CHARTIS | CLINICAL QUALITY SOLUTIONS

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Quality, Safety and High Reliability:

Leading the Transformation

SPEAKERS

Andrew Resnick, MD

Andrew Resnick, MD, serves as a Director and the Chief Medical and Quality Officer, leading Clinical Quality, Safety, and High Reliability efforts in a role that spans both Chartis Consulting and Chartis Clinical Quality Solutions. A nationally recognized expert in quality, patient safety, and high reliability, Andrew helps organizations set and reach goals of top performance through both specific projects and transformational change.

Christian Dankers, MD

Christian Dankers, MD, MBA, is an Associate Chief Medical Quality Officer at Chartis Clinical Quality Solutions whose career spans 12 years working as a leader in clinical quality and high reliability care. Dr. Dankers has worked in the areas of medical staff optimization, quality, patient safety, and clinical operations to create an enterprise-wide practice focused on the quality of care for patients across the country.

Jen Beloff, RN, MSN, APN

Jennifer Beloff is a Principal and VP of Quality, Safety, High Reliability for Chartis Consulting and Chartis Clinical Quality Solutions. She brings more than 20 years of healthcare experience to the firm and is a nationally recognized leader in quality, including performance improvement, pay-for performance, measurement/rankings/ratings, and clinical documentation integrity (CDI).

COURSE DESCRIPTION

The essential promise of healthcare – helping people at their most vulnerable – has never been more challenging to deliver. Since the release of To Err is Human and Crossing the Quality Chasm over two decades ago, many organizations have pursued programs to achieve higher levels of performance, reduce harm, and evolve their cultures of safety. While such initiatives help promote quality and safety improvement, they lack a comprehensive, integrated view of whole-hospital care.

Building true reliability that is sustainable over time requires a deliberate, coordinated, organization-wide approach. What is required is not a "program," but a comprehensive operating model. Our approach to high reliability offers a path forward for healthcare organizations who aspire to provide consistently excellent, equitable care, supported by hardwired capabilities to detect and avoid harm.

Achieving high reliability will result in more equitable clinical outcomes and greater patient and employee engagement. And, by extension, it will also improve public rankings and pay for performance program outcomes and produce significantly greater financial return. This course will provide high reliability tactics as well as the operating model's component structures, processes, and supporting functions required to embed reliability in your organization.

LEARNING OBJECTIVES

- Understand the current healthcare climate and challenges healthcare providers face
- Describe the essential characteristics and capabilities of a high reliability organization
- Understand the importance of structure and alignment in an effective quality and safety enterprise
- Define the elements of a comprehensive quality and safety program
- Articulate a high reliability approach to performance management that can be used for medical staff and employees more broadly
- Understand how HRO enables reliable detection of inequitable care and implementation of practical solutions
- Describe the elements of a disclosure and apology program
- Understand the role of peer support programs in patient safety
- Understand the challenges, opportunities, and ROI of new quality and safety technologies
- Articulate the business case for becoming a high reliability organization

AGENDA

See reverse side

Agenda

SUBJECT TO CHANGE

DAY 1: THURSDAY

7:00 - 8:00 AM — **Registration and Breakfast**

8:00 - 9:30 AM — **Bonus Session**

Optional to attend. Thought-provoking context, perspectives, and insights on the most critical issues facing healthcare professionals

10:00 AM - 12:00 PM — **Education Session**

The Healthcare Crisis and Why Change Can't Wait

- The intersection of the pandemic, the great resignation, health inequities, and capacity challenges – The impact of the current healthcare climate on quality and safety – Staff response to the crisis – the problem of burnout
- Why now?

What is a High Reliability Healthcare Organization?

- Defining high reliability – the goal state – High reliability concepts and capabilities – Health equity as a core component of reliability
- The importance of structural alignment – Hardwiring quality and safety processes
- Developing a culture of accountability and safety -Supporting the enterprise with the right resources

Aligning Quality, Safety, and Operations Through an Intentional Structure

- Establishing a unified quality, safety, and operations governance and accountability model from the board to the bedside – Unit-based team structure – Front line dyad/triad model -Integration with leadership, physician enterprise, and nursing
- Domain team structure – aligning best practice with execution – Patient safety/reliability management – integrating risk, safety, and grievances

12:00 - 12:45 PM — **Lunch**

12:45 - 3:00 PM — **Education Sessions (continued)**

3:00 PM — **Adjourn**

DAY 2: FRIDAY

7:00 - 8:00 AM — **Breakfast**

8:00 AM - 12:30 PM — **Education Session**

Developing a Comprehensive Approach to Quality

- Adoption of best practices for domains: mortality, readmissions, LOS, patient experience, HAIs, and other HACs – Clinical pathways for reduced variation, improved quality, and cost – Building best practice programs – palliative care/ hospice - Creating effective stewardship programs

Developing a Comprehensive Approach to Patient Safety

- Best practices for detecting harm and potential harm – The modern HRO investigative algorithm – integration with peer review, credentialing, compliance, and HR – Managing organizational vulnerabilities – classifying and tracking
- Building the bridge between safety and risk – Integrating clinical compliance into a quality, safety, and reliability program

Managing Measures – Reimbursement, Ratings, and Rankings

- The lay of the land – CMS programs, U.S. News & World Report, Leapfrog, P4P contracts, databases, and registries Understanding and modeling external programs -Clinical documentation improvement for quality -Utilizing measurement programs to prioritize and set organizational goals

Ambulatory Quality and Safety

- Chronic disease management and prevention – measure landscape -Ambulatory safety – hidden risks -Missed and delayed diagnosis – safety net programs, closed loop referral management

12:30 -1:30 PM — **Lunch**

DAY 3: SATURDAY

7:00 -8:00 AM | **Breakfast**

8:00 AM - 12:00 PM | **Education Session**

High Reliability People Management – HR and the Medical Staff Office

- Performance and behavior-based evaluation and improvement pathways – The role of HR in a high reliability organization – Credentialing and privileging as the first step in physician performance management – Using OPPE/FPPE and peer review to manage and improve physician performance

Health Equity – an Essential Part of Quality and Safety Improvement

- Health equity as a quality and safety issue and opportunity
- Building equity into quality measurement – Identifying equity issues in risk and harm evaluation

Doing the Right Thing – Disclosure and Apology with Peer Support Programs

- The many victims of a patient harm – The case for disclosure and apology – aligning safety, risk, and legal – Developing a disclosure and apology program – essential capabilities – Peer support – caring for our caregivers

Advanced Technology for Improving Quality and Safety

- Inpatient applications – the virtual ICU and early warning systems -Telehealth – new issues in quality and safety – Monitor and alarm management – safe application of technology
- ROI – making the case for technology investment

Creating an Action Plan – Making the Case for Investing in High Reliability

- Mapping the path to high reliability for your organization – what are the priorities and what is the return on investment – Better care for patients – quantifying quality and safety improvements – Direct and indirect cost reduction – Pay for performance improvement – Coding for quality and reimbursement -Employee impact – safety culture, engagement, and decreasing turnover – Ranking and reputation

12:00 PM | **Adjourn**