SAFETY SUMMIT 2017
Reliability Realized: Achieving Zero Harm
HPI PRESS GANEY  Charlotte, N.C. | Oct. 2-4

Register Today!
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WELCOME

The HPI Press Ganey Safety Summit has become the leading forum for health care executives to connect, share best practices and explore the science and strategy behind reducing serious safety events. This year’s theme, **Reliability Realized: Achieving Zero Harm**, represents the progress we’ve made as an industry in reducing patient harm as well as our vision of a future where we eliminate safety events using proven reliability methods.

WELCOME REMARKS

Carl S. Armato, MBA | President & CEO, Novant Health

Carl S. Armato is the president and chief executive officer for Novant Health. Since joining Novant Health in 1998 as the vice president of finance and operations for the physician divisions in both Charlotte and Winston-Salem, Armato has also served as senior vice president of materials management and logistics for Novant Health. In 2003, Presbyterian Healthcare appointed Armato as chief operating officer and then promoted him to president and chief executive officer in January 2004. In 2008, the health system promoted him to president of Novant Health markets and in 2011 as chief operating officer. The board of trustees appointed him to his current position in January 2012.

Thomas N. Zweng, MD, FACS | EVP & Chief Medical Officer, Novant Health

Thomas Zweng serves as Novant Health’s Executive Vice President and Chief Medical Officer since March, 2014. From 2006 – 2014 he was the SVP of Medical Affairs for the five Charlotte based hospitals of Novant Health. He is a board certified general surgeon and prior to his role as VPMA, he was the Chief of General Surgery for the Novant Health Presbyterian Hospitals for two years while practicing in Charlotte with a general surgery group. Thomas has been a member of the Opera Carolina Board of Directors and served as the co-chair for the Mecklenburg County Arts and Science 2010 annual fund drive. Currently he serves on the boards of Charlotte’s CBI, Community Building Initiative, which focuses on racial and ethnic inclusion and equity, Discovery Place, which is an organization dedicated to the exploration of the natural and social worlds through exhibits and programming, and the Medic Board of Commissioners, the Mecklenburg county EMS system.

SUMMIT HOSTS

James Merlino, MD | President and Chief Medical Officer, Press Ganey Strategic Consulting

Dr. James Merlino joined Press Ganey as president and chief medical officer of the strategic consulting division in 2015. As an accomplished surgeon and industry leader in improving the patient experience, Jim draws from more than two decades of health care experience to oversee Press Ganey’s consultancy division. Under his leadership, the consulting team helps providers improve the delivery of safe, high-quality care in a patient-centered environment.

Prior to joining Press Ganey, Jim served as chief experience officer and associate chief of staff at the Cleveland Clinic health system, as well as a practicing staff colorectal surgeon at the organization’s Digestive Disease Institute. At Cleveland Clinic, Jim was responsible for leading strategic programs to improve the patient experience across the system. He spearheaded numerous groundbreaking initiatives to ensure the highest standards for patient care, and improve patient access and referring physician relations. He championed organizational cultural alignment around the patient as a key component of patient-centered care.
SUMMIT HOSTS

Gary Yates, MD | Partner, Press Ganey Strategic Consulting

Formerly, Gary was President of HPI as well as Senior Vice President and Chief Medical Officer for Sentara Healthcare whose responsibilities included the clinical effectiveness programs, patient safety programs, physician integration efforts and medical management initiatives for its 12-hospital system and 450,000 member health plan. He provided leadership for the quality and patient safety initiatives leading to Sentara Norfolk General Hospital being recognized as the 2004 recipient of the American Hospital Association-McKesson Quest for Quality Prize and Sentara Healthcare being recognized as the 2005 recipient of the John M. Eisenberg Award for Patient Safety and Quality from the Joint Commission and the National Quality Forum.

Gary was also a member of the Executive Committee for the Institute for Healthcare Improvement’s (IHI) Quality Management Network and served as co-chair of IHI’s ninth annual National Forum on Quality Improvement in Health Care. Gary is a board-certified family physician and fellow of the American Academy of Family Physicians.

Craig Clapper, PE, CMQ/OE | Partner, Press Ganey Strategic Consulting

Before he started with Press Ganey, Craig was a founding Partner and the Chief Knowledge Officer of HPI. Craig has over 25 years of experience improving reliability in nuclear power, transportation, manufacturing, and health care. He specializes in cause analysis (including nuclear power events and component failures, commercial aviation components, and the Texas A&M bonfire structure collapse), reliability improvement (including Feed Water & Main Turbine systems in nuclear power, manufacturing at Baker Hughes, and chemotherapy processes at St. Jude’s Children’s Hospital), and safety culture improvements (for Duke Energy, US Department of Energy, ABB, Westinghouse, Framatome ANP, Sentara Healthcare, and others). He now is the lead consultant on several safety culture engagements for healthcare systems.

Prior to forming HPI, Craig was the Chief Operating Officer of Performance Improvement International, Chief Engineer for Hope Creek Nuclear Generating Station and Systems Engineering Manager for Palo Verde Nuclear Generation Station. He is a registered professional engineer in Arizona, has a Master in Business Administration, and is a Certified Manager of Quality and Organizational Excellence by the American Society for Quality (ASQ).

Carole Stockmeier | Partner, Press Ganey Strategic Consulting

Prior to joining Press Ganey, Carole was Managing Partner and Chief Operating Officer of HPI. She has over 15 years of experience in hospital operations leadership. Carole is the senior consultant for comprehensive safety culture engagements of hospitals and integrated health systems and has helped organizations achieve significant improvement in safety reliability. Prior to joining HPI, she served as the Director of Safety & Performance Excellence at Sentara Healthcare where she guided leaders in the implementation of strategies for human error prevention and high-reliability performance.

