New Hampshire Hospital Association | Foundation *for* Healthy Communities

Accelerating Progress on Safety and Quality: The Essential Role of Leadership and Governance

Tejal Gandhi, MD, MPH, CPPS
Chief Safety and Transformation Officer at Press Ganey

PressGaney

The State of Safety: How Do We Accelerate?

Tejal Gandhi, MD, MPH, CPPS

Chief Safety and Transformation Officer, Press Ganey

a PG Forsta company

Patient Safety

> Patient safety is a public health issue.
> Despite progress, preventable harm remains unacceptably frequent.
>
> Significant mortality and morbidity quality of life implications
> adversely affects patients in every care setting.

Gandhi TK et al. NEJM Catalyst 2020

Harm in Healthcare – Patient Safety

251,000

Americans die from preventable hospital errors.[1]

3rd

Leading cause of death in the US.[1]

1 in 25

Hospitalized patients develop a preventable hospital infection.[2]

~ $2,013

per discharge

Patient injury/error related cost to hospitals.[3]

"There is no such thing as high-quality, safe care that is inequitable."

1. Makary & Daniel. (2016). *Medical error—the third leading cause of death in the US.*
2. Magill, et al. (2014). *Multistate Point-Prevalence Survey of Health Care–Associated Infections..*
3. Mello, et al. (2007). *Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement.*

Harm in Healthcare – Workforce Safety

220,000

Hospital workers injured, or job acquired illness each year.[1]

71,000

Hospital workers cannot perform their jobs each year.[1]

6 of 100

Hospital workers injured or acquire illness on job each year.[1]

$13 Billion

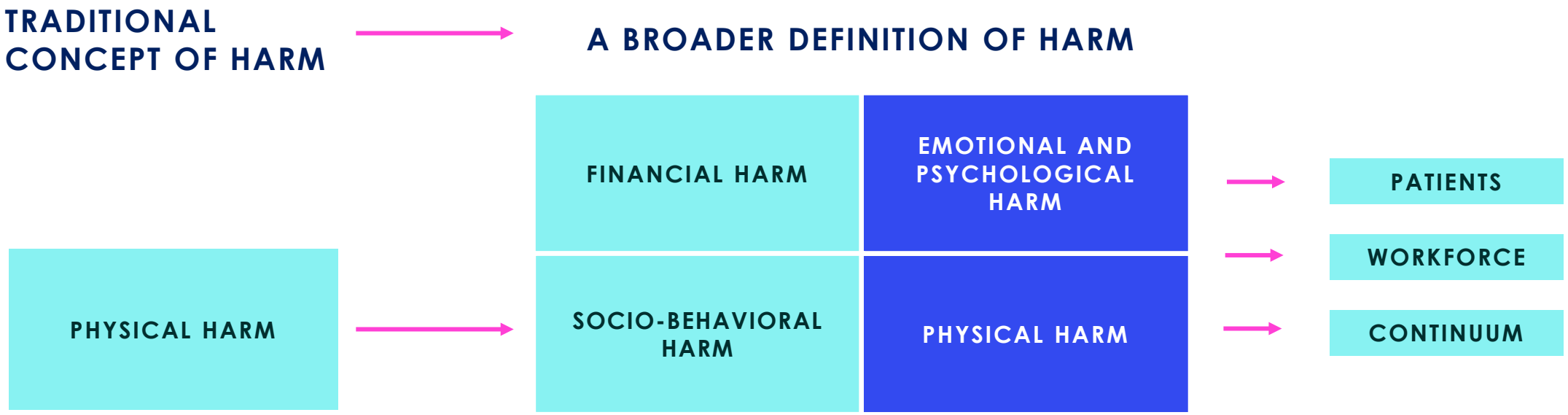
Total costs of illness and injury each year.[2]

It is safer to build a hospital than it is to work in one![1]

Hospital TCIR	***5.5***
Construction TCIR	1.7

1. US Bureau of Labor Statistics. (2019). *Injuries, Illnesses, and Fatalities: TABLE 2. Numbers of nonfatal occupational injuries and illnesses by industry and case types.*
2. Harris. (2013). *Safety Culture in Healthcare: The $13 Billion Case.*

We See Harm Beyond Physical Safety



The Traditional Conception of Harm and Compared to a Broader Definition of Harm
Dr Tejal Gandhi, NEJM Catalyst

Inequities Cause Harm

> *There is no such thing as high-quality, safe care that is inequitable.*

Sivashanker K and Gandhi TK. NEJM 2020

Goal of Zero Harm

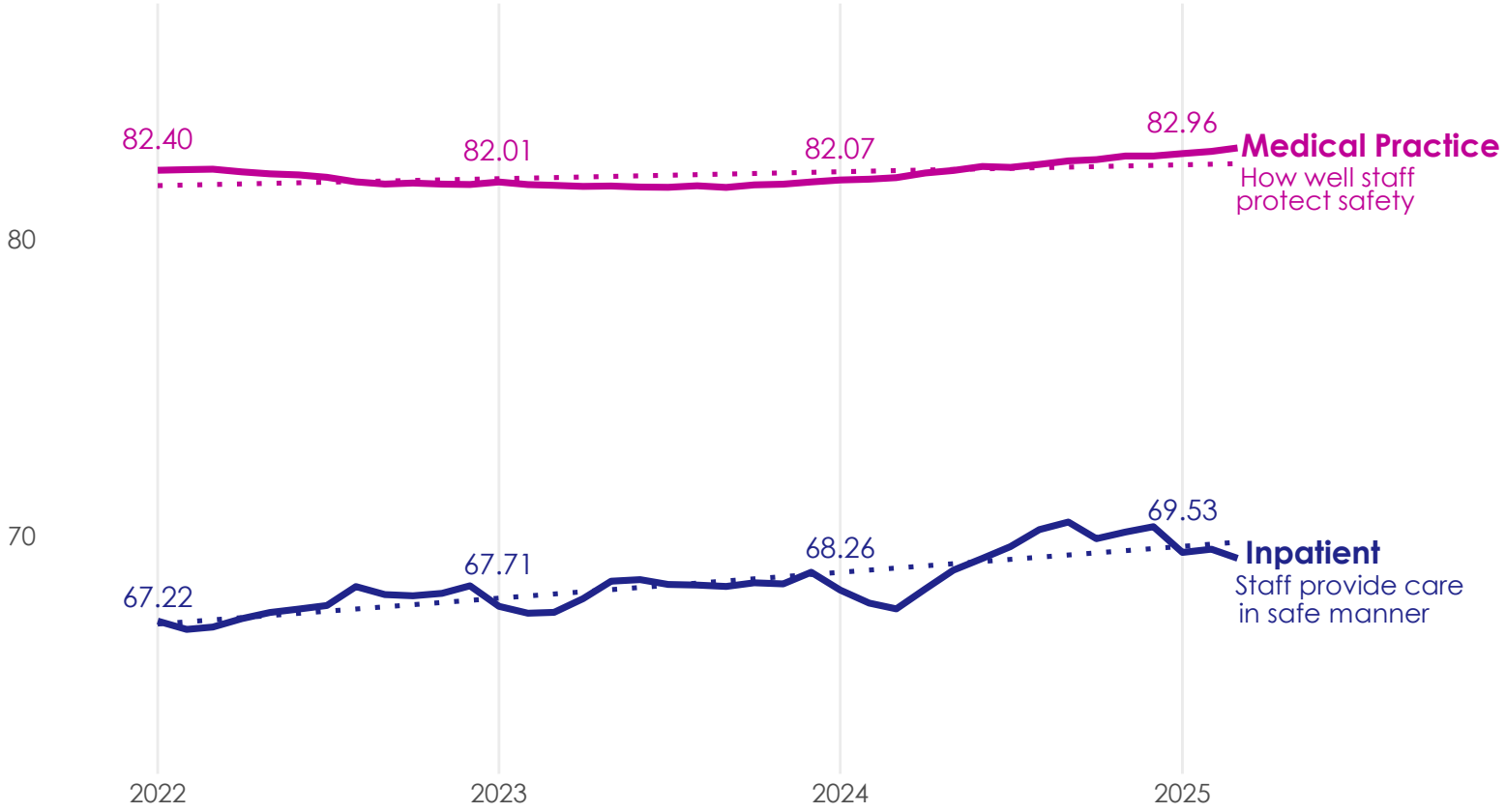
Vince Lombardi, the venerated head coach of the NFL's Green Bay Packers in the 1960s, famously told his players:

Perfection is not attainable. But if we chase perfection, we can catch excellence.

This is exactly what's occurring in ambitious, forward-looking health systems today. By chasing zero, they are achieving excellence.

Gandhi TK et al NEJM Catalyst 2020

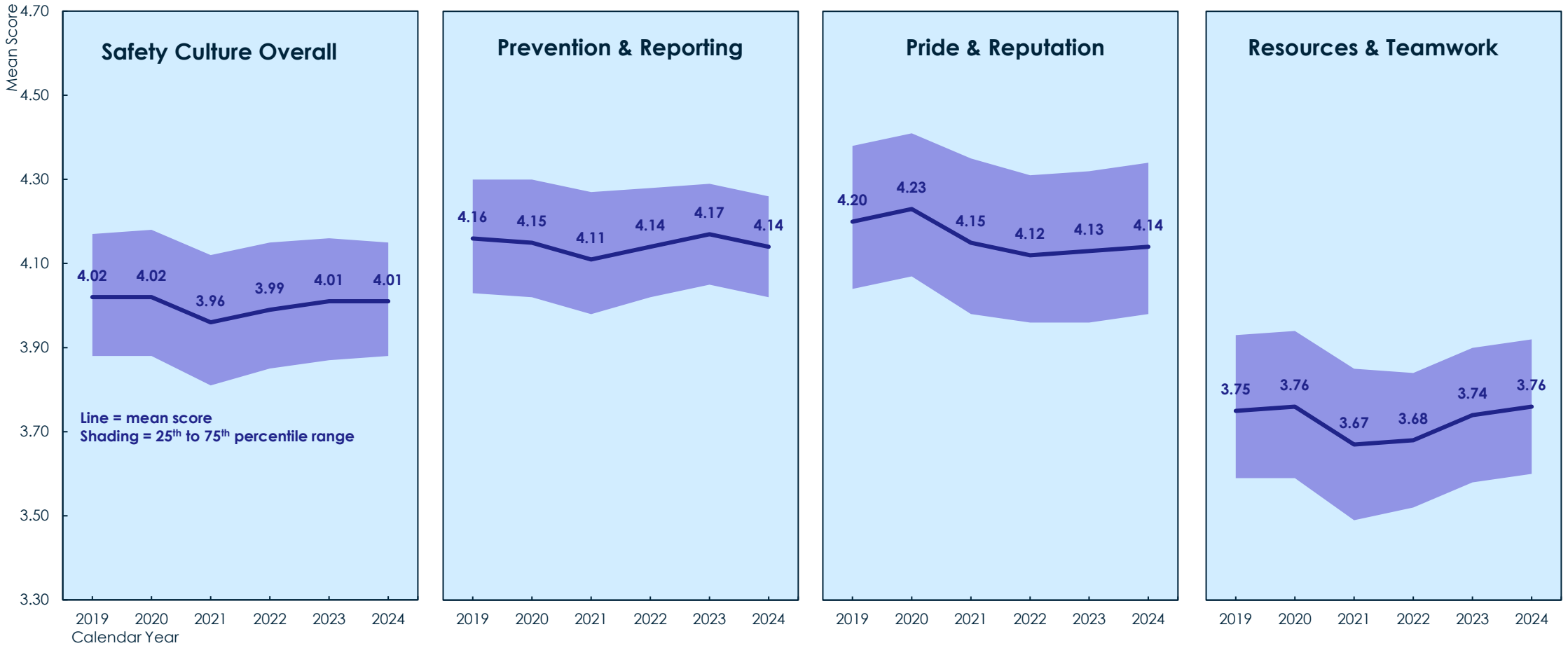
Patient Perceptions of Safety: 2022-2024



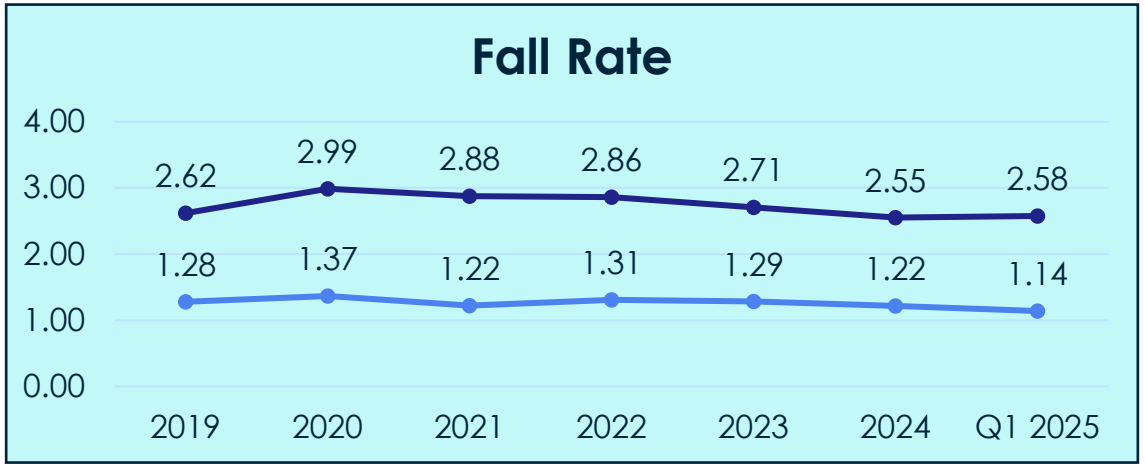
Source: Database top box scores, All PG Database (IN) and National Facilities (MD) peer groups.

