

2022.11.14 HHS Convening to Advance Patient Safety

Transcript of Questions and Answers

>> Beth Daley Ullem: Thank you, Mr. Secretary. And as we've just heard from the HHS divisions, they intend to create -- co-create a public-private partnership with the national healthcare delivery system Action Alliance. And as such, HHS would like to hear from the healthcare community about your ideas of how it can be most effective. They have posed three listening questions for them to hear from the executive leaders here today.

The first question is, what are the main challenges your system is facing in meeting your commitments to advance patient safety as you emerge from the pandemic? The second question is, what can HHS bring to this Action Alliance in terms of coordination, alignment, tools, training, nonfinancial resources to support the effectiveness of the Action Alliance in assisting healthcare delivery systems to advance patient safety and healthcare workforce safety? And then the third question is, how can the Action Alliance most effectively support your organization in advancing patient safety? Are there specific priorities for your system or for specific settings of care?

We are going to address the questions one at a time and hear from our guests today. The guest will each have one minute to respond. And at the beginning of the response, they will tell you which organization they are here with. Just a reminder to those who are responding to turn your microphone on before you speak and turn it off after you -- after your remarks to reduce interference noise. If what you want to -- if you -- what you want to say has already been shared, please do not feel pressured to use your full time. After all of you respond, I will ask one of the patient and family advocates to reflect on what they heard and how HHS and health systems might best partner with patients and families to accelerate safety improvements. I will start with different people around the table for each of the questions.

Before we begin, I just want to remind everyone that because of his change in his schedule, Secretary Becerra will only be able to stay a part of the listening session. But he asked me to assure you that he has great confidence in his leadership team who will continue to be with us for the entire session and we'll discuss your ideas. HHS also wants to hear from those of you not in the room today listening through live stream. To do this, they will be publishing a formal request for comment in the Federal Register, which will include those same three questions and we encourage you to file public comments.

So, to the first question, let's begin. What are the main challenges your system is facing in meeting your commitments to advance patient safety as you emerge from the pandemic? This first question, we'll turn to you, Kerry Heinrich from Adventist Health.

>> Kerry Heinrich: Thank you, Beth. Mr. Secretary, thank you for the honor of being here today and to each of the members of HHS. I hail from just out of Sacramento, California, and represent Adventist Health as its CEO. I'll cut to the chase. Today in California, there are tents

going up outside of hospitals across multiple metropolitan areas in California. Why? Because we're struggling to deal with the realities of a new round of challenges and the truth is, there simply aren't resources.

When you're dealing with the quadruple challenges of wage increases and staff shortages and inflation and the change of our business model itself from ambulatory away from inpatient, it is stressing the system in a very real way. So, my plea is help us address safety by helping us address the ability of our systems financially. In Boyle Heights, a neighborhood Mr. Secretary that you know very, very well in East Los Angeles, there's a different access to care than probably in affluent areas of Los Angeles. So, for quality, we need resources and the Medicaid program doesn't help us provide those resources so -- oh, the safety of the safety net by preserving it. Thank you so much.

>> Gary Stuck: Thank you. Mr. Secretary, thank you for the honor to join you and colleagues today. Those were tremendous presentations. I'm Gary Stuck. I'm the chief medical officer of Advocate Aurora, Wisconsin, and Illinois. We're privileged to serve 3 million patients in 27 hospitals and an ambulatory footprint of 500 [unintelligible]. We've been very fortunate to be on this journey for the high reliability since 2011. Okay. Thank you, sir.

>> Beth Daley Ullem: It's Gary Stuck of Advocate Aurora.

>> Gary Stuck: -- since 2011. And we believe that patient safety is a fundamental right. And Armando, your remarks were so impactful. We had a death of an infant in 2010 that changed us and changed our hearts and minds and put us on this journey and we've been advancing this across starting with our leadership. Our board, our -- we have a safety committee of our board. We have all -- we have high-reliability training for all of our leaders and it cascades down to the frontline. We're very proud that we've been able to develop a just culture with strong safety event reporting and year-over-year reduction in serious safety events, reduced mortality, reduced infections, in spite of some of the data, you know, big challenges.

But building that just culture, one problem is, you know, we have challenges like the RaDonda Vaught verdict. And so, decriminalizing human error and helping us to create the safe place -- our clinicians don't want to commit error, but sometimes we don't create the right environment. And we need research around that, around human factors, research, and others. Also, Mr. Blum, Jonathan Blum, I love your comments about payment reform and value-based programs. We would, at Advocate Aurora, fully embrace more transformation around payment reform with health equity and patient safety. We would be all in on this.

So, thank you for the opportunity. I think my time's up, but thank you for the opportunity for us to share with you today and count us in.

>> Beth Daley Ullem: Thank you.

>> Joseph Impicciche: Mr. Secretary, my name is Joe Impicciche. I'm with Ascension, the CEO of Ascension. We're based in St. Louis. We have about 145 hospitals across the country in about 19 states. You know, when I look at your question, one of the main challenges that we're

facing right now is stable workforce. I'm sure everybody in this room is experiencing what we're experiencing and we've had high attrition. We've had a significant increase in contract labor. We have staff that's burnout and we have staff that's been ill. And it's very difficult to create even though we continue to value very highly a culture of safety and high reliability. It's very difficult to do that when you don't have a stable workforce.

So, I think that's probably one of the biggest challenges that we face and it's being able to get, you know, get the talent, you know, and it's in such a shortage right now. It's very difficult to be able to recruit the number of professionals that we need to make up for those that we've lost during the pandemic. And then I would just also add very quickly -- and I think, again, it's been mentioned before -- but reimbursement simply is not keeping up with the costs that we are experiencing and it's putting an incredible strain on resources within all of our systems. Thank you very much for inviting us here.

