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Executive Summary

The Hospital Quality Institute (HQI) was established in April 2013 to realize statewide impact of improving patient safety and quality care for all Californians, to accelerate the rate of improvement, and to advance California as a national leader in quality performance.

HQI was founded as a 501(c)(3) organization through a collaboration of the California Hospital Association (CHA), Hospital Council of Northern and Central California, Hospital Association of Southern California (HASC) and Hospital Association of San Diego & Imperial Counties (HASD&IC). HQI is led by a 14-member Board of Directors including CEO.

HQI is structured to:

- Develop a statewide culture of improvement that inspires, engages and achieves results.
- Simplify and harmonize activities and initiatives and set priorities for statewide impact.
- Capture economies of scale for statewide and local initiatives.
- Reduce the burden of reporting and compliance on hospitals.
- Honor and build on successful work-in-progress and take best practices to scale.
- Tell the story of quality and patient safety in California.

Quality principles provide the foundation for improving safety and quality of care for patients and families as well as improving the workforce experience. The full Blueprint describes these principles with an emphasis on leadership.
EXECUTIVE SUMMARY

HQI’s core programs include:

**California Hospital Patient Safety Organization:**
Analyze reports of harm, near misses and system vulnerabilities. Communicate lessons learned, and identify leverage points for change and safer care. Provide interprofessional and experiential education in safety systems and practices. Provide peer review protection of work products.

**California Hospital Engagement Network:**
Decrease readmissions by 20 percent and health care-associated conditions (HACs) by 40 percent through targeted interventions, benchmarking and spreading best practices, with ongoing new targets to set the theoretical limits of what is possible (zero defect or 100 percent compliance).

**Patient Safety First:**
Collaborative learning model to improve patient safety and spread evidence-based practices to improve care, save lives and reduce health care cost, with initial focus on reducing *C. difficile*, sepsis mortality, early elective deliveries and retained surgical items. This unique program is a partnership among a nonprofit foundation, the National Health Foundation; a health plan, Anthem Blue Cross; and the Hospital Associations — CHA, Hospital Council, HASC and HASD&IC.

**Vehicles of Engagement, Communication and Problem Solving:**
A network of committees and workgroups to provide broad multidirectional communication, alignment and problem solving across hospitals and subject matter experts on focused topics such as health care-associated infections (HAIs) and HACs. The Hospital Quality Committee shares information and learning and gauges the rate of progress in quality and safety improvement.

**Chartered Workgroups:**
Specifically designated forums — including the HAI Workgroup — to study evidence-based improvements related to clinical care and delivery issues.

Eight long-range strategies serve to advance safety, quality and reliability, and establish a statewide culture of transparency, learning and innovation to take excellence to scale:

- Cultivate shared leadership and commitment to patient safety and quality principles and establish accountability for improvement.
- Engage physician commitment and participation in patient safety and quality improvement.
- Enhance strategic planning processes to fully integrate quality and safety within hospital strategic plans.
- Establish infrastructure — including technical and facilitative resources, educational vehicles and communication channels — to support aims and strategies, and to reduce cost and complexity.
- Enhance capacity to gather, refine and disseminate customer knowledge and performance data as the basis for decision-making and action. This includes, but is not limited to, patient and family satisfaction and complaint data, payer requirements, employee and physician satisfaction data, as well as measured performance on quality indicators and aggregated event reporting.
- Advance the systemic and rigorous measurement of strategies and priorities to achieve clinical effectiveness and reliability.
- Advance evidence-based medicine, evidence-based practice and clinical decision support, as well as build implementation evidence across the full continuum of care.
- Enhance and protect a statewide culture of professionalism and teamwork that fosters respect, sharing, meaning and accountability in work.
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Blueprint

The Purpose of the Hospital Quality Institute

The Hospital Quality Institute (HQI) was established through a collaboration of the California Hospital Association (CHA), Hospital Council of Northern and Central California, Hospital Association of Southern California (HASC) and the Hospital Association of San Diego & Imperial Counties (HASD&IC). It was established to realize statewide impact of improving patient safety and quality care for all Californians, to accelerate the rate of improvement, and to advance California as a national leader in quality performance.