Carole provided operational leadership for Sentara’s patient safety initiatives, with outcomes recognized by award of the American Hospital Association 2004 Quest for Quality Prize and the 2005 John M. Eisenberg Award for Patient Safety and Quality. She holds a Master in Health Administration from Virginia Commonwealth University, where she is a Fellow of the Williamson Institute of the Department of Health Administration, and a Bachelor of Science in Public Health from the University of North Carolina at Chapel Hill.

Kerry Johnson | Partner, Press Ganey Strategic Consulting

Prior to joining Press Ganey, Kerry was a founding Partner and the Chief Innovation Officer of HPI. Kerry has over 25 years of experience improving reliability in nuclear power, transportation, manufacturing, and health care. He specializes in designing and implementing human performance reliability programs for large organizations, resulting in dramatically reduced event rates. He is now the lead consultant on several safety culture engagements for integrated health care systems.

Formerly, Kerry was the Chief Operating Officer of Performance Improvement International, Technical Advisor & Assistant Engineering Manager for the Palo Verde Nuclear Generating Station, and Assistant Chief Test Engineer at the Pearl Harbor Naval Shipyard. Kerry holds a Master in Mechanical Engineering from the University of Utah and a Bachelor of Science in Applied Physics.
KEYNOTES

Tuesday, Oct. 3, 8:45 - 9:45 a.m.

Mark Rosenker, Former Chairman, National Transportation Safety Board

As two-time chairman of the National Transportation Safety Board (NTSB), Mark Rosenker led the investigations that followed any civil aviation accident in the nation, as well as significant accidents involving highway, railroad, marine and pipeline. Rosenker calls his time at the NTSB “the best job I ever had” because of the opportunity to recommend and implement safety regulations that save lives and prevent more accidents from happening. Called the “Master of Disaster,” he is currently the transportation and safety analyst for CBS news and radio. Prior to this, he was a contributor to NBC News, appearing on programs like TODAY, Nightly News with Brian Williams and MSNBC. Rosenker is a firm believer in the power of technology to prevent accidents and tells gripping tales of aviation accidents that could have been prevented by the implementation of new software or technology. He is also a staunch spokesman for the benefits of thorough preparation and training and discusses balancing safety and quality.

Wednesday, Oct. 4, 8:15 - 9:45 a.m.

Providing Perspectives: Vidant Health’s Journey to Engage Patients and Families in Safety and Reliability

In an ongoing 12 year-long journey to build a culture of safety and reliability, embedding the patient perspective—and voice—in the work has been transformative for Vidant Health. In this session, you’ll gain a deep understanding of their journey and the challenges they overcame from three integral perspectives: the Chief Executive Officer, the Chief Quality Officer and the patient. Speakers will explore the catalyst that originally prompted Vidant to engage patients and families formally by establishing the Patient Family Advisor Council (PFAC) across the system. Additionally, you’ll hear directly from a Patient Advisor as she describes the role advisors play today and shares her journey. Finally, you’ll hear from the Vidant CEO as he explains how he took steps early in his tenure to foster reliability, accelerate the pace of improvement and advance patient and family engagement.

Wednesday, Oct. 4, 2:45 - 3:45 p.m.

Preparing for Success in Uncertain Times through Reliability

While there is uncertainty surrounding the future of health care, the imperative to reliably deliver safe, quality and patient-centered care remains. Organizations who continue to focus on quality improvement and High Reliability organizing will be uniquely positioned to achieve competitive success. In this session, Craig will explore strategies for using High Reliability best practices to improve the core principles of care (safety, quality, experience, efficiency and caregiver engagement), becoming a top-performer and preparing for the future of health care.
Focus Areas

- **Building a High Reliability Framework**
  Successfully implementing reliability culture transformation across your organization requires a solid foundation and program framework. In these sessions, speakers will review effective strategies for applying reliability oversight and management techniques that can help you begin or move forward on the path to High Reliability.

- **Creating a Transparency Strategy to Share Safety Data Internally and Externally**
  To create the “burning platform” for improving safety, organizations must develop strategies and mechanisms to share safety events and data with internal stakeholders, patients and their wider communities. In this track, you’ll learn how organizations have created and sustained successful approaches to safety transparency.

- **Determining and Addressing the Root Causes of Serious Safety Events**
  Sessions in this track feature strategies for improving the detection (identification) and correction (remediating the causes) of serious safety events as a part of a comprehensive safety culture transformation.

- **Executive Track**
  INVITATION ONLY. Designed exclusively for senior-level executives, this C-suite-only track features high-level leadership strategies and perspectives on reliability from safety experts inside and outside of health care.

- **Exploring the Relationship between High Reliability Strategies and the Patient Experience**
  Suffering is a natural part of the patient experience. Some suffering, like pain associated with a condition, is inherent and cannot be avoided. Some suffering, such as poor care coordination or other service failures, is avoidable. Sessions in this track will explain how High Reliability practices can be implemented to mitigate inherent suffering and eliminate avoidable suffering, thereby improving the safety, quality and overall experience of care.

- **Implementing and Sustaining a High Reliability Culture**
  Once your organization has started its journey to High Reliability, there are many tools, methods and improvement opportunities you can leverage to build upon current successes and culture initiatives. In this track, speakers will explore practical applications for advancing and maintaining an organizational focus on safety as well as developing reliability as the chassis for other system-wide improvements.

- **Utilizing Safety Event Classification and Serious Safety Event Rate**
  The Safety Event Classification System® and SSER® provide organizations with a lagging metric to monitor progress on the safety and reliability journey. Presenters in these sessions will explore how they have used this metric to drive improvements.