>> Beth Daley Ullem: Thank you, Shelly.

>> Shelly Schlenker: Good afternoon. Shelly Schlenker with CommonSpirit Health. Thank you, Mr. Secretary, for convening us and all of you. We couldn't agree more that patient safety is of the utmost importance and we want to -- we stand ready to participate in the alliance. As many others here have said, you know, some of the basic blocking and tackling like workforce and finances are important. We also believe that we need to rethink our view of harm.

We need a standard definition and we need a more comprehensive and holistic view that goes beyond hospital-acquired conditions and really addresses the full continuum of care as we heard from some of our speakers and we need to modernize the measures. We need to reduce measurement burden, much of it is still manually extracted. And without a standard definition, it makes it even harder for that. We need simple definitions and we need reproducible risk adjustment so that we all can benchmark as an industry. We don't need to compete on patient safety. We need to collaborate on patient safety.

And then the last thing I'll add, so I don't go over time -- and we heard a little bit -- it's really a lack of a public health infrastructure in this nation. If there's one thing the pandemic brought to light, it was that that has been underfunded for decades. And honestly, absent the large health systems, the response to the pandemic would have been much different, but that was an added burden on all of us with a staff that was already stressed. So, we would like to see HHS really call on Congress and others to look at what is that public health infrastructure. This won't be our last pandemic or public health emergency and that's the interface with the social determinants of health that we believe could make a big difference in overall patient safety.

Thank you.

>> Beth Daley Ullem: Thank you. Michael? I just want to remind everyone to keep us moving along as well.

>> Michael Cuffe: Hi. So, I'm Michael Cuffe. I'm the chief clinical officer for HCA Healthcare, 180 hospital systems across 40 major U.S. and U.K. markets. I would say that we

are dedicated to helping the actual alliance improve the safety and care of all of our patients. It's our top priority and, frankly, it's in our mission statement as well.

I'll make two points here. One, for your consideration, is that in our experience, hospital-acquired infections have not increased over the past three years in the 92 percent of patients who did not experience COVID. They were very high in the 8 percent of patients that we saw in the 347,000 patients we took care of who had COVID. And diving on that fact and understanding, whether that is all of our experience, is vital to not only that ongoing care and the choices of care that we've made around the care of these patients but also to the treatment of patients and the future pandemic.

So, the staffing dynamic is the worst and I view over the rest of my career is that being the predominant challenge. If you think about solving for health, equity access, and aging growing population against the workforce demands, I don't see how that math works out. And so, in our opinion, and increased emphasis on the full digital transformation of healthcare workspaces in the hospital and outside of the hospital with a new focus from our agencies on implementation science, human factors, and workflow engineering, this will help the company solve for workforce shortages in the face of increasing healthcare demand and I think perhaps most directly improve patient safety as well as the care of our patients and families. Thank you, sir.

>> Beth Daley Ullem: Thank you. Andrew?

>> Andrew Bindman: Thanks very much. I'm Andrew Bindman. I'm the chief medical officer at Kaiser Permanente. It's a real pleasure to be here today. Thank you for the opportunity. Thank you for your comments, Mr. Secretary, and for all of -- the comments were really fantastic and really resonated very strongly. Kaiser Permanente, I know the Secretary knows us well, we're about 12.5 million members in the eight regions across the United States. I'm very proud of the commitment our organization has made to safety. But I would say right here that we can and all of us need to do better to address this issue. So, thank you for the attention you're giving it today.

I would reinforce a couple of comments that are made earlier. I do think workforce has been an enormous challenge coming out of this. I do think we could benefit from more research and knowledge about how to build resilience in our workforce so that we can help keep healthcare providers in the game. We saw incredible energy and commitment, real heroes, in our healthcare system. But we need to recognize that we're in this for the long haul and to build that resilience. So, we're not just in the process of rebuilding but, in fact, sustaining the workforce that we have.

The issues that were raised about cost, I guess, I would particularly want to focus that on and link it to the comments that were made about having a strong public health infrastructure is absolutely critical in clarity of roles about expectations on the healthcare system and the role that we can play in association with the public health infrastructure. We have faced unprecedented costs not only in the care of patients with COVID but ongoing testing and additional issues that have come up related to COVID and we need to find the right balance of how to work together. I mean, I think your comments, Dr. Califf, about how health systems can work to provide post-surveillance information is an important role that health systems can play. But let's find the right

balance in the resources for that.

And finally, related to some of the question -- or comments that were raised about burden, I think it's -- there is a responsibility, obviously, of the health system to be accountable related to these issues. But let's get, again, the right balance. You know, CMS has put a lot of emphasis, for example, on care experience in some of their measures in recent years. Very important, but it's squeezing out the real estate available to measure patient safety.

So, let's get back to the right balance, if safety is a priority, which I believe everyone in this room is saying it is. Let's make sure there are appropriate waiting of measures related to safety. And do it in a consistent way throughout the system, so that we aren't running around to different parts of the program or the different payers trying to meet different kinds of needs and ways that do create burden.

So, I think there's ways to bring that alignment, and I look forward -- KP looks forward to working with you in this new endeavor in bringing more energy to the focus on safety. So, thank you very much.

>> Beth Daley Ullem: Thank you. Christopher?