This Blueprint outlines what it will take for HQI to realize this vision and deliver on its mission. The document identifies fundamental principles, recommended best practices in roles and responsibilities, and supportive infrastructure needed to advance this journey of collaboration. It also proposes long-range strategies to coordinate patient safety, quality improvement and reliable care, while respecting the unique governance and cultures of CHA, Hospital Council, HASC and HASD&IC (the Hospital Associations) and their members. It is a living document to be modified and enhanced as our knowledge expands and our experience requires. The focus is in two areas: 1) building cooperation and context in which learning, improvement, experimentation and innovation flourish, and 2) providing focus, clarity and relevance to support hospitals in meeting the needs of their customers — patients, families, communities and each other. The intent is to create the structure to:

- Develop a statewide culture of improvement that inspires, engages and achieves results.
- Simplify and harmonize activities and initiatives and set priorities for statewide impact.
- Capture economies of scale for state and local initiatives.
- Reduce the burden of reporting and compliance on hospitals.
- Honor and build on successful work-in-progress and take best practices to scale.
- Tell the story of quality and patient safety in California.

The Blueprint recognizes the vision for HQI and reflects an early assessment of aspirations, information on past performance, and scans of the external environment to move toward the vision. It is an initial starting point for participation in the HQI operational design.

The vision and mission statements are:

HQI Vision:
California hospitals will lead the nation in patient safety and quality performance with high reliability and zero defects in care on behalf of the people and communities they serve. They will lead through respect for people and a culture of habitual excellence.

HQI Mission:
To advance and accelerate patient safety and quality improvement for coordinated statewide impact, with aims to achieve zero defects, optimize clinical effectiveness, and enhance patient and family experience in health care.
HQI Core Programs

**California Hospital Patient Safety Organization (CHPSO):**
Analyze reports of harm, near misses and system vulnerabilities. Communicate lessons learned, and identify leverage points for change and safer care. Provide interprofessional and experiential education in safety systems and practices. Provide peer review protection of work products.

**California Hospital Engagement Network (CalHEN):**
Decrease readmissions by 20 percent and health care-associated conditions (HACs) by 40 percent through targeted interventions, benchmarking and spreading best practices, with ongoing new targets to set the theoretical limits of what is possible (zero defect or 100 percent compliance).

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**Chartered Workgroups:**
Specifically designated forums — including the HAI Workgroup — to study evidence-based improvements related to clinical care and delivery issues.
The Bold Vision for California

This is a call to action to match the bold vision for California, and sets forth a journey for achieving quality and patient safety. Appendix I outlines the evidence-based roles that governance and leadership must fill to realize the vision of a statewide culture of improvement and results. Appendix II outlines the roles and responsibilities of quality professionals to inspire, support, and provide expert consultation and leadership in this work. The Blueprint is also an engagement strategy in which HQI stakeholders can come together to confirm shared vision and initial strategies, and prioritize initiatives. The shared vision for patient safety and quality will serve as a vehicle to harmonize the efforts and accomplishments to serve Californians; and in so doing, lead the nation in high quality, safe and reliable health care, resulting in greater value and better health.

The context in which we do this work is important. The world we live in is changing in significant ways. Our society is aging and becoming more diverse. Homicide and suicide are now greater threats than illness in many communities. Divorce, stress and changing work environments are causing numerous health care coverage and stress-related health problems. New antibiotic-resistant diseases are on the rise. Diagnostic and treatment capabilities are expanding. Technology and bioinformatics are expanding platforms to enable care delivery and knowledge transfer across providers, sites and services. People are living longer and surviving diseases that were once fatal, increasing the prevalence of chronic conditions and diseases and introducing new vulnerabilities. The workforce is also changing—aging with the rest of society and becoming more diverse. Increased complexity of care delivery is introducing greater risk in and across all care settings.

The costs of health care and the burdens of illness continue to rise. Additional challenges facing hospitals include legislative initiatives that are changing the context and financing of health care. Failures or gaps in hospital care result in penalties and lost revenues. While the specifics continue to shift, it is clear that payments will decrease or stop for HAIs and HACs, incentives will be structured to move “rewards” from lower to higher performers and there will be penalties for preventable readmissions. Failure to meet mandatory reporting requirements will continue to result in penalties. Our hospitals work in this increasingly complex and demanding environment.