**Session Level Descriptions**

To further assist you in selecting sessions of interest, we have also categorized presentations based on organizational experience with safety and High Reliability practices. If you’re just beginning your safety and High Reliability journey, select a novice session. If you’re looking for more advanced strategies for continuing or improving existing efforts, sessions marked with our experienced label will be of most value. Designations include:

- **All Organizations**: Regardless of experience level
- **Novice**: Organizations beginning the safety & reliability journey (<1 years)
- **Experienced**: Organizations with moderate/advanced safety & reliability experience (2-3 years)
**AGENDA**

### MONDAY, OCT. 2

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<th>Time</th>
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<td>3:00 - 5:00 p.m.</td>
<td>Registration</td>
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<tr>
<td>4:00 - 5:30 p.m.</td>
<td>Meet &amp; Greet</td>
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### TUESDAY, OCT. 3

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<th>Time</th>
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<tr>
<td>7:00 - 7:45 a.m.</td>
<td>Breakfast</td>
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<tr>
<td>8:00 - 8:45 a.m.</td>
<td>Welcome Remarks:</td>
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<tr>
<td>Dr. Jim Merlino &amp; Carl Armato</td>
<td>8:00 - 8:45 a.m.</td>
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<tr>
<td>8:45 - 9:45 a.m.</td>
<td>Keynote: Mark Rosenker</td>
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<tr>
<td>9:45 - 10:00 a.m.</td>
<td>Break</td>
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<tr>
<td>10:00 a.m. - Noon</td>
<td>Reliability Institute Courses</td>
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<tr>
<td>Noon - 1:00 p.m.</td>
<td>Lunch</td>
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<tr>
<td>1:15 - 2:15 p.m.</td>
<td>Breakout Sessions:</td>
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<tr>
<td>Increasing Physician Engagement in Safety through Event Reporting</td>
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<td>Using Simulation to Assess Root Cause Analysis Competency</td>
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<td>Transforming Relationships in the Operating Room: A Reflection in the MirrOR</td>
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<td>Improving Medical Staff Engagement in a Large Medical Center</td>
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<td>The Perfect Pair: A Daily Management System and High Reliability</td>
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<tr>
<td>2:30 - 3:30 p.m.</td>
<td>Breakout Sessions:</td>
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<tr>
<td>Converting Safety Event Data into Actionable Information</td>
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<td>A Standardized Approach to Cause Analysis of Patient and Worker Safety Events</td>
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<td>Fulfilling the Patient Promise: The Convergence of Safety, Quality, Experience and Caregiver Engagement</td>
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<td>Achieving and Maintaining High Reliability in Ambulatory Care</td>
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<td>Designing High Reliability Training for Non-Clinical Staff and Leadership</td>
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<tr>
<td>3:30 - 3:45 p.m.</td>
<td>Safety Cinema Viewing</td>
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<td>5:00 - 6:30 p.m.</td>
<td>Safety Share Reception</td>
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### WEDNESDAY, OCT. 4

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<th>Time</th>
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<tr>
<td>7:00 - 8:00 a.m.</td>
<td>Breakfast</td>
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<tr>
<td>8:15 - 9:45 a.m.</td>
<td>Keynote: Vidant Health</td>
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<tr>
<td>10:00 - 11:00 a.m.</td>
<td>Breakout Sessions:</td>
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<tr>
<td>Implementing High Reliability Principles Using a Layered Learning Approach</td>
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<td>Using Safety Success Stories to Drive Health System Safety</td>
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<td>Safety and Patient Experience: The Health Care Complete Package</td>
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<tr>
<td>The Journey Continues: Deploying Zero Harm in Non-Clinical Settings</td>
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<td>The Teachers of Quality Academy: A Novel Approach to Teaching Reliability</td>
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<tr>
<td>11:00 - 11:15 a.m.</td>
<td>Break</td>
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<tr>
<td>10:00 - 11:00 a.m.</td>
<td>Breakout Sessions:</td>
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<tr>
<td>A Journey to High Reliability: Preventing Unassisted Falls</td>
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<td>Integrating High Reliability into Your Lean Management System</td>
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<tr>
<td>Engaging and Supporting Clinic Leaders around Human Experience Work</td>
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<td>Utilizing In Situ Simulation to Improve High Reliability Outcomes: A Case Study</td>
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<tr>
<td>Leveraging Safety Coaching to Improve Patient Safety in an Ambulatory Setting</td>
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<tr>
<td>12:15 - 1:15 p.m.</td>
<td>Lunch</td>
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<tr>
<td>1:30 - 2:30 p.m.</td>
<td>Breakout Sessions:</td>
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<tr>
<td>Advancing High Reliability Culture through Error Prevention, Visual Literacy &amp; Simulations</td>
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<td>A Centralized Discharge Center Improves both Patient Outcomes and Experience</td>
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<td>Refining Texas Health’s HRO Interprofessional Education Program</td>
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<td>The Road to High Reliability: A Medical Staff Educational Journey</td>
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<td>Incorporating Peer Review Events into HPI’s Safety Event Classification</td>
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<td>2:45 - 3:45 p.m.</td>
<td>Closing Keynote: Craig Clapper</td>
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<td>3:45 - 4:15 p.m.</td>
<td>Closing Remarks:</td>
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**Focus Area Legend:**
- Building a High Reliability Framework
- Creating a Transparency Strategy to Share Safety Data Internally and Externally
- Determining and Addressing the Root Causes of Serious Safety Events
- Executive Track
- Exploring the Relationship between High Reliability Strategies and the Patient Experience
- Implementing and Sustaining a High Reliability Culture
- Utilizing Safety Event Classification and Serious Safety Event Rate
10:00 a.m. - Noon

To facilitate in-depth learning, networking and best-practice sharing, we offer six Reliability Institute workshop courses Tuesday morning that enable attendees to explore topics and issues specific to leadership, integrating safety, quality and experience of care, evidence-based cause analysis, workforce safety, HRO culture and collaborative zero harm initiatives. Each session will be led by senior HPI consultants who will offer deep insight and measurable solutions to help you improve care.

High Reliability Organizing to Optimize Safety, Quality and Experience of Care
Craig Clapper, PE, CMQ/OE, Partner, Strategic Consulting, Press Ganey
Stacie Pallotta, MPH, Partner, Strategic Consulting, Press Ganey
Hannah Shipton, Manager, Process and Performance Improvement

All Organizations
Improving the safety, quality and experience of care is a complex goal that requires dedicated resources, cultural support and a collaborative, multifaceted approach. Often, organizations must simultaneously work on these efforts while balancing other projects and a healthy bottom line. Furthermore, a silo-approach to improvement initiatives can lead to sub-optimization of outcomes, resource competition and a failure to recognize the synergies among efforts. Learn how reliability principles and practices can serve as the underpinning and operating system essential to optimizing outcomes across domains.