>> Christopher Rehm: Secretary, thank you very much for allowing us to be here. So, my name is Christopher Rehm. I'm LifePoint's chief medical officer. And LifePoint is based in Nashville, with over 60 acute care hospitals and roughly 30 rehab centers in 29 states.

And I'm going to just triple down on three things you've already heard, so I'll be brief. Workforce. I think the CDC -- the slide that you showed for the harms, and that is as people taking care of people, nothing materially change other than the workforce got stressed, the patients got sicker, experienced -- vacated the hospital, and found employment in other healthcare settings or left healthcare altogether. So, workforce, challenge number one.

Reimbursement and the cost burden. So, the mismatch between reimbursement and not keeping pace with our cost with no labor and/or just the clinical care that a sicker population requires. And then the third challenge is just measurement burden, similar to what you were stating. We got 24 hours a day. We have staff that is wearing -- they're wearing multiple hats, and so how do we prioritize their work? So, how do we do that in an efficient fashion?

So, workforce, reimbursement and cost mismatch, and measurement burden. Thank you very much.

>> Beth Daley Ullem: Thank you. Ms. Sonali [spelled phonetically]?

>> Female Speaker: Thank you so much for the invitation. [inaudible]

>> Beth Daley Ullem: Thank you.

>> Cynthia Bentzen-Mercer: [inaudible].

>> Beth Daley Ullem: Thank you. And that was Cynthia from Mercy Health.

>> Jill Kalman: Good afternoon. Jill Kalman from Northwell Health, the chief medical officer. And again, Secretary and team, thank you for having us today. We are based in New York. Mostly in New York State, in Long Island, in New York City, 23 hospitals, 850 ambulatory sites, 80,000 employees, and about five and a half million patient visits a year.

Again, reemphasizing, but to add a couple of new -- but the reemphasis on workforce, and that workforce resiliency, and really the effects that we're seeing in the fatigue of our workforce in the frontline value-based care journey. It is not the same across the country. And how can we really say that we're committed to value care when the different parts of this country are still, we'd like to say, addicted to fee for service? So, how can we really make a commitment that that's the journey we'd like to be on? And also, that disconnect between what's true quality versus regulatory that doesn't contribute to quality is an overburden.

And lastly, I'll just add to the issues the decrease in clinical variability across our journey to safety and quality. We really saw in COVID for the first time a true decrease in variability, because we did not know what to do. So, we didn't know what to do or how to treat COVID. Everybody quickly adapted the protocols that needed to happen. We don't have that same clinical standards. We have them, we just can't cascade. So, I think we have to have that renewed vigor that we really learned from COVID.

>> Beth Daley Ullem: Thank you.

>> Patricia Sullivan: There you go. Okay. Hello. Thank you for having me. I'm Patricia Sullivan. I'm the chief quality officer of the University of Pennsylvania Health System. We are based in Philadelphia. And we're about a \$10 billion organization. And we continue to grow.

I guess workforce is the first thing, when I was writing down, that came to my mind. I think everybody has made great points. I think we started a high reliability journey about a year or 15 months ago. And it's a long journey. But I think it's well worth it. I think psychological safety is one of the major impediments to our being able to understand and have people share with us freely and openly about, you know, what's happening at the frontlines.

I will say that in particular in Philadelphia, but probably other venues, now practice is a big issue for us. We have -- our attorneys are, you know, really sticklers about what we can and can't share. So, I think that that really impacts our ability to have a forthright dialogue with patient advocates and with patients and for all of us -- and for staff and physicians in particular to feel comfortable having these kind of discussions in terms of what really went on.

>> Beth Daley Ullem: Thank you.

>> Jacquelyn Bombard: Hi. Jacquelyn Bombard with Providence. I'm here representing our chief quality officer, Jennifer Bayersdorfer, who unfortunately had a family emergency and was unable to attend today. Providence is a large not-for-profit health system based in the Pacific

Northwest. And we have 52 hospitals, 1,000 clinics spread across our seven state footprint from Alaska to Texas. Secretary and all, thank you so much for having us here today to discuss this important matter.

Healthcare is a uniquely human endeavor. And by no means are we perfect, we cannot solve this problem alone. No hospital can solve this problem alone. We need a federal private and public partnership. So, so grateful for your support here today.

In terms of our policy asks for our challenges today is that we really do need regulations that allow flexibility to allow us to design innovative care delivery models. And then the second is policies to strengthen and heal our workforce, which my colleagues have shared here today. We cannot be successful in improving patient healthcare if we don't have a strong workforce, so thank you.

>> Beth Daley Ullem: Thank you.

>> Laura Kaiser: I'm going to bring this over, so we're on deck. I'm Laura Kaiser, the CEO of SSM Health. We're based in St. Louis, and we serve in four states in the Midwest. Thank you for having all of us here today and grateful for your remarks.

I would echo my colleagues around many of the issues that have been pointed out, but the way I view this is our U.S. healthcare system is at an inflection point. Patient safety, high reliability were big issues before the pandemic. They remain, and what was exacerbated and continues is the workforce challenges. As I have yet to meet a caregiver that's looking to hurt anyone, it's more about the stresses of an overwhelming system.

And so, I would be very grateful to be able to solve the workforce challenges. But short of that, I think we need to really lean in together around modifying our entire system around alignment of reform for payment to help people live their healthiest lives in collaboration with federal, state, public-private partnerships, the public health system, all the providers, and others that are a part of this health system equation, including payers and other parties that are together providing patient care.

>> Beth Daley Ullem: Thank you, Laura. Lynn?

