# Leadership and Leadership Principles for Safety
# July 16, 2009
# Webinar Transcript

**Charles Denham:** Good day. This is Charles Denham, chairman of TMIT, and I would like to welcome all of the participants in the National Quality Forum Safe Practices for Better Healthcare 2009 Update Webinar. Very excited about this webinar today. We're addressing leadership and leadership principles for safety. We will be focused on the National Quality Forum Safe Practices 1 through 4. This webinar is hosted jointly by NQF and TMIT. It is part of a series that TMIT started three or four years ago and we're very honored to be co-hosting this with the National Quality Forum which is doing a tremendous job in helping us understand the measures and focus areas that we need to address in patient safety.

What we'd like to do is address the Safe Practices with some leading speakers and I will lead off with an overview of the Safe Practices. However, I'd like to introduce my co-panelist, Dr. Peter Angood, who is the safety leader at National Quality Forum. As the senior safety advisor, Dr. Angood, who I'll introduce a little bit later, brings to us a wealth of experience as a trauma surgeon, an academic, and as a recent leader and vice president of The Joint Commission safety initiatives. Jim Conway, who many know to be a great contributor to this area of leadership, in the areas that overlap with the Safe Practices and most specifically on his perspectives with reference to boards of directors and the leadership rule that they can take – the role that they have and most importantly the voice of the patient. Dan Ford, a national patient safety advocate and expert in patient safety, will give us a great perspective from the standpoint of the National Quality Forum Safe Practices and how to involve patients and families, and I think some highlight ideas that will be very, very helpful as we all proceed forward involving patients and families in the care that we deliver.

As I kick off, I will start with just a few minutes' introduction to just set up some of the dialogue, and the Slide No. 6 shows the relative thicknesses of the Safe Practices for Better Healthcare reports. The National Quality Forum undertook a terrific project in 2002, producing in May 2003 the top book which is fairly thin, about a quarter of an inch. That set of Safe Practices was the start and they were based on a lot of terrific evidence that was assembled by the Agency for Healthcare Quality and Research. In 2006, the book grew in length and I'll be addressing that in my section a little bit later. What is of critical importance is the standardization approach that was taken and the fact that we had terrific harmonization across multiple organizations and stakeholders, which Dr. Angood and I will address. And the most recent 2009 report, that now addresses 34 Safe Practices, is much thicker, much more evidence-based, and probably the most synchronized and harmonized set of practices ever created with a number of additional harmonization partners. So, this picture just gives you the relative expression of the thickness and hopefully the effectiveness in terms of implementation.

The Safe Practices were organized into seven functional categories and I am on Slide 7. Culture addresses the leadership practices one through four, which are being addressed today. Consent and disclosure, as well as end of life, are addressed in the chapter that follows. Workforce issues, addressing nursing, direct work force, and ICU coverage, are addressed in the black box that you see there before you, which is one of the functional chapters. And then a number of Safe Practices in information management and continuity of care, and CPOE lives there because of its vital nature as an information management and continuity of care issue, in addition to discharge planning and critical test results. Medication management, a key area, is the next chapter, and we with a forklift upgrade if you will, incorporating a number of the key practices that existed in 2006, with real emphasis on leadership and the leadership of the health organization and pharmacists both in acute-care nursing homes and other organizations. And then healthcare-associated infections, a major area in the 2009 update, is really an exciting update for us because the harmonization partners included the six that we typically described, in addition to CDC, and this was harmonized with the Infectious Disease Society of America, APIC, and SHEA representation through harmonization with a compendium that was released in October 2008. And then a number of condition-specific practices in the last chapter. The Slide No. 8 is really kind of an eye

chart; however, it allows teams to really be able to organize and look at which practices were new, which practices had material changes, and which practices maintained their continuity.

I'm going to turn things over to Dr. Peter Angood who will address the important national highlights regarding leadership and culture; and also as an introduction to Dr. Angood, he undertook a terrific challenge and job at The Joint Commission and was just a fantastic and steadfast supporter of the harmonization efforts with the 2006 practices, as well as the 2009 practices; and now being at the National Quality Forum and having been a practicing trauma surgeon, brings a wealth of experience and now really can give us some highlights about what we can expect and what is really important, pertinent to these four Safe Practices. Peter?

**Peter Angood:** Thank you, Chuck, and welcome to all of you who have joined us today. I think these webinars that we have begun, along with Safe Practices, in collaboration with TMIT, is actually just a small reflection of the degree of collaboration that's going on in healthcare overall. In my 25-plus years of healthcare, I have never witnessed a period where there has been as much willingness and desire for harmonization and to collaborate as much as we can, and the Safe Practices are very much an example of that.

Now my focus for the next little while shall be on some of the broader-based issues related to the Safe Practices that are the focus for today's discussion. As a backdrop, I wanted to just highlight that from the very top of this country we have obviously a clear focus on healthcare. And if you look at the timelines of where healthcare reform has occurred, it's on average about every 17 or 18 years and we are on that timeline cycle again. So this is an opportunity for the country. The current president and administration are moving in very closely behind this-as you can see from this clipping out of the budget proposal, (it will obviously get changed and morphed as legislation goes through). But the focus on improvement of patient safety and quality care is clearly there, and as I watch and monitor the legislative initiatives that are currently in process, I'm quite comfortable that we will have safety and quality of care continue to be profiled., it's a lovely time to be in healthcare, a lovely time to be in Washington doing healthcare.

The NQF Safe Practices, are very much being reviewed critically by the Department of Health and Human Services, as well as a subsection within HHS, and so these Safe Practices really have some important influence, as well as impact on the reform processes that are moving forward. And for me, in terms of trying to create change within healthcare, these first four practices I think are amongst the most important. It's very clear over the last five to ten years how critical the leadership, the culture, two work approaches in the identification and mitigation of risk in healthcare, have really come to the forefront and the recognition that they need to be paid close and critical attention to. And so these Safe Practices are efforts along those regards, and Chuck will provide us more specific details during his segment, and our other two presenters will certainly reaffirm the importance of these concepts in these first four Practices.

To think about it, CEOs of institutions and the leadership within organizations of all sorts across different environments out there, are struggling heavily right now. There's ongoing concern with revenue enhancements, how do you in the face of an economic downturn continue with capital enhancement, how do you invest for technology, especially as HIT is getting also heavily profiled, how do you continue to engage your medical staff, how do you get more involved in the cross-fertilization – are all critical components? But fortunately for us, when you look at some of the leadership surveys out there, safety and quality also remain high on their top five list of items that need to be taken care of in their organization. So, you've got consistency of focus from the Obama administration all way down into the CEOs, and part of our focus in this set of Practices is to make sure that we can further drive this whole issue of culture, leadership, and teamwork approaches into this, all the way down to the bedside through all layers of the organization at all different disciplines.

The late Peter Drucker once made a comment about leadership, and he's a well-recognized leader of leadership strategies in the business world, but he eloquently stated that the management and leading of healthcare organization is the most complex type of an organization to lead or manage across all industries. And I think that's really quite true, given how healthcare has evolved, and we really need to look at trying to make sure that the leadership strategies are over and above just management, if you will.