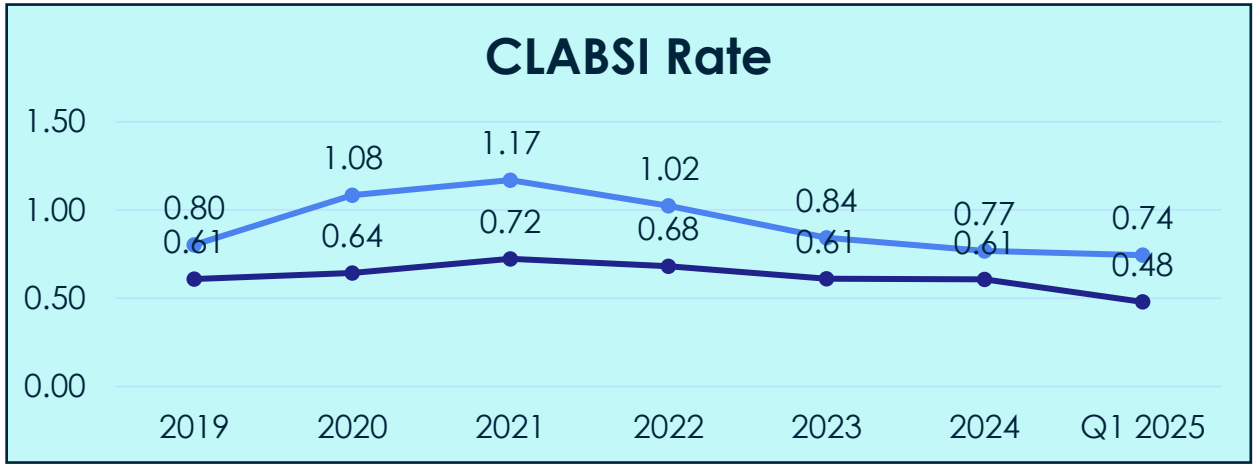
Safety Culture Improvement is Flattening

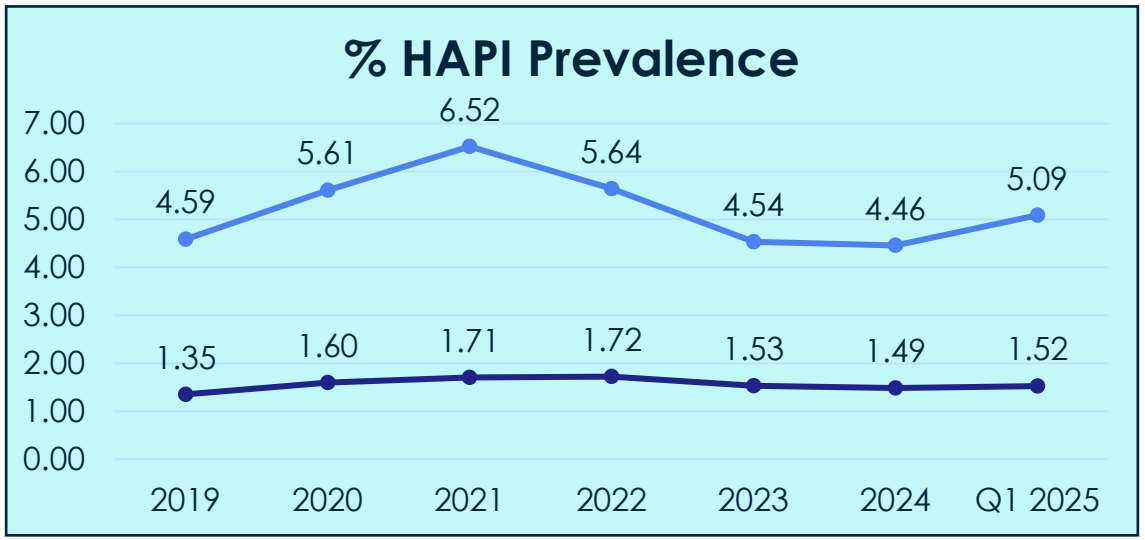
Resources & Teamwork remain the lowest sub-component. While prevention & reporting saw an uptick previously, we now see a downward trend for the most recent year

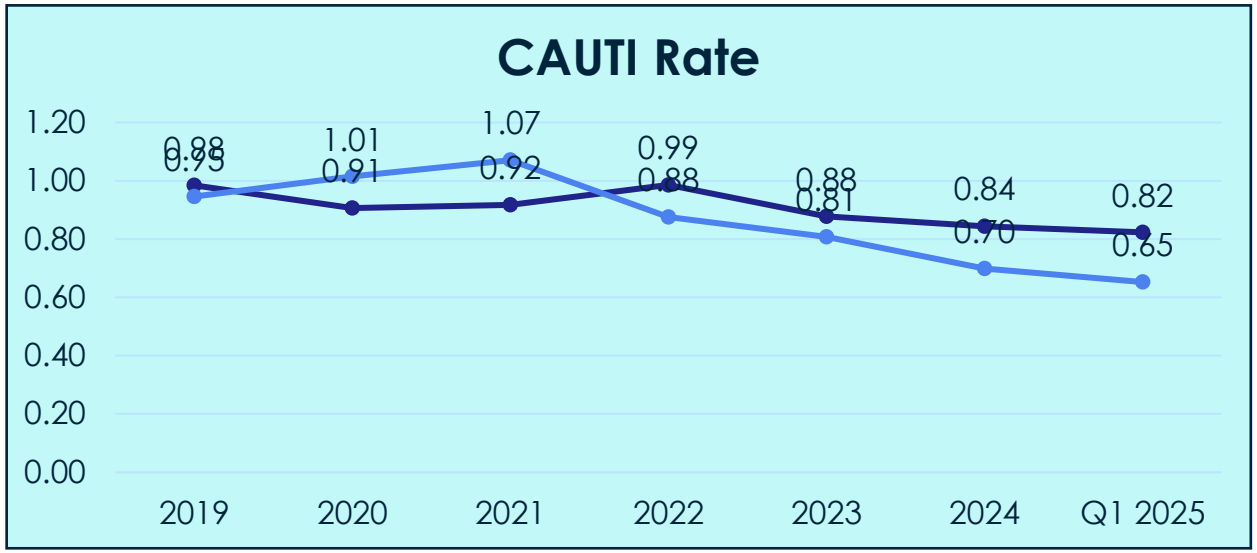


Safety outcomes are generally improving









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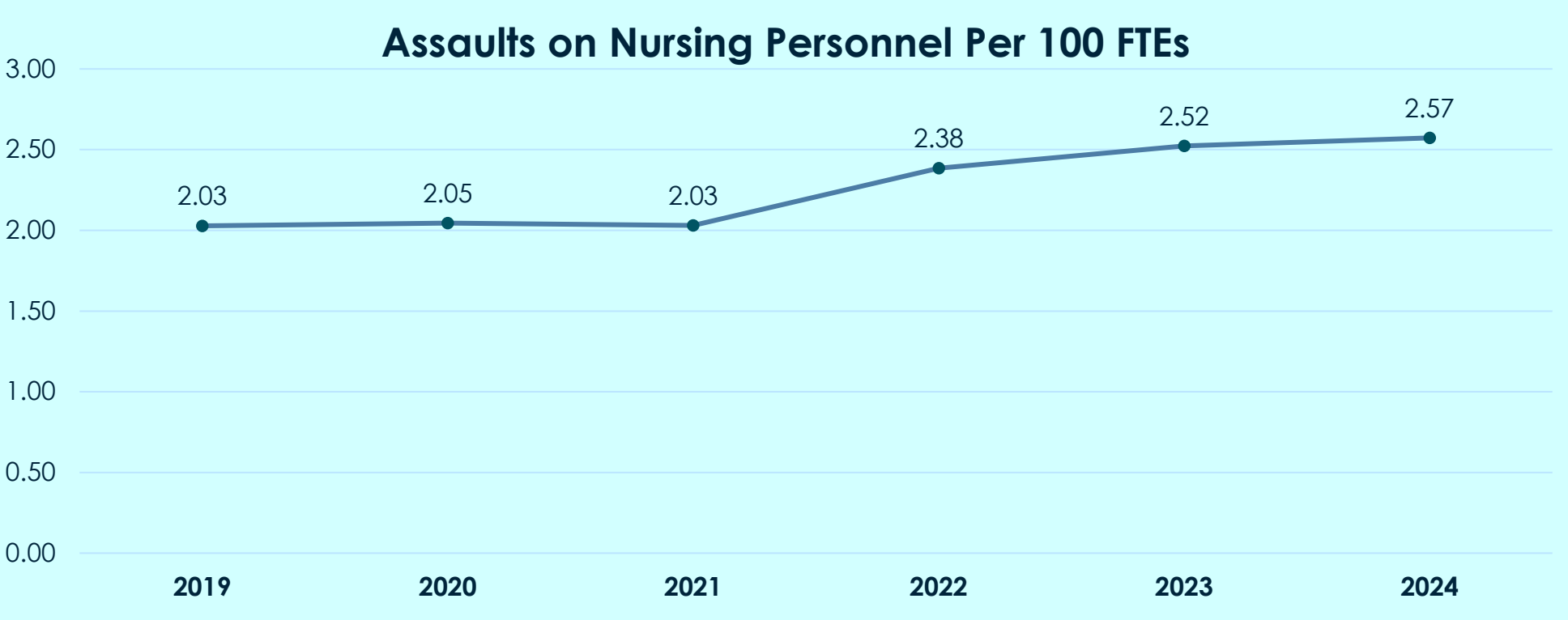
Medical-Surgical

Critical Care

The Crisis of Workplace Violence

The safety of our people is just as important as the safety of our patients



29%
of RNs report occasionally or frequently experiencing violence in the workplace

Press Ganey Industry Insights, Safety in Healthcare 2024

So How Do We Accelerate Progress?

- Focus on breaking down silos across dimensions of quality
- Focus on foundations rather than “whack a mole”

