PUBLIC WEBINAR

Quality Counts, Safety Matters

Prioritizing Patient Safety Through Quality Measurement

Precious McCowan, MS
Michelle Schreiber, MD | CMS
Arjun Srinivasan, MD | CDC
Reena Duseja, MD, MS | VHA
Craig A. Umscheid, MD, MS | AHRQ
You will hear:

- A **patient’s perspective** on the importance of patient safety.
- **Insights from health care experts** on using quality measurement to drive patient safety improvements.
- How the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), CMS, and the Veterans Health Administration (VHA) are addressing preventable harms.
Today’s Presenters

- Precious McCowan, Patient Advocate
- Michelle Schreiber, CMS
- Arjun Srinivasan, Centers for Disease Control and Prevention
- Reena Duseja, Veterans Health Administration
- Craig A. Umscheid, Agency for Healthcare Research and Quality
Presenting the Patient Perspective
Presenting the Patient Perspective

Precious McCowan, MS
End-Stage Renal Disease (ESRD)
Patient Advocate, Educator, and Mentor
Presenting the Patient Perspective
Presenting the Patient Perspective
CMS Strategies for Patient Safety

Michelle Schreiber, M.D.
Deputy Director, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
Michelle.Schreiber@cms.hhs.gov
“If I were to tell you that more than 200 people were going to die today from a medical error, you could say, "That can't be," but that's exactly what's happening. We're essentially losing an airplane full of Americans pretty much every day from medical errors, but we don't think about it. But is it still the third, fourth leading cause of death in America?”
Lessons from COVID Influence Safety Strategy

• Marked reduction in Patient Safety (in some cases nearly eliminating many years of improvement)
• Expansion of digital and telehealth capabilities but need for interoperable data
• Rapid Scientific Advances
• Expanded Collaboration
• Stark Equity Gap
• Nursing Home care issues
• Need for interoperable data
• Resilience challenges - including workforce

The only mistake in life is a lesson not learned. Albert Einstein
CMS National Quality Strategy Goals

The Eight Goals of the CMS National Quality Strategy are Organized into Four Priority Areas:

**Equity**
Advance health equity and whole-person care

**Engagement**
Engage individuals and communities to become partners in their care

**Safety**
Achieve zero preventable harm

**Resiliency**
Enable a responsive and resilient health care system to improve quality

**Outcomes and Alignment**
Outcomes
Improve quality and health outcomes across the care journey

Alignment
Align and coordinate across programs and care settings

**Interoperability and Scientific Advancement**
Interoperability
Accelerate and support the transition to a digital and data-driven health care system

Scientific Advancement
Transform health care using science, analytics, and technology
**Safety and Resiliency**

**Safety: Achieve Zero Preventable Harm**

**OBJECTIVE**

Improve performance on key patient safety metrics through the application of CMS levers such as quality measurement, payment, health and safety standards, and quality improvement support.

**SUCCESS TARGET**

Improve safety metrics with a goal to return to pre-pandemic levels by 2025 and reduce harm by an additional 25% by 2030 through expanded safety metrics, targeted quality improvement, patient engagement, and Conditions of Participation.

**HIGHLIGHTED INITIAL ACTIONS**

- Implement tracking to show progress towards reducing harm (e.g., healthcare-associated infections) to pre-pandemic levels and beyond.
- Expand the collection and use of safety indicator data across programs, including data on key areas such as maternal health, behavioral health, adverse events, and workforce issues.
- Align across HHS to implement actions from the President’s Council of Advisors on Science and Technology (PCAST) to further enhance patient safety.
CMS Quality Levers, Programs & Activities

- Advanced Alternative payment models
- ACOs, PCMH, Bundles
- Multi-payer State agreements
- Prevention and Population Health
- Rapid Cycle Evaluation

- National & Local decisions
- Mechanisms to support innovation (CED, parallel review, other)