If you think about management, oftentimes it's categorized how you best cope with complexity of your work environment or doing things right, if you will. Whereas the leadership is much more focused on coping with the change and the changes that are occurring – put a slightly different way - doing the right thing at the right time so there are tremendous challenges for our leaderships all around.

Leadership is very much, about openly identifying problems, setting goals for organizations, and trying to empower the organizations and the work force to do this right thing, if you will. And that culture piece fits in all of that. I think one of the advantages we have in this is that The Joint Commission actually was a lead organization in releasing its leadership chapter within the standard. That chapter has been out since January and it does look critically at the structural processes, end processes, I'm sorry, that need to be within any type of healthcare organization. It looks at how the relationship within an organization works, including those areas where there's conflict, and that there are specific communication strategies and efforts to build a healthy organizational culture. The code of conduct that is in that chapter is, I think, a critically important piece of all of this, and there are a variety of operational issues that need to be put into place as well.

For the culture and ethics of trying to do the right thing, are all the components that will provide success in the leadership strategy overall. Well, culture, you know we talk about the safety culture, it's actually, bigger than just a safety culture. It's how people do their business and it's based upon the values and the beliefs and the behaviors that are exhibited within an organization, and healthcare is based upon its legacy of professionalism and its education foundations; but that professionalism – unfortunately for many – is felt to be eroded in the last couple of decades, and we need to rebuild that. Many of us have heard the term that normalization of deviance where any one of us workers goes into our workday, we figure out how to do the work-around, we figure out to make it work for our particular activities in that day that shift; but, collectively that creates deviance away from what is the optimal type of work force environment. We need to break down that normalization of the deviant behaviors and make it more of a, some use this term as well, a positive deviance. Let's get the healthy behaviors occurring so that the best things are being done for the right reasons, at the right time. And as you measure those cultures while AHRQ, Agency for Healthcare Research and Quality from the federal government, has guided culture surveys. There's a few other tools out there as well and regular evaluation of cultures is important, and fortunately I think more and more organizations across all environment of care are beginning to tackle that.

Teamwork is the third element in these series of four Safe Practices. This is equally complicated. I always come back to the wrong-site surgery example for this and the implementation of the Universal Protocol. You know the operating room is a relatively small, contained environment. There are a limited number of disciplines. They've worked there every day and the busy ORs in this country doing 35,000, 40,000, 50,000 cases a day, you would think the teamwork would be simple and easy in terms of creating change, and yet the full integration and assimilation of the Universal Protocol across the country is not quite there yet. That doesn't mean there aren't many organizations doing well with that Universal Protocol, but several are still struggling; and the fact remains that the occurrence of these wrong-site surgery continues and it continues to increase. And no, don't tell me it's just increased reporting. The fact of the matter is these events are occurring despite strong efforts. So this issue of teamwork and having you bring it together is difficult. Fortunately, AHRQ has got some good tools in place. The whole TeamSTEPPS program is very successful so far, as well as several of the academic health centers are putting into place simulations for education and training. They're not just putting in for the surgeons of practice and procedures; they are taking team-based strategies in a simulation environment.

So how do the doctors, nurses and pharmacists work together on different scenarios? The American College of Surgeons has accredited about 40 of the different education institutes around the country now, and virtually all of them are taking team-based strategies. So that is an under-the-radar set of initiatives that are going on out there. I think our Safe Practices continue to reaffirm the need for the team-based strategies.

Well, wrapping up on a couple of other comments and then we'll get into the next presentation. I think identification and mitigation of risks and hazards is equally getting a lot of important profile on a national

level. Many of you will have heard of high-reliability organizations, as well as how you need to develop this culture where there's a preoccupation with safety, the development that will stop the line mentality, if you will, where any type of worker within that work force could say, hey look, something is going on here that's not quite right. We need to reevaluate where the processes are and let's make sure that we're doing the right thing at the right time. So, there is this concept of the high-reliability organization and it's not just about efficiency, that's about safety, that's about being able to provide quality care without compromising the outcome. And coupled with that is the need for mature uses of the root cause analysis tools, the failure modes and effects analysis, et cetera. NQF is working with HHS in this regard as well expanding into other environments of care.

We will be developing, over the next short period of time, a number of newer patient safety measures, and these together will be working in concert with the Safe Practices so that we weave the overlap of the serious reportable events, the practices and measures all together. And as many of you know, half of the states roughly have stated mandated reporting systems. There is federal oversight beginning to occur from the Office of the Inspector General to make sure that there's been the detection and the reporting and the prevention of the adverse events that are out there and the patient safety organization initiatives coming from, again, AHRQ. NQF is helping to develop the common format for that PSO activity. That's going to be launched in August and the first meeting of all of the 65-plus safety organizations occurs in September. So there are numerous national, as well as state and regional, activities going on in order to create these changes. Now, we had some change in terms of breaking the original leadership and culture Safe Practices into these four specific Practices. And some of these components in these practices have been minimally changed, others have more detail, and Chuck will get into those overall.

I think, as we look though, closing out and coming back to my opening comments, it's a good time to be in healthcare. Healthcare reform is occurring, numerous organizations are working together. NQF is the convener of this National Priority Partnership. There's now 32 different high-profile organizations involved with that and it is going to continue to work within this environment of collaboration, partnership, harmonization in order to drive the many important priorities and components that are embedded within the Safe Practices. Leadership is pivotal and quote there on the last slide pretty much I think sums it up because we really are trying to change the care that we provide the patient and their families – the highest quality care, and that we do it as a collection of organizations around this country through all the different environments and overall we improve healthcare to the level that we all want it to become. So with that, Chuck, thank you very much and I'll turn it over to you for some further details.

**Charles Denham:** Great, thank you very much. Thank you, Peter, for giving us that perspective. There's no question that there are some terrific changes that are going on, and as Clay Christiansen from Harvard would say, disruptive innovation, I think, may come to the fore. I'm going to be in effect Jim Conway's warm-up man and provide a little bit of a context regarding the practices and really address some of the new rules for leaders to really open the door for Jim to really kind of address the power alley of the new rules and give some really good examples of leaders that are doing a great job.

Slide 18 actually is a slide we use at the beginning of videos to describe the major changes that are going on, and there's no question that we do have a "no-outcome no-income tsunami" that is bearing down on us. We now are in an era of transparency and an era with healthcare reform, CMS being short on funds, measures coming on strong, a great new NQF really being a terrific convener of major organizations. I think that an industry that moves at a glacial pace is really changing. I think one of the things that we need to recognize and put the quotes of Thomas Hamilton, who is the director of the survey and certification group at CMS, a terrific public servant and is a very, very eloquent and thoughtful systems-oriented person who really gets patient safety and quality sense to us as leaders as organizations – "if you lose the patient, don't lose the lesson" – meaning that that information is critical and so I'm going to emphasize the importance of information and information flowing in the new roles of the new leaders. Another quote I like of Thomas Hamilton is that he said we know that hospitals are dancing in the spotlight. What we're worried about is what's going on the dark and as the houselights of transparency come up on the stage of healthcare and healthcare leaders of hospitals and nursing homes and other organizations, I think our leaders are going to be the ones that will take the bows, but they'll also be the ones that face the music as we start to find out where our really gaping issues are that are a problem.