>> Lynn Simon: Thank you. I'm Lynn Simon from Community Health Systems. We're 80 hospitals in 16 states from Alaska to Key West, Florida. So, thank you for the ability and the opportunity to participate in this important conversation today.

I join my colleagues in expressing the challenges that we've all had around workforce. And we have been on a high reliability journey since 2011 and share that journey with many people in this room. We're getting down to sort of practical opportunities. I'd like to discuss the opportunity to reduce clinical documentation burden. That's really been shown to be -- you know, have a profound negative effect on the provision of care. Even prior to the COVID pandemic, it's been linked to job attrition, burnout among healthcare professionals, and an increase in medical errors and hospital-acquired conditions.

So, healthcare staff, they can spend up to two times as much of their -- two times as much time on clinical documentation as they do in patient care. So, I think some attention needs to be paid to reducing the regulatory requirements or reducing documentation similar to and in addition to the flexibilities that were given in the current public health emergency waivers. And that would help us relieve at least some of the burden on our clinical workforce. Thank you.

>> Beth Daley Ullem: Thank you.

>> William Isenberg: Thank you, Mr. Secretary. Bill Isenberg, chief medical officer from Sutter Health, your neck of woods. Twenty-six hospitals, many, many clinics, about three and a half million patients we serve.

I think I'm two-thirds of the way around the table. There are many brilliant things that have been said, and I don't want to repeat any of them. I would just like to say that in addition to the wonderful team you've put here, it might be very well to bring in colleagues from OSHA, because people who don't feel safe doing their jobs cannot render safe care. And so, I think it would be a real big value to include that as a partner as we pursue this journey together. And we're excited to do so.

>> Beth Daley Ullem: Thank you.

>> Mike Slubowski: Good afternoon. Thank you, Secretary. I'm Mike Slubowski from Trinity Health. We're a Catholic health system in 26 states, 89 hospitals. We're the second -- we're the largest not-for-profit patient provider in the country in senior services.

Safety is one of our core values. I would echo what everyone said here about staffing situation and the impact that it's had on safety, as well as linking colleagues' safety to patient safety. For our system alone, just to give you a statistic, we're hiring 2,500 people per month, we are losing 2,500 people per month. So, the staffing situation is definitely number one.

The second thing in terms of the challenges is we put everything in our zero harm journey with delay. Our safety training, our common platforms in transformational technology, the standard event classification work, which is all heavy duty work, really was slowed during the pandemic, a major issue for us.

You've heard a lot on finances. Fifty percent of the COVID admissions happened between October '21 and March of '22, a period in which there was zero additional provider relief funding to help us through this journey. And we're very open to total cost of care opportunities. We've been successful. Those are an answer to the future. Thank you.

>> Beth Daley Ullem: Thank you.

>> Anne Foster: Thank you very much, Secretary Becerra. I'm Dr. Anne Foster, chief clinical strategy officer, from the University of California Health System. And I am filling in for Dr. Carrie Byington, who sends her regrets. And she is our EVP, as many of you may know.

So, you know, as the largest academic health system in the country and representing our five academic medical centers throughout the State of California, what we've found really as a major challenge is the increasing demand for tertiary and quaternary care. That's part of what AMCs do, right? We fill in -- we fill a very important niche. We need all of us around the table, but we fill an important niche because of that demand. And that is exceeding our capacity and really potentially limiting access to both inpatient and outpatient service.

Now, I think everyone knows we have multiple factors that contribute to this national trend amongst academic medical centers, but access to care has become a critical safety issue at this time. And that is especially in the context of constrained resources in the current macroeconomic environment.

So, let me just say something about access. Access equals equity. Equity equals access. We cannot have these conversations without focusing on equity.

>> Beth Daley Ullem: Thank you.

[laughter]

>> Anne Foster: Oh, you're trying to stop me.

>> Beth Daley Ullem: [affirmative] Well --

>> Anne Foster: Let me enlarge this theoretical framework around equity briefly. So, I'm not talking about equity only in the context of social disparities because that is core to the entire discussion, but payment equity, right, how -- what are we going to do in equalizing reimbursement? Because we can't continue to have a two-tiered system in this country and expect to achieve these goals. The other area would be, how can we better -- another challenge is, how can we continue to empower all team members, so that everybody really is completely aligned and empowered to drive that patient safety journey?

>> Beth Daley Ullem: Thank you.

>> Anne Foster: I think the greatest challenge that my system has, but I think it's a challenge for all of us is really --

>> Beth Daley Ullem: Anne, if you can wrap.

>> Anne Foster: Yeah.

>> Beth Daley Ullem: We -- I have -- we have to get through this. Thank you.

>> Anne Foster: This is it. How do we garner sustained political will as a nation to really drive patient safety? Thank you.

>> Beth Daley Ullem: Thank you.

>> Dave Williams: Mr. Secretary and team, thank you so much. It's an honor to be here. I'm Dave Williams. I'm a pediatrician and chief clinical officer for UnityPoint Health in Iowa, Illinois, and Wisconsin.

Armando, you are so brave. I'm so sorry for your loss. And thank you so much for putting a necessary face on this issue and tell us our primary mission has to be safety for our patients.

I'm going to take a page from Dr. Isenberg and not repeat any of the great comments I've heard in our system that is all about staffing. It is all about workplace violence. I'm going to put a face on that. We've recently instituted a system-wide daily safety huddle system, where we get reports from all of our hospitals and clinics to our CEO's office by 11:45 a.m. each morning. One of the many metrics we tracked is workplace violence with injury. It has to be a significant injury to be tracked. I think our current record this year is two days without significant injury to a healthcare worker. Thank you.

