Getting to Zero ~ A Journey to Better Outcomes for Moms and Babies

Barbara Pelletreau
Senior Vice President, Patient Safety

Suzanne Wiesner
Director, Maternal and Child Services

February 26, 2014
CSHRM - Napa

Dignity Health

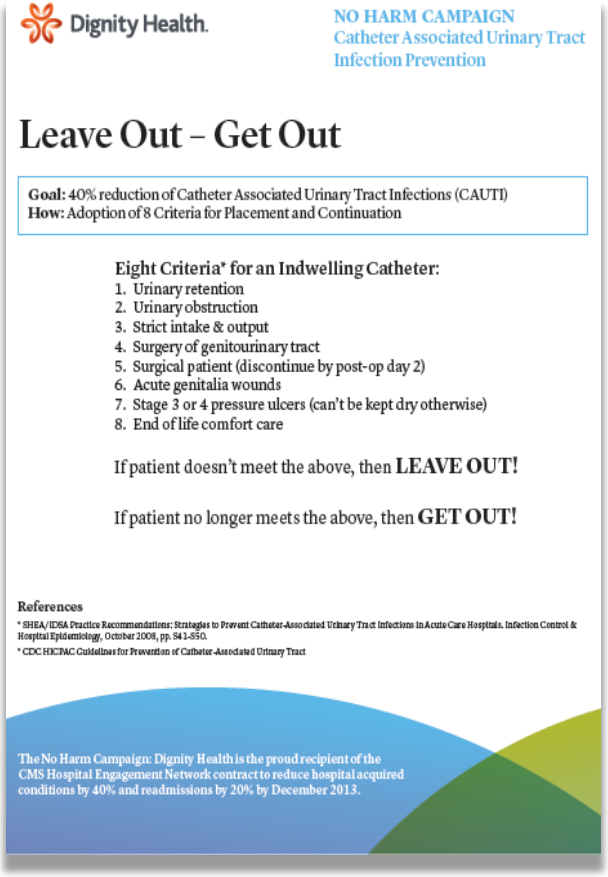
Overview

- Foundation
- Perinatal Safety Initiatives
  - Phase 1 Fiscal Years 2012 and 2013
  - Phase 2 Fiscal Year 2014
- Results for Patients
- The Checklist for Risk Managers & Patient Safety Officers

No Harm Campaign

Contract with CMS

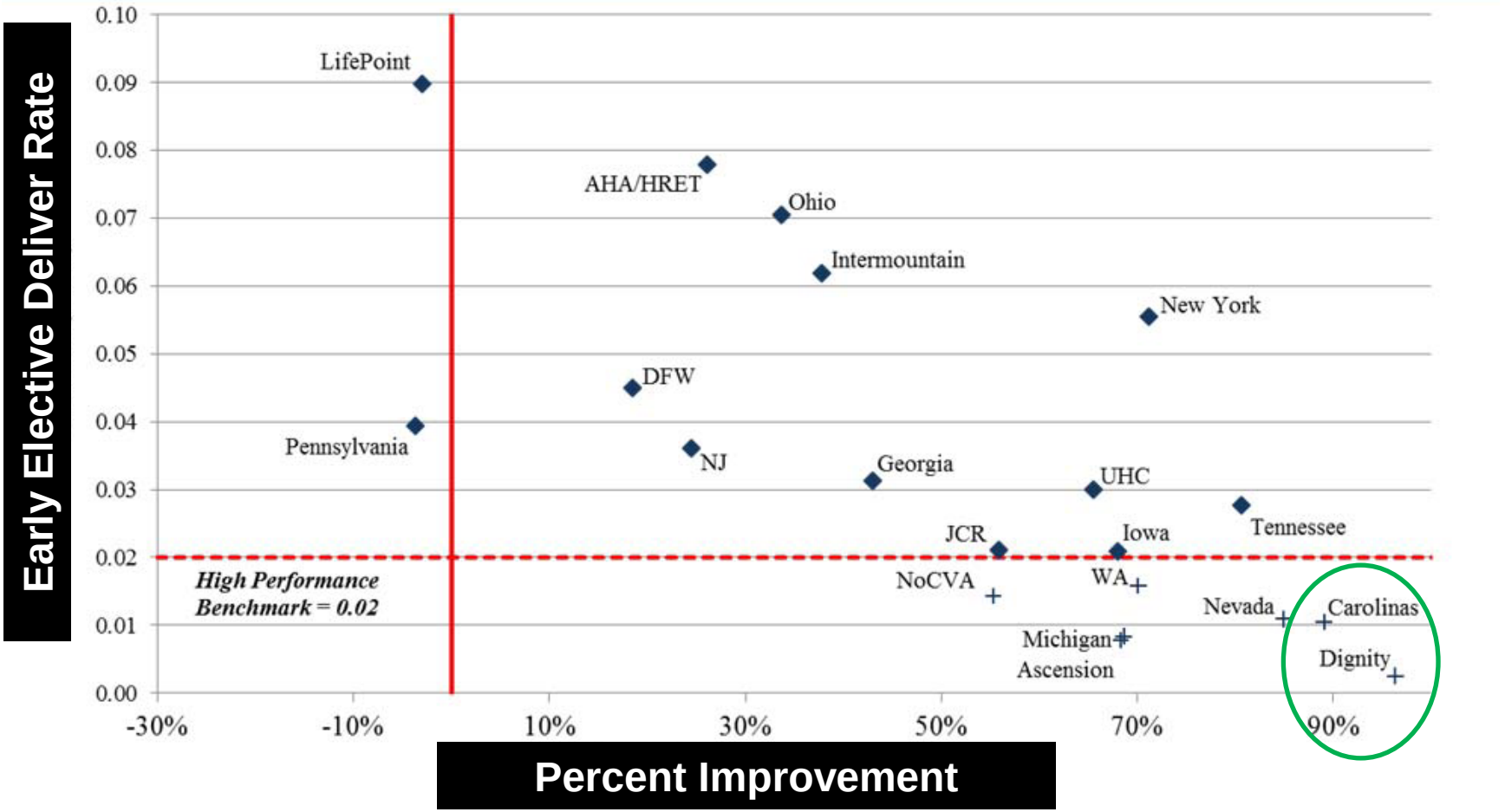
- 40% reduction in hospital-acquired conditions
- 20% reduction in preventable re-admissions
- $8 Million, 3 year contract