Given these changes, it is not enough to provide quality health care to those who are ill or injured. We must be prepared to partner to address the root causes of health problems — whether poverty, education, violence, smoking, obesity or stress — and find ways to intervene before people end up in our emergency rooms and hospitals or are readmitted from preventable causes. Working with providers, corporations, agencies, communities, and state and national organizations, California hospitals will find innovative ways to improve the health of the people they serve. They will find ways to improve access and timeliness of services, and create therapeutic environments in which patients and families feel relieved, respected, cared for and safe during each encounter. The education and research mission within the academic medical centers and teaching hospitals adds depth and discovery to health care and care delivery initiatives now and in the future, while innovations flourish in all care settings and community hospitals.
Key assumptions underlying the Blueprint’s development include:

- HQI builds on the successes of its founders.
- Collaboration and networks of engagement will create synergies, efficiencies, acceleration of change and greater value.
- The ultimate aims are improvements in patient safety, quality and value to those served.
- Patients and families are the reason for the health care delivery system. They have a voice and decision-making role, and need to be engaged as partners in care.
- Our quality and patient safety journey is inclusive and cooperative.
- Quality and patient safety are key components of a system of surveillance, improvement, resilience and learning aimed to take excellence to scale across all hospitals.
- Our team members deserve respect, knowledge and tools to do their work, and recognition for their contributions. A respectful and safe workplace is a precondition for excellence in care delivery.
- Change is constant.

Multiple stakeholders will be involved in the process — from frontline physicians, providers and staff directly caring for and serving patients to executive and physician leaders and consumers. This will occur through local and state engagement channels.

What is Quality?

Quality, grounded in patient safety, is a value and a discipline of knowledge, skills and practices to achieve excellence in products, services and environments based on the requirements, perceptions and future needs of those served. The foundations for quality include evidence-based medicine and practice, relevant and rigorous measurement, teamwork and transparency, detection and reduction of errors and defects, and design of reliable systems of care to prevent harm, eliminate waste and unnecessary complexity in all forms.

Quality Principles

A set of principles characterizes quality-driven organizations and guides an approach for cohesion across organizations for workforce members to use in their individual work, in their work with each other and in relationships with customers and other key stakeholders.

Quality principles include:

- Leadership
- Customer-focus, with the patient and family as the primary customers
- Results and outcome-focus
- Shared meaning and values
- Evidence-based and evidence-generating practice
- Statistical thinking
- Data-based decision-making
- A systems or process flow perspective
- Continual improvement: learning through cycles of inquiry and evaluation (PDSA tests of change)
- A just and fair culture that promotes reporting, transparency and disclosure
- Open sharing of data, successes and challenges between professionals and organizations to foster continuous learning for continuous improvement
- Continual pursuit of eliminating waste and adding value in care delivery
- Informatics solutions for data capture, clinical decision support and information transfer
- Teamwork in an environment of respect, communication and willingness to give and receive feedback
- Methods, tools and common language to accelerate learning and achieve rapid replication, scale and spread of change
**HQI Strategic Contributions**

As part of an annual operational plan, the HQI Board will confirm and measure the organization’s strategic contributions. Contributions to be considered include:

- Provide engagement and alignment strategies to build shared vision among the entire health care workforce: executives, physicians, nurses, health care providers and staff.
- Provide resources to the boards and CEOs of hospitals and the Hospital Associations regarding their role in quality and patient safety.
- Integrate and consolidate existing quality and patient safety activities, programs and initiatives — including Patient Safety First, CHPSO and CalHEN — that serve the members of the Hospital Associations.
- Create new opportunities and strategies to be proactive and leading edge in safety, quality and reliable care.

- Based on needs assessment, offer relevant programs or activities that promote and support improvements in patient safety and quality that are streamlined and do not create duplication.
- Seek and identify funding sources through philanthropy, grants and other sources and partnerships.
- Provide leadership to improve data integrity and reduce the burden of reporting, including data definitions, data collection, measurement and reporting for local improvement and statewide and federal priorities.
- Provide regular, respectful and reliable performance feedback to organizations and leaders.
- Convene resources to analyze, prioritize and advise on quality issues of strategic importance and regulatory scrutiny, including:
  - HACs (falls, pressure ulcers, medication events, VTE/DVT and other preventable complications)
  - Drug utilization and stewardship
  - Failure to rescue
  - Blood management
  - HAIs
  - Preventable readmissions
  - Core measures in clinical conditions
  - Transfers and transitions of care, including medication reconciliation
  - All harm events
  - Patient and family experience
- Orchestrated standard educational support in the knowledge, skills and tools for improvement to streamline efforts and reduce costs. This may include identifying resources for education and training in PDSA, LEAN, Six Sigma, change management, safety science, improvement science, reliability and resilience, team performance and communication, basic statistics, event analysis, and "just culture."
- Alert and advise advocacy professionals with information and implications to influence at state and federal levels concerning quality and safety rules, standards and reporting requirements.
- Produce an annual report on the state of quality and patient safety.
HQI Core Programs and Functions

