13th Annual HPI Safety Summit

SAFETY SUMMIT 2016
Leading to Zero

HPI | PRESS GANEY Chicago, Sept. 19-21

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WELCOME

The 13th Annual HPI Safety Summit is a collegial gathering of those who share a common goal—creating a reliability culture that results in zero events of harm. Join us to gain insight into reliability science, share proven best practices and network with other health care professionals dedicated to improving patient safety. Together, we will explore the power of reliability culture to drive results in safety, quality, patient experience and other domains of performance.

SUMMIT HOSTS

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

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 consultancy 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.

Gary Yates, MD | Partner, Press Ganey Strategic Consulting

Formerly, Gary was President of HPI; 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. He served two years as President of Virginians Improving Patient Care and Safety (VIPCS), the statewide patient safety consortium for Virginia. In 2005, Dr. Yates was awarded the Physician Executive Award of Excellence from Modern Physician and the American College of Physician Executives (ACPE). He currently serves on the Board of Stewardship Trustees for Catholic Health Initiatives (CHI) and is a member of the American Hospital Association- McKesson Quest for Quality Prize Selection Committee. Dr. Yates 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 health care 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

Carole is a partner at Press Ganey Strategic Consulting. Previously, 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.
Leading to Zero: The Key Role of Leadership in the Journey to High Reliability

Health care organizations that want to use the principle of High Reliability as the chassis on their journey to achieve Zero Harm and eliminate serious safety events require deliberate and mindful leadership—from the C-suite to sharp-end operational leaders—who will support and drive the effort. In this opening session, we will explore a number of proven leadership methods, beginning with perspectives from the national landscape shared by AHA’s current board chairman, and followed by techniques being employed by a multihospital system that is currently on its own strategic journey to eliminate harm.

Jim Skogsbergh
President and Chief Executive Officer,
Advocate Health Care, AHA Chairman

Rishi Sikka, MD
Senior Vice President,
Clinical Transformation
Advocate Health Care

Lee Sacks, MD
Executive Vice President
and Chief Medical Officer
Advocate Health Care

KEYNOTE
Tuesday 8:30 - 9:30 a.m.

Closing Keynote: Zero Harm: Keeping the Faith and Advancing the Cause

This November will mark 17 years since the Institute of Medicine published its report *To Err Is Human*. Since that time, many health care systems have begun their journey to Zero Harm. Today, the demands on health care systems have only increased—better quality, fewer health care associated infections, better patient experience, more access, lower costs. Safety may survive as the first priority, but it cannot thrive as the only priority.

This session will explore what is known—and what is new—in sustaining safety cultures and using High Reliability principles, which support those safety cultures, to advance our causes of compassionate, connected care that is safe (zero harm) and effective (100% appropriate care).

Craig Clapper
PE, CMO/OE, Partner,
Press Ganey Strategic Consulting

KEYNOTE
Tuesday 3:30 - 4:30 p.m.

Trusted Care: Building a High Reliability Organization

The Air Force Surgeon General describes the Air Force Medical Service as an organization that delivers trusted care, anywhere by continuously learning and improving with a single-minded focus on safety and Zero Harm. According to the Air Force Surgeon General, the path to the Trusted Care, Anywhere methodology requires the consistent and long-term engagement of senior leadership. In this session, Brig. Gen. (Dr.) Robert I. Miller, Commander of the Air Force Medical Operations Agency, will share the organization’s proven approach to reaching its goal of Trusted Care, Anywhere. The session will draw on specific Air Force mission challenges and operating environments to illustrate the range and scope of medical requirements that must be met in parallel with the delivery of safe, highly reliable care.

Brigadier General
Robert I. Miller
Commander, Air Force Medical Operations Agency, Joint Base San Antonio-Lackland, Texas

KEYNOTE
Wednesday 10:30 - 11:30 a.m.
To assist you as you make your selections, a focus area is included in each session description. This descriptor identifies the core focus of that particular session.

Focus Areas

- **Setting Behavior Expectations for Error Prevention**
  In this focus area, sessions will present leading practices for cultivating safety behaviors and expectations that prevent human error and align accountability systems to ensure compliance.

- **Enhancing High Reliability Leadership Strategies**
  Leadership is essential to instituting safety culture transformation. Sessions in this track explore evidence-based leadership techniques that can help health care organizations reduce practice variation and improve reliability in achieving performance expectations.

- **Establishing Safety and Reliability Governance**
  Successfully implementing safety culture transformation across your organization requires a solid foundation and program framework. In these sessions, speakers will review effective structures for safety and reliability oversight and management that can help you in the journey to High Reliability.

- **Improving Cause Analysis Methods**
  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.

- **Sustaining and Spreading Safety**
  Once your organization has started down the path to High Reliability, the work has just begun. In this track, speakers will explore practical applications for maintaining a focus on safety while developing reliability as the chassis for other organizational improvements.