Focus Areas

- Adverse Drug Events
- Catheter Urinary Tract Infection
- Central Line Infections
- Falls
- Obstetrical Adverse Events
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism
- Ventilator - Acquired Pneumonia
- Readmissions
- ED Throughput
- Culture of Safety

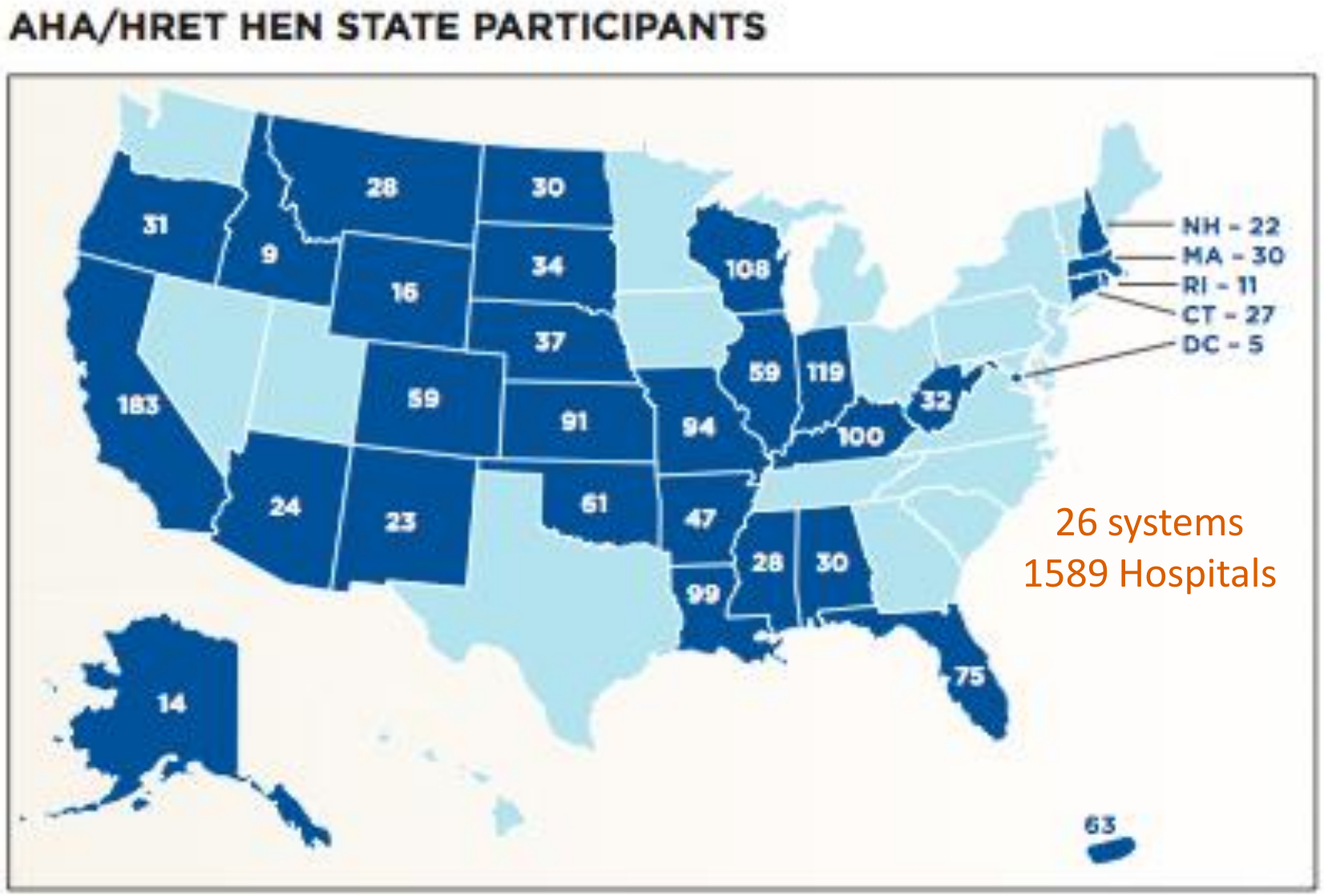
Dignity Health - Tracking as a Hospital Engagement Network