I'm on Slide No. 20. We like to use this slide to help organizations understand these new set of four practices. Practice No. 1 is leadership structures and systems and basically it defines new structures and new systems with flow of information, flow of authority. We address the four A's of awareness, accountability, ability, and action and have very specific tasks that can be undertaken and should be undertaken by any and all organizations playing to the strength of the NQF. These are generalizeable, meaning that from a 6-bed hospital to a 2,000-bed hospital the board absolutely has to have key safety information. They need to make informed decisions regarding budgets, people system investments, technology system investments, investments in the care process and they need to have direct access to real-time information as to risks that are occurring. Too often, we've run our hospitals with three-year rolling budgets and plans and ignored the early warning issues that are key.

So the leadership structures and systems practice, because we want to give ample time to Jim Conway, we will go into them in detail, but as you, if you have not purchased the NQF Safe Practices report, again, go to www.qualityform.org and order it. As you did get to the key specifications, they provide a terrific blueprint and a roadmap that have been harmonized across The Joint Commission and the ARHQ and The Leapfrog Group, and the other organizations that we're harmonizing.

The second yellow box in this graphic addresses culture measurement, feedback, and intervention, and I don't think there's anyone on this call or any of the subject matter experts, and we are so honored at TMIT to have 500 contributors, subject matter experts from clinical operation or financial disciplines in healthcare and even out of industry in aviation and HR, et cetera, who would not agree that culture measurement is in the beginning of the beginning. It's in its infancy. So this practice we've kept constant since the 2006 Update because we know that this is an area where the puck is moving and the requirements of measuring culture and applying those learnings are really very flexible, and I think as time goes on we'll see organizations customize them and tie them to their values.

The third Practice, SP3, is teamwork training and skill building. We undertook a terrific amount of work in developing that Practice in 2006, with a lot of hands-on input from people like Dr. Jim Bagian, who leads the patient safety center at the Veterans Administration organization. We've had terrific input from Jim Battles and the leaders of the TeamSTEPPS development team at AHRQ, and a number of contributors. And we have tested this out in the field and have found that this practice has held up as the minimum, the minimum requirements for being able to pass on information regarding human factors understanding, high-reliability organizations as Peter described, migration of boundaries. When we have those boundaries migrate and then we have normalization of those new boundaries clearly operating outside the performance envelope of our people, this teamwork and training area also calls for one hour of training and patient safety for the entire organization. We kept that intact in the 2009 Update and will be continuing to review that as Peter leads us at the NQF through the process for 2010 and then on to 2011.

The fourth Practice, identification and mitigation of risks and hazards, is probably one of the most important practices to address. The transformation and culture, and I always think of our friend, Tim McDonald, with the quote that he said that disclosure is the Trojan Horse of cultural change because disclosure really requires that we share information that heretofore had been in risk management. So this Practice really addresses specific activities and tactics and we can't get to go through them because we want to give air time to Jim Conway, but as we, in the months ahead, we will be hosting more webinars with deep-down focus on each of the tactical specifics of these practices and how you can get a quick start and implement them and get them to work in your organization. And it's really important that they be read and understood, and again if there was a great eye towards our co-chair with the NQF Safe Practices Program, Gregg Meyer, would say having enough structure to be solid and flexibility to be able to be implemented. And so, on the left side of this graphic the values really as Ann Rhoades, one of our international business gurus in business and HR talent development would say, leaders drive the values, values drive the behaviors, the behaviors drive the performance, and the collective behaviors of the organization drive the outcomes. So, the two blue chevron graphics on the left really describe those very important structures and systems that I think that Jim will address as he tells us about some really great success stories and his lessons learned from the boards on board effort.

Just a couple of highlights on the next slide, Slide 21, I showed at the beginning of this presentation the thickness of the Safe Practices, a huge amount of work by so many folks to develop the 2006 Update that took an original report that was never really designed to be measured by Leapfrog or another organization, but really was a starter set of Practices in 2006. These were harmonized across the organizations you see on the slide: NQF, ARHQ, Joint Commission, CMS, IHI, The Leapfrog Group. And it would not have happened without the dedicated leadership or risk-taking at the top of those organizations, which are kind of quasi-competitors. And yet they agreed, based on values, it was the right thing to do to get those harmonized. Leadership structures and systems was held firm and expanded care settings were standardized, implementation guides were added. This was really thoroughly evidence-based with detailed literature cited.

In the 2009 Update, which has just been released in March, are harmonizations for our partners, grew to the CDC, APIC, HRSA, and a number of other organizations. The leadership structures and systems held firm as well. We added a patient involvement chapter, which Dan Ford will address in just a few moments, and we really took a very detailed, with the great NQF staff working hand in glove with so many of the harmonization organizations, developed a comprehensive update to the evidence. Now, so many of the Practices are really cited all the way through problem statements, implementation guides, and care settings, were also modified to adjust to CMS. We had a terrific, I think, the harmonization of this Practice and this set of Practices is a testimony against what the skeptics would say that we in healthcare can't get our act together. There's no question that a lot of teamwork was involved in developing that.

What I wanted to do, so we get to Jim right away, is just to address some of the things that will be available addressing the Practices. I'm on Slide 22. All of these webinars, and also 30 to 40 short video clips that you can use in presentations to help draw an implementation of the Practices in addition to slides and other resources, will be available. The slide you see before you is a "Coming Soon" page that will have a podcast center that will have both the streaming video that you could play on your computer and have a 22-inch experience, as well as downloading them on your iPods and your players that will allow you to be able to take the webinars with you and be able to watch them or be able to listen to them on your own personal devices.

We also, now on Page 23, just addressing both of these, we will be developing and continue to develop libraries of multimedia assets made entirely available free to our test bed and to the general public that will help drive implementation, because these Practices really are of very little value unless people put them to work.

We're going to put a huge emphasis on leadership because leadership is so critical and so key; so the Page 24 that you see here is a page that will come soon in the next couple of weeks that will allow you to select the category chapter of the Safe Practices and then be able to drill down to the specific Practice, and then be able to access a starter, quick starter sets of slides and video and references for which we have the copyright authority to give you articles from. The *Journal of Patient Safety* has been so gracious to give us complete copyright authority of everything that is published that ties to the Safe Practices.

So, Slide 25 really gives you the layout of the page and so, those that are on the webinar, we'll be notifying you. When it's available we'll be able to have a quick-start pack for those that are just getting started, as well as having much more implementation tools. And again, in the spirit of harmonization, these will be crossing back over to IHI and to NQF and to The Joint Commission, so that they're not competitive materials, but materials that can be used together. And then, as I close my piece here and turn things over to Jim, our rock star, we're kind of the warm-up band, Peter and I, for Jim Conway and we're counting on Dan Ford to be our anchorman closer.