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

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**Many Thanks to Our Sponsors**

- Cancer Treatment Centers of America
- Advocate Health Care

*Winning the fight against cancer, every day.*
# AGENDA

## MONDAY

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<tr>
<td>HPI Reliability Institute</td>
<td>1:00 - 2:15 p.m.</td>
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<tr>
<td>Break</td>
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<tr>
<td>HPI Reliability Institute</td>
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<td>Break</td>
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<tr>
<td>HPI Reliability Institute</td>
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<td>Safety Summit Orientation</td>
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<td>Welcome Reception &amp; Safety Share</td>
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<td>- The Road to High Reliability: Engaging Physician Safety Champions</td>
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<td>- A New Horizon: Partnering with Patients and Families</td>
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<td>- Closing the Loop: Implementing a Fourth Meeting in the RCA Process to Share Lessons Learned</td>
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<td>- Safety Culture Transformation in Post-Acute: Thinking Outside the Acute Box</td>
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<td>- Implementing In Situ Simulation to Support Safe and Reliable Outcomes</td>
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<tr>
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<td>Breakout Session Two</td>
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<td>- Deploying a Sepsis Search and Rescue Program across an Integrated Health Care System</td>
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<td>- An Early Adoption Success Story: The Merging of a Patient and Employee Safety Coach Program</td>
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<td>- Improving Vaccine Safety through Standardization in the Ambulatory Setting</td>
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<td>- Reenergizing a Safety Coach Program: “Simming Your Program Up to the Next Level”</td>
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<td>- Leading to Zero: Success from the Front Line</td>
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<td>Safety Cinema Luncheon</td>
<td>12:15 - 1:45 p.m.</td>
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<tr>
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<td>- Leadership Methods and Error Prevention Tools Drive Reduction in Patient Falls</td>
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<td>- Rowing in Sync to Move a Very Large Ship: Lessons Learned Operationalizing a Large, Complex Health System toward Caring Reliably</td>
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<td>- The Next Frontier for Reliability</td>
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<td>- Create a Safe Night: Advancing Preoccupation with Failure on Night Shift</td>
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<td>- High Reliability in a Health System: Essential, but Not Sufficient</td>
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### Focus Area Legend:
- Setting Behavior Expectations for Error Prevention
- Enhancing High Reliability Leadership Strategies
- Establishing Safety and Reliability Governance
- Improving Cause Analysis Methods
- Sustaining and Spreading Safety
- Executive Track
AGENDA

TUESDAY cont’d

- Integrating High Reliability into a Planetree Model of Care
  Break............................................................. 3:15 - 3:30 p.m.
- Keynote .................................................................... 3:30 - 4:30 p.m.
  Reception—A Taste of Chicago, Featuring Safety
  Cinema Award Ceremony .................................... 5:30 - 7:00 p.m.

WEDNESDAY

Breakfast ........................................................... 7:00 - 8:00 a.m.

Breakout Session Four ............................... 8:00 - 9:00 a.m.
- From the Ground Up: Building a Patient Safety Structure in a
  Large Medical Group
- Improving Patient Safety Event Reporting through a Rate-
  Based Comparison of Performance within a Health System
- Quality and Safety Scorecard for Outpatient Imaging:
  Development Implementation, Results
- Changing and Maintaining a Culture of Safety
- Obstetric Vital Sign Alert: Development of a Real-Time
  Surveillance Model for Improved Maternal Outcomes in Acute
  Care Obstetrics Units
- Patient Safety Liaisons: An Innovative Approach to Patient
  Safety
  Break................................................................. 9:00 - 9:15 a.m.

Breakout Session Five ............................... 9:15 - 10:15 a.m.
- Using Focus and Simplify to Make It Easy for Staff to Do the
  Right Thing
- Overwhelmed by Managing Your Safety Event Review
  Process? Abacus Is the Answer
- We ARE Safe: If We Knew Then What We Know Now
- Measuring Behavioral Expectations: Minding the
  Gap to Zero Harm
- Care Redesign Helps Reduce Readmissions
- It Takes a Village—and Then Another 168 More
  Break................................................................. 10:15 - 10:30 a.m.

Closing Keynote: Zero Harm: Keeping the Faith
  and Advancing the Cause .................................... 10:30 - 11:30 a.m.

Closing Statements ........................................ 11:30 - Noon

“Many actionable ideas and tools are presented.”

“The Summit is more valuable than any other event I attend.”

“I appreciate the extensive networking opportunities.”

- Summit Attendees
To facilitate in-depth learning, networking and best-practice sharing, we offer optional six HPI Reliability Institute courses Monday afternoon that enable attendees to explore topics and issues specific to culture, physician engagement, workforce safety, sustaining reliability program outcomes, and patient and family integration. Additional speakers may be invited to supplement session content.

**Aligning Lean and HRO as a Single Chassis for Performance Culture**

*Tamra Strong Senior Manager, Press Ganey Strategic Consulting*

*Charles Hagood, MBA, Partner, Press Ganey Strategic Consulting*

*Bill Dunwoody, Lean Facilitator, Kadlec Regional Medical Center*

*Lynn Valz, Director, Lean Six Sigma Ops; Cancer Treatment Centers of America*

*Michael Wulf, Lean Manager, Genesis Health System*

Today’s health care organizations focus their attention and resources on the topics of safety culture, Lean principles, patient experience and operational excellence in an effort to transform their performance culture. Initiatives are often launched as independent interventions in reaction to a specific demand and are deployed within the same change space, leading to a competition for time, attention and resources.

Deploying independent interventions has negative consequences, including increased system complexity, waste and change fatigue, until ultimately the human desire to persevere is extinguished. Furthermore, synergies among initiatives are often overlooked.