Applying Evidence-Based Cause Analysis to Peer Review
Laura Goldhahn, MBA, FACHE, Consultant, Press Ganey
Chris Hubble, MD, Manager, Consulting, Press Ganey
Donna Cheek, MSN, MHA, Consultant, Press Ganey

Experienced
Establishing and sustaining a consistent and equitable peer review program is one of the greatest challenges faced by medical staffs. Medical leaders take this responsibility seriously yet can be frustrated by ineffective assessment methodologies and inadequate educational tools that fail to foster improvement. Event-based peer review, in contrast, uses a human performance framework to evaluate deviations in physician performance that is fair, consistent and offers constructive learning. This session will provide an overview of principles and practice examples of event-based peer review.

Optimizing Workforce Safety through High Reliability
Steve Kreiser, CDR, USN (Ret.), MBA, MSM, Director, Consulting, Press Ganey
Emily Halu, RN, MSN, CPPS, Consultant, Press Ganey
Martin Wright, Sr. Manager, Consulting, Press Ganey

All Organizations
According to the Occupational Safety and Health Administration, the health care industry has one of the highest rates of work-related injuries and illnesses. Measured in terms of dollars, health care worker injury costs exceed malpractice claims by a factor of three. In spite of this, many organizations come up short in realizing improvement in workforce safety. In this course, speakers will illustrate how health care systems are integrating workforce safety into culture transformation and positioning workforce safety as a core element of engagement, patient safety and the greater patient experience.

Tough Topics for HRO Culture Transformation
Judy Ewald, BS, MPA, CPHQ, Sr. Manager, Consulting, Press Ganey
Dave Varnes, CDR, USN (Ret.), MSAE, Sr. Manager, Consulting, Press Ganey
Tami Strong, BA, BSN, RN, MSN-HCQ, Sr. Manager, Consulting, Press Ganey

All Organizations
Admiral Hyman Rickover, dubbed The Father of the Nuclear Navy, once said, "Good ideas are not adopted automatically. They must be driven into practice with courageous impatience. Once implemented, they can be easily overturned or subverted through apathy or lack of follow-up, so a continuous effort is required." Even though reaching zero harm is a compelling goal, the journey to that goal is complex. This session will address the top challenges to implementing and sustaining HRO culture and offer creative, effective solutions.
10:00 a.m. - Noon cont’d

Sharing & Learning to Realize ZERO Harm
Shannon Sayles, RN, MS, MA, Sr. Manager, Consulting, Press Ganey
Rob Douglass, Consultant, Press Ganey

In his book *Hostages of Each Other: The Transformation of Nuclear Safety*, author Joseph Rees illustrates how the Three Mile Island accident demonstrated the importance of interdependence and shared learning among nuclear power utilities. In order to perfect safety systems, it was imperative that these organizations share knowledge and work collaboratively to build a safer system. In this course, speakers explore principles for sharing and learning from events of harm within a system and among other organizations within the industry.

Improving Safety through Leadership
Gary Yates, MD, Partner, Strategic Consulting, Press Ganey
Doug Cropper, President & CEO, Genesis Health System
Debra Flores, MSM, BSN, RN, FACHE, President, Sentara CarePlex Hospital
Denise Mihal, RN, MBA, CNO, Novant Health
Jane Hanson, RN, BSN, MHA, CPHQ, COO, Dignity Health Chandler Regional & Mercy Gilbert Medical
Brian Kaminski, DO, VP, Quality & Safety, ProMedica Health System

As a leader, what you say about safety is important, but what you do about safety influences the perspectives and behaviors of staff. Creating and sustaining a culture of zero harm requires deliberate, sustained effort from executive leaders. Additionally, finding the time and resources to effectively create and communicate a culture of safety while leading other priorities may be challenging. In this C-suite only course, we will explore leadership techniques that can be readily implemented and have significant impact on improving complex safety initiatives.

“Invaluable. My first summit and I am completely motivated to invest and apply some of these ideas to the challenges in my own environment.”

“It was of overwhelming value. All of the breakout sessions I attended were spot on. The keynote speakers were engaging. They do amazing work with amazing people.”

- 2016 Summit Attendees
1:15 - 2:15 p.m.

Increasing Physician Engagement in Safety through Event Reporting

Jenifer Murphy, MHA, CPPS, Patient Safety Manager, VCU Health
Jose Munoz, MD, Chief Quality & Safety Officer, VCU Health

- **Focus Area:** Creating a Transparency Strategy to Share Safety Data Internally and Externally
  - **Session Level:** Experienced

Robust safety event reporting is a key indicator of a strong safety culture. While the volume of event reporting at VCU Health was strong, the professional areas reporting were predominantly nursing. In an effort to create a more comprehensive and robust safety environment, the organization undertook a targeted effort to increase attending and resident participation in safety event reporting. During this session, attendees will learn more about how the process was developed, the critical role of physician champions, and the tools and systems used to support the approach, including a user-friendly online reporting system.

Using Simulation to Assess Root Cause Analysis Competency

Ellen Macone, RN, BSN, Patient Safety Specialist, Yale New Haven Health System
Theresa Vander Vennet, BSN, JD, Associate General Counsel, Risk Management, Yale New Haven Health System

- **Focus Area:** Determining and Addressing the Root Causes of Serious Safety Events
  - **Session Level:** All Organizations

Root cause analysis is the tool most frequently used by patient safety professionals when evaluating causal factors of preventable harm events. It is essential that those who perform and facilitate the root cause analyses are not only formally trained, but also periodically assessed for competency. To address these needs, Yale New Haven Hospital developed and internally validated a competency assessment utilizing simulation techniques. During this interactive session, attendees will assess their own competencies in performing the critical tasks involved in a root cause analysis. Speakers will also share best practices learned during implementation and application of their program.