- Conditions of Participation
- Hospital Inpatient/Outpatient
- In-patient psychiatric hospitals
- Cancer hospitals
- Nursing homes
- Home Health Agencies
- Long-term Care Acute Hospitals
- In-patient rehabilitation facilities
- Hospices

- Provider Enrollment
- Fraud, Waste & Abuse Prevention & Detection
- Medical Review
- Audits and Investigations

- Value-Based Incentive Models
- Medicaid and Medicare Coordination
- Clinical Standards

- 1115 Waivers
- Demonstration programs
- Innovation Accelerator Program

- CLIA
- Target surveys
- Quality Assurance
- Performance Improvement
- Survey and Certification

- Quality Improvement Organizations
- Hospital Innovation & Improvement Networks

- Hospitals, Home Health Agencies, Hospices, ESRD facilities, Post Acute Care, Inpatient Psychiatry, Cancer Hospitals, Clinicians
- MA Stars
- Medicaid Core Sets
- Marketplace QRS
- Quality Measurement/Measures
- Care Compare and Stars Programs

- Coverage
- Payment
- Program Integrity
- Quality Improvement
- Quality & Safety Oversight
- Quality & Public Reporting

- Part D
- VBP hospitals, SNF, HHA, ESRD
- Payment adjustments HAC, hospital RRP
- Physician Quality Payment Program (QPP)
CMS - Safety Action Steps

- New performance measures to support patient safety (OIG) - new eCQM to cover common safety events
- Maternal Safety – new metrics and “Birthing Friendly” designation
- Nursing Home Safety – expanded VBP and safety focus including staffing turnover and minimum staffing levels
- Expanded VBP Programs - new areas of safety focus
  - Rural Health – Rural Emergency Hospitals
  - Opioid Safety – Electronic Prescribing; Mandatory Query of PDMP
  - Expanded Home Health Value Based Program (expanded CMMI Model)
- Developing structural safety measure (hospital)
- Measure stratification for equity

Additional Safety Action Steps

- Working across CMS for integrated safety action steps
- Targeted Quality Improvement Network support – Specific focus on patient safety
- Focus on leadership and governance – updated QAPI guidelines March 2023
- Support of Interoperability, TEFCA and FHIR - Transition to Digital Measurement as a safety issue (data completeness and availability)
- Public transparency and reporting (should safety be weighted more highly in Stars/public reporting?)
- Conditions of Participation and Survey
# New Electronic Clinical Quality Measures for Safety

<table>
<thead>
<tr>
<th>Measure</th>
<th>Status</th>
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<tbody>
<tr>
<td>Hyper and Hypoglycemia</td>
<td>Finalized</td>
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<td>Opioid Overdose – Naloxone Administration</td>
<td>Finalized</td>
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<td>Acute Kidney Injury</td>
<td>Finalized</td>
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<td>Pressure Injury</td>
<td>Finalized</td>
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<td>Severe Maternal Morbidity</td>
<td>Finalized</td>
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<td>Falls With Injury</td>
<td>Under Consideration 2023</td>
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<td>Post Operative Respiratory Failure</td>
<td>Under Consideration 2023</td>
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<td>Sepsis Outcome</td>
<td>2024</td>
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<td>Venous Thromboembolic Events</td>
<td>2024</td>
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<td>Medication Related Bleeding</td>
<td>2024</td>
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<tr>
<td>Death Among Surgical Inpatients</td>
<td>Under Consideration 2023</td>
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Measures begin in IQR before being considered for Hospital Acquired Condition (HAC) Program
Example: CMS’ National Quality Improvement Support for Patient Safety (www.qioprogram.org)