I just want to mention the Medication Management Collaborative that we'll be undertaking. And this is a collaborative focused 100 percent on implementation of the practices and providing input as to how we can have best practices of implementation of the best practices that the NQF has provided to us. We'll also have a leadership collaborative kickoff session. Bill George, the former CEO and chairman of Medtronic who probably, and I'm just grateful to be with Bill at a meeting today, Bill led Medtronic from $1.6 billion to $61 billion in revenue. He did it with core values. His books include *Authentic Leadership*,

*True North,* and the most recent book is the *Seven Lessons for Leading and Crisis*, and if there wasn't a time in healthcare when we've had crisis it's going to be now, and Bill has agreed to be our lead speaker on implementation of the leadership practices and this will be for board members, C-Suite, midlevel managers, directors at the hospital level, and we'll be addressing the specific tactical issues that are related to the Practices. The date is likely August 25th and we'll be letting you know about that.

And then finally, we will, IHI and the *British Medical Journal* Group have a meeting in Nice in 2010. It kicks off on the 20th of April in 2010 and we have a national or an international global workshop that we'll be hosting. Dr. Angood will be one of the speakers. Janet Corrigan, the CEO of NQF, Carolyn Clancy, the head of AHRQ, David Hunt, from now the secretary's office, the quality leaders from the Mayo Clinic, Cleveland Clinic, Vanderbilt, will all be participants. Dr. David Bates from the Brigham. It really will be focused on high-performance care and the leaders, and at that meeting we'll also be making a global patient safety award, multiple awards to those of the C-Suite, the boards, pharmacy leaders, and leaders of hospitals; and there will be more to follow and we'll be looking for people that will, we'll be letting you know how you could submit stories about heroes and patient safety that can really things up to a higher pitch. And then finally, we are going to be producing a documentary with Dennis Quaid that will be addressing the event that occurred with his kids as the kick-off story. But this documentary will address the 34 Safe Practices and we'll be going session by session by session with the high-impact stories that address them, with high emphasis on healthcare-associated infections and high emphasis on medication management and the solutions that one can address those. And the international premier of that movie, that documentary will be at Nice. So with that, I'll turn things over to Jim Conway. Jim, it's your show.

**Jim Conway:** Chuck, thank you very much. You can do a lead-in for me any time, but frankly I'd prefer to follow you and pick up a lot of the extraordinary nuggets that you are contributing to the industry. It certainly is an honor to be here. I think my adult kids would choke at the notion of me being a rock star, but it's fun to pretend like that. I've had the privilege of over 40 years of serving as a leader and the opportunity to spend part of an hour of a day with 832 leaders looking to advance the quality and safety of the nation's healthcare is really just an exceptional privilege.

IHI, as Peter suggested in the beginning, is thrilled to be part of this community that's coming together to align and focus the nation's quality improvement journey. I was on the call earlier this week with the leadership of National Quality Forum. As many of the people of this call know, Massachusetts is in the middle of a health reform effort and we are using routinely and explicitly the guidance of NQF and National Priorities Partnership to really help and focus our work that's going on in this state and help moving beyond the chaos that people are currently feeling within the system. Many of you know as part of the 5 Million Lives Campaign, IHI had an intervention called "Boards on Board," and one of the very proud moments in that intervention is over 2,000 healthcare organizations joined with IHI to look at how we optimize the engagement of governance and executive leadership in quality and safety.

So, what I am first going to talk about today are the key elements of the board-on-board intervention. Then, what I am going to advance the contents specifically into the NQF Safe Practices. As I was putting together this presentation, I was reading some evaluations from students for a course I was giving, and one of the students said for the first two classes all I talked about was theory and he thought this was going to be a dog course. But then when I started talking about how it got applied every day in our work then it really became very exciting.

So, I thought what we would do in this particular presentation, over the next 20 minutes, is really talk about how the NQF Safe Practices are executed, how we're seeing them being executed in organizations using very real examples. You know what many people talk about is a notion that I call "spray and pray." What we do is talk about it and talk about it and talk about it and we hope somewhere it sticks, but in fact what we are now seeing in organizations all across the country is publicly verifiable results from the application of the NQF Safe Practices 1 through 4 and interventions like, the board on board. Then I will just do some concluding comments and I will be pointing you for further information. The vast majority of organizations that I am profiling in my talk are all mentors for the board-on-board intervention for the 5 Million Lives Campaign, so all the contents and more that I am talking about today is taken from that site

and you are able to call those organizations, speak to their leaders, and get more information. Then the real fun part is the Q and As.

Moving to Slide 31, the board-on-board intervention in the 5 Million Lives Campaign has these six key components. The first was organizations have to set aims. We have to define what success looks like. People told me over and over around the country, it is tough to get it right if you don't know what that notion of success looks like? The second is we have to ask are the governance and executive leadership getting the data and hearing the stories – not only the stories of the great care and caring, the research and the discovery that goes on in our organizations, but we have to confront the suffering, the harm, the tragedy, the death. Peter Senge, a very important teacher of learning, taught us this notion of creative tension. Peter said if you really want to drive improvement, you have to set both aims and then confront the reality, and if you do that an amazing tension can emerge that, appropriately focused, can drive dramatic improvement. The third point is that you have to establish and monitor system level measures. One of the things that we have seen as we've done the board-on-board training is organizations that have dashboard data that go 5, 10, 15 pages and trustees have said to me, Jim, I know what we're doing on prophylactic antibiotics on Six West, but I can't tell whether infections are going up or infections are going down. I can't tell whether or not we're having more medication errors or fewer. So, how are we as an organization able to get above all of these various measures that are out there and at the end of the day find out if we are truly improving? And then the fourth, something that we've already talked about a lot, is culture. A couple of things we've learned is "culture trumps strategy 100 percent of the time, and another is culture is defined as "what gets rewarded around here." So, as Peter and Chuck had talked about, culture is important in driving this work forward.

We also have to celebrate learning. When you have a tragedy, a serious event, a serious outcome that's an enormous burden, you carry that burden forever; but carrying the burden is not enough. You must responsibly pursue correcting what happened to ensure it never happens again. Then you should use the power of that tragedy to take your organization to a very different place. Finally, there is establishing executive accountably. At the end of the day the governing board holds the CEO ultimately responsible for quality and safety in your organization. When I walk into organizations, I routinely ask who's responsible for quality and safety. If they tell me the director of quality, I know that this organization doesn't get it. If they tell me it's the CEO, then I know that organization is writing its story. Each of the organizations, which I will profile today, is an organization that gets the fact that the CEO, in partnership with governance and executive leadership, is ultimately responsible for the quality and safety of the healthcare organizations they lead.