Improving Medical Staff Engagement in a Large Medical Center

Gary Hoffman, MD, Chief, Women and Children’s Division, Providence St. Vincent Medical Center
Scott Marsal, MD, Chief of Medicine, Providence St. Vincent Medical Center

- **Focus Area:** Implementing and Sustaining a High Reliability Culture
  - **Session Level:** Novice

Fostering medical staff engagement is vital to changing organizational culture and achieving High Reliability. To continue to advance patient safety and experience, Providence St. Vincent Medical Center, a 523-bed hospital with a mixed-model medical staff, trained roughly 800 medical staff members on High Reliability principles. This class comprised the most active medical staff who provide the majority of services. In this session, our speakers will share lessons learned while implementing this program and proven strategies for engaging and training medical staff members around High Reliability and zero harm initiatives.

The Perfect Pair: A Daily Management System and High Reliability

Donna Donovan, RN, MSN, Director of Patient Safety, Connecticut Children’s Medical Center
Kirt Tassmer, Senior Continual Improvement Advisor, Connecticut Children’s Medical Center

- **Focus Area:** Implementing and Sustaining a High Reliability Culture
  - **Session Level:** All Organizations

Following a successful implementation of High Reliability principles, Connecticut Children’s Hospital experienced a relapse of serious safety events and a decline in key metrics. In an effort to recover, leadership implemented a daily management system aimed at optimizing efficiency, effectiveness and prioritization of clinical care. The goal was to provide all areas of the organization with tools they could use daily to manage safety, quality, service, finance and growth at the same time. During this session, you will learn how Connecticut Children’s established and leveraged a tiered approach to operationalize the system; how the metrics for the system were defined; and how the organization overcame challenges and barriers.
1:15 - 2:15 p.m. cont’d

Transforming Relationships in the Operating Room: A Reflection in the MirrOR

Tanya Blackmon, LCSW, MBA, EVP & Chief Diversity and Inclusion Officer, Novant Health
Diana Best, BSN, RN, Senior Vice President, Clinical Improvement, Novant Health

Focus Area: Executive Track
Invitation Only

In this session, attendees will explore the operating room (OR) care journey from four perspectives: that of the patient, the surgeon, the nurse and the hospital administrator. After journey mapping the OR experience from all sides, speakers will guide facilitated discussion and will help attendees understand how their role in creating a safe environment and delivering compassionate, connected care impacts a patient’s overall experience.

2:30 - 3:30 p.m.

Converting Safety Event Data into Actionable Information

Danelle Higgins, RN, BSN, MHA, PSO Administrator, Carolinas HealthCare System
Shayla Stroud, MPH, Sr. Clinical Analyst, Carolinas HealthCare System

Focus Area: Creating a Transparency Strategy to Share Safety Data Internally and Externally
Session Level: Experienced

One of the most difficult tasks related to managing safety event data is finding a way to share relevant, actionable information with the teams that need it. Carolinas HealthCare System uses the federal protection of its Patient Safety Organization (PSO) to share information as transparently as possible across its system. The PSO team uses safety event data collected using the HPI methodology to create a variety of reports and analyses, and focuses on converting this data into actionable information. Speakers will share the processes used to ultimately help caregivers protect patients from harm.

A Standardized Approach to Cause Analysis of Patient and Worker Safety Events

Wing-Si Luk, MSHc, Director, Patient Safety, University Health Network
Jeanette MacLean, Director, Occupational Health and Hygiene, University Health Network

Focus Area: Determining and Addressing the Root Causes of Serious Safety Events
Session Level: All Organizations

Medical errors and preventable harm to patients and caregivers continue to be significant issues for health care organizations in the U.S. and Canada. University Health Network (UHN), Canada’s largest academic hospital system, has embarked on a strategic journey to become a High Reliability Organization to achieve the goal of eliminating preventable harm for patients and create a safe work environment for staff. In this session, speakers will discuss how UHN created a standardized incident cause analysis program to prevent patient and worker safety events. Specifically, they’ll share how clinical, operational and safety leaders were engaged during program development and the involvement of human factors specialists in the identification and design of root cause solutions.

Achieving and Maintaining High Reliability in Ambulatory Care

Karen L. Birmingham, PharmD, Patient Safety Officer, Kaiser Permanente Health Plan of Washington

Focus Area: Implementing and Sustaining a High Reliability Culture
Session Level: All Organizations

In 2014, Group Health (now Kaiser Permanente Washington Region) embarked on a cultural transformation journey to improve the reliability, safety, quality and experience of care throughout its 25 ambulatory care medical centers. To achieve this goal, all staff members were trained on tools for error prevention and behaviors that show respect for both customers and colleagues. During this session, our speaker will share how focusing on safety and behavioral expectations helped reduce serious safety events by over 80% in two years. Specifically, she will explain how transparent learnings from all harm events, leadership accountability for root cause analysis and transformation coaches strengthened commitment to creating a value-based High Reliability Organization.
2:30 - 3:30 p.m. cont'd

Designing High Reliability Training for Non-Clinical Staff and Leadership
Glenda Battey, PhD, Sr. Project Manager, Clinical Quality & Patient Safety, Providence St. Joseph Health

- Focus Area: Implementing and Sustaining a High Reliability Culture
  - Session Level: All Organizations

At Providence St. Joseph Health, every employee is considered a caregiver. When the organization embarked upon its High Reliability journey, their Care Reliably training program and materials were redesigned to be inclusive of both clinical and non-clinical staff. The speaker will share how PSJH revised talking points, included business operations scenarios, and implemented the Caring Reliably Toolbox for Everyone across business ops departments. Attendees will learn how to bring High Reliability materials to life for non-clinical business operation employees and leaders.