- **Immunizations including COVID-19 Vax**
  - RCA to identify quality gaps, create Improvement Plan, & provide technical assistance
  - One-on-one or Group coaching, connecting with network of providers for support
- **COVID-19 Response**
  - Quality improvement tools & resources, end to end support
  - Sharing evidence-based best practices and help scale across the organization
- **Infection Prevention**
  - Customized trainings & clinician office hours
  - Individualized, actionable real-time data feedback & national benchmarking
- **Patient Safety**
  - Help understand federal, state & local guidance, and help with reporting on patient safety measures
- **Behavioral Health & Opioid Misuse**
  - Improve Internal Operational Efficiency and Care Coordination between settings
  - Best Practices - staff onboarding, training, retention and preventing workplace violence
- **Chronic Disease Management**
  - Coaching and Process Improvement to prevent clinician burnout
- **Care Coordination**
  - Improve Discharge Planning & Follow up to prevent readmissions

**Current Work**

- ~11,000 Community Partnerships in areas of highest disparities
- ~15,000 Nursing homes for vaccination and infection control assistance
- ~1,965 small, rural, CAH for patient safety and process improvements
- 24 Medicare-certified IHS hospitals for patient safety and coordination
- ~7,726 Dialysis Facilities for various improvement activities to improve quality & safety
## QIO Focus on Safety

<table>
<thead>
<tr>
<th>Focus of Safety – 12th SOW by Facility</th>
<th>Decreasing hemodialysis catheter infection rates, decreasing incidence of peritonitis, decreasing hospital admissions/readmissions</th>
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<tr>
<td>ESRD</td>
<td>C. Difficile, Adverse Drug Events, Hospitalizations related to infections including Covid 19</td>
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<tr>
<td>Nursing Homes</td>
<td>CAUTI, CLABSI, Pressure Injuries, Sepsis and Septic Shock, Adverse Drug Events especially from anticoagulation, hypoglycemia</td>
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HHS Cross Agency Collaboration

AHRQ – CDC – CMS – FDA – ONC

• Leadership Action Alliance for Safety webinar series
• Safer Together: A National Action Plan to Advance Patient Safety (Institute for Healthcare Improvement)
• CDC expanded patient safety reporting through NHSN using digital tools
• Promoting Interoperability and Digital Data Collection thru Standard Data Elements/USCDI and USCDI+
• Patient Safety Organization – use of AHRQ Network of Patient Safety Databases
• Assessment of safety of new devices and medications
• Alignment of Quality and Safety measures
• Collaboration across other agencies including VA, DoD and others
Future Considerations: System Approaches

- How to develop more standardization in healthcare
- Human factors engineering
- Learning from error – advanced analytics, machine learning, NLP
- Standardized definition of safety (including taxonomy of error reporting)
- Direct link of safety to productivity/finance

Thank You!
Measuring For Prevention

Arjun Srinivasan, MD
CAPT USPHS
Deputy Director for Program Improvement
Division of Healthcare Quality Promotion

Disclaimer: The findings and conclusions herein are draft and have not been formally disseminated by the Centers for Disease Control and Prevention and should not be construed to represent any agency determination or policy.
What Gets Measured Gets Done

- Patient safety successes of the past several years include significant pre-pandemic reductions in healthcare associated infections and antimicrobial resistance.
- Healthcare associated infections - reductions in central line associated blood stream infections (approaching 50% over 5 years), catheter associated urinary tract infections, modest reductions in some surgical site infections.
- Antimicrobial resistance: reductions in Methicillin resistant *S. aureus*, *Clostridioides difficile* and carbapenem resistant Enterobacterales (very hard to treat bacteria)
What Contributes to Safety Success?

- Many have pointed out that the long-standing presence of a dedicated monitoring system with well established definitions and dedicated expertise have been foundational to our success in reducing healthcare associated infections and antimicrobial resistance.

- The system is important- CDC’s National Healthcare Safety Network is used by more than 35,000 healthcare facilities of all types to report safety events.