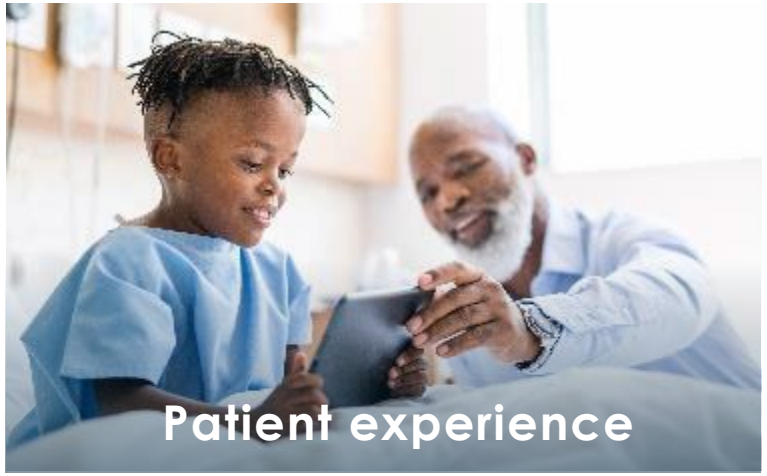
Delivering the optimal care experience

Safe

High Quality

Compassionate

Equitable

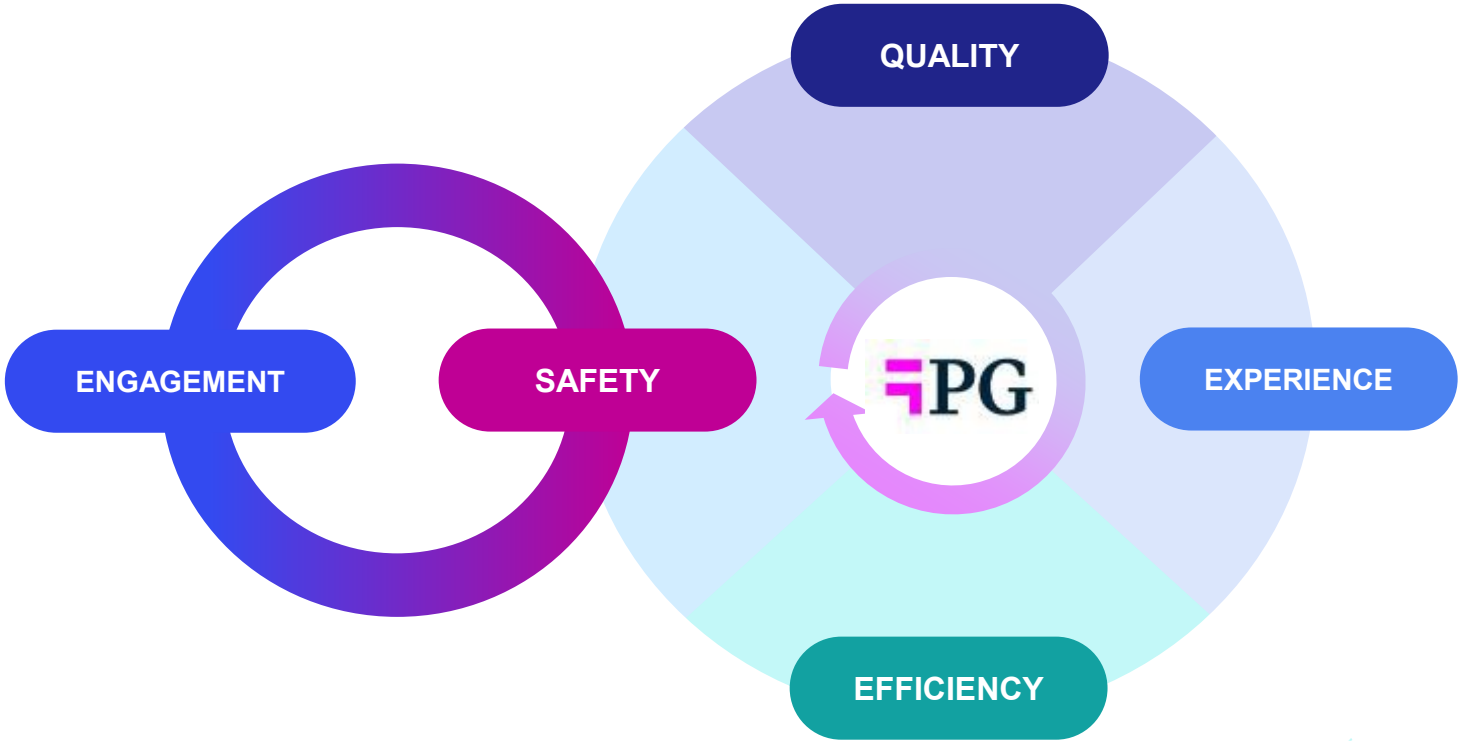


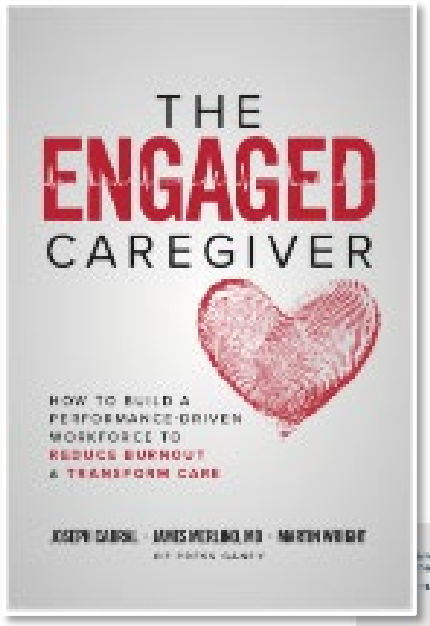
THE CONTINUUM OF CARE

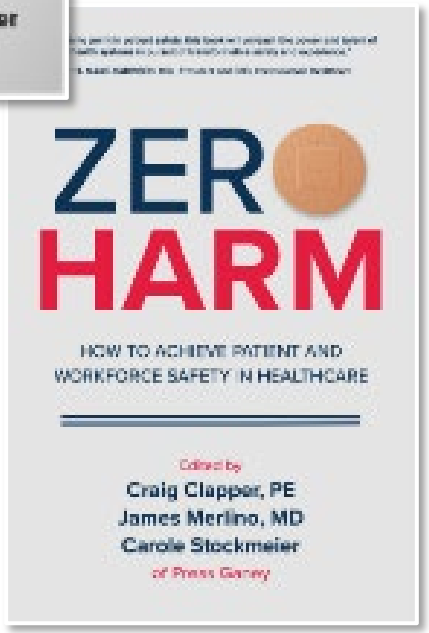
Telehealth | Virtual visits | Ambulatory | Acute | Post acute | Home | Hospice | Online

PressGaney

The Virtuous Cycle







Organizations leading with safety and high reliability achieve reduced harm, improved experiences, and a 10x ROI in financial outcomes.

Safety leads the way
Unlocking better experience and outcomes

30% lower staff turnover

80% reduction
in serious safety events

Patients are
2.5x more likely
to recommend a facility

Rising from
1 to 5 Stars
12% increase in health plan care quality rating

Advancing the Industry Toward Transformation

INCREMENTAL IMPROVEMENT

Improvement Initiatives

CAHPS	Employee Engagement	NDNQI	Safety Consulting
CBS	RN Engagement	Nursing Excellence	SMS
Point of Care	Physical Engagement	RN Engagement	PSO
Transparency	Safety Culture	CCC Training	Process Improvement

DOMAIN-LEVEL IMPROVEMENT

Strategic Solutions

Patient Experience | Workforce & Engagement | Clinical Excellence | Safety

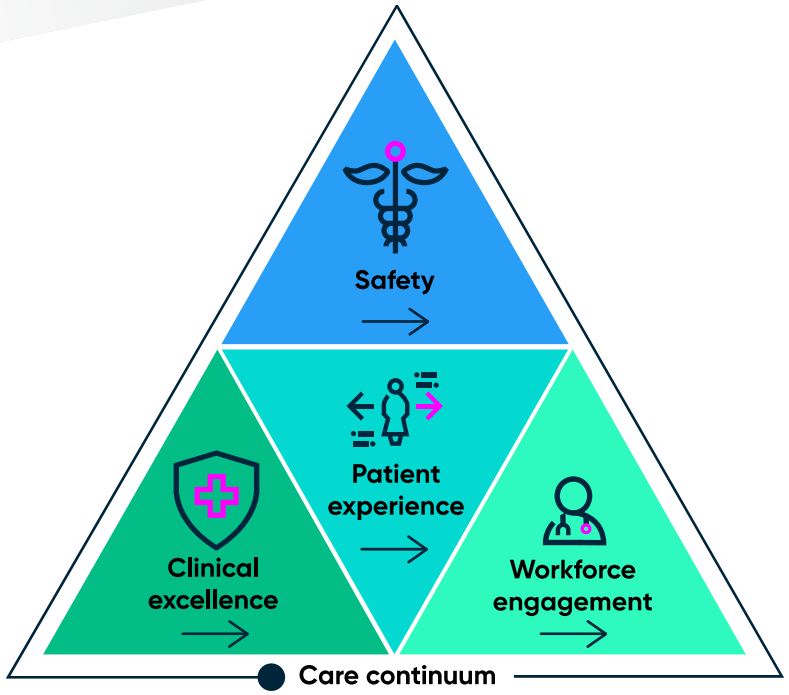
Measurement

Reporting/Analytics

Advisory

SUSTAINED, CROSS-DOMAIN IMPROVEMENT

Enterprise Transformation



Perception of safety is strongly related to engagement

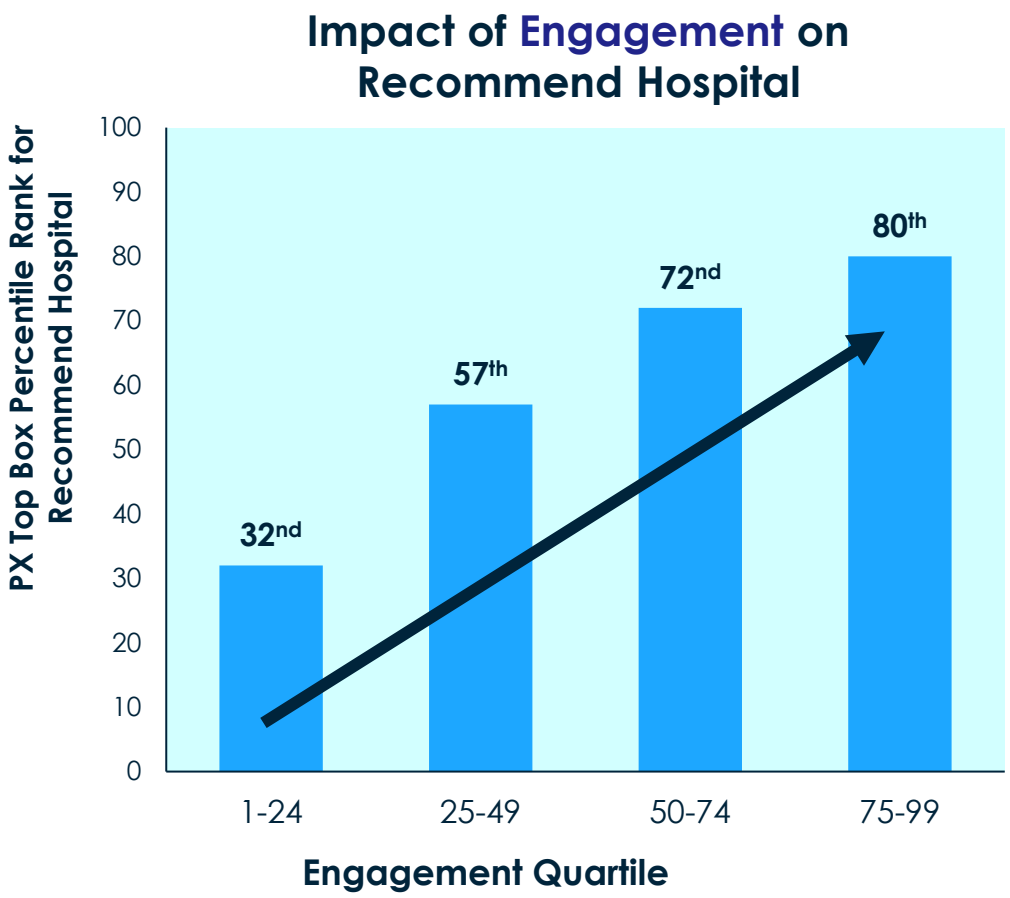
Safety culture – overall

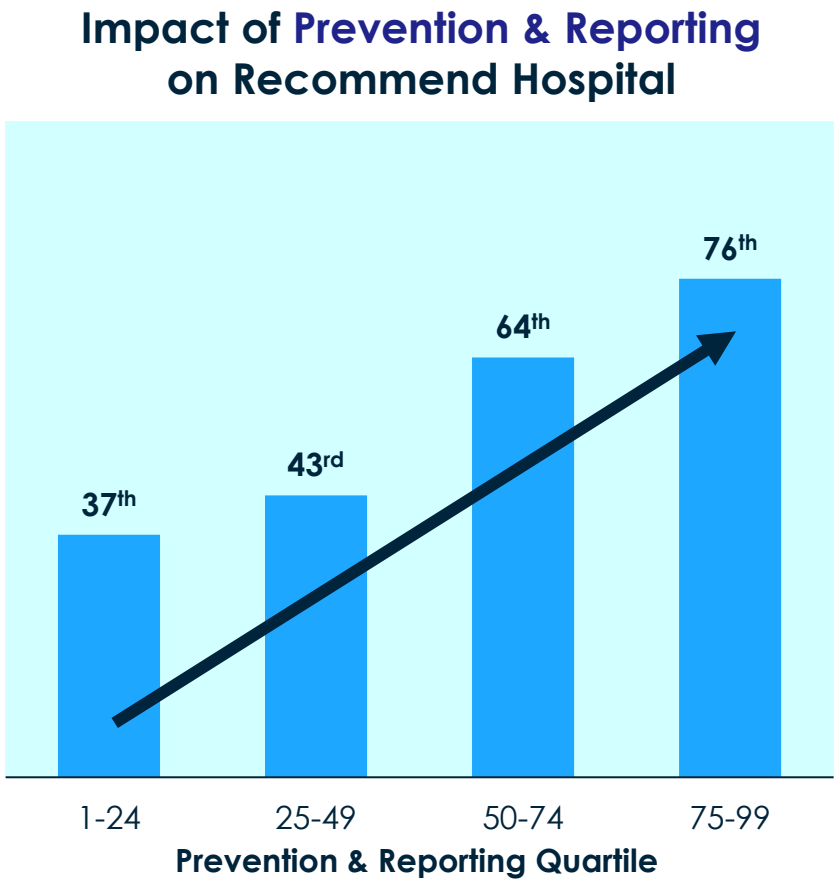
- When employees report **high perceptions of safety**, their average Engagement score is **4.51**
- However, when employees **do not report optimal perceptions of safety**, their Engagement mean score **decreases to 3.44**

Data from 2023 EV Projects measuring both Safety Culture and Engagement (complete modules). N = 192 projects, n = 993,165 employees.

It's all connected

Facilities top performing in Engagement and Prevention & Reporting (Safety Culture theme) have patients who rate their experiences better





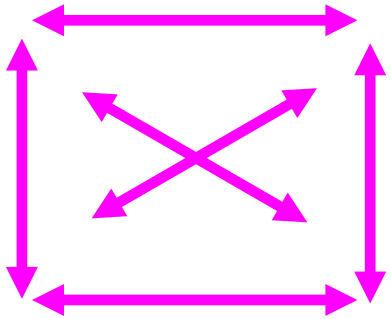
Focus on Foundations: National Steering Committee Vision

Working together to ensure that health care is safe, reliable, and free from harm.