In this session, speakers will decode common causes of transformation failures. In addition, they will describe how you can take systematic approaches to High Reliability as the chassis for operational excellence, and employ “strategic integrated thinking” as a method to align leading practices and similarities across initiatives, thereby reenergizing your transformation efforts.

**Engaging Physicians in Safety, Quality and High Reliability**

*Chris Hubble, MD, Consultant, Press Ganey Strategic Consulting*

*Julie Hickethier, RN, MAS, FACHE, Consultant, Press Ganey Strategic Consulting*

*Don Kennerly, MD, PhD, Specialist Consultant, Press Ganey Strategic Consulting*

*Jim Ketterhagen, MD, Consultant, Press Ganey Strategic Consulting*

Engaging physicians in safety, quality and High Reliability has always been a challenge in culture transformation. New, value-based reimbursement models for physicians and hospitals require reliably delivering safe, high-quality outcomes in an efficient manner.

In addition to reviewing physician engagement best practices, speakers will discuss a case study of successful engagement. Specific topics to be covered include the following:

- Engaging physicians in culture transformation training programs
- Engaging physicians as champions in culture transformation
- Quality improvement using local learning systems
- Lower-fidelity simulation for teamwork knowledge, skills and attitudes
- In situ simulation as the Triple Play
- Learning systems in peer review

**The Evolution of Patient Experience: Integrating Safety, Patient Experience and Employee Engagement**

*Stacie Pallotta, MPH Senior Manager, Press Ganey Strategic Consulting*

*Lynn Pierce, BSN, RN, Specialist Consultant, Press Ganey Strategic Consulting*

As health care organizations have continued to mature in the patient experience space, they have become increasingly interested in aligning and even integrating efforts that improve safety, patient experience and employee engagement. In this session, we will evaluate the relationships among these elements, review case study examples of successful and sustainable integration efforts and explore the overall value of an aligned organizational strategy.
First, Continue to Do No Harm: Sustaining the High Reliability Journey
Greg Prentiss, CAPT, USN Ret., MS, Consultant, Press Ganey Strategic Consulting
Laura Goldhahn, BA, MBA, FACHE, Consultant and Executive Coach, Press Ganey Strategic Consulting

All health care leaders face the challenge of losing the gains they have achieved in patient safety and reliability. Even when there is a positive trend in safety performance there will be a plateau in harm reduction (SSER, event reporting rates, etc.).

This session is for leaders who have been on the High Reliability journey for some time and are now facing challenges in sustaining their gains and continuing their progress toward the goal of Zero Harm. Topics include:
- A review of common factors that contribute to losing momentum/achieving gains in reliability and patient safety
- Strategies for reinvigorating leadership methods to enhance organizational engagement
- Methods for self-assessing the implementation and integration of leadership methods and nontechnical skills to detect drift and continuously drive High Reliability

Incorporating the Patient Voice and Principles of High Reliability across the Care Continuum
Donna Cheek, RN, BSN, MSN, MHA, Consultant, Press Ganey Strategic Consulting
Gordon Smith, CAPT, USN Ret., BA/BS, Consultant, Press Ganey Strategic Consulting
Karen Smith, Patient Advocate

Health care organizations have traditionally focused on delivering complex patient care in the acute care setting. However, patients receive health care services in all types of care settings.

Over the past decade, health care organizations have begun to incorporate principles of High Reliability into their strategic and operational practices across all services. This session will explore how incorporating the untapped power of the patient/family as a central part of the collegial/collaborative care team to build, manage and sustain High Reliability team-based principles can substantially enhance positive outcomes across the continuum of care.

Safer Workforce Equals Safer Care
Steve Kreiser, Director, Press Ganey Strategic Consulting

In health care, worker injury costs are often three times as high as malpractice claims. And according to OSHA, the health care industry has one of the highest rates of work-related injuries and illnesses. Despite this, many organizations struggle with applying safety/reliability tools and techniques toward improving worker safety.

This session will explore leading practices for incorporating worker safety into your safety and reliability culture transformation, and will show you how several health care systems are using worker safety as a producer of staff engagement, patient safety and a greater patient experience.

HPI Office Hours: The Doctor Is In
Judith Ewald, Senior Manager, Press Ganey Strategic Consulting
Shannon Sayles, Senior Manager, Press Ganey Strategic Consulting
Cheri Throop, Senior Manager, Press Ganey Strategic Consulting
Dave Varnes, Senior Manager, Press Ganey Strategic Consulting

Do you have questions about or challenges with the safety and reliability transformation at your organization? For example, are you struggling with leader or physician engagement? Do you need coaching on performing root cause analyses? Do you have a question about safety event classification?

During this informal session, you can connect with HPI consultants for one-on-one or small-group consultations on these topics, and more.
9:45 - 10:45 a.m.

The Road to High Reliability: Engaging Physician Safety Champions

Lori Beckwith, RN, Senior RN Safety Consultant, Advocate Health Care
Leo Kelly, MD, Vice President, Medical Management, Advocate Health Care

Focus Area: Establishing Safety and Reliability Governance

Advocate Health Care embarked on a journey to High Reliability with the goal of eliminating by 2020 patient safety events resulting in serious harm. On this journey to High Reliability, it was imperative that we have the support and leadership of our physicians. To that end, Advocate launched the Physician Safety Champion Program. To date, we have recruited 188 Physician Safety Champions and provided them with education and training on the science of High Reliability through the use of safety behaviors and error prevention tools. In this session, we will share details of our program, including goals, physician champion roles, training, oversight, program design and benefits to our Physician Safety Champions.