- Familiarity is really important in life- that applies to healthcare too.
The National Healthcare Safety Network is a System Supported By Deep Expertise

- The National Healthcare Safety Network is so much more than a “reporting platform” because it is embedded within a prevention oriented division, The CDC’s Division of Healthcare Quality Promotion.
- NHSN is supported by a team of experts, not just with specific expertise on analyzing healthcare safety data. But also by a team with extensive expertise on investigating, researching and preventing healthcare associated infections and antimicrobial resistance.
- This combination of measurement and action has been essential to success. The data informs action and then helps us know if the actions are working.
Advancing Measurement

- The growing power of electronic health records and the ability to securely share healthcare data through means like Fast Healthcare Interoperability Resources (FHIR) is allowing important advances in safety measurement.
- It allows us to expand event reporting in ways that would be too burdensome for manual collection.
  - Expanded data collection also facilitates the collection of ancillary safety measures.
- It allows for far more detailed and sophisticated risk adjustment.
A Practical Example- Moving Beyond Central Line Associated Bloodstream Infections

- Many patients develop bloodstream infections in hospitals that are not related to central lines but that might be preventable.
  - For example- bloodstream infections due to peripheral intravenous catheters.
- Electronic data capture makes reporting of all hospital onset bacteremia events practical.
- And would allow us to calculate other important safety measures- for example, how often blood cultures might represent contamination during collection.
CDC’s Approach for Expanding Reporting to Hospital Onset Bacteremia Events

- All of our work in this area is informed by extensive partnerships at every step.
- Developing a definition that has clinical importance
- Assessing risk adjustment options
- Testing to see that the measure will respond as expected to prevention efforts.
  - A measure that doesn’t respond to an intervention is not a very useful measure!
What’s Next? Near Term

- Using electronic reporting via FHIR to improve measurement of *Clostridioides difficile*
  - Combining a positive test with treatment of the infection yields a measure that’s more clinically meaningful.
- An electronic measure of outcomes in patients with sepsis
  - In partnership with CMS
What’s Next? Slightly Longer Term

- We are starting to work with CMS to consider how NHSN can be used to support and inform the reporting and prevention of non-infectious harms.
- Though NHSN has long focused on infectious harms, there is no reason why this same approach could not be effective in other areas.
- We have begun work on:
  - Glycemic events, Deep venous thrombosis, Opioid related adverse events, Kidney injury in hospitalized patients
- We are partnering with CMS to think about how best to bring our efforts together to advance safety measures. And how to partner with the broader community.
What’s Next? Longer Term

- What are harms that we can’t measure at all right now that we might be able to capture with electronic reporting
  - “Electronic native” measures
- These are areas where we first have to define how to measure the harm, e.g. pediatric sepsis, sepsis in pregnant patients
We Have to Remember

- With electronic reporting and technology like FHIR, we are approaching a day where the burden of reporting will not be the primary challenge.
- With that new power comes even more responsibility.
- How do we collaborate to ensure that we have a well-developed prevention portfolio that can accompany and support any measure we develop?
- How do we collaborate to ensure those prevention measures are implemented effectively and equitably?
  - Measurement without prevention is just counting.
  - Prevention without measurement is just guessing.
VHA Patient Safety Journey and Impact on Performance

Reena Duseja, MD, MS

Senior Advisor
Office of Assistant Undersecretary for Health for Quality and Patient Safety
Veterans Health Administration
What is a High Reliability Organization?

High Reliability Organizations excel in safety and consistently prevent errors and accidents, despite operating in highly complex, high-risk environments.

• Originally adopted in the aviation and nuclear power industries, the concept expanded to health care systems – including VHA.

• **HRO Vision:** Safest Health Care System for All

• **HRO Goal:** High reliability is integrated into the fabric of VHA operations and culture
HROs experience fewer than anticipated accidents or events of harm, despite operating in complex, high-risk environments

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<thead>
<tr>
<th>Fewer than anticipated accidents or events of harm</th>
<th>Operating in complex, high-risk environments</th>
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<tbody>
<tr>
<td>An “accident or event of harm” could be more broadly defined as <strong>any event that causes disruption to safe and reliable operations across the system</strong></td>
<td>VHA leaders and staff members help manage business processes for the <strong>most complex health care system in the nation</strong></td>
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- Unclear Policy
- Error in Data Report
- Unjust Response to Adverse Event
- Unique Veteran Health Care Needs
- Legislative Requirements
- Community Partnership
# HRO Principles, Pillars, and Values