>> Cliff Megerian: Secretary Becerra, thank you very much. It's an honor to be here with you and your entire team. From University Hospitals in Cleveland. I'm Cliff Megerian. I'm a physician, otolaryngologist, and CEO.

Our entire system, which serves about 23 hospitals in Northeast Ohio, and millions of patients, over 55 large medical office buildings, has it really been built around the notion of quality and value, we were fortunate enough to win by American Hospital Association this year's Quest for Quality award, which is based on many of the metrics that your team elucidated should be the best in the business.

In addition to that, in MSSP, in Medicare Shared Savings Program, in which we participate we annually and especially recently, have had some of the best results at achieving quality at very, very low cost. But the point I want to make is that this is at risk much like the data presented by Dr. Houry that not only through COVID, but now with the financial issues that are affecting our hospitals, which allows us to do the discretionary work that gives those kind of good results are at risk.

And then secondly I think, which hasn't been mentioned, is that risk in hospitals that are not seated here today, that are smaller at the rural hospitals, close to 71 in the last few months have gone bankrupt, and our state's seven has gone bankrupt, and then our city, one of our largest safety net hospitals have gone bankrupt. And now, those patients are streaming into our hospitals. So, we have a financial sort of Damocles which is laying over the people that we need, we all need, you need to be working that is impeding that ability. So, hopefully, I'd love to work with you on solutions.

>> Beth Daley Ullem: Thank you. All right. And the last comment for this question.

>> Donald Yealy: Hi, I'm Don Yealy. I'm the chief medical officer from the University of Pittsburgh Medical Center, and emergency physician by training.

One of the things we had to learn during the pandemic was to be a learning healthcare system. Take every day and every opportunity as an opportunity to learn what we did well and what we had opportunities for improvement on. And COVID-19 was actually a gift for that. We found out that going from a period of uncertainty and fear that we could actually manage that pretty quickly by carefully looking at what we're doing and what we shouldn't be doing. I think we actually have to capture that moving forward.

You've heard again and again the biggest threat is actually about our people, whether it's the people we serve, your son wasn't a patient as a person who was getting served. Our workforce are people who are trying to serve. We have to have a different new workforce that has the freedom to react the needs as it exists day to day, week to week, and has the support both financially and health-wise to perform, so that they can perform together with people. That's what we need from you.

>> Beth Daley Ullem: Thank you very much. So, now, I'd like to invite Helen Haskell from Consumers Advancing Patient Safety, and then Lisa McGiffert from the Patient Safety Action Network, to share their responses to what they heard from these comments.

>> Helen Haskell: Okay. Have I got the right button on?

>> Beth Daley Ullem: Yeah, just speak up.

>> Helen Haskell: [laughs] Okay. Well --

>> Beth Daley Ullem: A little louder. Maybe a little closer.

>> Helen Haskell: Yes. This was an interesting exercise for me. I think it was a good illustration of the gulf between perceptions of healthcare providers and patients.

So, I'm a representative of a very old patient organization, Consumers Advancing Patient Safety. Like Armando, I lost a child, a young child to a medical error in a large teaching hospital. And the words that I was looking for, a lot of the things that we are talking about in the national action plan, I didn't hear. You all are focused on very different issues. You focused on financial issues. You focused on staffing. I understand those issues, but I've been thinking about different issues, especially as I was thinking about my comments today.

So, one of the words that I only heard once was "transparency." I think that that is a critical component. It's one of the real reasons that patient safety has failed to progress as we thought it would. The failure to be transparent with patients in the public, because they are the ones who can hold you accountable, who can guide you. If you're not looking at your end user, you're not learning what you need to learn. A learning system is only as good as the people who are contributing to it, and patients want to contribute by and large.

The other word, which I also only heard once, was "equity." So, I conflate equity not with access, although I can certainly see that, with respect, with patient engagement, unless people are

listened to, unless people have information, because the biggest inequity is disequilibrium of information. But unless you have people contributing to their own care invited to contribute to their own care and to your learning, you won't learn what you need to learn. So, bring patients in. Welcome them.

And I'm not just talking about equity in terms of -- we often -- you know, people are thinking of it as socioeconomic, as racial, as ethnic. But what I see far more are people who are differently abled, disabled people, people with stigmatized conditions, people that are just not respected in the healthcare system. That's something that needs to change. It needs to be taught. And I think if you bring these people, you can have learning systems. And you'll find really, that most of your questions will end up being answered by patients.

>> Beth Daley Ullem: Thank you, Helen. And Lisa McGiffert from the Patient Safety Action Network sharing her response to what she heard.

>> Lisa McGiffert: Good afternoon. Patient Safety Action Network is a national coalition working to end the medical arm through transparency and accountability. We are patient led and patient driven. We are people who have been harmed by medical care. And we are rooted in the experience of trying to get the healthcare facilities and providers to be accountable for their actions and to be willing to correct those actions for a safer future.

Secrecy has not worked. In fact, safety improvement has been directly related to transparency, because you cannot know where you need to improve if you do not identify where preventable errors and infections are occurring. We have seen this through hospital infection reporting, and now getting nursing homes to report about COVID, granted we need better ways to collect information about these events that is not a burden on healthcare providers and cannot be gamed by them.

We have ideas on how to do that that would give us more accurate information than we now get. And we look forward to working with you on that. The agencies in this room have endless ways to create accountability. First, you must do your jobs and use the tools you are given to protect patients in the public. Then make public information you possess more, well, more public. Do this online. Aggregate the information about specific providers. Make it easy for the average person to find. Look up and understand.