A New Horizon: Partnering with Patients and Families

Marcia Baker, RN, BSN, MSN, DHA, CPPS, Director of Patient Safety, Novant Health
Sandy Cox, RN, BSN, CIC, Director of Patient Safety, Novant Health

Focus Area: Enhancing High Reliability Leadership Strategies

Novant Health’s ultimate goal for Patient Family Engagement (PFE) is to create partnerships between the health care team and patients and their families that lead to best outcomes, enhanced quality and safety. This presentation will highlight the importance of working with patients and their families as partners to create a safe, warm, welcoming environment in which patients and families feel supported to speak freely and participate in their care. In addition, the presentation will include an eight-step process that outlines how to build a viable PFE team within your health care facility as well as offer examples around activities and projects that support PFE.

Closing the Loop: Implementing a Fourth Meeting in the RCA Process to Share Lessons Learned

Nicole Justus, RN, Safety Coordinator, ProMedica Health System

Focus Area: Improving Cause Analysis Methods

After utilizing the three-meeting RCA model for several years, we found we needed to do more to inform our staff of the outcomes of our investigations and share lessons learned. With the collaboration of quality, safety, risk and legal, and by using known best practices from the industry, we added a fourth meeting to the RCA model. The fourth meeting not only encompasses a description of the event and sharing of lessons learned, but also includes a discussion of the action plan put in place and, most important, solicits input and feedback from those in attendance. Join us for a description of how we trialed and refined this concept at the largest of our hospitals, with the intent and ability to roll it out at each facility in our 12-hospital system.

Leadership Proficiency in Reliability

Susan Landahl, Senior Vice-President, Exelon Generation
Kerry Johnson, Partner, Press Ganey Strategic Consulting

Focus Area: Executive Track

What makes a leader proficient in reliability? In this session, you will learn how the practices used by High Reliability organizations in the high-risk industries of nuclear engineering and health physics can be applied in health care.
Safety Culture Transformation in Post-Acute: Thinking Outside the Acute Box
Sonja Beute, Director, Compliance, Risk and Safety, SHCC, Spectrum Health
Deb Cress, MSN, RN, NE-BC, Chief Nursing Officer, SHCC, Spectrum Health

Focus Area: Setting Behavior Expectations for Error Prevention

Spectrum Health Continuing Care (SHCC) encompasses visiting nurses, hospice and palliative care, neuro home and community, rehab and nursing, home and community therapy, inpatient and outpatient therapy, neuro residential and LTACH. More than 600 of the organization’s 1,800 staff members care for patients in their homes. This presentation will share how we structured foundational elements such as daily check-in, training, change management and safety coach utilization within the first 18 months of our safety transformation journey.

Implementing In Situ Simulation to Support Safe and Reliable Outcomes
Susan Teman, BSN, RN, CPPS, Senior Improvement Specialist, Simulation, Helen DeVos Children’s Hospital

Focus Area: Sustaining and Spreading Safety

Traditionally, health care simulation has been an academic exercise designed for competency and task training. Large simulation labs and expensive, high-fidelity simulators seem out of reach to many organizations. Simulation as part of a High Reliability organization goes beyond the lab. Moving simulation out to units and departments provides an opportunity for improving teamwork and communication among staff and physicians. Teams can then identify the human and environmental factors that affect patient care. This presentation will show how any organization can implement in situ simulation and will provide the tools and framework to do so.

11:00 a.m. - Noon

Deploying a Sepsis Search and Rescue Program across an Integrated Health Care System
Debra O’Connor, DO, Vice President, Clinical Effectiveness, Advocate Health Care

Focus Area: Enhancing High Reliability Leadership Strategies

With a mortality rate that can exceed cancer and heart disease, sepsis is an emerging challenge to health care organizations across the country. A key element in the lethality of this condition is its occult nature: The best chance to rescue the patient exists when the syndrome is least visible.

In 2015, Advocate Health Care decided that a concerted, focused, system-based effort to search for these patients and rescue them from sepsis would be a key organizational focus. This presentation outlines the reason for action, the core strategies employed and the challenges presented in empowering first responders to detect the condition and begin rescuing the patient across a 10-hospital system.

Leading to Zero: Success from the Front Line (Panel)
Gary Yates, MD, Partner, Press Ganey Strategic Consulting
Jennifer Nolan, President, Our Lady of Peace and Sts. Mary & Elizabeth Hospitals, KentuckyOne Health
Scott Jones, FACHE, MHA, President and CEO, Cancer Treatment Centers of America at Midwestern Regional Medical Center
Doug Cropper, President and Chief Executive Officer, Genesis Health System

Focus Area: Executive Track

During this panel discussion, exemplary health care leaders will share best practices for achieving Zero Harm, including putting a face on safety; holding executives and front-line leaders accountable; managing multiple priorities while maintaining the relentless drumbeat for safety; and sustaining focus on the goal of Zero Harm over time. Additional panel members will be announced soon.
An Early Adoption Success Story: The Merging of a Patient and Employee Safety Coach Program

Donna Donovan, RN, MSN, Director of Patient Safety and Simulation, Connecticut Children’s Medical Center
Michael Tortora, MSOSH, Director of Safety and Security, Connecticut Children’s Medical Center

Focus Area: Safety and Reliability Governance

In 2012, Connecticut Children’s Medical Center joined 13 other hospitals in Connecticut in a statewide collaborative to implement the principles and practice of High Reliability. As a part of this effort, we implemented the role of the safety coach. After training all of our staff and leadership on High Reliability concepts and behaviors, we experienced a steady decline in our serious safety event rate. We began to see an increase in our serious safety event rate in 2014, and we recognized there was a corresponding increase in our employee safety events (specifically, needle sticks).