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<thead>
<tr>
<th>Pillars</th>
<th>Principles</th>
<th>Values</th>
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<tr>
<td><strong>3 Pillars</strong></td>
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<tr>
<td>LEADERSHIP COMMITMENT</td>
<td>Sensitivity to Operations: Focus on the Front Line Staff and Care Processes</td>
<td>It's About the Veteran</td>
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<tr>
<td>Safety and reliability is reflected in leadership’s vision, decisions and actions.</td>
<td>Preoccupation with Failure: Anticipate Risk - Every Staff Member is a Problem Solver</td>
<td>Support a Culture of Safety</td>
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<tr>
<td>CULTURE OF SAFETY</td>
<td>Reluctance to Simplify: Get to the Root Causes</td>
<td>Commit to Zero Harm</td>
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<tr>
<td>Throughout our organization, safety values and practices are used to prevent harm and learn from mistakes.</td>
<td>Commitment to Resilience: Bounce Back from Mistakes</td>
<td>Learn, Inquire and Improve</td>
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<tr>
<td>CONTINUOUS PROCESS IMPROVEMENT</td>
<td>Deference to Expertise: Empower and Value Expertise and Diversity</td>
<td>Duty to Speak Up</td>
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<td>Across the organization, teams use effective tools for continuous learning and improvement.</td>
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<td>Respect for People</td>
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<td>Clear Communications</td>
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### Six Enterprise-wide HRO Activities

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<th>Leadership Commitment</th>
<th>Culture of Safety</th>
<th>Continuous Process Improvement (CPI)</th>
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<tr>
<td><strong>HRO Baseline Training</strong></td>
<td>Standard training is provided in HRO concepts, Just Culture and safety behaviors for all new employees.</td>
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<td><strong>Assessment and Planning</strong></td>
<td>Organizations/sites assess HRO maturity, strengths and gaps to identify strategies for HRO improvement and sustainment.</td>
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<td><strong>HRO Leader Coaching</strong></td>
<td>Leader coaches provide expert guidance, tools and feedback to integrate HRO leadership behaviors and practices into daily operations.</td>
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<td><strong>Team Training</strong></td>
<td>Unit-level teams learn communication tools toward error management and routinely apply these tools to continuously improve unit-based processes.</td>
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<td><strong>CPI/Lean Training</strong></td>
<td>Front line teams, with support from VISNs and program offices, lead improvement projects focused on safety and reliability.</td>
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<td><strong>Experiential Learning</strong></td>
<td>Strong safety and improvement practices are spread across the enterprise, creating and leveraging opportunities to learn from the experiences of colleagues.</td>
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Joint Patient Safety Reporting System (JPSR)

- **JPSR**: Veterans Health Administration (VHA) patient safety event reporting system and database.

- **Adverse Event**: Adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers.

- **Close Call**: Close calls are events or situations that could have resulted in an adverse event but did not, either by change or through timely intervention.
"I have trust and confidence in my supervisor."

Between FY 19, at the beginning of VHA’s Journey, and FY 22, positive responses to this question rose from 3.94 to 4.06, increasing each year.

"Staff will freely speak up if they see something that may negatively affect patient care."

All Employee Survey scores for this question steadily increased across all HRO Cohorts.

A high CC/AE reporting ratio may indicate a positive reporting culture in which Close Calls are reported and Adverse Events are prevented.