National Action Plan Foundational Areas

Culture, Leadership & Governance

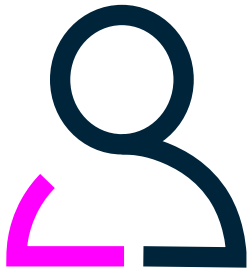
Patient & Family (Person) Engagement



Learning Systems

Workforce Safety

Culture, Leadership, and Governance

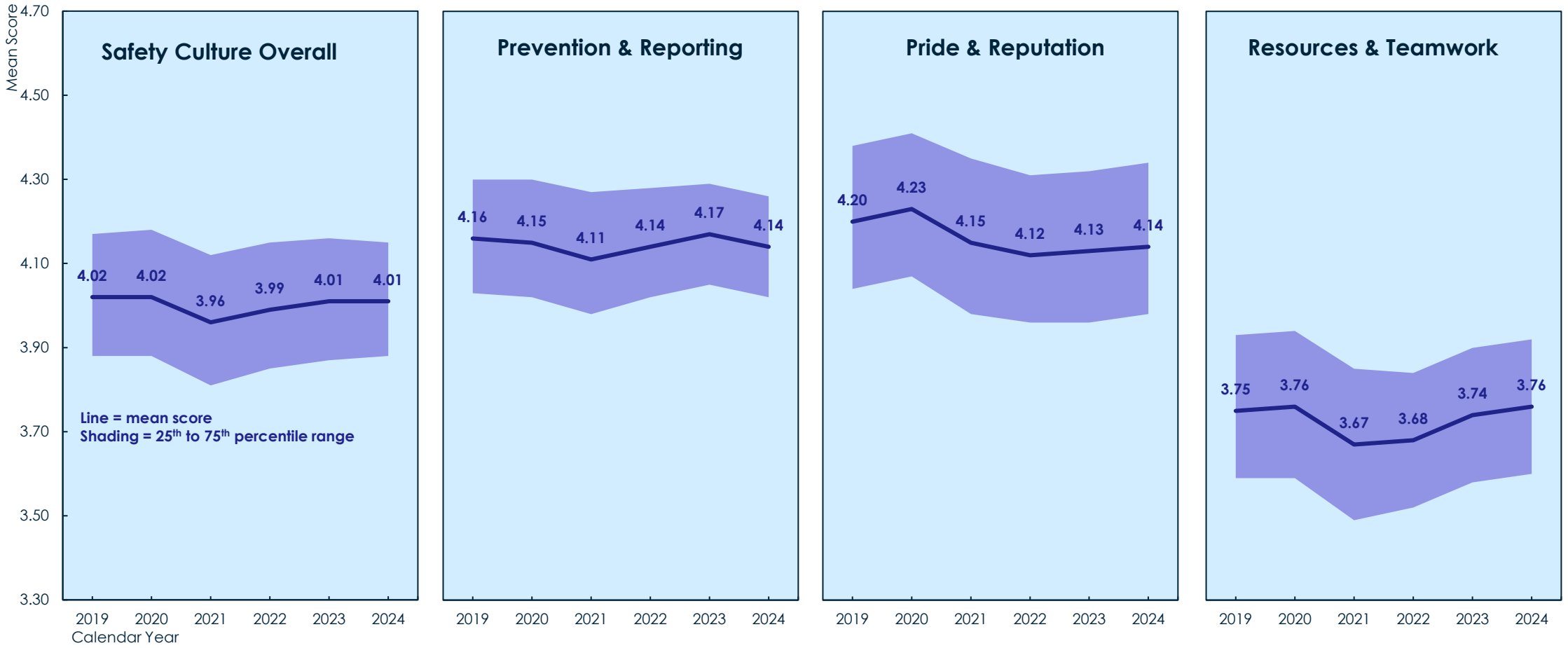


Culture, Leadership, Governance
Aim: Health care organization governing boards and CEOs across the care continuum establish and sustain a strong culture of safety in a way that is equitable and engaging of patients, families, care partners, and the health care workforce.

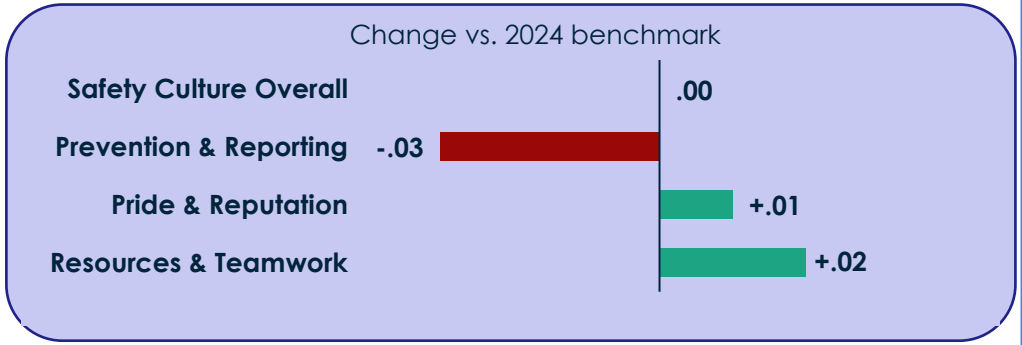
Leverage the influence of leadership and governance to commit to safety as a core value of the organization and drive the creation of a strong organizational culture.

Safety Culture Improvement is Flattening

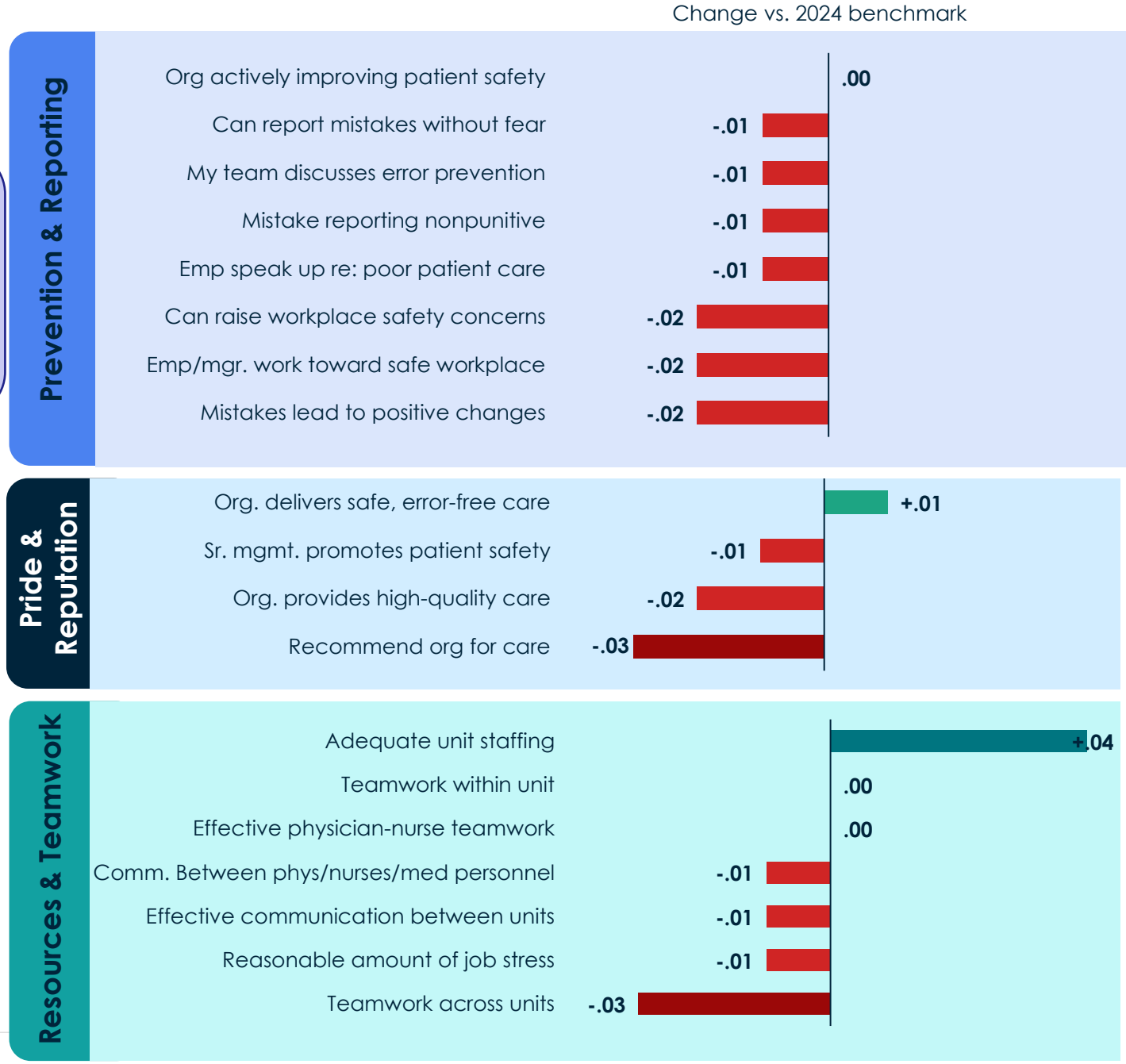
Resources & Teamwork remain the lowest sub-component. While prevention & reporting saw an uptick previously, we now see a downward trend for the most recent year



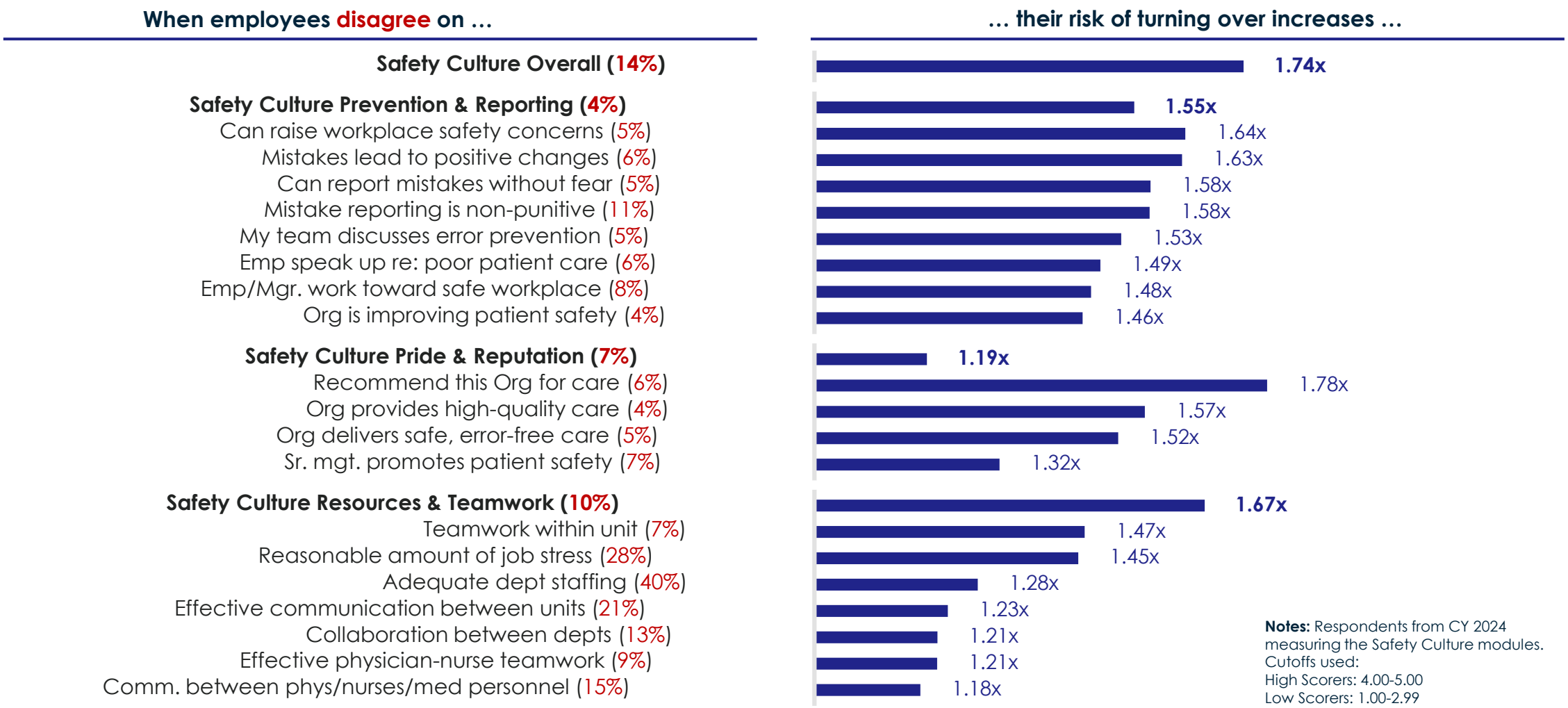
Safety Culture



- Safety culture has maintained
- The largest declines overall were seen in prevention & reporting
- Perceptions of staffing continue to improve, while teamwork has declined