In response, we merged our Employee Safety and Safety Coach committees. With our High Reliability efforts well under way, it then became evident that these concepts could be applied to both patient and employee safety, so we extended the work of our Safety Coach program to our well-established Employee Safety program.

In this session, we will discuss how joining the Patient and Employee Safety committees has increased the engagement and effectiveness of the safety coaches in both domains, and how applying a standard set of behaviors and tools to both employee and patient safety aligns perfectly with the concept of High Reliability.

Change Is Good?

Andrea Locklear, BSN, RN, Quality Nurse Specialist, Vidant Health
Susan Ingram, MSN, RN, CPHQ, Director, Patient Safety, Vidant Health

Focus Area: Improving Cause Analysis Methods

In 2015, Vidant Health Corporate (Risk, Quality, Accreditation and Peer Review), with new leadership at the helm, was challenged to reassess our standard process for event management. The goal was to reduce process time between the occurrence of a patient event to the deployment of resources, event assessment, formal analysis, patient/staff support and, finally, implementation of new system actions. We developed a new Patient Event Triage Process that triggers a notification within 24 hours of a patient event. We found that earlier notification of Corporate Quality, Entity Quality and Operations allows for parallel investigation and entity support for patients and staff. In this session, we will provide an overview of our Patient Event Triage Process, the improvement methods we used and the lessons we continue to learn in our patient safety work.

Improving Vaccine Safety through Standardization in the Ambulatory Setting

Aaron West, Director, Patient Safety, Novant Health Medical Group

Focus Area: Setting Behavior Expectations for Error Prevention

Novant Health Medical Group is working to reduce variation and improve safety and reliability in the administration of vaccines for pediatric, adolescent and adult patients. In this session, we will discuss the strategic initiatives we are using to achieve this reliability, which include value stream mapping for standard workflow, systemwide adoption of vaccination schedules, investigation into the use of bar code scanning and the formation of a vaccine advisory council to guide, validate and spread this work.
Reenergizing a Safety Coach Program: “Simming Your Program Up to the Next Level”
Kristina Kehlenbach, MPT, BS, Quality and Patient Safety Coordinator, Middlesex Hospital

Focus Area: Sustaining and Spreading Safety

One of the major drivers behind the sustainability of our High Reliability culture is our robust safety coach program. One year after we initiated the program, we reevaluated it and discovered that our team was not achieving the level of growth in safety science knowledge or active coaching skills that we had anticipated they would. So we partnered with our safety coaches to develop a new learning approach that incorporates a data-driven simulation lab experience, complete with case scenarios and objectives based on data and actual events. Use of this simulation lab has resulted in improved real-time coaching skills. In this presentation, we will explain how to use simulation techniques to improve safety coach effectiveness.

2:15 - 3:15 p.m.

Leadership Methods and Error Prevention Tools Drive Reduction in Patient Falls
Terrie Van Buren, RN, MBA, CPPS, Patient Safety Officer, Community Health Systems, PSO LLC.

Focus Area: Enhancing High Reliability Leadership Strategies

Learn how a Patient Safety Organization analyzed common causes of patient falls and aligned leadership methods and error prevention tools to prevent falls and falls with serious injuries.

Rowing in Sync to Move a Very Large Ship: Lessons Learned Operationalizing a Large, Complex Health System toward Caring Reliably
Marly J. Christenson, PhD, MS, RN, FNP, CPHQ, System Director, Patient Safety, Providence Health & Services
Glenda Battey, PhD, Senior Project Manager, Clinical Quality and Patient Safety, Providence Health & Services

Focus Area: Establishing Safety and Reliability Governance

In August 2014, Providence Health & Services (PHS) embarked on Caring Reliably, its journey to High Reliability, with a fundamental intent to engage all care settings and all areas of operation in achieving excellence by providing the right care to the right person in the right way, every time and in every place. At that time, PHS covered five western states comprising eight regions, and included 34 hospitals, 600 physician clinics, 19 hospice and home health programs, 22 long-term care facilities and 14 supportive housing facilities, totaling 82,269 employees and approximately 15,000 independent providers.

Through the commitment of system-level executives, regional chief executives, chief medical officers, chief nursing officers and designated High Reliability leads, this very large vessel continues to move in sync. In this session, we will share our plan and discuss how it has evolved over time as a result of the lessons we have learned along the way. We also will discuss adaptive strategies for moving big ships (and small boats) toward the mission of Caring Reliably.