We have many ideas about what agencies can do, and here are a few examples. Include information about errors and infections on death certificates, which would put medical harm on the list with other leading causes of death and lead to more focus, more activity, and more funding. Provide a publicly supported avenue for harmed patients to report these events similar to the FDA's adverse events reporting system for drugs and devices. Make information in the National Practitioner Data Bank public. Rethink how these harm events are treated right after they happened. We can do this collaboratively, with the patients have to be engaged as equal partners.

If I had more time, I would tell you more about a collaborative effort I've been involved in to develop a framework on infection outbreak response and disclosure with public health

professionals. It should be implemented nationwide.

Measurement is important. But from the public and patient's point of view, we want to know, was the medical harm prevented or not? Whatever the providers are doing, is it working? Whatever work is done after this meeting and I have faith that much good work can be done, agencies must specifically measure whether healthcare provider activities lead to less patient harm. You must act quickly, when harm occurs. And you must reveal those results in more real time to the public than we're getting today.

Most importantly, healthcare providers must reveal what happened to patients and their families in actual real time without strings attached, and then engage them in your investigations and actions for change. Thank you very much.

>> Beth Daley Ullem: Thank you, Helen and Lisa. I would like to switch to -- because of our timing and we have so much great discussion, what I'm going to ask that we do is merge our comments for question two and question three, since they're kind of two sides of the same coin.

Question two, you can move, "What can HHS bring to the Action Alliance in terms of coordination, alignment, tools, training, non-financial resources to support the effectiveness of the Action Alliance in assisting healthcare delivery systems to advance patient safety?" And other specific ideas you have for how HHS can support your organization to advance patient safety. So, if everyone could kind of bring their one or two biggest, best ideas forward, that would be very helpful. Thank you.

We're going to start with Sonali at the -- for this last question here.

>> Female Speaker: Thank you again. [inaudible].

>> Beth Daley Ullem: Please speak up.

>> Female Speaker: In order to make patient safety a national [inaudible].

>> Beth Daley Ullem: Thank you.

>> Female Speaker: [inaudible].

>> Beth Daley Ullem: Thank you.

>> Female Speaker: [inaudible].

>> Beth Daley Ullem: Thank you. Cynthia?

>> Cynthia Bentzen-Mercer: So, Cynthia Bentzen-Mercer -- I failed to introduce myself -- with Mercy, out of Chesterfield in the Midwest. We have 40 acute hospitals and locations and over 4000 integrated positions in the Midwest. We are going to get tactical for a moment. And we're deeply concerned about the growing number of patients presenting mental illness and the impact

that has both patients and healthcare [inaudible].

>> Beth Daley Ullem: Thank you. Jill?

>> Jill Kalman: Jill Kalman, Northwell. I think in terms of support, I'll go back to the truly determining best practices in helping healthcare systems implement them and really determining what those best practices are. And there should be a decrease in that variability across the country with especially the highest in terms of errors and medical safety that we'd see.

I also think in terms of advocating with government, again, that regulatory versus quality divide that actually adds to our workload. And the other thing I'll say in terms of workforce safety, I think we need to elevate that as a national issue as high as patient safety who don't think it's the same awareness as they are in the public that it is for patient safety.

>> Beth Daley Ullem: Thank you. Patricia?

>> Patricia Sullivan: Hello. I think a lot about the -- all the payers that we have. And Medicare isn't the only payer that we have. So, we have a value-based quality programs with all the private payers as well as the government. And we have more staff that have to sort of chase all these measures and measure them and have different definitions. And, you know, I would be interested in what HHS could potentially do to leverage their influence to get more of the private payers consistent with what it is that you're doing. So, that's -- I guess that would be the one bigger idea that I have.

>> Beth Daley Ullem: Thank you. Jacquelyn, your big idea?

>> Jacquelyn Bombard: Yes. Hi. Jacquelyn Bombard with Providence. There's two things I would add as I'm -- again, like I said earlier, I'm very excited about this public-private partnership. I see this National Alliance really being a convener for all of us to be able to share best practices, to have that transparency part, to have that accountability part, or else we're never going to get upstream.

And then two, healthcare, there's no one-size-fits-all approach. And so, allowing us to innovate and be flexible when we create our care delivery team, so that we can meet the unique needs of each of our patients.

>> Beth Daley Ullem: Thank you. Laura, your big idea for HHS for the Action Alliance?

>> Laura Kaiser: I'd like to just underscore what Patricia said. I would reduce the total number of metrics, because the color that in, I think on a monthly basis last I knew, we are reporting into 168 different entities and more than 1,600 measures a month. So, it'd be really wonderful to reach agreement on a reduced number and do that across the continuum. So, it's all of us in this room, and add the payers, and add everyone that is seeking metrics for the right reasons, but to harmonize.

>> Beth Daley Ullem: Thank you. All right. Lynn?

>> Lynn Simon: My big idea relates to an old idea of patient safety organizations. So, the Patient Safety and Quality Improvement Act back in 2005 authorized the creation of PSOs, and that was specifically to improve quality and safety by reducing the incidence of events that adversely affect patients. A PSO works with healthcare providers to help better improve patient safety and encourage a culture of safety. PSOs served to assist providers in analyzing data sharing evidence-based practices known to reduce harm and improve patient and workforce safety.

Currently, there are only 100 listed PSOs. We do have a listed PSO, and through that over the last 10 years, we've been able to reduce serious safety events by 80 percent. Our work is not done. We are not done yet until we reach zero harm, but we have made progress.