So, let's move on to Slide 32 and the first area of focus of leadership structures and systems. I'm not going to go to through all of these, but let's just highlight a few from Children's Hospital in Minneapolis-Saint Paul was one of the early leaders in quality and safety. Note this first bullet: Any sentinel event is reviewed at the board quality committee. Not a few, not a couple. That's a characteristic also of Virginia Mason. One of the things that we also see is they routinely discuss their stuff. You will also find this in Johns Hopkins. You will find this in many organizations, that there is a report that goes out weekly or monthly that talks about the suffering, the harm, the key indicators like infection rates, medication rates, mortality rates, readmission. So, the organization is never far from the realities of practice in their institution.

There are also organizations that are very clear in their goal. Virginia Mason, one of the great leaders in quality in the country, has one organizational goal: to ensure the safety of their patients through the elimination of avoidable death and injury. Not to improve, not to make it better, but to eliminate avoidable death and injury within that system. Children's Hospital in Cincinnati, another early and very important leader in quality and safety has in the specificity of the board's aim that over a two-year period of time they're going to reduce serious safety events, 80 percent from baseline. For anybody in that organization the aim is important. One of the things that shows how significant this is to Children's in Cincinnati is on their intranet, in the upper right-hand corner. It shows the number of days that have gone by since a child was seriously harmed as a result of preventable harm within their healthcare system – never confusion from the aim. This is not solely the work of academic institutions.

The next two organizations I feature here are Delnor Community Hospital and Mary Imogene Bassett Hospital. These are community and rural institutions where we also have seen this clarity of leadership. Look at Delnor on Slide 33. A patient experience story has been presented at board meetings since January of 2006. Each story is specifically selected and connected to highlight a big dot or driver of the clinical dashboard. The story is told by either the patient himself, a medical staff member, or a senior person in the organization. I had the privilege to be a leader at the Dana-Farber Cancer Institution and Dan will talk about this more. For 10 years, patients and family members populated the board quality committee. The walls didn't fall in, the ceiling didn't come down. What we had at the table was four people who were so thrilled at the level of focus we were putting on quality and safety. Every day they could bring the experience of care that they, their family members, their friends, their community were having to the boardroom to help us collectively, with the executive leadership, make the system higher quality and safer for everybody involved. At a rural hospital, Hot Springs Memorial Hospital, in Thermopolis, Wyoming, the board of trustees spent 30 percent of their time, overall time, on issues related to quality and safety. And here's another organization that brings patients and family members who have suffered medical errors, bringing them directly to the boardroom. So let's move on to the second piece, this piece of culture.

I am so thrilled with the emphasis that Peter and others have brought to an environment of culture and quality and safety within healthcare organizations. Children's Hospital in Cincinnati uses the AHRQ culture survey and they promote a notion of 200 percent of accountability for safety, the notion that we as individuals working in the system are not only accountable for our own practice, but we're also accountable as a member of the team in which we serve. Again, the Hot Springs County Memorial Hospital in Thermopolis conducts quarterly, not every-two-year, employee satisfaction surveys While I was at Dana Farber Cancer Institute, at the suggestion of one of our board members, we developed principles of fair and just culture. Our staff should not learn how we're going to act after an event. Since we all know that the vast majority of errors are not the result of bad people, but the results of bad systems, we should memorialize within our culture what the principles of a fair and just culture are. On Slide 36 you can again see the work of Henry Ford Health System very much focused on a just culture, as well as the Mary Imogene Bassett Hospital advancing this important theory.

The third piece is organization-wide approaches to team-based care. IHI has been very excited to be able to work with the Contra Costa Regional Medical Center, and their CMO said the tremendous collegiality that goes on here is not just a miracle that happens, but it's the result of a very conscious effort from the top down and bottom up to create a culture of collaboration and teamwork. Through this teamwork, even in a very challenged public hospital system, they've been able to improve care processes and outcomes in areas that range from surgical-site infections to reduced heart attacks. I've been away from Dana Farber for almost five years. One of the things that I was thrilled to learn, as an organization that like many have introduced TeamSTEPPS, is when they implemented team training they actually invited the patients and families to participate. What an idea! Often in simulator training programs people will have people who pretend to be patients in the simulator center. What Lucille Packard has done is actually invited actual parents and family members to participate actively in simulation training exercises with staff. IHI, as many of you know, has a program called the Open School and very much in the spirit of a rock star, which has already been brought up, they have brought up the importance of culture change in medicine. Within the open school they talk about the significant work that's been done by the Beth Israel-Deaconess in Boston and Virginia Mason Medical Center in Seattle in this space.

Moving on to Slide 38, Chuck has also highlighted this whole notion of identifying and mitigating patient safety risks and hazards. The relentless focus at Virginia Mason on this notion of a patient safety alert, the very comprehensive approach that's taken to these, and the realization their PSA is the equivalent of many organizations root cause analysis. What's very striking in this organization is the only people who can close the RCA or the PSA is the board of trustees. Owensboro is a remarkable story for any organization to monitor. This is an organization that six or seven years ago confronted the reality that, compared to many of the hospitals in the country, they had a very high mortality rate. In their organization and at the governance, executive leadership, clinical leadership, and across the organization, they made a commitment to change that dramatically. Over the last year they have been recognized as having one of the lowest hospital mortality rates of any hospital in the country.

In this same space, I wanted to bring up a conversation that we've been having at IHI that I'm very worried about in this area of could it happen here?, That's how do we, how do all of the organizations represented on the call, take the events that happen somewhere else and ask the question could it happen here? Could what happened to the Quaids happen in your organization? This is an article that IHI posted in the journal *Healthcare Executive* back in 2008. We were struck at the organizations that were writing just amazing stories of knowledge management. But we found that the vast majority of hospitals in the country have no opportunity or no system in place to really hardwire that question, could it happen here? And it's not even just events that happen across the country, but it's learning from the events that happen within their own system.

In closing, I am again so excited by the community that's on the call and the realization that thousands of boards have begun this journey. One of the things that Peter made very clear in his opening comment is the emphasis on accountability and responsibility in healthcare is growing and accelerating daily. All we have to do is listen to what's going on in Washington or read any of the blogs that follow any of the articles, and to be struck with this. And what we're finding is that we have many great examples to draw from if we are going to achieve the depth and pace of change that's going to be required. It's only going to be achieved by the systematic application of a framework for improvement. IHI uses one, which is based on these five elements of: aim, foundation, will, ideas, and execution. It's going to involve the governing board and executive leadership working closely with staff across the organization and doing it in partnership with patients, families, and with the communities in which they practice.

Let me just end with these "three bullets" that we've set up here. The first hyperlink talks about these mentor organizations that I have been talking about on this call, the second is for those of you who want more information on the board-on-board intervention, and the third is IHI's overall information on leading system improvement within the healthcare setting. So, Chuck, with that I'll turn it back to you.