Fulfilling the Patient Promise: The Convergence of Safety, Quality, Experience and Caregiver Engagement
Jim Merlino, MD, President and Chief Medical Officer, Strategic Consulting, Press Ganey

- Focus Area: Executive Track
  - Invitation Only

Safety, quality and experience of care are critical components of the promise providers make to patients and their families. Organizations that value and keep this promise understand the relationship between safety, quality, experience, and physician and caregiver engagement. These organizations also know how to leverage that understanding to identify and act on opportunities for improvement that will have maximum impact. During this session, Dr. Merlino will discuss the connections between safety, quality, experience and engagement. He will also explain how organizations can leverage this knowledge to improve strategy, align culture and design integrated tactics to improve leadership, messaging and overall performance improvement.

“I came away with helpful information causing me to re-think a few aspects of what we have done or have planned to do. I think the new ideas will improve our transformation efforts. I was already highly engaged and now I am SUPER engaged!”

- 2016 Summit Attendee
10:00 - 11:00 a.m.

Implementing High Reliability Principles Using a Layered Learning Approach
Lea Toppino, MBA, Curriculum Coordinator, John Muir Health

Focus Area: Building a High Reliability Framework
Session Level: Novice

In this session, the speaker will share how proven organization development practices were woven into a multi-year, iterative plan to help staff, physicians, contractors and volunteers effectively learn and adopt High Reliability concepts. Starting with an initial focus on patient safety, the curriculum has been expanded over time to incorporate changing behaviors to improve employee safety and patient experience by connecting the dots to foundational High Reliability practices. An integral part of the training plan includes a number of layered approaches to address the different learning styles and needs of our diverse workforce.

Using Safety Success Stories to Drive Health System Safety
Patti Said, MSN, RN, Patient Safety Officer, Genesis Health System
Tricia DeMarlie, Data Analyst, Genesis Health System

Focus Area: Creating a Transparency Strategy to Share Safety Data Internally and Externally
Session Level: Experienced

As part of its safety journey, launched in 2008, Genesis Health System instituted a training program for all 5,000 staff members, including providers. During this training, safety coaches were identified and asked to develop safety success stories highlighting staff using the proper safety behaviors and error prevention techniques taught during the training. In this session, you’ll learn how this program has evolved and continues to positively shape the organization’s safety culture and its ongoing efforts to promote safety event reporting and safety transparency. The speaker will also share how data from the safety success stories helped identify safety-critical categories which informed further process improvements.

Safety and Patient Experience: The Health Care Complete Package
Jennifer Kreiser, MS, BSN, RN, NE-BC, Vice President Patient Care Services, Nurse Executive, Sentara Leigh Hospital, Sentara Healthcare

Focus Area: Exploring The Relationship between High Reliability Strategies and the Patient Experience
Session Level: All Organizations

A successful safety culture is built on a strong organizational foundation sustained by a team of clinical staff who are empowered, innovative and fully engaged in delivering positive patient outcomes. With the support of senior leadership, the patient experience team at Sentara Leigh Hospital created a new educational workshop, The Gold Standard of Caring. The program’s goal is to educate new team members on Sentara Leigh’s commitment to safety and patient experience, and equip them with the tools needed to succeed and excel. In this session, speakers will share their experiences nurturing and maintaining a culture of excellence and improving performance on multiple safety and quality measures.

The Journey Continues: Deploying Zero Harm in Non-Clinical Settings
Jeanne Nelson, MSNEd, RN, Clinical Ops Initiative Manager, Quality Consultant, Intermountain Healthcare
Mike Rogers, MBA, Clinical Ops Initiatives Manager, Intermountain Healthcare

Focus Area: Implementing and Sustaining a High Reliability Culture
Session Level: Experienced

Having trained clinical staff in the acute, outpatient and post-acute facilities in 2016, Intermountain Healthcare is now deploying zero harm and High Reliability principles to the more than 5,000 employees who work in non-clinical areas. Although these employees do not work directly with patients, their work ultimately affects patient care and the patient experience. Each of these operational units has unique needs, requiring customized training, unusual implementation logistics, and modifications to make Zero Harm messaging relevant. The speakers will share strategies, examples of customization as well as the roadblocks they encountered.
WEDNESDAY, OCT. 4

10:00 - 11:00 a.m. cont’d

The Teachers of Quality Academy: A Novel Approach to Teaching Reliability
Danielle Walsh, MD, FACS, FAAP, Associate Professor of Surgery, East Carolina University Brody School of Medicine
Niti Armistead, MD, FACP, Senior Medical Director for Quality, Vidant Medical Center; East Carolina University Brody School of Medicine

Focus Area: Implementing and Sustaining a High Reliability Culture
Session Level: All Organizations

One of the most significant barriers to creating a High Reliability culture focused on safety is the lack of prior training for physicians and health care professionals. Learn how East Carolina University Brody School of Medicine addressed this issue by establishing a year-long Teachers of Quality Academy (TQA) to create a learning community of clinicians and professionals working together to gain competency in patient safety, quality improvement, inter-professionalism and population health. Speakers will discuss the implementation strategy for TQA as well as evaluation methods, outcomes and lessons learned from this novel approach to teaching the next generation of health care professionals.

11:15 a.m. - 12:15 p.m.

A Journey to High Reliability: Preventing Unassisted Falls
Rita Morris, RN, MSN, MJ, CPHQ, CPPS, Director, Quality & Patient Safety, Silver Cross Hospital

Focus Area: Building a High Reliability Framework
Session Level: All Organizations

In pursuit of becoming a High Reliability Organization, Silver Cross Hospital began the process of addressing its most prevalent serious safety event, unassisted falls. Prior to the initiative, no standard process for preventing falls existed and there was a large variation in care practices. During this session, attendees will learn how Silver Cross Hospital engaged leadership across the organization to prioritize patient safety, remove safety barriers and reduce unassisted falls. Their work helped the organization move from the 43rd percentile for fall prevention to the 90th percentile in the National Database of Nursing Quality Indicators® (NDNQI®).