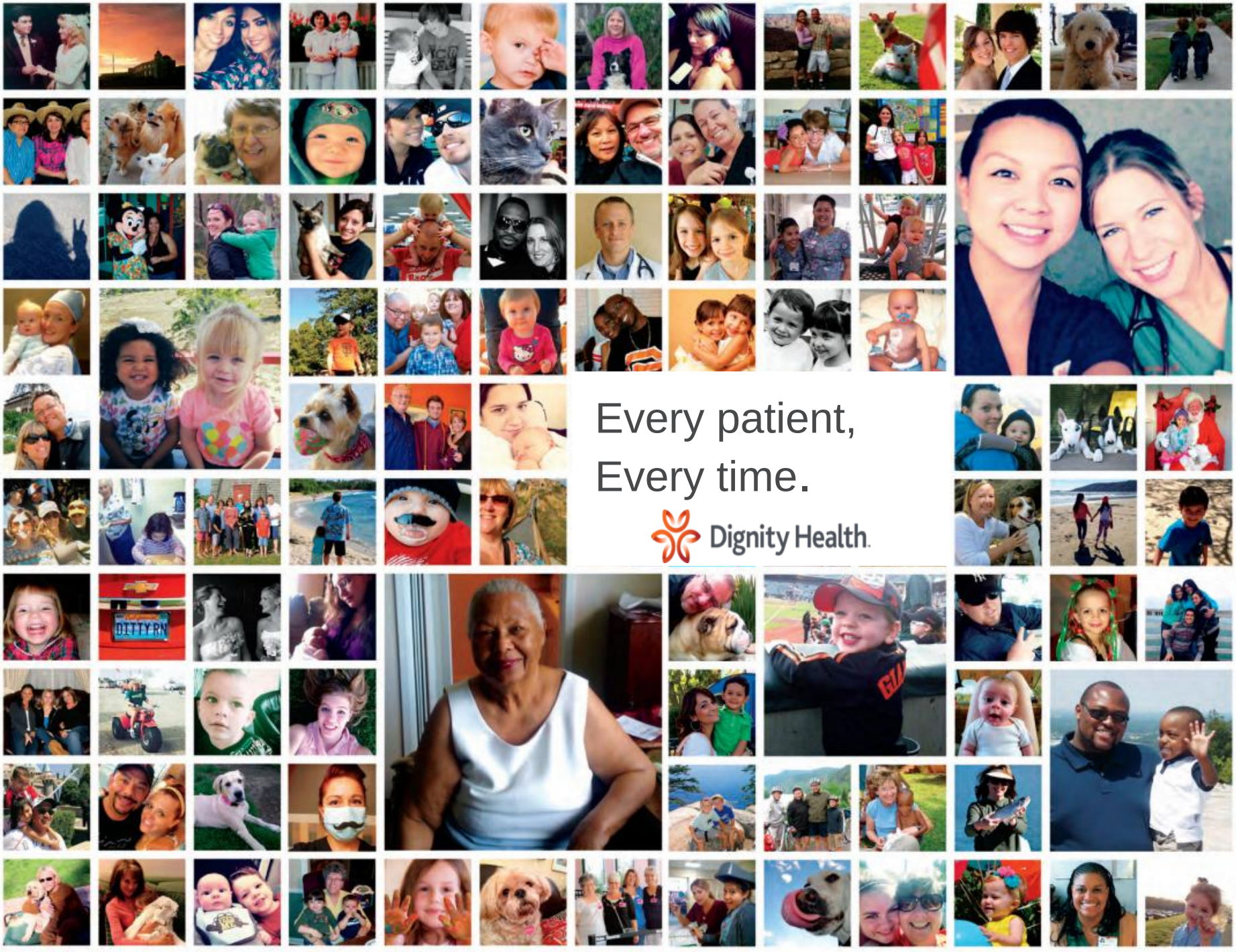
Safety Across the Board at Dignity Health