**Charles Denham:** Thank you very much, Jim, terrific, and I know we'll have a number of questions regarding practical implementation opportunities and some tactical issues. However, what's really, really important is, oh, it's just critical that we get the voice of the patient and the voice of the patients involved in our discussions. Sometimes we in quality improvement and performance improvement start to breathe our own exhaust and forget how powerful and important their view is, and really make them insiders and leaders inside. And so what I'd like to do is just introduce Dan Ford as somebody who has been a steadfast champion of patient safety. He's representing the patient advocacy role and view. He's a surgical consultant that knows and understands the inside of how hospitals and healthcare organizations work, but I think more importantly Dan brings to us a constant bridge between the patients that are just starting to have bad events occur and not know how to deal with the healthcare system all the way across to dealing with it and engaging and involving them in boards. And I think it's really, really critical that we have this voice and that we have a final word from Dan representing a new role perhaps for patients as leaders and how we engage them and involve them in what we're doing.

The slide that I've advanced to is Slide 43 and it was a real honor to work with them and I really want to thank NQF and Janet Corrigan and Helen Burstin at that time when I asked them whether we could have a chapter written by and with patients and patient advocates and perhaps could we even have a section in each Safe Practice that they could contribute to. And it was the great leadership and values-grounded leadership of Janet and Helen that said, "yes, that makes a lot of sense, let's go ahead and put that in." Not that they're in specifications and not part of the evidence-based sections yet, but they are part of the implementation guide and Dan is one of the six people that every Saturday morning I meet with and provide input to assist. We are moving forward and moving the ball forward with hosts and hundreds of actually patient advocates that they all represent. So, Dan, would you give us a final of our formal statements, would you close us with five minutes and then we'll come right back to Jim with a bunch of questions that I'm getting by e-mails and also in our chat.

**Dan Ford:** Sounds good, Chuck, thank you very much. I'm really honored to be here and I commend both NQF and TMIT for, and so many other organizations, for recognizing the value of the patient and the family involvement. I would suggest that we begin to think about the patient also as leader. The active

involvement by patients and families can really help to change our culture and that is very worthy. Virtually every organization I know that involves patients and family members considers it a positive experience and most of the time a pleasantly surprising experience. Let me give you some practical ways of involving patients and family members.

First of all let's set the stage early. It seems logical and practical that the earlier and more we involve the patient and family, the better the relationship that we will have along the continuum of care. This has got to start in the doctor's office. It's got to start with respect, with listening, with focusing. Likewise, when a patient is in the hospital – again respect, listening, and focus. One of the most common complaints that I've heard after a medical error is, I tried and tried to get them to listen to me and they just wouldn't. I would suggest that we invite patients and families to serve on committees and councils. Dana Farber has done that for years, under Jim's direction, with virtually every board and committee in the hospital, including the search committee for Jim's successor when he moved on to IHI. Cleveland Clinic does it, a number of children's hospitals have been doing this for years. Here in Arizona where I physically live, although I spend much of the time on the road, Scottsdale Healthcare, Saint Joseph's Hospital Medical Center, and Cardon Children's Medical Center in Mesa, which are all in the Phoenix area, do this, among others in the state, and there are a number of others across the country. Many start with patients and family advisory councils and then begin to involve them on patient safety and quality committees and as Jim suggested, the walls will not fall in.

I would also encourage on national medical and healthcare boards and councils that we consider patient and family involvement. I would suggest that there be at least two, not one, on each committee. One may be viewed as a token and it might be more comfortable for those that are actually involved. Storytelling, many of you do this already, I would suggest that you do this if you're not doing it. Invite a patient in or a family member in who's had a bad experience or an uncomfortable experience to talk at every level of the organization. Root cause analysis, and when Peter was at The Joint Commission, he heard me rather persistently with a suggestion when I served on a committee there that we invite patients – and I use the word invite – invite patients and family members to participate in the root cause analysis. I know this is a hot potato. I know this involves fear, egos, change. Some start by putting their toe in the water with a patient advocate and not the specific patient with the problem. And some hospital risk managers and inside attorneys invite patients and family members who have experienced medical errors to serve as very discreet sounding boards for settlement details that are being worked out with someone else who has had a similar event. We may have creative and constructive ideas that didn't occur to the outside legal counsel.

What are the sources for identifying patients? I would suggest that provider referrals, physicians, nurses, social workers. Risk management is a good source. Administration can be a good source and the patient and family members will volunteer. I realize this is not an inclusive list and there are a whole host of others. And what kind of characteristics should we look for in candidates to serve on committees and boards? I would suggest passion and courage, people who are genuine, people who are willing to speak up and to be candid and not thrown off by the occasional egos that may be in the room, a willingness to commit time, a good listener, a collaborator, somebody who wants to truly partner with providers, someone who has an interest in the greater good and who has moved beyond a horrible experience, desires to transition anger and hurt to constructive involvement for the greater good, somebody who can listen to diverse opinions and be comfortable with dialogue and the give-and-take that frequently happens. Again that greater good is so important. Somebody that understands the common purpose and is willing to pursue common goals. I personally think that patients and family members who have experienced medical errors can make terrific committee members. In summary, taking the action step of involving patients and family members is not as hard as one thinks. As Nike suggests, just do it. This will enhance the dynamic communications process that is so important to patient safety. For too long we've had what I would call the historical patronization of the patient. We need to convert that to respect. For too long we've left the patient alone in the room or outside the room. It's practical to involve patients and families. We actually could have good ideas, do have good ideas. This can also bring closure for many patients and family members who may have had some difficulty with providers of some sort and these folks can actually also become great supporters of your organization. Thanks, Chuck.

**Charles Denham:** Thank you, Dan, that was fabulous and I am so glad that we have again to remind everybody that is listening and watching, we've had upwards of over 850 participants and we know we know we're in the last 30 minutes of our discussion, but we are recording the entire webinar.

Jim, we'd like to come back to you with a few questions and to kick off likely other questions and answers that may respond here. Jim, one of the questions that we hear constantly is, it's great what these great organizations are doing, but as a patient safety officer or chief medical officer or chief nursing officer, how do I get my board, my C-Suite engaged and get with the program? If it doesn't start from the top can you give us some suggestions there, Question 1? Question 2, what tools could we tackle? What tools might be available to us to engage physicians at the front line – beyond TeamSTEPPS but maybe others to engage physicians? So, two-part question. What do we do if we're trying to activate our C-Suite and board and then two, engaging physicians specifically?

**Jim Conway:** Sure, on the first one I think is two opportunities. The first is, we're well past the tipping point. I think what people really need to appreciate is, all across the country, we are seeing a high level of engagement of boards of trustees. So if you just don't want to be on the wrong side of the discussion and engagement, that's an important conversation. The second is we have now, through the work of AHRQ and others, have a number of very important studies that make it very clear. Great outcomes are willing to engage governing boards and executive leadership. There is no confusion about the data. We are seeing it all over the place. The third is frankly to stay out of trouble. If the other two reasons don't get you there the ability to travel with your peers, the ability to achieve great outcomes, Peter Angood earlier talked about the focus on the Inspector General.