I would suggest that HHS and AHRQ consider how to more fully leverage the PSO infrastructure through standardized data collection and data definitions, education and training, and cross-organizational collaboration, as this may be an mechanism to further enhance patient safety and reduce harm.

>> Beth Daley Ullem: Thank you.

>> William Isenberg: I'd like to rephrase the words of our patient, "Don't hide it. Share it." As my colleague from the East Coast said at Northwell, many of us have really honed our learning organization skills during COVID. And now is the time for us to think about those areas where we have either within our own systems or actually within our own state. I think at the California Maternal Quality Care Collaborative, we have the lowest rate of maternal death in the country. We need to partner and share those kinds of efforts across the country. It shouldn't reside just in California.

>> Beth Daley Ullem: Thank you.

>> Donald Yealy: So, what I'd be seeking is a vision for a moonshot, which would be an integrated national public health system that would be a source of truth on communication and on things like vaccination coordination data and standardization of best practices, including things like disclosure. So, that's my vision.

>> Beth Daley Ullem: Thank you.

>> Anne Foster: Very briefly, I'll just add, I think what would be helpful would be focusing on effective models or best practices that enhance patient and family communication and also exploring how best to integrate patient and family advisory councils into our performance improvement efforts.

>> Beth Daley Ullem: Thank you.

>> Dave Williams: Yeah. I think that one idea I haven't heard in this session is continue our innovative efforts to allow patients to get the care where they want to receive it when possible,

which is in their home, through telehealth, care at home capabilities, and continue allowing us work on public and private sector to innovate.

>> Cliff Megerian: Agree upon standardized metrics built in hospital and out of hospital. Ambulatory quality metrics that everyone would participate and then begin tying with the more vigor, if you will, to reimbursement certainly at the federal level, and that's going to reward those who are fully committed and will encourage those who are not to get on board.

>> Beth Daley Ullem: Thank you.

>> Michael Slubowski: I think having a common simpler taxonomy that helps describe safety for all the people involved, people who deliver care and people who receive care. I don't ever want to use "provider" and "patient." I think those are isolating terms. And if we do that, communication and transparency happen, the name of the game for all of us -- what we're committed to UPMC -- is to provide the best care we can for the most people, not the most care for the few that make it into a certain location in the healthcare system. A simple read upon taxonomy will help us all achieve that best.

>> Beth Daley Ullem: Thank you. Secretary Becerra, you'd like to make a comment?

>> Xavier Becerra: Yeah, I'm going to just excuse myself. Thank you very much. The team is here. We will follow up. And I appreciate all the comments that are being made. And help us get some money from Congress to deal with the workforce issue, please.

[laughter]

>> Beth Daley Ullem: All right. Thank you.

>> Xavier Becerra: Thank you.

[applause]

>> Beth Daley Ullem: Although we're losing the Secretary right now, we still have his entire team here. And I think we still have some great big ideas to share with them on the National Alliance. So, Kerry, I want to move over to you. What's your big idea for them to consider?

>> Kerry Heinrich: I talk to clinicians a lot. The number one thing I hear from them is, what has happened to healthcare in the way of the interface between the patient and the provider of services? They feel like all they do is document, document, document. If you look at your "Conditions of Participation" book, there are hundreds of pages and metrics. And nurses feel like all they do is document. They never have FaceTime with their patient. And physicians feel like they've been turned into a billing machine. They're not able to practice medicine and connect. So, my simple idea is simplify, simplify, simplify what we have to document to be accredited and to provide care.

>> Beth Daley Ullem: Thank you. Gary?

>> Gary Stuck: Hi. Thank you. My big but short idea at this time, increased funding for human factors research, research in human performance. I think that we could use some help there. That would help us all learn these learning health systems.

>> Beth Daley Ullem: Okay. Thank you.

>> Joseph Impicciche: Yeah. I'll just -- it's already been alluded to, but just more incentives and facilitation of greater transparency that you -- we talked a little bit about the national patient safety database. But today, the PSO reporting is all voluntary. We need to find ways for -- to encourage more reporting.

>> Beth Daley Ullem: Okay. Thank you. Shelly?

>> Shelly Schlenker: Thank you. I introduced myself last time, but not the system. We have 147 hospitals in 21 states. And I think standardized measure and data sets are important. And we fully support the PSO statement, but we'd like the Alliance to consider the tool CANDOR, which is Communication and Optimal Resolution. It speaks to what is patients want, transparency real time, what happened, and finding that resolution for patients when things need to be communicated.

>> Beth Daley Ullem: Thank you, Shelly. Michael?

>> Michael Cuffe: I'm going to go off a script here and describe the quandary that I think we need to solve. Both the COVID pandemic and the hurricanes the past few years have consistently highlighted that larger learning systems, such as those invited here today, are better prepared to respond during times of stress. Whether that's financial stress, today's financial stress is hurting rural hospitals and independent providers. Or that's natural stress, fires and hurricanes, of course pandemic in origin, where a lot of our supply chains and labs stood up quickly, but the smaller hospitals did not. There are unique problems in this country of small and isolated hospitals.

And ultimately, for the Action Alliance to succeed, the integration of those hospitals, either economically or in some other way into larger learning systems and platforms, is going to be required in order for us to address access and care quality equity. I worry a lot about the access to high quality care in our most rural areas of the country and less so in New York. Thank you.

>> Beth Daley Ullem: Thank you. Andrew?