The health system-wide ratio of CC/AE rose from FY 22 Q2 to FY 23 Q3 (0.66 to 3.43).
### Multi-Site Improvement: Virtual Improvement Program (VIP)

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<tr>
<th>Quality Area</th>
<th>FY20Q4</th>
<th>FY21Q2</th>
<th>FY21Q3</th>
<th>FY21Q4</th>
<th>FY22Q2</th>
<th>FY22Q4</th>
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<th>FY23Q3</th>
<th>FY23Q4</th>
<th>FY24Q1</th>
<th>FY24Q2</th>
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<td>Influenza Immunizations</td>
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<td>Mental Health PDE1 Processes</td>
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<td>Emergency Department</td>
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<td>Delay of Admit from ED to IP</td>
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**This represents the work of 48% (67 out of 139) Medical Centers**
CLABSI (Acute Care & ICU)

- *Learning
- *Quarterly
- *Spread to Acute Care
- *Sharing of data for
- *Public
- *Continued mentoring
- *Educational offerings
- *COVID
- *Refocused on infections and included in Mortality

FY06Q4 FY07Q2 FY08Q2 FY09Q4 FY10Q2 FY11Q2 FY12Q2 FY13Q2 FY14Q2 FY15Q2 FY16Q2 FY17Q2 FY18Q2 FY19Q2 FY20Q2 FY21Q2 FY22Q2 FY23Q2 FY24Q2

QUALITY AND PATIENT SAFETY
**CAUTI (Acute Care & ICU)**

- *Mentoring*
- *Educational Training*
- *National Reporting*
- *Quarterly Reporting*
- *Continue to spread to Acute Care*
- *Continued mentoring with sites on bundle elements and evidence based practice*
- *COVID*
- *Refocused on infections included in*

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<thead>
<tr>
<th>FY11Q1</th>
<th>FY11Q3</th>
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<th>FY15Q1</th>
<th>FY15Q3</th>
<th>FY16Q1</th>
<th>FY16Q3</th>
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<th>FY20Q1</th>
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<th>FY22Q3</th>
<th>FY23Q1</th>
<th>FY23Q3</th>
<th>FY24Q1</th>
</tr>
</thead>
</table>
Comparison of Sepsis Composite (SEP-1) - Early Management Bundle with Sepsis 30-Day Standardized Mortality

FY21 FY22 FY23 FY24

Sepsis Composite
Sepsis SMR30
Thank you
The National Action Alliance for Patient and Workforce Safety

Craig Umscheid, MD, MS
Director, Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

Prioritizing Patient Safety Through Measurement
March 2024
National Action Alliance Timeline

- Sec. Becerra’s Call to Action: Nov. 2022
- RFI Results: Jan. 2023
- NAC: Mar. 2023
- Apr. – Nov. 2023 HHS Webinar Series
- Sept. - Dec. 2023 SNAC Convenes
- NAC: Nov. 2023
- National Action Alliance Launch: Mar. 2024

NATIONAL ACTION ALLIANCE for Patient and Workforce Safety

Subcommittee of the National Advisory Council: Informing the National Action Alliance to Advance Patient and Workforce Safety

Final Report: December 10, 2023

Submitted by: [Signature]
Five Aims of the National Action Alliance for Patient & Workforce Safety

   - make commitment
   - perform safety self-assessments
   - enact safety strategy

2. Empower Patient Voice in Safety Strategy
   - submission of safety events
   - inclusion in event review
   - input on safety initiatives
   - communication and resolution programs

3. Healthcare Safer by Design
   - identify/address five high-priority safety engineering needs

4. Strengthen Safety Competencies
   - develop, adopt and report
   - not just safety officers, but all team members

5. Learning and Research Network
   - scalable bundle of safe practices
   - learning and sharing across network
   - spotlighting change leaders
   - promoting robust system (and national) measurement
   - research to address high-priority needs
The National Action Alliance Builds Upon the Foundational Elements of the National Action Plan

• Culture, Leadership, Governance
  ► Organizational safety goals with champions
  ► Leader annual reviews incorporate safety
  ► Regular safety culture surveys

• Patient and Family Engagement
  ► Actively engaged PFACs
  ► Shared decision-making tools used widely
  ► Patient portals used widely
  ► Analyzing safety data using an “equity lens”

• Workforce Safety
  ► Organization has explicit worker safety strategy
  ► Organization employs occupational safety experts