The Inspector General of the United States is very interested in boards on board. Deputy counsel for the IG's office has been very concerned about the engagement of governing boards and executive leaders. The office of the U.S. Attorney and the inspector general from Medicaid and New York has defined as an element of fraud the failure of governing boards and executive leaders to lead quality and safety. Peter has also highlighted the new chapter on The Joint Commission standards around leadership. It's a very important chapter. So, whether or not it's from aspirational or stay out of trouble, it's really putting together a clear and balanced case to governing boards. And we would be certainly happy to forward any additional information to any organizations. I think those two push and pull have a significant opportunity of doing it. The IHI has a white paper on engaging physicians if people go to our website and just look up "white papers." IHI and others have really put a considerable amount of thought into this and includes a lot of very practical tools and techniques. I've had the opportunity of reviewing that document with the organized medical staff group of the American Medical Association, and that document was very well received. It's very well received when we are sitting in a room with front-line clinicians.

The other thing to do, if we do nothing else, for the front-line docs is stop having the task force for life and we all know what that is. It's some group which we give an enormous charge, we tell them to go off, come back in a year with a report to the med exec committees. Nobody is going to engage with that. But we're finding that if you pick topics that are important, and you use a technique of rapid cycle improvement that respects people's time, they absolutely want to engage. At the end of the day for the vast majority of clinicians, they come to work every day in the service of their patients. But don't waste their time.

**Charles Denham:** Jim, one of the things that Peter and I would want to underscore is the fact that in the Safe Practices there are line-item activities to engage the independent physician leadership, in addition to that that might be employed by the hospital, but the informal leaders in a community, in a community setting. And that there are specific tactics and activities that are part of the blueprint laid out in the Practice as there are specifics and we just didn't have time to address them today with what Dan had addressed and we had asked Dan to give us this wonderful sort of view of some strategies that could be undertaken to include patients in the structure of the leadership structures and systems. And there are line-item specifications that address that as well. Shifting gears, then, Jim, maybe you want to respond, and then Peter, how do you respond and what should be the response to the recent report released by the Consumer's Union on the state of safety in hospitals? We have that from Gabriel Keenan.

**Jim Conway:** Yeah, I have two responses on that. The first, the Consumer's Union has had a very targeted focus around reducing infections, and they are frustrated. In medication safety work and infection work they are seeing that the pace of change is much too slow and the Consumer's Union report came out all over that particular view. We've actually had, and I've had, the opportunity to talk about that with the President of Consumer's Union, Jim Guest. Many were concerned that the report wasn't balanced, that it did not acknowledge that all over the country we have seen a tremendous commitment to try to reduce harm, to reduce infections, and Jim acknowledges that. He actually spoke to that at the National Patient Safety Foundation annual meeting, but he also didn't apologize. He said their focus is to drive out the harm, drive out the suffering, to out the preventable infection. So, from an industry perspective, I think a little bit more balance would have been helpful and people would have maybe received the report better. But what he said about infection in that report I didn't fault.

**Charles Denham:** Great. Peter, would you like to respond to that question as well or any comment?

**Peter Angood:** Thank you, Chuck, and I think Jim made some important points there, but oftentimes you know progress and change occur from strong-minded nudges. And while Consumer's Union represents a large voice, I think they were fulfilling a needed voice and statement by releasing that report. I, too, think it was perhaps a little bit overstated and a little bit biased, but you know some, maybe we didn't want to hear that either. We're a decade into this real change process after the epiphany of the IOM report and we want to hear how well we are doing, not how badly we are doing.

But you know what, there is another report out there, and that's the AHRQ's annual report. And they recently released their update based on last year's data; and through a variety of the patient safety indicators that AHRQ utilizes, there's actually been a decrease in the improvement of patient safety, according to their data. So, if you combine these two reports and look at what we're doing, we're clearly not making the progress that we want to be able to demonstrate, emphasis on the demonstrate, because I think Jim very clearly states, you know, there is activity going on around this country. Most all of you on this call today have activity going on in your own organizations, but it's like that bad economy or the unemployment rate. You know it's different on the street compared to the statistics and the data you receive through these reports. And so, maybe we had a little bit of a lull, but we haven't seen the quantification of all these initiatives that are going on. And I'm actually quite confident that if you give it another year to two years, maybe three, we're going to see some strongly positive data and we'll have different tones in these types of reports compared to what we have just heard.

**Charles Denham:** Thank you, Peter. I've taken us back to slide 27, showing Bill George's recent book about the seven steps to focus on winning or leading in a crisis. And his steps are rethinking your industry strategy, shedding your weaknesses, reshaping the industry to play to your strengths, making vital investments during the downturn, keeping people focused on winning, creating your company or your organizations (and in our case healthcare organization) or department image as a leader, and developing rigorous execution plans. Jim, do you really believe that the crisis that's occurring today gives us a new opportunity to set a new stake in the ground about patient safety? Does the disruption give those of us that are leading units and PSOs and leaders and units of hospitals the opportunity to do something, or is it batten down the hatches and hold on for the ride?

**Jim Conway:** Well, it, you know, it depends ultimately on whether or not we choose to use it. So, we were actually having this conversation with the research and development community at IHI today. I was presenting where we are in health reform in Massachusetts. One of the things that's striking was while there's a lot of focus now on payment reform or coverage reform, what we really need is reform around the way we deliver care. As Don Berwick outlined with us today at IHI, there's basically three strategies we could use. We can get more money. That's pretty doubtful. We can cut the budget. Or, we can begin to redesign the system of care. I'm looking and frankly, I would like to see much more urgency than I'm seeing right now around the focus on redesigning care as opposed to how do we mitigate the budget cuts. So, I think there is an opportunity and I also think frankly we're moving toward a cliff. There have to be very significant budget reductions affecting Medicare and Medicaid. There's no question it's going to happen and how we seize the moment to redesign our care system to drive out the waste so we can find

that off-ramp before we hit the cliff. It's a golden opportunity. It's really up to the people on this call and the industry to see how we use it.

**Charles Denham:** Great. At the end we've got a couple of questions that we'd like to ask you. First is, any suggestions how to start introducing the idea to administration? Maybe Jim, after Dan you can zing in there, but because you've done such a great job at Dana Farber, and I'm sure that this question is asked quite a bit on how to start the ball rolling, but Dan, any suggestions how to introduce the idea to get started bringing patients and families into patient safety and quality committees specifically; and Dan the second question, could you comment a little more regarding risk management and the discreet use of families for case settlements? Two good questions.

**Dan Ford:** Yeah, very good questions. Regarding the first one, one is through storytelling. Let's bring in an outside person who had a bad experience maybe at our hospital, maybe not, and talk to the board. And that's one way of planting a seed if the idea will be accepted. Another is champions within the organization who can push and push and sometimes push more as an illustration. Because I really understand the sluggishness that prevails. During my day job of executive search, when I'm working on searches, I really also try to plant this seed. I think it can come from lots of different directions. Regarding my observation about working discreetly with risk managers, obviously you've got HIPAA considerations and somebody being involved from the outside shouldn't be aware of the specifics or the name. And when I've done this, you know, I honestly don't care. I would rather be more objective and just talk over the specifics of what is being considered. The organization can have blinders, legal counsel can have a narrow perspective, and we just haven't done this a lot at least in this new world. And I can talk offline too with anybody that wants to talk more.