Integrating High Reliability into Your Lean Management System
Robin Betts, RN, CPHQ, AVP Quality & Patient Safety, Intermountain Healthcare

Focus Area: Building a High Reliability Framework
Session Level: All Organizations

Lean management in health care is growing in popularity. Regardless of where an organization is on its High Reliability journey, lean methods can be adopted. During this session, attendees will learn how Intermountain Healthcare uses lean management to support, enhance and sustain its High Reliability initiatives. Speakers will explore strategies for operating High Reliability programs and a Lean Management System as a single operational model that supports safety as a priority. Specifically, they will discuss how integrating these guiding principles can help you achieve a safer, more reliable culture.

Engaging and Supporting Clinic Leaders around Human Experience Work
Renae Caldwell, RN, CMSRN, Manager, Patient Experience, Novant Health
Aaron West, Director, Patient Safety, Novant Health

Focus Area: Exploring the Relationship between High Reliability Strategies and the Patient Experience
Session Level: All Organizations

With the goal of developing a repeatable, predictable approach to engaging clinic leaders around human experience work, Novant Health System developed a program to assess all aspects of the human experience—patient experience, team member engagement and patient safety culture. Additionally, the project aimed to determine if improving one of these aspects would impact the others. During this session, leaders from Novant Health will discuss their new approach to engaging and supporting caregivers in human experience efforts, and share findings from their current program and future development plans.
11:15 a.m. - 12:15 p.m. cont'd

Utilizing In Situ Simulation to Improve High Reliability Outcomes: A Case Study
Susan Teman, BSN, RN, Simulation Program Manager, Helen DeVos Children’s Hospital
Amy Manderscheid, DNP, MSN, RN, Professor of Nursing Practice, Grand Valley State University

- **Focus Area: Implementing and Sustaining a High Reliability Culture**
- **Session Level: All Organizations**

Effective teamwork facilitates collective learning which, in turn, promotes a safe culture. The use of in situ simulation is a growing practice for building both technical competency and clinician confidence. This presentation will provide a framework for any organization interested in implementing in situ simulation, regardless of size or resources. A case study will demonstrate how a pediatric hospital used multidisciplinary in situ simulation to improve teamwork and communication. Outcomes data illustrate improvements in staff satisfaction, perception of communication, ability to escalate concerns and earlier recognition of patient deterioration. Speakers will also explore simpler simulation methodologies focused on improving patient experience.

Leveraging Safety Coaching to Improve Patient Safety in an Ambulatory Setting
Melanie Englen, BSN, RN, Director Quality Management, and Clinical Education, Sentara Medical Group, Sentara Healthcare
Betty Mahon, RN, BSN, Quality and Improvement Coordinator, Sentara Healthcare

- **Focus Area: Implementing and Sustaining a High Reliability Culture**
- **Session Level: All Organizations**

By 2016, Sentara Healthcare Group’s four-year-old safety coach program was in need of revitalization. A new vision, based on safety concerns and supported by practice managers and staff, poured new energy into the program to support a culture of safety in their office-based practices. By teaching the importance of High Reliability and consistency, the goal is to improve predictability in day-to-day processes, patient safety and clinical effectiveness by reducing or eliminating variances in practice. Speakers will explain the importance of staff education and recognition initiatives to promote and support the safety coach role, as well as how safety in the ambulatory setting impacts overall patient safety and clinical effectiveness.

1:30 - 2:30 p.m.

Advancing High Reliability Culture through Error Prevention, Visual Literacy & Simulations
Nicole Justus, MSN, RN, System Safety Coordinator, ProMedica Health System
Brian Kaminski, DO, CPPS, Vice President of Quality and Safety, ProMedica Health System

- **Focus Areas: Building a High Reliability Framework**
- **Session Level: All Organizations**

As a new and rapidly expanding academic medical center, ProMedica Health System sought to add the concepts of error prevention to the immersive clinical simulation activities of its medical residents. At the same time, the organization was working with a local art museum to utilize their concepts of visual literacy within the world of patient safety. ProMedica constructed and implemented learning scenarios that encompassed not only clinical skills, but also the concepts of High Reliability, error prevention and visual literacy into its hands-on simulations. Feedback from learners has been positive, and indicates that the concepts enhance both the simulation and its educational purpose.
1:30 - 2:30 p.m. cont'd

A Centralized Discharge Center Improves both Patient Outcomes and Experience

Ida Anderson, MSN, RN, ONC, Executive Director, Nursing, WellStar Kennestone Regional Medical Center
Robert M. Lubitz, MD, MP, MACP, Vice President of Medical Affairs, WellStar Kennestone Regional Medical Center

Focus Area: Exploring the Relationship between High Reliability Strategies and the Patient Experience
Session Level: All Organizations

Improving quality outcomes while simultaneously improving patient throughput is a challenge many health care organizations face. In particular, the discharge process has been identified as a common bottleneck to efficient, effective patient flow. In this session, leaders from WellStar Kennestone will explain how they optimized these transitions by implementing an innovative discharge center model to significantly improve patient flow, decrease process inefficiencies and lower costs. Use of the discharge center is now a lead measure for improving the patient experience and reducing hospital readmissions. Speakers will discuss the scalability of the model, provide data and formulas to help you calculate the ROI of the program, and offer strategies for developing an implementation and business plan for your organization.

Refining Texas Health’s HRO Interprofessional Education Program

Charisse Jimenez, CPLP, Program Manager, Physician Leadership Development, Texas Health Resources
Lynn Myers, MD, CPC, CHC, Vice President, Quality, Texas Health Physicians Group

Focus Area: Implementing and Sustaining a High Reliability Culture
Session Level: All Organizations

In many ways, coordinating the educational aspects of Texas Health’s journey to High Reliability has been like sanding a piece of wood. Sandpaper has hundreds of sharp edges that cut away and refine the wood; the higher the grit number, the smoother the surface becomes. In this session, you’ll learn how Texas Health built up their HRO education program from a simple meeting with system leaders to instructor-led training that includes online learning and orientation for new employees. Speakers will discuss the value and outcomes of their approach to designing, delivering and improving HRO education as well as proven methods to "sand down" and refine the process, eliminate persistent issues and smooth out challenges.

