipients received a tailored survey that asked questions related to the breakout group they participated in at the workshop. They were also given the option to provide input on the other two topic areas. Overall, the surveys had response rates as follows: 65 percent for HAI/SSI (11/17), 44 percent for SRE (7/16), and 79 percent for cross-disciplinary team approaches to care (15/19).

In an effort to prioritize the many thoughtful ideas raised, respondents were asked to select one action step from those discussed at the workshop that they felt had the greatest potential to make significant impact in their specific breakout group topic area. Those responses are summarized below by topic area: HAIs and SSIs (Chart 1); SREs (Chart 2); and cross-disciplinary team approaches to care (Chart 3).

Chart 1: Prioritized action steps for healthcare-associated infections (HAIs) and surgical site infections (SSIs)

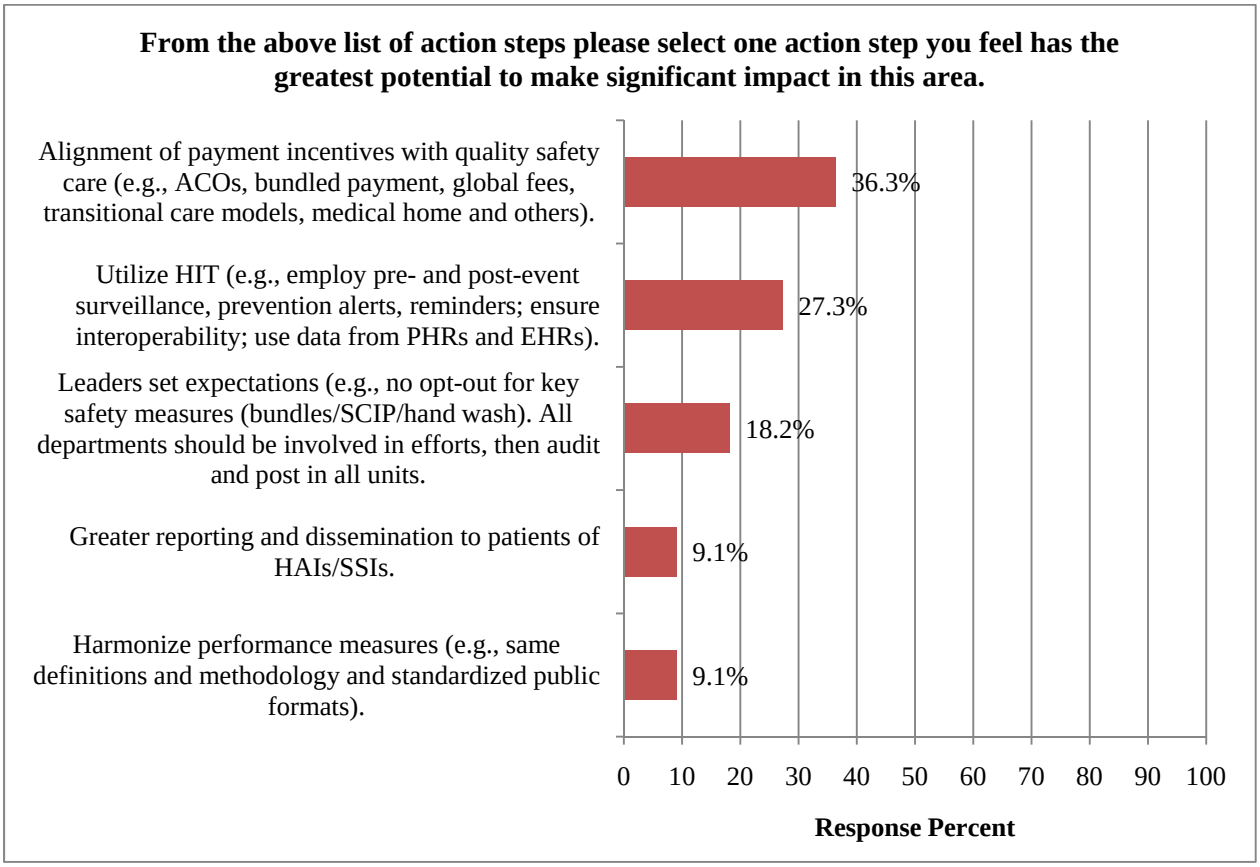

Chart 2: Prioritized action steps for serious reportable events (SREs)

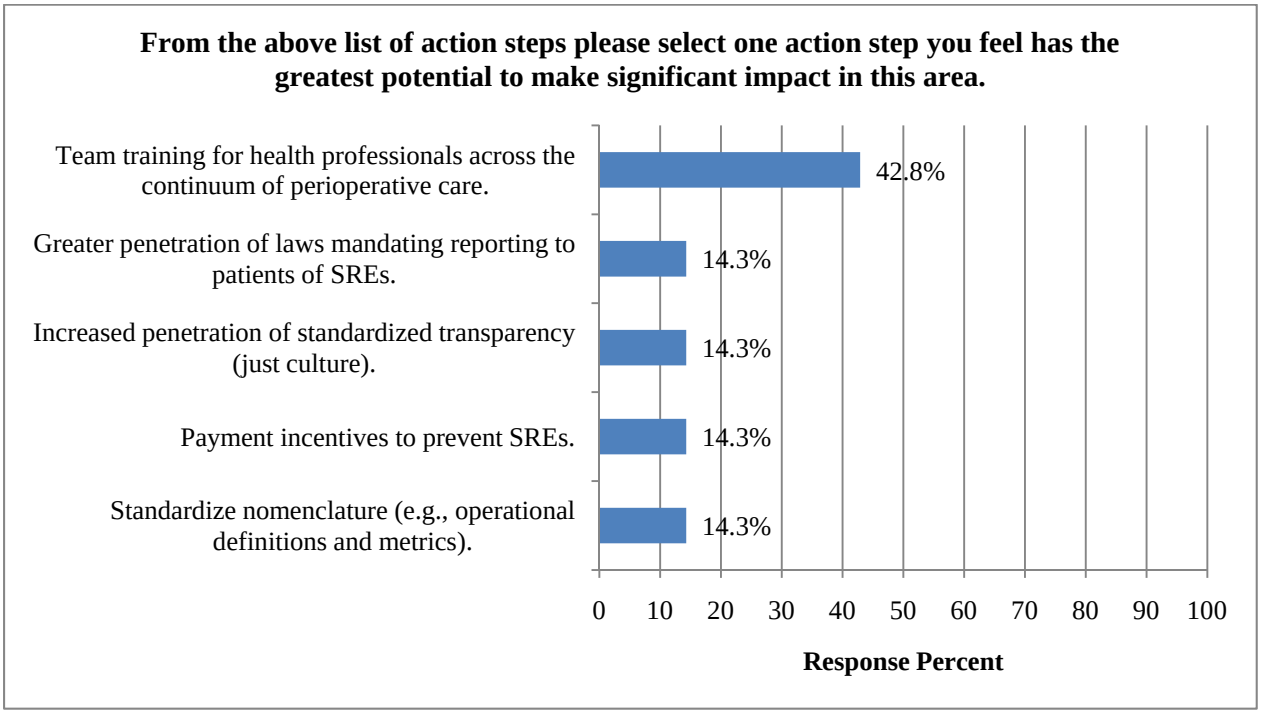

Chart 3: Prioritized action steps for cross-disciplinary team approaches to care