• Learning Healthcare Systems
  ► Defined safety education and competencies for all workers
  ► Organization regularly participates in learning networks
Organizing to Achieve Alliance Aims

**Healthcare Providers Organizations**
- Encourage and facilitate commitment to safety self-assessment to inform safety strategy
- Recruit high-performing organizations across the nation to serve as change leaders for the Action Alliance

**Potential partners:**
- AHA, AEH, ACHE, AAMC
- CMS, CDC, HRSA, IHS, VA, DOD, PCORI
- Joint Commission, DNV
- Press Ganey, Vizient, PSOs

**Engineering Safe Practices Group**
- Identify high-priority opportunities to further engineer safety into technologies used in healthcare
- Work collaboratively with federal and private partners including patients and clinicians to identify solutions and implement

**Potential partners:**
- FDA, ONC, ARPA
- EHR vendors
- Device manufacturers
- ECRI

**Safety Science Competencies Group**
- Engage partners on curriculum development, education, training and accreditation
- Develop or update safety science competencies for healthcare community
- Work collaboratively to drive implementation

**Potential partners:**
- AAMC, ACGME
- ABMS
- NAHQ, IHI, Vizient
- ANA, AMA, ACP, ACHE
Engaging the National Action Alliance Engine to Power “Safe Care Everywhere, Zero Preventable Harm for All”

By 2026, Reduce Harms by 50% from Peak of Pandemic

Learning Health Organizations
- Learning from Network
- Best Practice Implementation
- Research Support
- Aligned with VBP

National Action Alliance Engine
- National Webinars
- Implementation Initiatives
- Tools and Resources
  - HHS Tools
  - Other Vetted Tools
- Funding Opportunities
- Measures and Safety Dashboard

Identify needs through baseline safety self-assessments
Examples of Select Tools, Funding Opportunities, and Implementation Initiatives from AHRQ

<table>
<thead>
<tr>
<th>Culture, Leadership, and Governance</th>
<th>Patient and Family Engagement</th>
<th>Workforce Safety</th>
<th>Learning System</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surveys on Patient Safety Culture (tool)</td>
<td>• TeamSTEPPS 3.0 (tool &amp; implementation initiative)</td>
<td>• New AHRQ R01: Systems-Based Approaches to Improve Patient Safety by Improving Healthcare Worker Safety and Well-Being (up to $2M in funding)</td>
<td>• PSNet (tool)</td>
</tr>
<tr>
<td></td>
<td>• CANDOR (tool)</td>
<td></td>
<td>• Calibrate Dx: Resource to Improve Diagnostic Decisions (tool &amp; implementation initiative)</td>
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</tbody>
</table>
Proposed National Healthcare Safety Dashboard

Adapted from current AHRQ NHQDR data tool: https://www.ahrq.gov/data/data-tools/index.html
Proposed National Healthcare Safety Dashboard

Postoperative sepsis per 1,000 elective-surgery admissions, age 18 and over, 2020

Legend
1st (Best) Quartile
2nd Quartile
3rd Quartile
4th (Worst) Quartile
Missing

Download Data
Download PDF
Committing to the National Action Alliance for Patient and Workforce Safety

1. **Championing patient and workforce safety** by designating an Executive Lead accountable for safety

2. **Performing an organizational safety self-assessment** and implementing a safety plan that addresses gaps, including in healthcare equity

3. **Empowering the patient's voice** in all aspects of safety

4. **Strengthening safety competencies** for all team members

5. **Collaborating when it comes to safety** by sharing lessons learned and using and contributing to safety resources as an active Alliance participant
The National Action Alliance Website Serves as a Hub to Engage

https://www.ahrq.gov/action-alliance/index.html
craig.umscheid@ahrq.hhs.gov
Questions & Answers
Stay Connected

Visit MMS Hub Website: mmshub.cms.gov

Sign Up for E-mail Updates: https://lp.constantcontactpages.com/su/wjKejGa/MMS

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