Connection of Safety Culture and Turnover

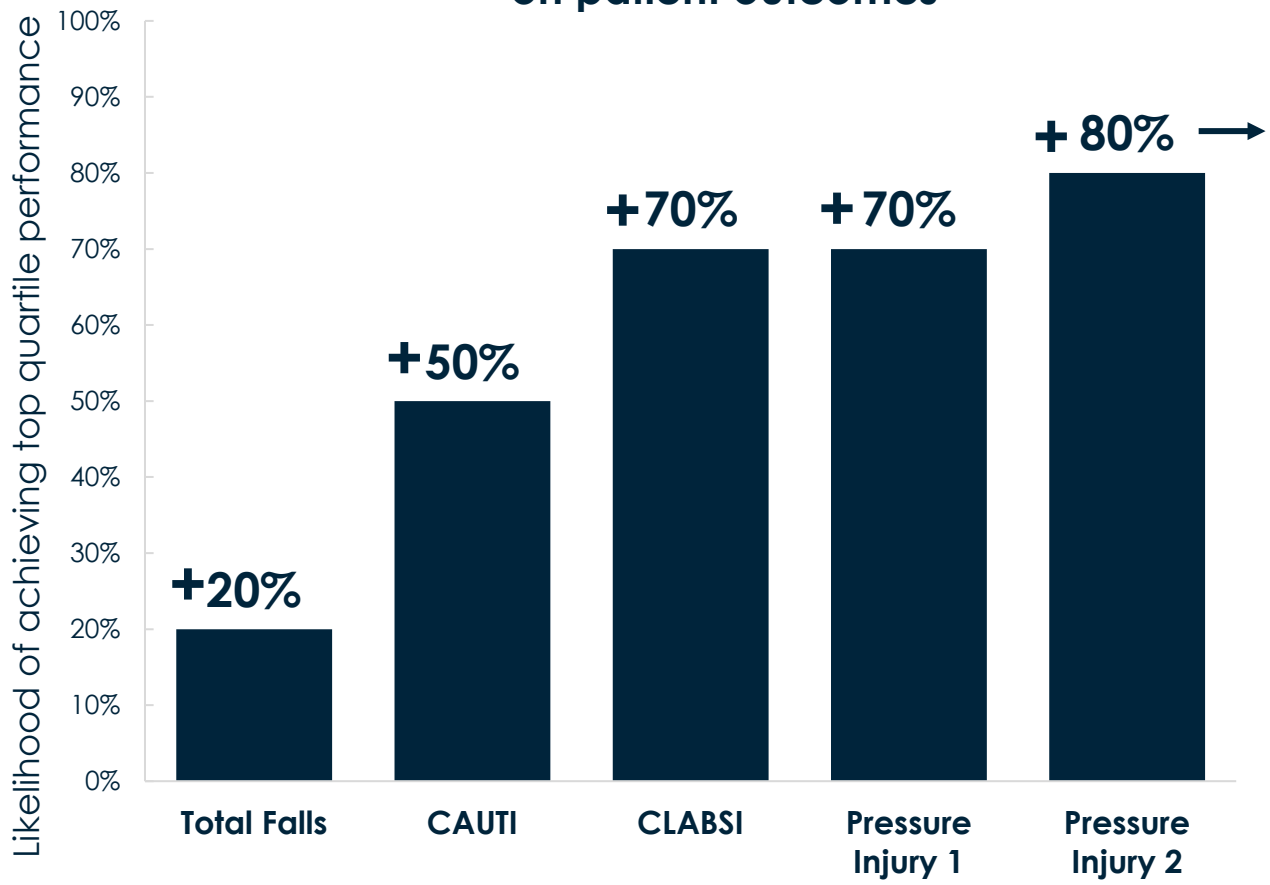


Notes: Respondents from CY 2024 measuring the Safety Culture modules.
Cutoffs used:
High Scorers: 4.00-5.00
Low Scorers: 1.00-2.99

Value in parentheses shows the percent of employees who disagreed on each metric.

Strong teams drive patient outcomes

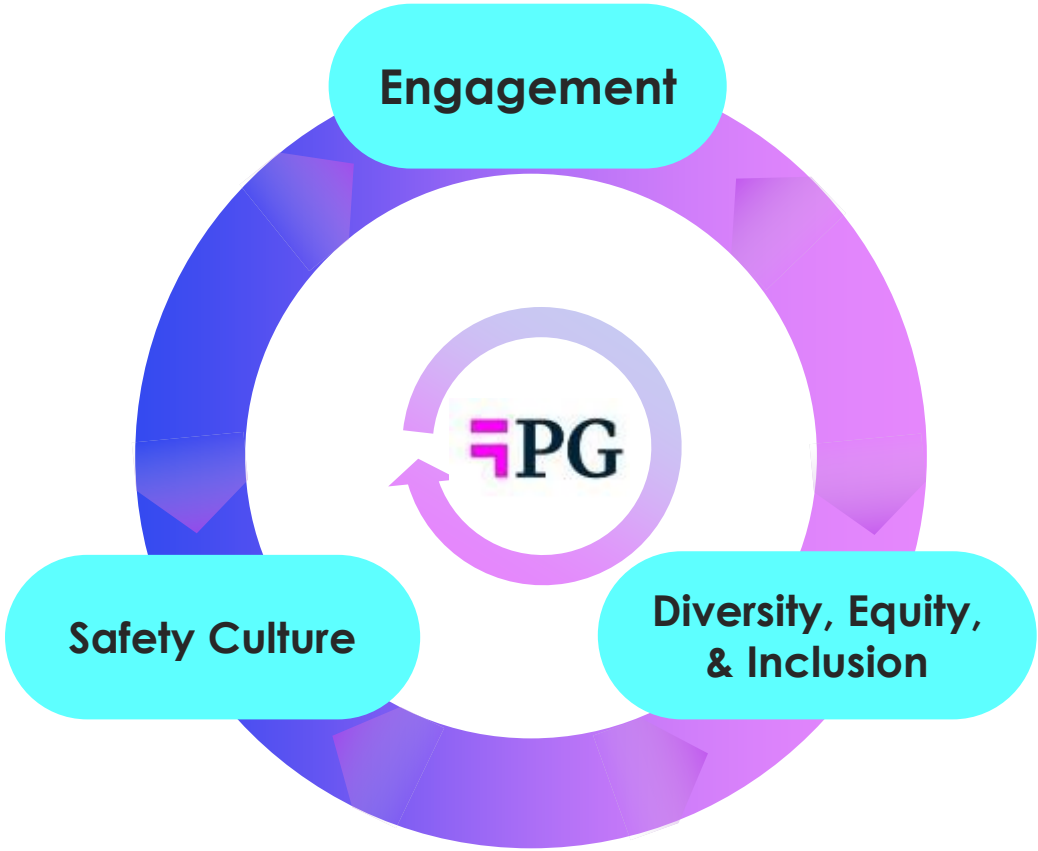
Top performers on teamwork have a higher likelihood of achieving top quartile performance on patient outcomes



Organizations top performing on teamwork, are 80% more likely to be top performing on Pressure Injury 2

Connections

- Safety Culture is strongly correlated with engagement
- Perceptions of Diversity and Engagement are strongly related
- Perceptions of Diversity are strongly related to Safety Culture



Safety Culture Transformation

“

Adopt a goal of Zero Harm and message on safety. Measure and make harm visible.

Foster a fair and just culture.

Practice daily check-ins for safety (e.g. huddles)

Zero Harm: Fundamentals for Safety Culture Transformation, Press Ganey 2018

CMS Patient Safety Structural Measure: Governance

1.1 Our hospital **senior governing board** prioritizes safety as a core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership performance reviews and compensation.

1.2 One or more C-suite leaders oversee a system-wide assessment on safety, and the execution of patient safety initiatives and operations, with specific improvement plans and metrics. These plans and metrics are widely shared across the hospital and **governing board**.

1.3 Our **hospital governing board**, in collaboration with leadership, ensures adequate resources to support patient safety (such as equipment, training, systems, personnel, and technology).

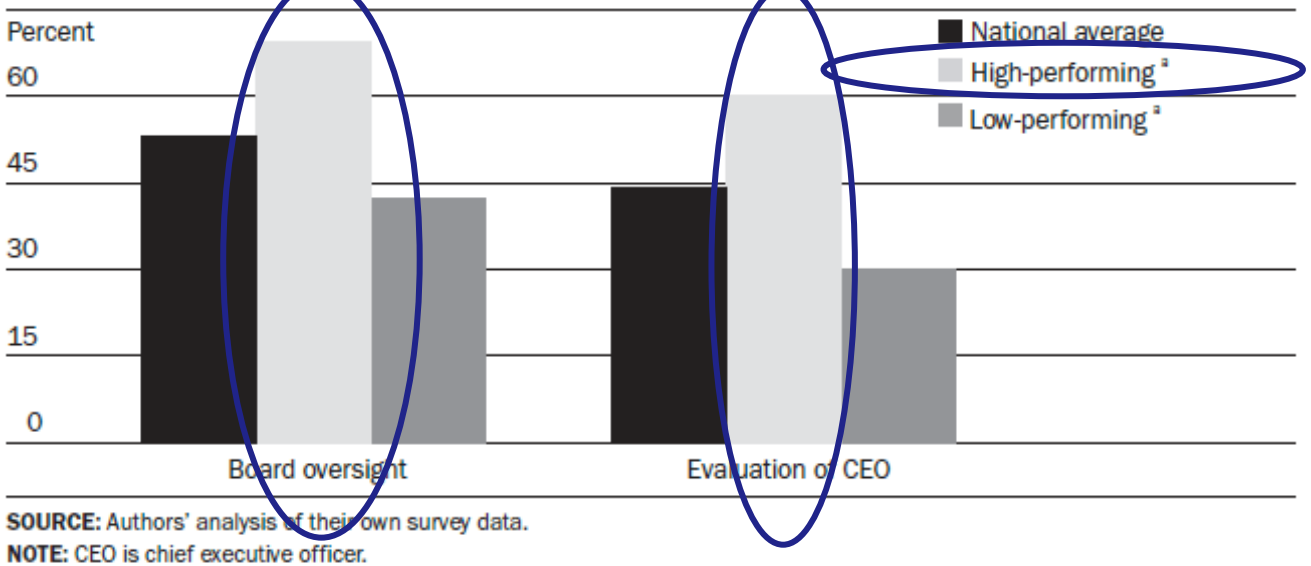
1.4 Reporting on patient and workforce safety events and initiatives (such as safety outcomes, improvement work, risk assessments, event cause analysis, infection outbreak, culture of safety, or other patient safety topics) accounts for at least 20% of the **regular board agenda and discussion time for senior governing board meetings**.

1.5 C-suite executives and individuals on the **governing board are notified** within 3 business days of any confirmed serious safety events resulting in significant morbidity, mortality, or other harm.

Board Oversight of Quality and Safety Matters

EXHIBIT 1

Percentage Of Hospital Board Chairs Reporting That Quality Of Care Is One Of The Top Two Priorities For Board Oversight Or Evaluation Of CEO Performance, 2007–08



SOURCE: Authors' analysis of their own survey data.
NOTE: CEO is chief executive officer.
[a] Statistical significance ($p < 0.001$) for comparisons of the difference between the highest- and lowest-performing hospitals. Rates are adjusted for the number of beds, region, location (urban versus rural), teaching status, and ownership.

In 2010, *fewer than half* of nonprofit hospital Boards surveyed ranked quality of care among top two priorities, and about one-third received training on clinical quality.

Hospitals that perform high on quality metrics *correlate* with Board time spent on quality.

Source: Jha A, Epstein A. Hospital Governance and the Quality of Care. *Health Affairs*. 2010;29(1):182-187.

Core Components of Quality
The Patient's Perspective

*IOM STEEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient centered

Effective Governance of Quality & Safety

I understand the domains of and key concepts underlying quality care.

I understand the process to assess, prioritize, and improve care.

Our board culture demonstrates a commitment to delivering quality for all patients.

Source: Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. *Framework for Effective Board Governance of Health System Quality*. IHI White Paper. Boston, MA: Institute for Healthcare Improvement; 2018. ihi.org/BoardQuality

Board's Role in High Reliability Organizing

- Start all Board Meetings with a Safety Message
- Demonstrate Safety First in Decision Making
- Normalize transparency about harm
  - Set notification timelines for significant events
- Create a psychologically safe environment for senior leaders to escalate challenges and concerns
- Focus questions on system/process, avoid blame
- Ensure there is fair accountability and no punishment for unintended human error
- Devote sufficient time and attention to safety and quality at Board meetings
  - Don't delegate to the Quality Committee

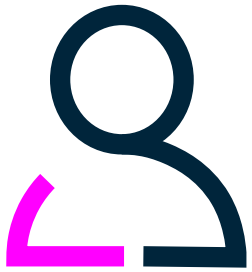
Board's Role in High Reliability Organizing (Cont.)

- **Consider a Board resolution for patient and workforce safety**
- **Conduct Board education on High Reliability**
- **Monitor Metrics (leading, real-time, lagging)**
  - Serious Safety Event Rate, Workforce injury rate
  - Patient and Workforce Safety
  - Patient Experience
  - Workforce Engagement and Safety Culture
  - Percentage of leaders trained in High Reliability Leader Skills
  - Percentage of staff & medical staff trained in Everybody Skills
  - Number of Good Catches using Everybody Skills

Eight Generative Questions for Boards

1. Have we clearly positioned safety as an uncompromising core value? How would we know? What indicators would we look for to verify this?
2. Have we adopted a comprehensive, multiyear plan for improving patient and workforce safety and for monitoring progress regularly?
3. Have we embraced transparency for sharing events of harm and lessons learned across our system?
4. Have we established a healthy reporting environment and a "fair and just culture"?
5. Have we clearly established respect for patients, coworkers, and physicians as an expectation within the organization?
6. Do we put a face on harm and hear patient stories regularly, ideally directly from patients?
7. Do we consider the safety and quality implications of all major organizational decisions?
8. Do we devote sufficient board time and attention to safety, quality, patient experience of care?