The Road to High Reliability: A Medical Staff Educational Journey

Sandy Cox, RN, BSN, CIC, Director Patient Safety, Novant Health
Sid Fletcher, MD, FACEP, Senior Vice President Medical Affairs, Novant Health
Tim Hall, MBA, MEd, Instructional Designer, Novant Health

Focus Area: Implementing and Sustaining a High Reliability Culture
Session Level: All Organizations

Medical staff engagement is a critical component in an organization’s journey to High Reliability. In this session, attendees will learn Novant Health’s detailed methodology for planning, developing, implementing and evaluating education programs for its physician partners. The speakers will provide an overview of the instructional design elements of this program such as robust learning objectives, interactive content, knowledge checks and relevant content. In addition, they will share how to weave education into the credentialing process and promote a collegial culture of patient safety.

Incorporating Peer Review Events into HPI’s Safety Event Classification

Mark Rumans, MD, Chief Medical Officer, Vidant Health

Focus Area: Utilizing Safety Event Classification and Serious Safety Event Rate
Session Level: All Organizations

Vidant Health adopted the HPI Safety Event Classification taxonomy early in the health system’s safety journey; however the organization lacked a consistent method for capturing and classifying safety events routed through the peer review process. With leadership support and guidance, a new process was developed to solidify capture of these events with harm-level classification. During this session, attendees will learn how input from key physician leaders across the health system was used to revise the internal peer review form. Engaging physicians in the design and implementation of the process has increased ownership of event resolution and safety leadership.
Hotel Information

For your convenience, a block of rooms has been reserved at both the Sheraton Charlotte Hotel and Le Méridien Charlotte Hotel. You may reserve your room at either hotel, as both have access to the meeting space at the lobby level.

Space is limited; reserve your room early. Don’t forget to mention Press Ganey when booking. Hotel accommodations are not included in the Summit registration fee. Please contact the hotel directly to make reservations, cancellations or changes to your hotel reservation. Reservation and cancellation policies vary by hotel.

Le Méridien Charlotte
555 South McDowell St. North Tower
Charlotte, NC 28204
Phone: 1-800-543-4300
Reserve your room online
Room Rate: $219/night plus taxes
Cutoff Date: Sept. 11, 2017

Sheraton Charlotte Hotel
555 South McDowell St. South Tower
Charlotte, NC 28204
Phone: 1-800-325-3535
Reserve your room online
Room Rate: $219/night plus taxes
Cutoff Date: Sept. 11, 2017

Registration Information

Registration Rate: $595 per person.

Registration is open only to current members of the Press Ganey and HPI client community. Register online to reserve your spot.

Cancellations

Cancellations must be sent in writing to HPISafetySummit@pressganey.com. To receive a full refund, cancellations must be made by Monday, Sept. 11, 2017. If cancellations are made after that time, or if a registrant does not attend, the full registration fee will be charged.

Attendee Substitution

If you’ve registered for the Summit, but can no longer attend and want to send someone in your place, you must cancel your registration by sending an email to HPISafetySummit@pressganey.com. You must then register the new attendee online.

Attire

Business casual attire is appropriate for all sessions. Please note that it is difficult to control the temperature in the meeting rooms. Therefore, you may want to bring a light sweater or jacket. We’ll do our best to ensure that room conditions are comfortable.

Travel Recommendations

The closest airport to the Sheraton Charlotte Hotel or Le Méridien Charlotte is the Charlotte-Douglas International Airport (CLT). We recommend travelers plan to arrive before 3:00 p.m. on Monday, Oct. 2 to register for the event and attend the evening networking reception. Sessions begin at 8 a.m. on Tuesday, Oct. 3. Attendees should plan to depart the Summit on Wednesday Oct. 4 after 4:15 p.m., when the event concludes.

Many Thanks to Our Summit Co-hosts

HPI Press Ganey Safety Summit 2017 | Website: pressganey.com/SafetySummit
Safety Cinema Awards
Each year, a select group of client-produced safety videos are presented during our Safety Cinema competition. These videos illustrate various aspects of safety culture transformation and are normally three-to-five minutes in length. All organizations of the HPI Press Ganey Client Community are invited to submit a video. Submission details will be announced soon.

Digital Posters
Throughout the Summit, we will display brief presentations from members of the HPI Press Ganey client community that demonstrate the successes they have achieved in their safety and reliability culture transformation. Presentations typically consist of one-to-two slides that detail an organization’s safety journey and how staff improved safety culture or reduced patient harm by specific means. If you’re interested in submitting your organization’s success or if you have questions about Digital Posters, please contact HPISafetySummit@pressganey.com.

Meet & Greet
On Monday, Oct. 2 from 4:00 – 5:30 p.m., we invite you to join fellow attendees to discuss important issues, share best practices and network in an informal setting. You’ll also have the opportunity to get to know our consulting team, their respective backgrounds and enjoy light refreshments.

Safety Share Reception
Join us for the Safety Share Reception on Tuesday Oct. 3 from 5:00 - 6:30 p.m. to enjoy networking with fellow safety executives, great food and even more advanced learning. Select organizations will be available for intimate, informal presentations and share how they are working to reduce serious safety events across their organizations.

Social Media
Join the conversation, stay connected and share insights on Twitter using the hashtag #HPISafetySummit.

Earn Continuing Education Credits for Attending the Summit
This program is eligible for 9.5 contact hours.

In support of improving patient care, Press Ganey is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Press Ganey is authorized to award pre-approved ACHE Qualified Education credit for programs toward advancement, or recertification in the American College of Healthcare Executives. Participants in select programs wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or recertification.

If you have questions about continuing education, please email continuingeducation@pressganey.com.

Due to potential scheduling conflicts, speaker substitutions may occur.

“Outstanding! Best event I attend all year.”
- 2016 Summit Attendee