The Next Frontier for Reliability
Craig Clapper, PE, CMQ/OE, Partner, Press Ganey Strategic Consulting

Focus Area: Executive Track

The foundation for safety and reliability is good design and behavioral accountability. In this session, you will learn strategies for taking your organization to the next level in your journey toward Zero Harm.
Create a Safe Night: Advancing Preoccupation with Failure on Night Shift
Maureen Frye, MSN, CRNP, Director, Center for Patient Safety and Healthcare Quality, Abington Jefferson Health
Doron Schneider, MD, FACP, Chief Patient Safety and Quality Officer, Abington Jefferson Health

**Focus Area: Sustaining and Spreading Safety**

In this session, we will discuss Create a Safe Night, a novel approach to High Reliability and situational awareness for patients who may be the most fragile from the perspectives of the caregiving team. Through sharing their “watcher” patients, staff developed enhanced critical thinking and can detect and avoid biases and diagnostic errors through teamwork and communication.

High Reliability in a Health System: Essential, but Not Sufficient
John Greene, MD, HHC Regional Vice President, Medical Affairs, Hartford HealthCare
Pepper Sobieski, RN, BSN, CPHQ, Vice President Quality and Safety, Hartford HealthCare

**Focus Area: Sustaining and Spreading Safety**

Hartford HealthCare, a health system comprising five hospitals and annual revenue of $2.5 billion, sought to transform care by defining safety as the most important of its four values. This initiative resulted in H3W—How Hartford HealthCare Works, a three-stage, organization-wide approach to continuous improvement. Launched in 2009, H3W includes such principles as staff involvement, transparent communications and systemwide development of leadership behaviors by all staff in an effort to promote authentic, humanistic behaviors and clear accountability for results. In Stage Two, we introduced High Reliability with assistance from HPI, using our H3W language and cultural expectations to accelerate the process. As a result, we have observed a 57% reduction in the occurrence of serious safety events over a two-year period.

In this session, we will provide details on the H3W approach, the benefits we have achieved thus far and our goals for the future.

Integrating High Reliability into a Planetree Model of Care
Kathleen Martin, RN, BS, CCM, CPC-H, Vice President, Patient Safety and Care Improvement, Griffin Hospital
Kenneth Dobuler, MD, Chairperson of Medicine, Griffin Hospital

**Focus Area: Sustaining and Spreading Safety**

As a Planetree hospital, Griffin is committed to engaging patients and families as partners in their health care by providing access to information and education. Every employee is considered a caregiver. In 2014, a review of two years’ worth of data revealed that our hospital had a baseline serious safety event rate of 2.32 per 10,000 adjusted patient days. This was unacceptable for a patient-centered model of care.

That same year, we endorsed the Connecticut Hospital Association and HPI’s High Reliability Program and held a Management Conference to set the expectation that we would create a common safety language and hold all staff, including executive, medical and front-line staff, accountable to wrapping safety around our patient-centered culture. In less than two years, we saw an 88% decrease in serious safety events (to a 0.27 SSER).

We attribute this success to five safety habits that incorporate 10 error prevention tools. In this session, we will discuss how consistent use of these safety habits over time enabled us to achieve our goals.
8:00 - 9:00 a.m.

From the Ground Up: Building a Patient Safety Structure in a Large Medical Group
Julie Wright, RN, Quality and Risk Management Director, Intermountain Medical Group
Jeanne Nelson, MSNEd, RN, Clinical Operations, Intermountain Medical Group

Focus Area: Enhancing High Reliability Leadership Strategies

Implementing High Reliability principles can be challenging in the outpatient clinic setting. We will share how Intermountain Healthcare identified and addressed the unique needs of the Intermountain Medical Group during implementation and rollout of the Continuous Improvement Zero Harm initiative, and how Medical Group leadership built a Patient Safety Structure to support High Reliability principles across all 185 clinics.

Improving Patient Safety Event Reporting through a Rate-Based Comparison of Performance within a Health System
Kate Kovich, MS, OTL, CPPS, Vice President, Patient Safety, Advocate Health Care
Jennifer Carpenter, RHIA, CPPS, Senior Patient Safety Consultant, Advocate Health Care

Focus Area: Enhancing High Reliability Leadership Strategies

We all are well aware that event reporting from the sharp end is a key foundational element to a High Reliability Organization, but do you know how your organization compares on volume of event reports? Advocate created a patient safety event reporting rate in order to compare event reporting among its hospitals and medical groups, enabling us to identify targeted opportunities to improve. In this session, we will explain how we use this metric as a key result area for leader accountability throughout our organization.

Quality and Safety Scorecard for Outpatient Imaging: Development, Implementation, Results
Sophia Brothers Peterman, MD, MPH, Chief Medical Officer, Novant Health/MedQuest Associates

Focus Area: Establishing Safety and Reliability Governance

MedQuest Associates, a multicenter, multistate outpatient imaging company, developed seven quality and safety metrics to be included in its overall scorecard in 2010. In 2015, MedQuest Associates added four metrics. The metrics were designed to evaluate the quality or safety of an imaging process or outcome. The company utilized available variables, which were measurable via computerized data inquiry. Three of the metrics followed CMS Hospital Outpatient Quality Reporting Imaging Efficiency measures.