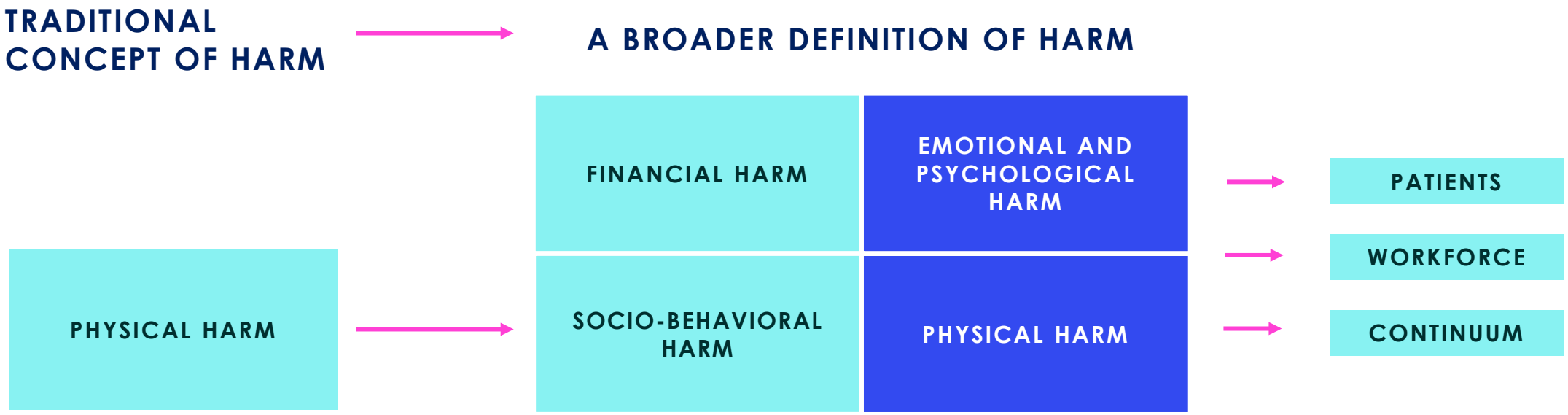
Workforce Safety



Workforce Safety
Aim: Health care organizations across the care continuum implement strategies to measurably and equitably improve safety for health care professionals and all staff in their organizations.

Commit to workforce physical, psychological, and emotional safety and wellness, and full and equitable support of workers.

We See Harm Beyond Physical Safety



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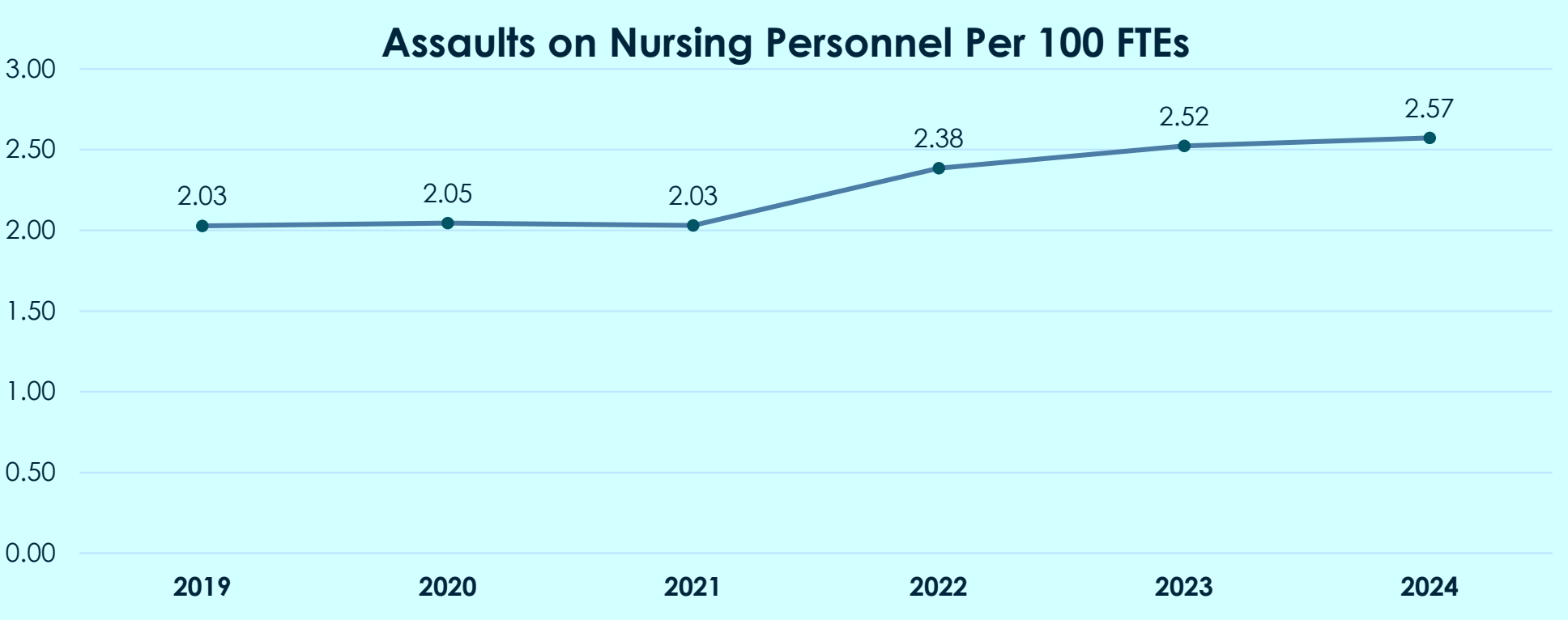
The Crisis of Workplace Violence

The safety of our people is just as important as the safety of our patients



29%
of RNs report occasionally or frequently experiencing violence in the workplace

Press Ganey Industry Insights, Safety in Healthcare 2024

Surveys on Patient Safety Culture®

Findings from the 2024 Surveys on Patient Safety Culture® (SOPS®) Workplace Safety Supplemental Items for Hospitals

The Hospital Workplace Safety Supplemental Items assess the extent to which the organizational culture of a hospital supports workplace safety for providers and staff. The 2024 results include data from:

94
Participating Hospitals

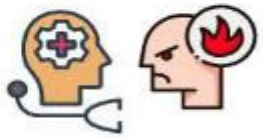
61,767
Provider and Staff Respondents

47%
Average Hospital Response Rate

Highest Composite Measure:
Protection From Workplace Hazards

91% of respondents agreed that procedures are in place to protect providers and staff from workplace hazards, providers and staff are provided with personal protective equipment (PPE), and they use PPE appropriately.

Lowest Composite Measure:
Addressing Workplace Aggression From Patients or Visitors



49% of respondents agreed that physical and verbal aggression from patients or visitors is appropriately addressed.

Improving Engagement and Resilience

- Rounding, Listening
- Workflow, Operational Efficiency
- Job Do-ability

- Psychological Safety
- Development & Training
- Coaching & Mentoring
- Build community

- Pro-active peer support outreach
- De-stigmatize MH support & make it easy to access
- Financial support where needed

Pyramid Of Harm

Slide courtesy of Dr. Steve Muething, Cincinnati Children's

Patient and Family Engagement

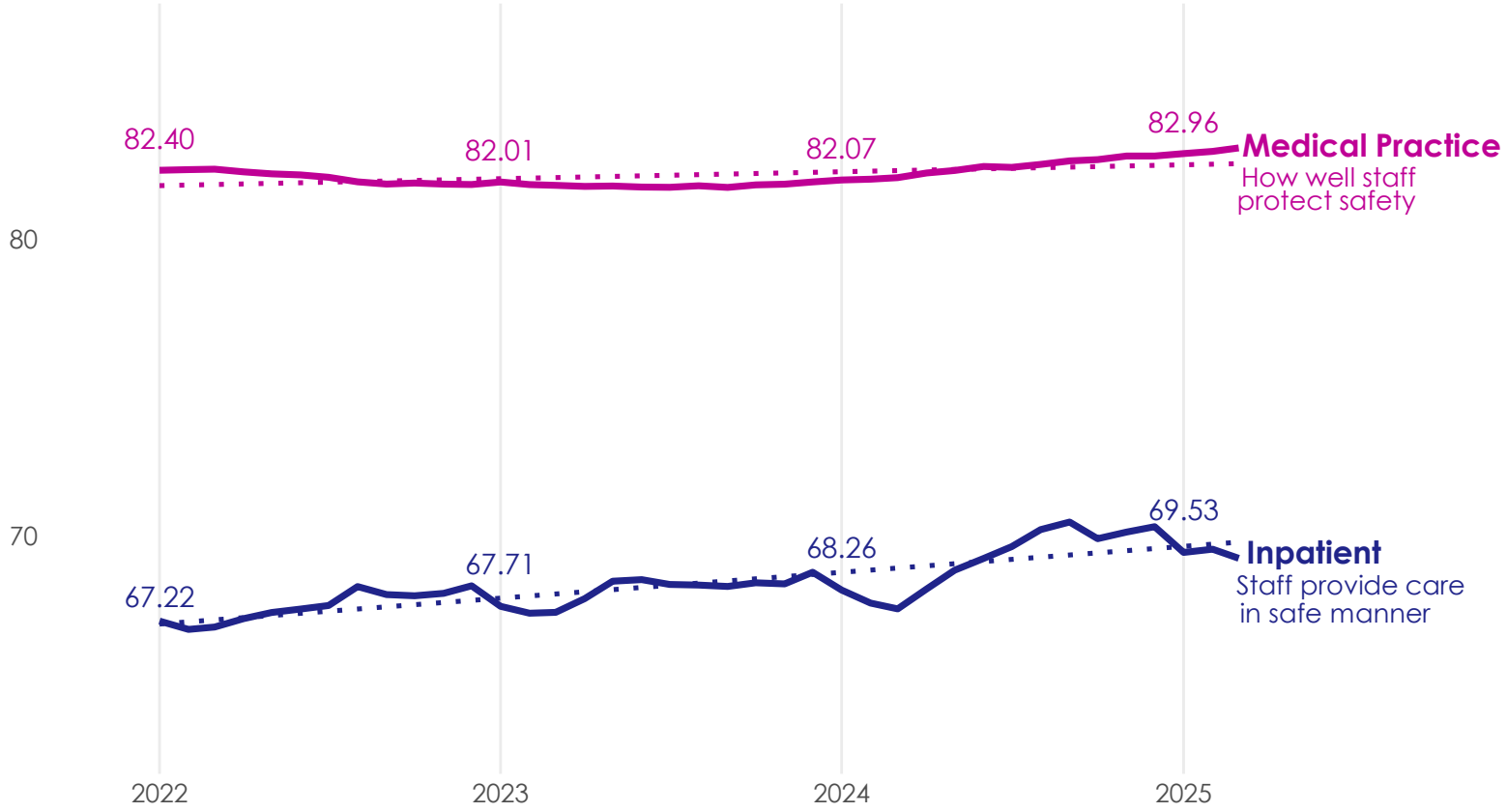
Patient and Family Engagement
Aim: Health care organizations institute strategies to improve safety, as defined by patients, families, care partners, and the workforce, ni all settings across the care continuum.

Commit to the goal of fully engaging patients, families, and care partners in all aspects of care at all levels.

The Four Levels of Engagement

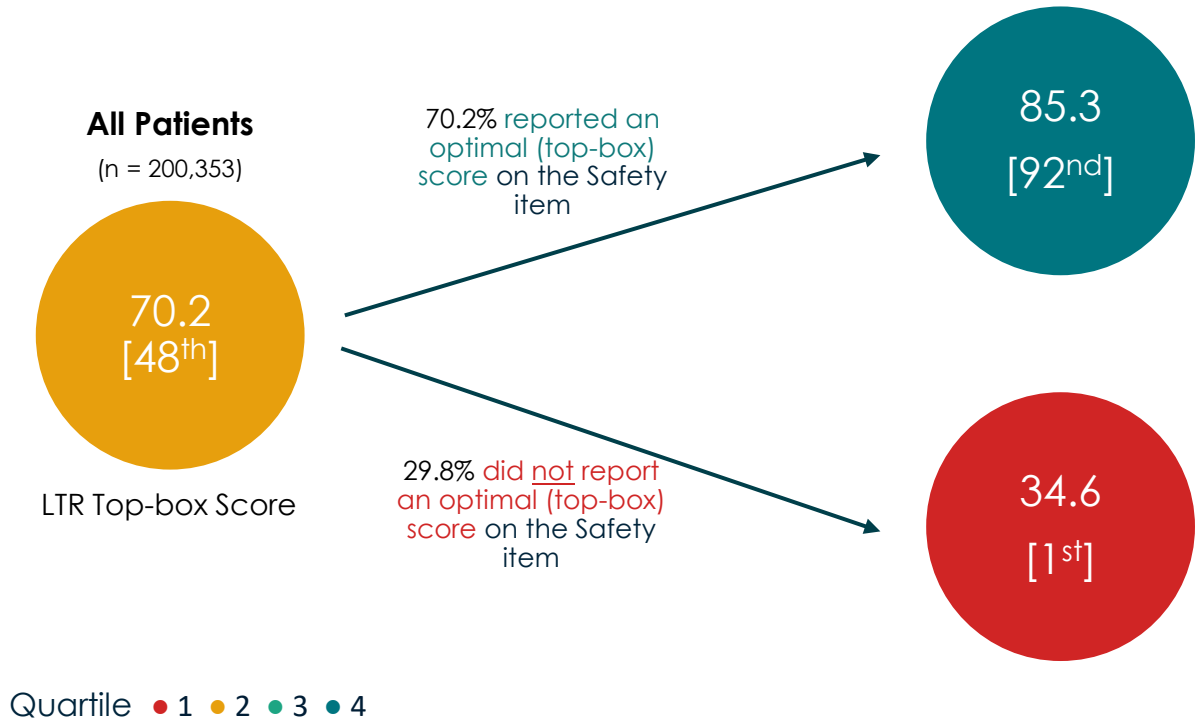
The framework/declaration was originally developed for the World Innovation Summit for Health (WISH) 2013, an initiative of Qatar Foundation. See WISH Patient Engagement Report (available at www.wish-qatar.org/reports/2013-reports).