- Patient Safety First — Collaborative Learning & Spread
- CalHEN — Facilitation, reporting, program development
- Workgroups — Promoting Evidenced-Based Improvements
- Education, Skill Development, Consultation
- CHPSO — Event Reporting, Analysis, Risk Mitigation
- Patient-Family Experience & Service Excellence
- Continuous Improvement & Innovation
- Strategic Development
- Transparency & Learning
- Regional & State Networks of Engagement, Communication, & Problem Solving
- Proposed Standards & Measurement Review & Comment

Culture of Respect & Excellence
Strategies to Advance Patient Safety and Quality

Eight strategies have emerged to advance safety and quality-driven cultures that perform with high reliability. Decreasing the burden of illness and discovering new and better ways to provide care are inherent in these strategies. The intent of the strategies is to assist member hospitals to be prepared, proactive and cost effective to achieve the Institute of Medicine’s health care aims (safe, timely, efficient, effective, patient-centered and equitable) through cooperation, collaboration, alignment and consolidation of efforts and initiatives. These eight strategies are the building blocks to create a statewide culture of respect that enables physicians and caregivers to report and discuss systemic or individual deficiencies and become part of the problem-solving team. They support a culture that creates an environment of trust, transparency, and continuous learning for improving care.

These eight long-range strategies are:

- Cultivate shared leadership and commitment to patient safety and quality principles and establish accountability for improvement.
- Engage physician commitment and participation in patient safety and quality improvement.
- Enhance strategic planning processes to fully integrate quality and safety within hospital strategic plans.
- Establish infrastructure — including technical and facilitative resources, educational vehicles and communication channels — to support aims and strategies, and to reduce cost and complexity.
- Enhance the capacity to gather, refine, and disseminate customer knowledge and performance data as the basis for decision-making and action. This includes, but is not limited to, patient and family satisfaction and complaint data, payer requirements, employee and physician satisfaction data, as well as measured performance on quality indicators and aggregated event reporting.
- Advance the systemic and rigorous measurement of strategies and priorities to achieve clinical effectiveness and reliability.
- Advance evidence-based medicine, evidence-based practice, and clinical decision support, as well as build implementation evidence across the full continuum of care.
- Enhance and protect a statewide culture of professionalism and teamwork that fosters respect, sharing, meaning and accountability in work.

Tactics to advance each strategy are detailed in Appendix III.
Appendix I —
Evidence-Based Leadership Practices to Advance Quality and Patient Safety

**LEADERSHIP**

*Governing and Oversight Boards*

Board governance provides patient safety and quality oversight. Many of the roles and responsibilities of each board are the same, but the focus and scope differ according to hospital or operating entity governance, the governance of the Hospital Associations, and HQI governance. The table below attempts to identify and clarify those distinctions and cascading responsibilities. The board of each governing organization is ultimately responsible for the work of its organization and the quality of work under its oversight.