With its scorecard, MedQuest Associates elevated the quality and safety of outpatient imaging processes and outcomes to a higher, ongoing standard. In addition, attention to the CMS Imaging Efficiency measures helped impact the CT ordering behavior of the referral community to reduce patient radiation exposure. During this presentation, we will discuss the definition, relevance and interventions for each metric in the scorecard.
Changing and Maintaining a Culture of Safety
Jennifer Nolan, Licensed Professional Counselor, Licensed Marriage and Family Therapist, President, Our Lady of Peace and Sts. Mary & Elizabeth Hospitals, KentuckyOne Health
Sherri Boggs, RN, BC, Quality, Risk & Safety Manager, KentuckyOne Health–Our Lady of Peace/Sts. Mary & Elizabeth

Focus Area: Sustaining and Spreading Safety

In this session, we will discuss our journey to High Reliability and how we achieved dramatic improvements in safety, quality of care, staff engagement and morale over a six-year span. In addition to outlining the steps we took on a daily basis to maintain and sustain a culture of safety, we will demonstrate how celebrating safety successes/wins and telling safety stories instills the importance of this safety work in our teams. We also will discuss how we recruit, maintain and recognize our safety coaches—one of the key drivers of our Safety First initiative.

Obstetric Vital Sign Alert: Development of a Real-Time Surveillance Model for Improved Maternal Outcomes in Acute Care Obstetrics Units
Diana Behling, DNP, RN, MJ, CPPS, Ob Right Program Manager, Sentara Healthcare

Focus Area: Sustaining and Spreading Safety

Preventable maternal morbidity and mortality is a national health problem. Causal analysis of near-miss and actual serious patient safety events, including those resulting in maternal death, within obstetrics units often highlights a failure to promptly recognize and treat women who were exhibiting signs of decompensation/deterioration. The Obstetric Vital Sign Alert is an innovative early-warning tool that leverages discreet data points in the electronic health record, calculating a risk score that is displayed as a visual cue for acute care obstetrics staff. In this session, we will discuss how this tool supported improved outcomes in the postpartum hemorrhage cohort by reducing symptom to response and intervention time, as well as improving key process and outcome measures.

Patient Safety Liaisons: An Innovative Approach to Patient Safety
Chele Wells, BA, RN, BSN, Patient Safety Liaison Coordinator, Northwestern Medicine Delnor Hospital
Linda Ptack, RN, CCRN, Patient Safety Liaison Coordinator, Northwestern Medicine Delnor Hospital

Focus Area: Sustaining and Spreading Safety

Front-line staff members understand process gaps, errors and near misses that interfere with patient care. Safety professionals understand how disruptive patient-care issues impact safety. Quality professionals know how to improve processes. Managers know some or most of this, but have limited time for project work. One nurse’s quest to reduce central line-associated bloodstream infection (CLABSI) in the intensive care unit (ICU) led to the creation of a safety role to decrease the aforementioned role gaps. The Patient Safety Liaison (PSL) program was formed as an innovative approach to patient safety within the organization. PSLs have protected time to work on process improvement; standardizing and simplifying processes, identifying opportunities for the provision of safer care, ensuring protected, robust reporting of safety concerns and providing front-line safety science expertise to patient care improvement teams throughout the hospital and health care system. PSLs—different from safety coaches—have a unique role in the journey to becoming a High Reliability Organization while aiming for zero harm.
9:15 - 10:15 a.m.

Using Focus and Simplify to Make It Easy for Staff to Do the Right Thing

Kathy McCoy, RN-BC, BSN, Director, Patient Safety and Performance Excellence, Sentara Healthcare
Sarah Darwin, RN, MSN, Director, Patient Safety and Performance Excellence, Sentara Healthcare

Focus Area: Enhancing High Reliability Leadership Strategies

Through our commitment to High Reliability, Sentara adopted Focus and Simplify methodology to transform our work processes and written guidance to achieve improved outcomes. More than 10 years later, we continue to utilize this methodology as work processes are developed or revised. In this session, we will discuss how we achieved a significant reduction in policies and procedures through the use of Focus and Simplify methodology.

Overwhelmed by Managing Your Safety Event Review Process?
Abacus Is the Answer

Mary Saccoccio, RN, BSN, Senior Manager of Clinical Quality & Patient Safety Measurement, Connecticut Children’s Medical Center
Donna Donovan, RN, MSN, Director of Patient Safety & Simulation, Connecticut Children’s Medical Center

Focus Area: Establishing Safety and Reliability Governance

Overwhelmed by managing your safety events? In this session, Connecticut Children’s Medical Center will discuss Abacus, our electronic Safety Event Management System, and how we used it to simplify management and review of more than 5,000 potential safety events annually. In addition to explaining how you can use its multiple components to adjudicate events, track needed follow-up from committee members and document rationale for classifying your decision making, we also will discuss how to route similar events to allow for easy analysis and trending.