Patient Perceptions of Safety: 2022-2024



Source: Database top box scores, All PG Database (IN) and National Facilities (MD) peer groups.

Patient Experience of Safety Directly Relates to LTR



- When patients report **optimal perceptions of safety**, their LTR top-box score is **85.3**
- However, when patients **do not report optimal perceptions of safety**, their LTR top-box score **decreases to 34.6**

- Inpatient HCAHPS & Integrated surveys received from 2024 CY.
- n = 200,353
- Respondents must have answered both safety and LTR items.

Understanding Patient Safety Comments

Topic: feel unsafe

- Environmental Cleanliness Concerns
  - Cleanliness of waiting room and patient room
  - Parking lot structure / personal safety
- Inadequate infection control practices
  - Crowded waiting rooms
  - Staff not wearing masks
- Dismissive attitudes
  - Not comfortable speaking freely / trust
  - Not allowing couple to stay together
- Administrative Errors
  - Mishandling medical records (info sent to another patient)

These issues significantly impacted the patients' sense of security and trust in the healthcare environment.

Topic: feeling safe

- Environmental Cleanliness
  - Washing hands practices
  - Well maintained elevators
- Comforting attitudes
  - Welcoming staff
  - Patient's health problems genuinely cared for
  - Nurses being attentive and supportive (especially during blood draws and ultrasounds)
  - Approachable nature of doctors (easier to discuss concerns and feel heard)

Patients frequently mention that medical professionals are friendly, caring, and professional, which helps them feel at ease and confident in the care they receive.

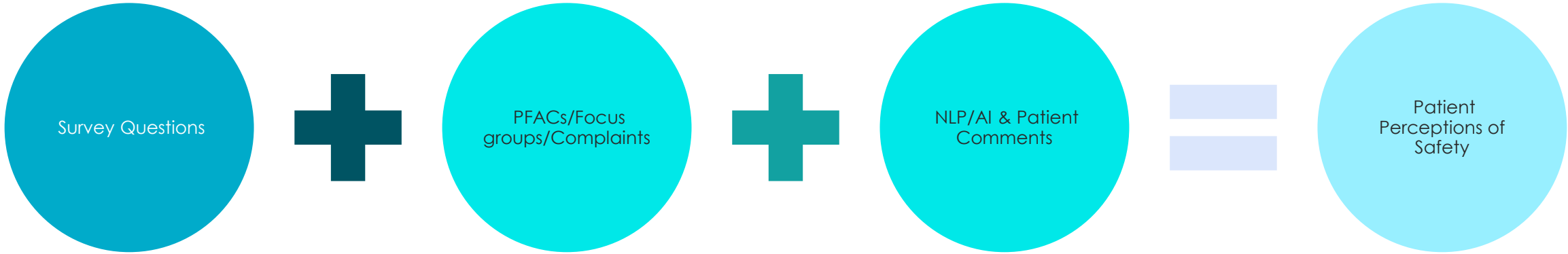
The Patient Voice is a Powerful Indicator of Quality of Care

How patients evaluate their experience is strongly associated with clinical and safety outcomes

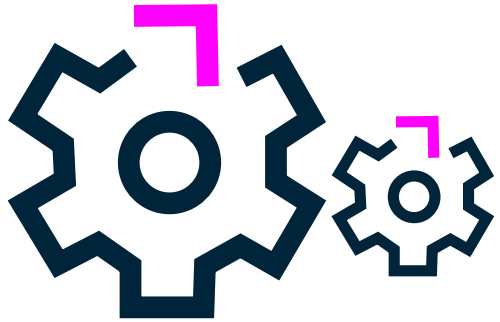
- When patients report high levels of teamwork (top quartile), those units are:
  - 44% more likely to be in the top quartile for total fall rate.
  - **Being a Top PX Performer (75th percentile and above) on "Staff Worked Together" is associated with 10% fewer Total Falls and 10% fewer Injury Falls.**

- When patients report high levels of safe care (top quartile) those units are:
  - 54% more likely to be in the top quartile for Falls with Injury rate.
  - **Being a Top PX performer (75th percentile and above) on "Staff provide care in safe manner" is associated with 8% fewer HAPI and 16% fewer Total Falls.**

Listening Everywhere for Safety



The Learning System



Learning System
Aim: Health care organizations and other stakeholders across the care continuum implement reliable learning systems. These learning systems actively engage with local, regional, state, or national learning systems to develop a national learning network of existing and future learning systems.

Commit to continuous learning within organizations by creating and strengthening internal processes that promote transparency and reliability, and through sharing as part of an integrated learning system and networks.

Learning System Strength Index

The strength of an organizational learning system is determined by the comprehensiveness of the system. Does your learning system include:

Learning from internal failures and external failures

Learning from internal successes and external successes

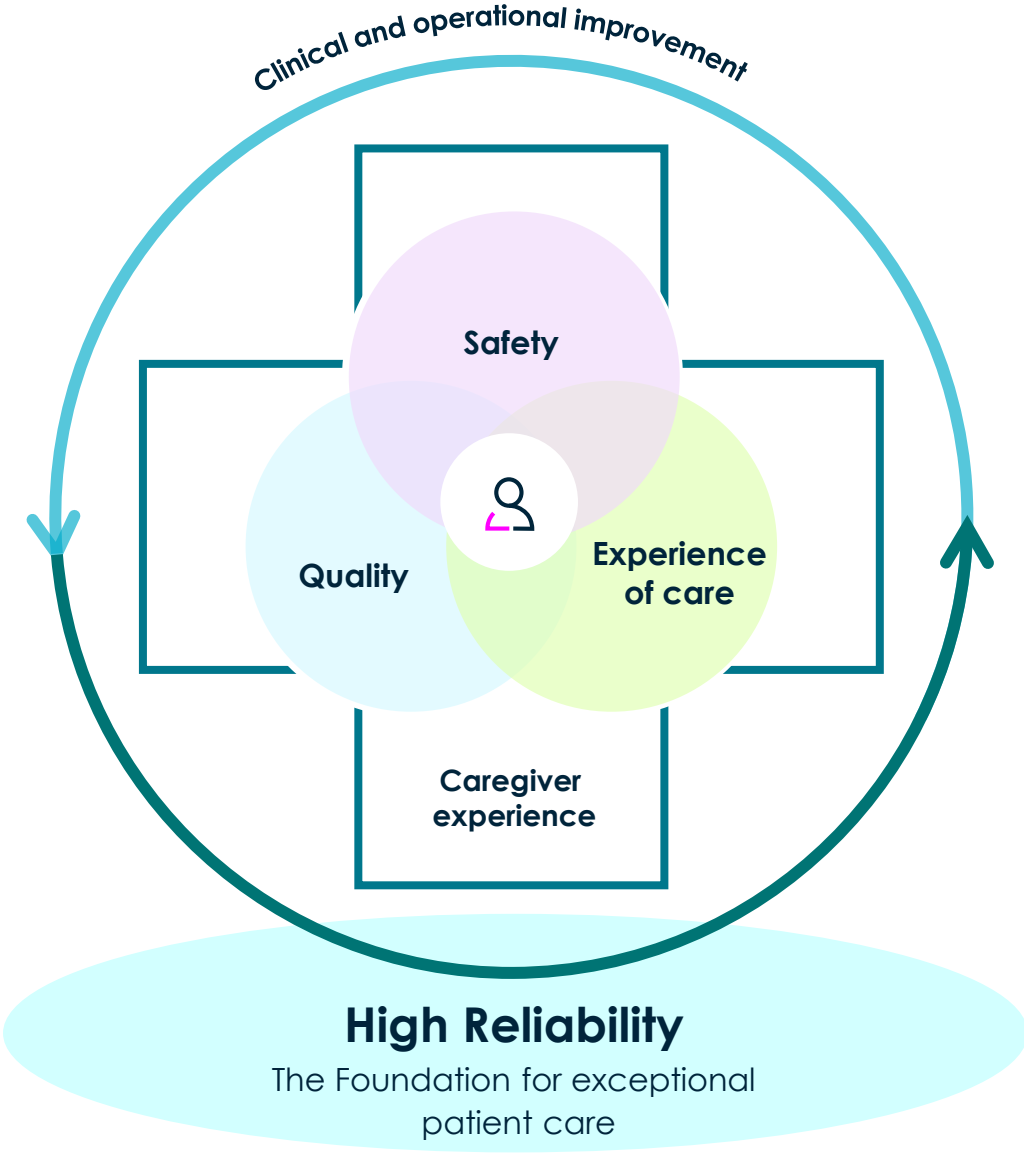
All harm – physical harm and emotional harm

All impacted – patients, workforce, and health plan members

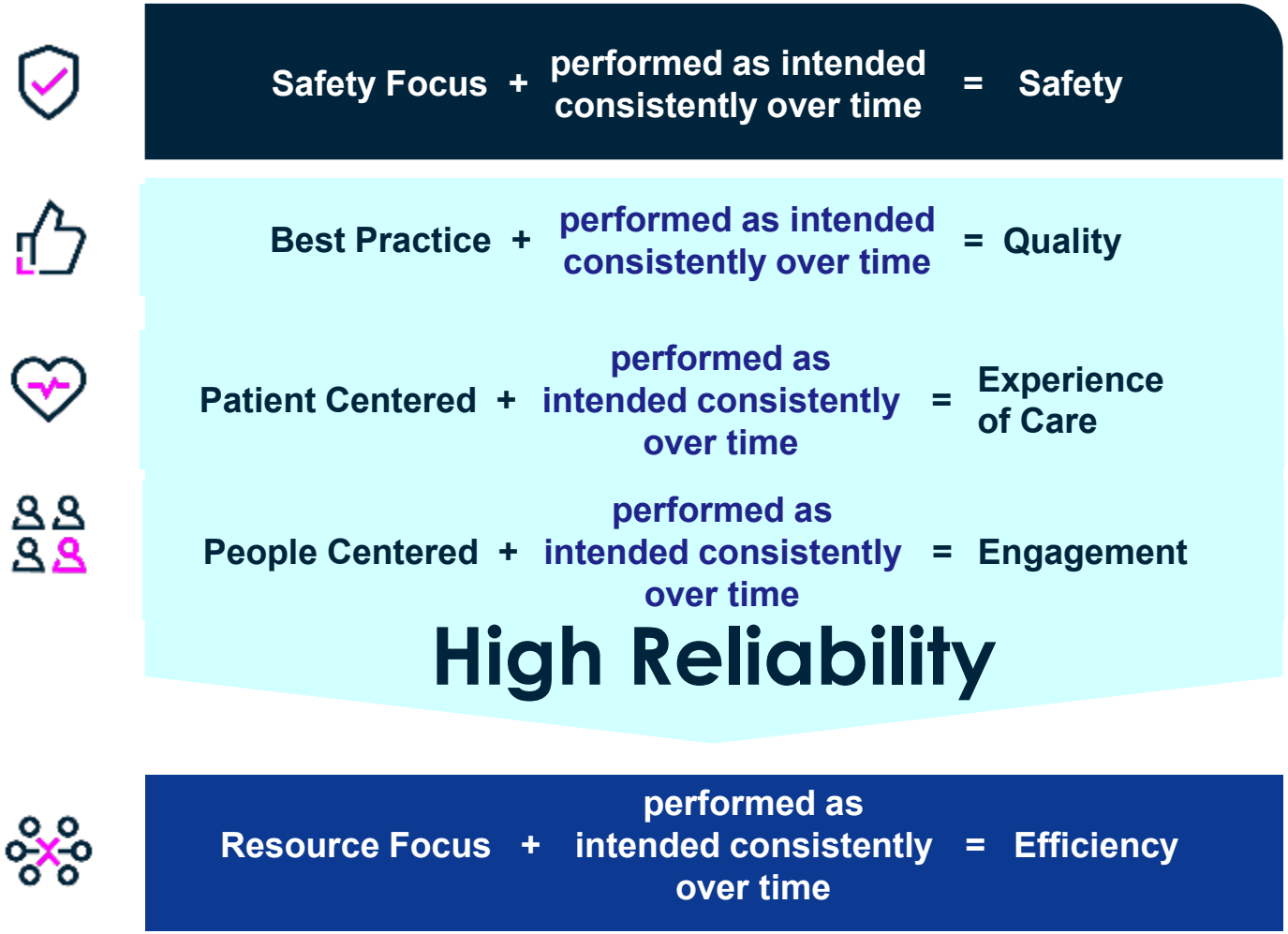
All sites of care (acute, ambulatory, long-term care, home care, telemedicine)