<table>
<thead>
<tr>
<th>Boards of Hospitals and Operating Entities</th>
<th>Boards of the Hospital Associations</th>
<th>HQI Board</th>
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<tbody>
<tr>
<td>• Assuring vision and mission</td>
<td>• Disseminating and reinforcing vision, mission and strategy</td>
<td>• Assuring vision and mission</td>
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<tr>
<td>• Participating in and approving local strategy to include quality and patient safety</td>
<td>• Providing opportunities for board and leadership development</td>
<td>• Actively engaging member organizations, administrative and clinical discipline leaders and physicians</td>
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<td></td>
<td>• Requiring and regularly reviewing quality performance within and across the Hospital Associations</td>
<td>• Assuring financial viability/sustainability</td>
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<td>• Approving policy, budget and partnerships for HQI</td>
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<td>• Promoting reporting transparency and learning</td>
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<td>• Planning and prioritizing for statewide strategic initiatives</td>
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<td>• Promoting opportunities to leverage improvement efforts for greatest impact</td>
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<td></td>
<td></td>
<td>• Contributing to board, executive and medical staff leadership development</td>
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<td>• Monitoring and gauging the rate of improvement in prioritized areas of focus</td>
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<td></td>
<td>• Building links and relationships to create new knowledge</td>
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<td>• Providing oversight to develop and advise on methods, tools and techniques</td>
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<td>• Promoting curiosity and a systemic view through rigorous performance measurement</td>
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<td>• Providing oversight of performance at statewide level through reports of measured performance</td>
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<td>• Requiring reports and/or studies if indicated by review of performance</td>
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<td>• Promoting and celebrating success</td>
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<td></td>
<td>• Identifying areas to engage advocacy to advance solutions or remove barriers to patient safety and quality performance</td>
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<tr>
<td></td>
<td></td>
<td>• Requiring cooperation and collaboration in quality and patient safety</td>
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<td></td>
<td></td>
<td>• Evaluating the performance of HQI</td>
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- Assuring resources to advance strategy
- Oversight of policies and operational goals
- Assuming responsibility and accountability for patient safety and quality performance
- Requiring regular reports of performance
- Assuring improvement is occurring
- Holding senior leadership accountable for results
- Assuring community needs are met
- Celebrating improvement milestones
- Participating in opportunities to increase understanding of performance metrics
- Partnering in policy and advocacy work to create the conditions in which excellence is possible
Within organizations, there are cascading roles and responsibilities to create the conditions in which excellence can flourish. The following are selected evidence-based leadership and management practices to advance quality and patient safety.

**Senior Leadership/Executive Team Leading Quality and Patient Safety Strategies**

The role of senior leadership is to set strategic direction, focus the patient safety and quality goals and assure resources and effective operations. Leadership teams exist within the operating entities and Hospital Associations. The roles and responsibilities are mirrored, but the scope changes from local to regional and statewide. Effective practices of senior leaders include:

- Providing vision, leadership, goals and accountability in carrying out the policies of the board
- Accepting accountability for safety and quality performance
- Creating, sustaining and perpetuating shared vision among all professionals, providers and support staff
- Setting quality and safety goals at the highest level of what is possible
- Creating, promoting and protecting a culture of respect for people and teamwork throughout the organization
- Keeping the patient and family and their experience at the center of the work
- Monitoring actual measured performance and identifying the gaps between actual and targeted results
- Nurturing commitment to quality principles and leading by example
- Insisting on improving the rate of change to achieve best-in-class results
- Providing resources for knowledge and skill development in improvement, innovation and safety
- Establishing the cultural norms and conditions for respect, trust, transparency and improvement
- Holding people accountable for changes that must take place at the frontline
- Recognizing and celebrating accomplishments and improvements

**Frontline Operations Managers Implementing Quality and Patient Safety Goals**

Managers nurture the environment, provide staff support and develop staff resources to integrate quality principles into the workplace. They also model quality principles. Responsibilities include:

- Anchoring the work to the vision and mission of their hospital organization
- Planning for aligned quality improvement within their area of responsibility and accountability (microsystem)
- Creating an environment of engagement, trust and accountability for improvement
- Intelligently creating and managing change
- Providing development opportunities for staff
- Encouraging staff to participate as part of the problem-solving team
- Partnering with clinical and physician leaders
- Reporting and analyzing all defects — things that have gone wrong in care
- Honoring teamwork
- Modeling the way

**WITHIN ORGANIZATIONS, THERE ARE CASCADING ROLES AND RESPONSIBILITIES TO CREATE THE CONDITIONS IN WHICH EXCELLENCE CAN FLOURISH.**
Appendix II —
Roles and Responsibilities of Quality Professionals

HQI QUALITY AND SAFETY PROFESSIONALS:

- Regional Quality and Patient Safety Vice Presidents
- CalHEN Improvement Facilitators
- CHPSO Safety Leaders
- Quality Leaders and Professionals

The quality and patient safety leaders are aligned within HQI and work with their leaders and constituent organizations. They are the dedicated resources to help operationalize the Blueprint and execute on strategy. They have a key role to coach and mentor leaders within the member hospitals to increase capabilities and capacities to advance quality, patient safety and reliability. They serve to promote multidirectional communication, design interventions to respond to hospital and system needs, and inspire frontline engagement in the journey. They do this by:

- Catalyzing the incorporation of quality principles throughout and across organizations through the Hospital Associations and collaboratives
- Monitoring local and statewide performance to provide timely feedback and identify areas for improvement
- Creating infrastructure and alignment for organizational learning and acceleration of improvement
- Providing access to expert consultation and technical assistance to align with strategic priorities for quality planning, design, measurement, project management and feedback
- Facilitating common knowledge, skills and practices through standard improvement tools and methods
- Enabling change
- Participating in identifying standard data definitions, data capture and reporting methods to reduce data and reporting burden and fatigue for hospitals
- Identifying areas for collaboration, alignment and expense reduction
- Achieving results in measurable goals and improvement targets as identified in strategic and operations plans
- Identifying local innovations in excellence and working with colleagues to promulgate these statewide
- Identifying and sharing expert resources
- Embodying quality principles
Appendix III —
Long-Range Strategies and Tactics

LEADERSHIP

1. Cultivate shared leadership and commitment to patient safety and quality principles and establish accountability for improvement.

Tactics to achieve this strategy include:

- Produce and endorse strategic planning process and alignment.
- Adapt curricula and establish forums to foster the development of both current and emerging leaders, as well as positional and informal leaders, to create and lead a quality driven organization.
- Endorse shared curricula and coaching strategies to enhance leadership performance.
- Integrate safety and quality performance in all executive, leadership and medical staff agendas.
- Identify vehicles to demonstrate shared leadership in practice.
- Endorse orientation and ongoing education in patient safety and quality responsibilities.
- Encourage coordination of centers of scholarship, research and education to leverage and advance patient safety and quality.
- Encourage aligned incentives for results.
- Endorse use of performance feedback reports and dashboards.
- Establish error and failure transparency for accountability and improvement.
- Ensure improvements are taken to scale for system-wide impact.
- Identify opportunities for collaborative interdisciplinary and experiential learning and skill development among executives, physicians and staff.
- Actively support and contribute to chief medical officer development to lead clinical safety and quality, in partnership with other executives and clinical leaders within the health care delivery system.
- Create the conditions for a culture of professionalism, transparency, continuous learning and improvement that is free from disrespect, fear and blame.
PHYSICIAN ENGAGEMENT

Engage physician commitment and participation in patient safety and quality improvement.

Tactics to achieve this strategy include:

- Partner with educational resources to develop curricula and training modules addressing core competencies (intrapersonal and team skills, systems thinking, problem solving, tools and methods of improvement based on needs assessment, key requirements and data sources).
- Establish communication linkages built on informatics technology.
- Charter pilot projects to improve issues in the practice setting that matter to physicians, nurses, and clinical leaders.
- Coordinate improvement efforts by building on work-in-progress to increase efficiency and reduce competing demands for frontline staff.
- Support and sustain the development of physician and nurse champions and clinical mentors, and apply resources to promote this strategy.
- Recognize that physicians, nurse leaders, and clinical discipline leaders (e.g., pharmacists, laboratory scientists, social workers, therapists) can be driving forces for quality in organizations if leadership is defined, if they are being engaged (frontline caregivers) and if they are included in ways that support the values and training of clinical disciplines.

These activities include an understanding that:

- Care is individual, patient-focused, and population-focused.
- Professionalism and a team-based culture are preconditions for excellence.
- Creativity and innovation must be balanced by a focus on reducing unintended variations in practice — using evidence-based medicine and evidence-based practice.
- Legal liabilities are real issues.
- New knowledge and skills may be needed.
- Physicians, nurses, and clinical disciplines bring experience and expertise that is synergistic, complementary, and essential for care improvement.

Clinical priorities include:

- HACs: falls, pressure ulcers, medication events and complications with emphasis on dementia and sepsis
- HAIs, including surgical site infection
- Observed-to-expected mortality (O/E mortality)
- Transfers and transitions of care, including medication reconciliation
- Communication and teamwork
- Failure to rescue
- Readmissions
- Preventative care
- Focused clinical conditions, including CMS publicly reported measures
- End-of-life care
- Maternity care
- Retained surgical items
STRATEGIC QUALITY PLANNING

3 Enhance strategic planning processes to fully integrate quality and safety within hospital strategic plans.

Tactics to achieve this strategy include:

- Identify quality goals and integrate in the planning and goal setting processes.
- Integrate quality, program, financial and strategic needs in the planning cycle.
- Use tools to establish accountability and reliably report progress in advancing strategy.
- Secure funding to appropriately resource quality priorities.
- Conduct value analysis to establish a business case for improvements when appropriate.