>> Andrew Bindman: Hi. A lot of great ideas around the table. Just maybe three buckets to suggest. One is first on measurement. I completely agree that we need better alignment both within CMS and ideally beyond in terms of our measures. I would emphasize measures that focus on outcomes and that focus on equity. To be able to do the work-related equity, we also need standardized ways to make sure that as we're stratifying populations to understand insights on equity, that we have clear guidance in doing it in consistent ways, so that we can all learn together in that space.

Second, I think we need additional investment in research. Obviously, this is an area that AHRQ has really led. But we need to do more. We need to focus more on diagnosis. If we make the wrong diagnosis, we go down a pathway of all sorts of things that are unnecessary for patients and that are basically introducing harms that can be avoided. So, we need to strengthen that. And we also need more research on how to use new technologies, not only for diagnosis, but also for remote monitoring tools in the hospital and to allow us to get our patients home sooner, where they are, of course, less likely to get hospital-acquired infections and the like.

And then finally, I want to come back to this issue of information. I think there's an opportunity for HHS to reward and call out information best practices. Information has emerged as a social determinant of health. And we need to make sure that we are being transparent with patients, because it's important for their own mental health and their family members for their mental health to understand what has gone on. And we also need to call out when healthcare providers or health systems are not being forthright in moving forward on the best knowledge related to evidence-based practices. So, we need to promote information as a social determinants of health. Thank you.

>> Beth Daley Ullem: Thank you, Andrew. And last, Christopher?

>> Christopher Rehm: Thank you. So, I think three things. To circle back to the workforce, in an innovation perspective, how do you incent and encourage innovation around the team who's caring for patients, particularly in the acute care setting? I think that's where we've had the flight of nurses. And so, how do you empower all of us around the table to redesign that care team that may be changes our perception of its physician, nurse, aide, tech? Like, how do we broaden that workforce, licensed and unlicensed, to provide high quality safe care?

Second would be, it was mentioned already, measurement burden, consolidation. I think if you're going to -- if there's anything new you want to measure, then get rid of two things. You've got to consolidate a line and eliminate, so that we can focus on that with appropriate kind of mental attention to address what we actually are measuring.

And then the third one, this is -- I'm not sure who shared this earlier. There's not a single person in this room that said, "I want to be a physician or a nurse or a caregiver, because I want to document." It's like, "I wanted to be a physician, so I wanted to help people." So, I think the broad picture is, how do you make this a career that physicians, nurses, techs, aides want to go into?

And today, if you get a bunch of physicians and nurses around the table, they're all like, "What do you want to do next?" That's just driving me crazy. So, I think from a -- whether it's documentation burden, billing burden, you know, I think you need to step back and say, "How do we make this a career that the best and brightest want to take care of all of us and our loved ones?" And if you don't have that environment, we've got a problem.

>> Beth Daley Ullem: Here, here. All right. Armando, we'd like to switch to you, because we heard an incredible amount of ideas here, and if you can give a reacting comment on what you

heard from those ideas. Turn your mic on.

>> Armando Nahum: Yes. Thank you, Carol.

[laughter]

Not Carol. I have Carol in my mind. I heard a lot of great ideas. And I can sympathize with all of you that are in the midst of this challenge with workforce. Obviously, if you don't have the right people, you can't keep us safe. Obviously, if your people are not safe, we're not safe. So, it goes back and forth. I don't know how we can help you get more doctors, more nurses to work at your place. But I do know how to help you and achieve better care once you reach that potential.

I also heard someone here say -- because it was very disturbing, I'm sorry to say that -- our attorneys don't allow us to say that. Well, fire those attorneys. They don't belong to your place. It is a fact, and you can ask every patient in your place of work, people that you serve, that when something bad happens, we're not there to sue you. We want the truth. We want to work with you and to find out how this happened, so it doesn't happen again to somebody else. That's it. And if your attorney say that you cannot apologize, again, they don't belong there.

In hearing all of your comments about what can HHS bring, in my opinion, and I think I can speak for patients and patient safety advocates all across our nation, that unless we have an agency or agencies on a federal level that would provide strict rules on how you operate and how you report, we're not going to achieve zero.

Does anyone here heard what happened to our digital coins? Yeah, everyone did. Right? Do you know why it happened? Because there was no oversight. This is what's happening in healthcare. There's no oversight. There's no federal agency that says, "If you don't do this, you're going to pay the price." We have it in another organizations. We seem to have an issue on how to create one in healthcare. I, for one, and I know many other people like me, would like to see one, not to make them more difficult on you, but actually to make it easier on you. It seems like the nuclear industry works very well that way, and the airline industry seems to work very well that way.

So, these are my comments. Thank you.

>> Beth Daley Ullem: Thank you. Thank you to HHS for publicly renewing your commitment to advancing patient safety and for being willing to listen. I know that if you're like me, you all probably will go home from this session and say, "Rats, I forgot to mention something." So, there's great opportunity to reach out and share those ideas that you forgot to mention or make sure that the ones that you articulated are clearly understood, because these really are read and dissected very thoughtfully by the leaders of these agencies.

I'd also like to recognize one more time the -- those who participated in Safer Together, the National Action Plan with AHRQ, CDC, CMS, FDA, and the many private sector and nonprofit contributors to this effort. The idea that we're coming together in an Action Alliance recognizing

that we have to rebuild, reconnect, and maybe challenge ourselves a little bit is a great opportunity. And we are so thankful to all of you, your agencies, your institutions, for being willing to step up for safety. Together, we can move forward towards the healthcare system that support safety of patients, safety of the workforce, and also can improve the ways that we support that system of safety. Thank you for stepping forward in this journey towards safety.

Right now, we're going to have a brief 15-minute break, and we will reconnect afterwards. Thank you.