RELIABLY IMPLEMENT

Systems Solutions To Reduce Harm

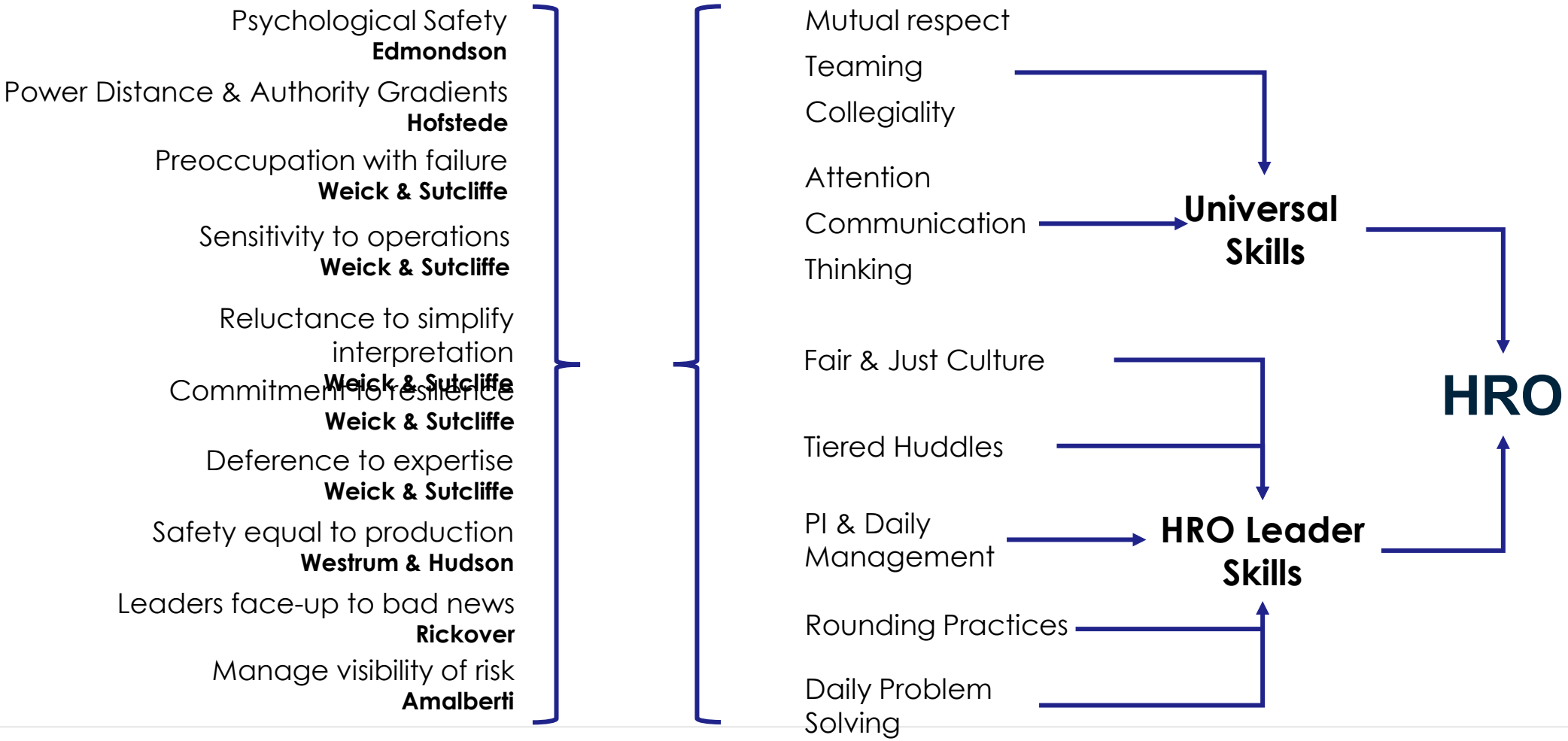


High Reliability Can Improve All Types of Performance

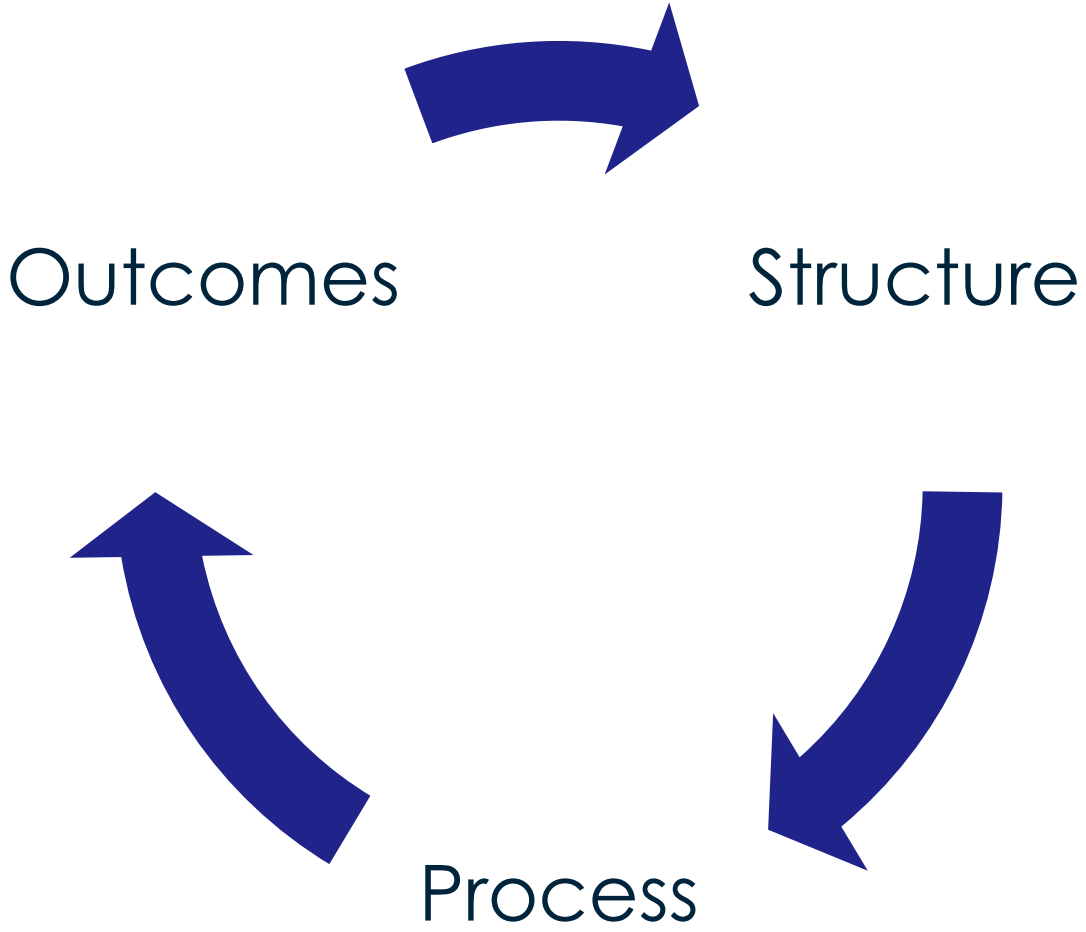


HRO Transformation Driver Diagram

Turning HRO Principles into Practices for Leaders, Staff and Physicians



The Evolution of CMS Measures for Safety and Equity



CMS Patient Safety Structural Measure

Roadmap to Safety and High Reliability

Domain 1:
Leadership Commitment to Eliminating Preventable Harm

Domain 2:
Strategic Planning

Domain 3:
Culture of Safety & Learning Health System

Domain 4:
Accountability & Transparency

Domain 5:
Patient & Family Engagement

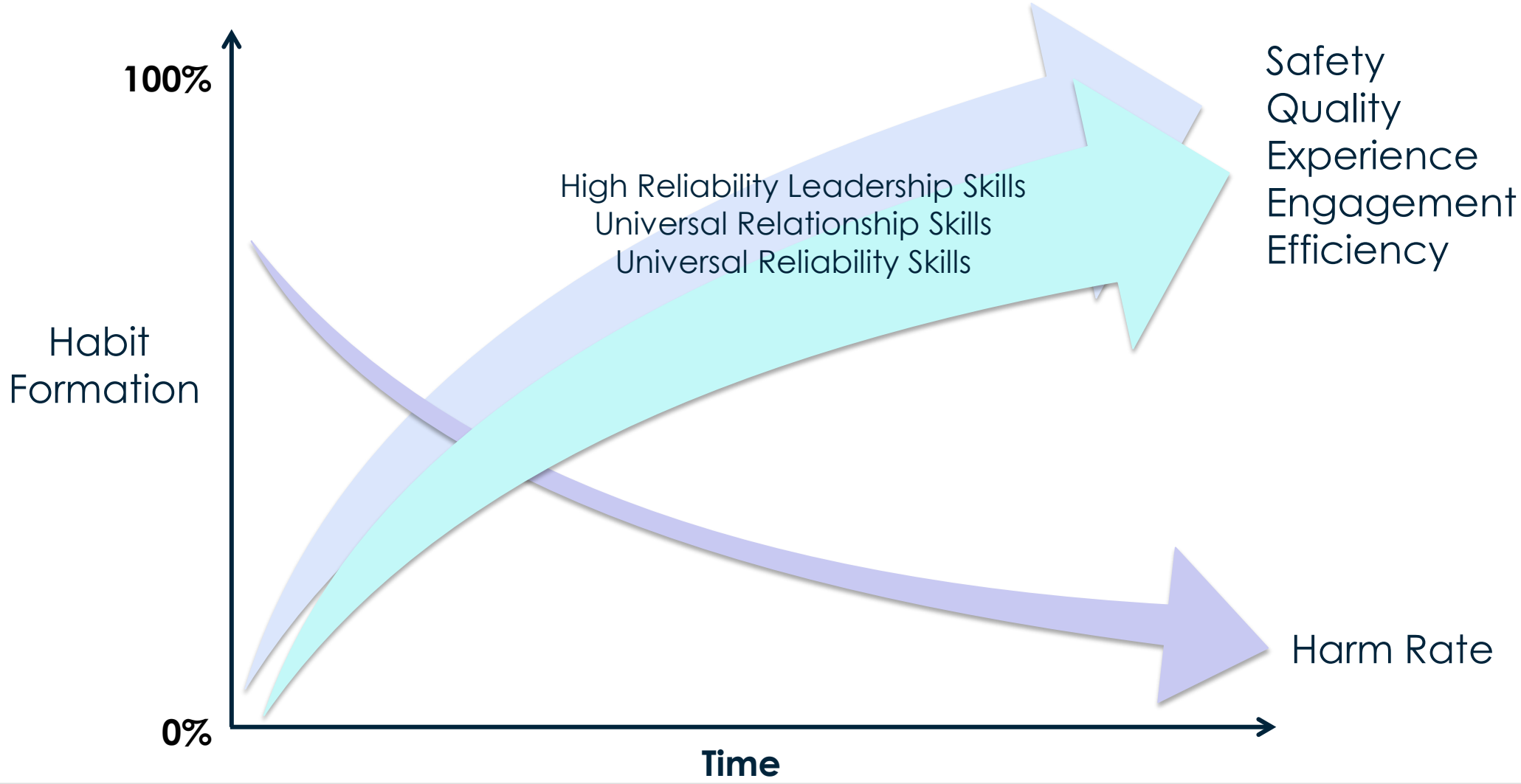
CMS PSSM – Five Domains & Key Specifications

CMS PSSM Domain	Key PSSM Specifications
Domain 1: Leadership Commitment to Eliminating Preventable Harm	• Governing board and hospital leaders prioritize safety as a core value, ensure resources, and assess/maintain safety improvement plans and metrics • Governing board and executives are notified within 3 business days of serious safety events
Domain 2: Strategic Planning	• Hospital publicly shares commitment to patient safety as a core value • Strategic plan includes safety goals/metrics, including goal of "zero preventable harm" and metrics to identify and address disparities in safety • Hospital has just culture policies and procedures; curriculum and competencies for advancing safety skills and behaviors; action plan for workforce safety
Domain 3: Culture of Safety & Learning Health System	• Hospital conducts hospital-wide culture of safety survey • Dedicated team that conducts/analyzes serious safety events using evidence-based root cause analysis • Patient safety dashboard with external benchmarks • Participation in large-scale learning networks for patient safety • Implementation of at least four of seven key high reliability practices
Domain 4: Accountability & Transparency	• Confidential safety reporting system with feedback loop to those who report • Voluntarily works with AHRQ-listed PSO • Safety metrics tracked and reported to all clinical/non-clinical staff and made public on hospital units • Evidence-based communication and resolution program with measures reported to the governing board
Domain 5: Patient & Family Engagement	• Hospital has representative Patient and Family Advisory Council (PFAC) that provides input on safety-related activities • Patients have comprehensive access to their own medical records via patient portals • Hospital incorporates patient/caregiver input about patient safety events

Using Standard Tactics Broadly and Reliably

BEST PRACTICE	QUALITY & SAFETY	PATIENT CENTEREDNESS & EXPERIENCE OF CARE	WORKFORCE ENGAGEMENT
CARE (INTERVAL) ROUNDING	X	X	X
TIERED HUDDLES	X	X	X
EXECUTIVE & LEADER ROUNDING	X	X	X
PATIENT & FAMILY ADVISORY COUNCIL	X	X	X

“Habitual Excellence”



“What if the best don’t focus on doing more, but doing **their best work more often**

In Conclusion

- In safety, much has improved but we have a long way to go.
  - ***Focus on foundations***
  - ***Patients must be at the center of all we do***
- We need to transform our organizations to an integrated approach to quality, safety, patient centeredness to drive patient experience.
  - ***We must lead with safety and engagement***
  - ***High reliability can be the chassis***
- We must accelerate efforts to create a world where patients and those who care for them are free from harm

Thank you

PressGaney

Strength in Unity

Navigating the evolving landscape *together*.

2025 ANNUAL MEETING

OCTOBER 19–21

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Overall Annual Meeting Evaluation

Individual Sessions Evaluation

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