**Charles Denham:** Jim, do you want to comment and we might come back to you, Dan, we've got another good question for you, and it's great to have people asking about engaging patients. Jim, any suggestions on getting started? I'm sure you hear it a lot after you've pioneered it at Dana Farber.

**Jim Conway:** Sure, well, the first is the Institute for Family Center Care has put together a great getting-started publication. And Chuck, I'll send that to you so you can post it. Bev has put it in the public domain. I think many organizations already have an activity in the NICU going on that never spreads to the organization. There's many NICUs or pediatric programs. So, I would just add that to the great ideas. Yeah, I would just point people nationally to Massachusetts. Consumers in Massachusetts sort of made this discussion sort of a non-discussion. The governor signed a law in Massachusetts last September that requires all hospitals in Massachusetts to begin by this year putting in place patient and family advisory councils. If you don't like, it too bad. And that's an important notion. One of the things that the industry is working with consumers on right now is to make sure that it's not just tokenism, that they in fact do this in a way that it realizes its potential, but in Massachusetts it's not if you're going to have them any more, it's when and how.

**Charles Denham:** Great. We have questions streaming in and one question, Jim, coming back to you as an operator, Kathleen Bulman has commented that we're seeing a lot of staff getting cut as we have poor economic times, with much of the care falling back to the RN at the bedside, which we know really increases patient safety risk. Are there any strategies or suggestions that you might have that our leaders who are on this call might take up with operating teams to just keep reminding them that they're, it's like not putting oil in the engine of your bus fleet? You will pay huge consequences later and the short-term cut may be very dangerous long term. Any suggestions as we're seeing that kind of behavior? We're hearing this from our entire test bed.

**Jim Conway:** Yeah, we were very struck at IHI. We had a call last week or a few weeks ago on improving the experience of the people close to the patient and we had over 2,000 people registered for that call. I think one of the very exciting notions for nursing is this work that RWJF, Robert Wood Johnson Foundation, and AONE and IHI have been involved in, called transforming care at the bedside. What we have found in studies around the country is 40, 50, 60 percent of a nurse's time is currently being invested in content that doesn't add value. So I think, and we can certainly point you to some content around transforming care at the bedside. The second thing is to understand that most, if you look at all of

the research, that says most change fails. Around 70 to 80 percent of the change efforts that we kick off unfortunately are going to fail – either fail to execute or fail to spread. And if you look at the primary drivers for that the single largest driver is, because we didn't effectively engage staff in the process. So, I think draconian measures will only continue to frustrate our efforts to drive this forward. Again, happy to answer the questions in detail and I will send you the content on TCAB.

**Charles Denham:** Great. And we have had a comment from Marie Abram who is from the Institute for Family Center Care and will send additional information. We really want to thank Marie. Coming back to both Jim and Peter, reflecting on a morning meeting this morning with Penny George and Bill George, who have been wonderful philanthropists, who have been funding integrative care, and focusing on areas where complementary care can work together, evidence-based complementary care working together with evidence-based typical conventional care. They've had spectacular results in pain management with dramatic reductions in procedures and beds and things that really cause preventable adverse drug events, while at the same time having tremendous improvement. Do you all see a time now during the crisis when some of these things that may not have been as fashionable, because they weren't part of what we reimbursed for, might become so, just because of the economic drivers and the fact that they do dramatically improve care as we start to focus in a patient-centered way, Jim?

**Jim Conway:** Yeah, I don't know if the economic drivers are going to be as powerful here as the consumer is. Seventy percent of cancer patients are using some form of integrated or complementary medicine. Most of them are paying for it out of their pocket and it's off-system. Ten years ago Dana Farber implemented their system. It wasn't because we wanted to go there, frankly; some people refer to it as voodoo, but it's because of the activated cancer patient says I want to have one system of care and not have on-the-books and off-the-books care. So, I think the voice of the consumer around wellness and the focus on prevention is going to drive this potentially much more than the economics – well, at least in the short term.

**Charles Denham:** Peter, comments?

**Peter Angood:** Sure, thanks. And, you know, I think we have to be careful when we use the term crisis that we're actually just mainly referring to this economic downturn, which will turn around in a shorter term. Healthcare is actually in its best opportunity in such a long period of time, nearly two decades. And so, we need to continue to leverage the systems in the processes that have been into place. I think the momentum and the upswing of consumer processes and their voice in here is highly important. And so, yeah, I think the consumer voices are going to drive some of this. However, you know, the balance of alternative approaches versus traditional approaches, I think some of that is also going to come out in a comparative effectiveness research strategy. One hundred top priority topics were just released a week or ten days ago? And so I would encourage you, any of you on the call, to look those up through the HHS website or a variety of others that have now posted secondarily. And a lot of the topics that come up in that top 100, we'll address or wind up addressing the alternative care strategies over and above traditional work.

**Charles Denham:** Great. Thank you, Peter. I just want to thank each one of our panelists for the terrific input that they have provided to us. Make sure that any of you that don't have the NQF Safe Practices for Better Healthcare 2009 Update to please go to the new National Quality Forum website. It's terrific. Keep your eye on it. NQF is just doing a terrific job on the work that they are continuing to build. They have deeper now, of support from HHS, and I think that we will have a terrific opportunity to really leverage those assets as they get better and better. There will be an audio stream of these webinars. The last slide that I had up was the upcoming podcasts and iPod-ready download packages that you'll have available to you shortly, and we will ping the folks that have expressed interest as you close off of the web and let you know when those will be available. And then our future webinars that we have coming up will be, I think, a terrific opportunity for similar dialogue. The webinars on the 17th of September are the condition-specific, 26 through 34 Practices. A number of them are hospital-acquired conditions, HACs. Then creating transparency openness and improve safety Safe Practices 5 through 8, which include those of consent, informed consent, and care of the caregiver. And then November 19th, the health of your communication and safe information management. Then at the IHI meeting in the first couple weeks

of December, Dan Ford and a number of the patient advocates will be involved in one of the one-day sessions, and we'll be really focusing on the quick-start package approach to implementing the Safe Practices and also tying patients into that as you proceed forward.

So, we'd like to thank all of you that have attended this webinar and consider it again a thankful success. Thank you, Dan Ford, for offering the perspective of patients. It was definitely a hot topic with our Q and A. Jim, as always, you are just such a champion for the cause and thank you for your work with Ford; and Peter, continue to do such a great job as you do with the rest of the NQF staff who we can't name on this call. Thank you so much and we'll be announcing the webinar, that it will be a deep dive into leadership area, with Bill George being our speaker. We will combine that with a medication management collaborative, so this will be directly focused at leaders at governance, the C-Suite, leadership of pharmacy, and focusing on the pharmacy leadership practice, in addition to leadership of mid-level managers. Thank you very much, and this webinar is now over.