INFRASTRUCTURE

4 Establish infrastructure — including technical and facilitative resources, educational vehicles and communication channels — to support aims and strategies, and to reduce cost and complexity.

Tactics to achieve this strategy include:

- Establish a measurement, data management, reporting and feedback system around key aims and priorities.
- Simplify and streamline reporting processes for hospitals.
- Leverage CHPSO knowledge and resources with improvement resources.
- Endorse improvement and change management toolkits.
- Sponsor education and training: performance measurement, safety science, improvement science, systems thinking, and reliability and resilience science and practice.
- Bring value to member hospitals by reducing research and design and curriculum duplication and fragmentation, while capitalizing on existing resources and work-in-progress.
- Establish HQI website — a catalogue of improvement initiatives, key learnings and contact people.

CUSTOMER EXPERIENCE/CUSTOMER VOICE, WITH PATIENT AND FAMILY AS THE PRIMARY CUSTOMER

5 Enhance capacity to gather, refine and disseminate customer knowledge and performance data as the basis for decision-making and action. This includes, but is not limited to, patient and family satisfaction and complaint data, payer requirements, employee and physician satisfaction data, as well as measured performance on quality indicators and aggregated event reporting.

Tactics to achieve this strategy include:

- Link customer knowledge to strategic planning and action plan development.
- Increase information sharing and coordination of efforts (leverage customer group "listening posts" for patients, employees, physicians, communities and employer purchasers).
- Incorporate customers in the planning and design of improvement initiatives.
- Enhance customer knowledge database (build on market research capabilities).
- Experiment with point-of-service vehicles for incorporating customer knowledge.
- Develop training modules (customer knowledge template, collection processes, interpretation, and application of results) for managers, nurses, physicians and staff.
- Address listening skills and capacity of frontline staff and caregivers to act to improve customer experience and service recovery when indicated.
- Increase employee customer contact time (even those not typically in contact roles) by establishing a high ratio of value to non-value work.
- Involve community in redesign efforts in areas of clinical priority.
- Consider and utilize standardized survey instruments as key tools for understanding customer experience of care and services.
- Focus improvements on patient/family hospital experience as reflected in HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey results.
MEASUREMENT

6 Advance the systemic and rigorous measurement of strategies and priorities to achieve clinical effectiveness and reliability.

Tactics to achieve this strategy include:
- Develop/expand hospital quality indicator sets, based on priorities to measure performance and advance strategy.
- Clarify definitions and develop an explicit performance measurement model.
- Measure what is relevant and matters to hospitals to improve care.
- Partner with informatics resources to clarify data sources, develop tools, design reporting vehicles and develop data repositories.
- Align and enhance capacity to obtain and apply comparative data.
- Enhance external interface (payers, regulators, accreditors and national forums that set standards) regarding performance measurement.
- Identify consultants and resources.
- Partner with resources in biostatistics for advanced analytics and visual displays of quantitative and qualitative data to create information for action.
- Reduce confusion, complexity, data-reporting burden and fatigue of member hospitals.
- Effectively advocate and influence the promulgation of publicly reported measures to harmonize and streamline requirements.
- Publish findings and results to inform system and individual performance.
- Require rigor in measurement so initiative results can be generalizable and publishable.

EVIDENCE-BASED DECISION SUPPORT

7 Advance evidence-based medicine, evidence-based practice, and clinical decision support, as well as build implementation evidence across the full continuum of care.

Tactics to achieve this strategy include:
- Inform patient care decisions without bypassing the expertise of clinical professionals.
- Optimize clinical efficiencies, improve interdisciplinary coordination, and reduce disparities in care.
- Support meaningful use of electronic health records in the inpatient and outpatient settings.
- Support facilitated consensus building to agree upon and generate clinical evidence.

PROFESSIONALISM

8 Enhance and protect a statewide culture of professionalism and teamwork that fosters respect, sharing, meaning and accountability in work.

Tactics to achieve this strategy include:
- Ensure everyone is treated with respect and is part of the problem-solving team.
- Confront non-professional/non-team promoting behavior with a fair, confidential step-wise approach.
- Develop training for teamwork skills, effective communications and peer mentoring and monitoring.
- Promote reporting and discussion of systematic or individual deficiencies through established processes.
- Celebrate improvements and accomplishments.
- Consider the systematic introduction of just culture.