Measuring Behavioral Expectations: Minding the Gap to Zero Harm

Ryan Leininger, CPHQ, PMP, CSSBB, Program Manager, Patient Safety, Seattle Children’s
Jacqueline Valentine, RPh, MPA, Director, Patient Safety, Seattle Children’s

Focus Area: Sustaining and Spreading Safety

Health care organizations build a culture of High Reliability and safety by embedding error prevention tools and behaviors into everyday practice habits. Leadership methods are used to mind the gap between expectations and actual behaviors, but how do we measure progress along this continuum? In this session, we will illustrate how Seattle Children’s supplemented its safety culture implementation by incorporating a measurement system to increase accountability in using its error prevention tools. We will also show how we used the data we collected to drive improvements and close the gap to zero harm.
We ARE Safe: If We Knew Then What We Know Now

Lana Poirier, MS, Director, Quality and Patient Safety, Cancer Treatment Centers of America at Midwestern Regional Medical Center

Katie Foley, BS, Quality Risk/Quality Resource Leader, Cancer Treatment Centers of America at Midwestern Regional Medical Center

Focus Area: Setting Behavior Expectations for Error Prevention

Cancer Treatment Centers of America® (CTCA) at Midwestern Regional Medical Center (Midwestern) first made its We ARE Safe patient safety commitment four years ago. Prior to making the We ARE Safe commitment, variance reporting was low, making it difficult to “find and fix” the causes of safety events. This session explores the many steps the hospital took to reach a record number of days since a serious safety event and substantially increase Safety Event Communications (formerly known as variance reporting). The session also covers such topics as the importance of having a communication strategy that includes key messages, the benefit of using communications in a variety of modalities, best practices for introducing and hardwiring safety behaviors through creative educational initiatives, and team-focused sessions.

Care Redesign Helps Reduce Readmissions

Vera De Palo, MD, MBA, Chief Medical Officer, Signature Healthcare

Focus Area: Sustaining and Spreading Safety

Readmission to a hospital within 30 days of a prior hospital stay continues to be a problem in many hospitals and health care systems. Through the years, Signature Healthcare has implemented several strategies to reduce its readmission rate.

In June 2015, we rolled out COPD PATHWAYS, a care redesign program for patients with chronic obstructive pulmonary disease (COPD). After initiating the program and achieving a dramatic decrease (42%) in COPD readmissions, we developed care redesign programs targeting additional chronic diseases. As a result, our overall 30-day readmission rates have decreased from 12.4% to 9.5%, a 23% reduction. In this session, we will discuss these programs and the goals we have achieved thus far.

It Takes a Village—and Then Another 168 More

Mary Reich Cooper, MD, JD, Chief Quality Officer, Connecticut Hospital Association

Focus Area: Sustaining and Spreading Safety

Large collaboratives are difficult to sustain because of multiple competing interests, lack of easily measured change, and strategies that shift to the next national phenomenon. But culture change takes five to seven years to accomplish and requires constant infusions of direction, enthusiasm and sustenance. Join the Connecticut Hospital Association and one of its partner organizations, Lawrence + Memorial Healthcare, to learn about innovative approaches to sustaining culture change.

“Every Safety Summit feels like a reunion.”

- Summit Attendee
Hotel Information

For your convenience, a block of rooms has been reserved at the Swissôtel Chicago. Mention Press Ganey when booking. Space is limited; reserve your room early. 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. Reserve your room online.

Swissôtel Chicago
323 E. Wacker Drive
Chicago, IL 60601
Phone: (312) 565-0565
Toll-Free: (888) 737-9477
Room Rate: $259/night plus taxes
Cutoff Date: Aug. 29, 2016

Registration Information

Registration Rate: $495 per person

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

Space at the Summit is limited, so register soon. We cannot guarantee registrations received within 10 business days of the Summit. Register online at www.pressganey.com/SafetySummitRegister.

Cancellations

Cancellations must be sent in writing to HPISafetySummit@pressganey.com. To receive a full refund, cancellations must be made by Monday, August 29, 2016. 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’t 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.

“Everyone speaks the same language because we are all working in the same way toward the same goal—it’s easy to apply the ideas and concepts we learn when we get back ‘home’”

- Summit Attendee
HPI Safety Cinema Awards

Each year, a select group of client-produced safety videos are presented during our Safety Cinema Luncheon. These videos illustrate various aspects of safety culture transformation and are normally three to five minutes in length. All organizations of the HPI Client Community are invited to submit a video. Winners will be announced Wednesday evening during the Taste of Chicago Reception. Submission details will be announced soon.

Impact Projects

Every year, we create visualizations of safety-related issues and statistics to further demonstrate the importance of patient safety in our industry. Held at critical points during the Summit, these demonstrations will help you envisage safety as it stands today, and how we can evolve the future.

Welcome Reception

Monday, Sept. 19, 5:30–7:00 p.m.

Enjoy light hors d’oeuvres and cool beverages with colleagues and friends, old and new at our welcome reception on day one of the Summit. You’ll expand your learning experience by networking and engaging with presenters featured at our Safety Share tables.

Networking Reception—A Taste of Chicago

Tuesday, Sept. 20, 5:30 –7:00 p.m.

Join us for the Taste of Chicago networking event to connect with fellow safety executives, enjoy great food and find out who takes top honors during the Safety Cinema Awards Ceremony.

Social Media

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

Earn Continuing Education Credits for Attending the Summit

Safety Summit attendees can earn up to 8 hours for attending the general conference. Attendees of the High Reliability Institute can earn an additional 3 hours. Press Ganey is authorized to award pre-approved qualified continuing education credit for this program toward advancement or re-certification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward qualified continuing education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or re-certification.

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Due to potential scheduling conflicts, speaker substitutions may occur.