Dignity Health 35 aligned hospitals, 100% of applicable hospitals are in each trend		**ADE**: 65% decrease in hypoglycemic rate (POC results<40 mg/dl)	**CAUTI**: 45.3% decrease in CAUTI per 1,000 catheter days (house-wide)
CLABSI: 34.5% decrease in CLABSI per 1,000 central line days	**Falls**: 35.8% decrease in falls with injury (NDNQI definition)	**EED**: 96.4% decrease in EED rate, sustaining rate <1%	**PrU**: 50% decrease in rate of HAPU (all stages)
SSI: 35.7% decrease in SSI/100 targeted procedures	**VAP**: 60.4% decrease in VAP per 1,000 vent days	**VTE**: Sustaining low (benchmark)VTE rate (PSI-12)for the Medicare population	**Readm**: 9.6% reduction in Medicare FFS readmissions

Hospital Engagement Network:
Sponsored by CMS as part ACA



Our Foundation


Every patient,
Every time.
Dignity Health.

Philosophy Starts with Mission and Values

Mission ~ *Delivering* compassionate, high quality, affordable health services while *Serving* and advocating for our brothers and sisters who are poor and disenfranchised; and *Partnering* with others in the community to improve the quality of life

Values ~

- Dignity
- Collaboration
- Justice
- Stewardship
- Excellence

We know that Culture Matters

Organizational Culture as a Source of High Reliability

Karl E. Weick

Creating high reliability in health care organizations

Pronovost PJ, Berenholtz SM, Goeschel CA, Needham DM, Sexton JB, Makary MA, Hunt E.

Department of Anesthesiology & Critical Care Medicine, Surgery, and Health Po University, 1901 Thames Street, 2nd floor, Baltimore, MD 21231, USA.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

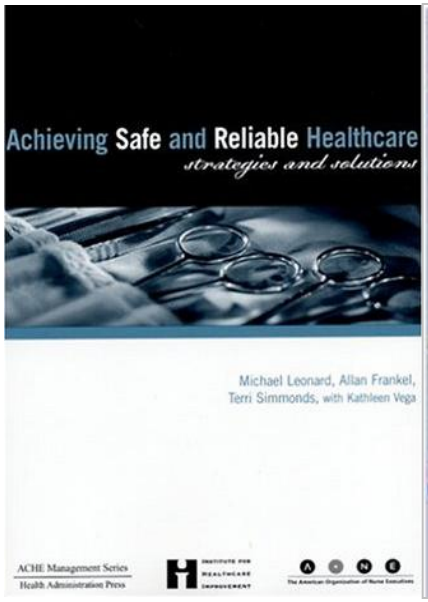
Temporal Trends in Rates of Patient Harm Resulting from Medical Care

Christopher P. Landrigan, M.D., M.P.H., Gareth J. Parry, Ph.D., Catherine B. Bones, M.S.W., Andrew D. Hackbarth, M.Phil., Donald A. Goldmann, M.D., and Paul J. Sharek, M.D., M.P.H.

The NEW ENGLAND JOURNAL of MEDICINE

Time for a Culture Change?

Richard Platt, M.D.

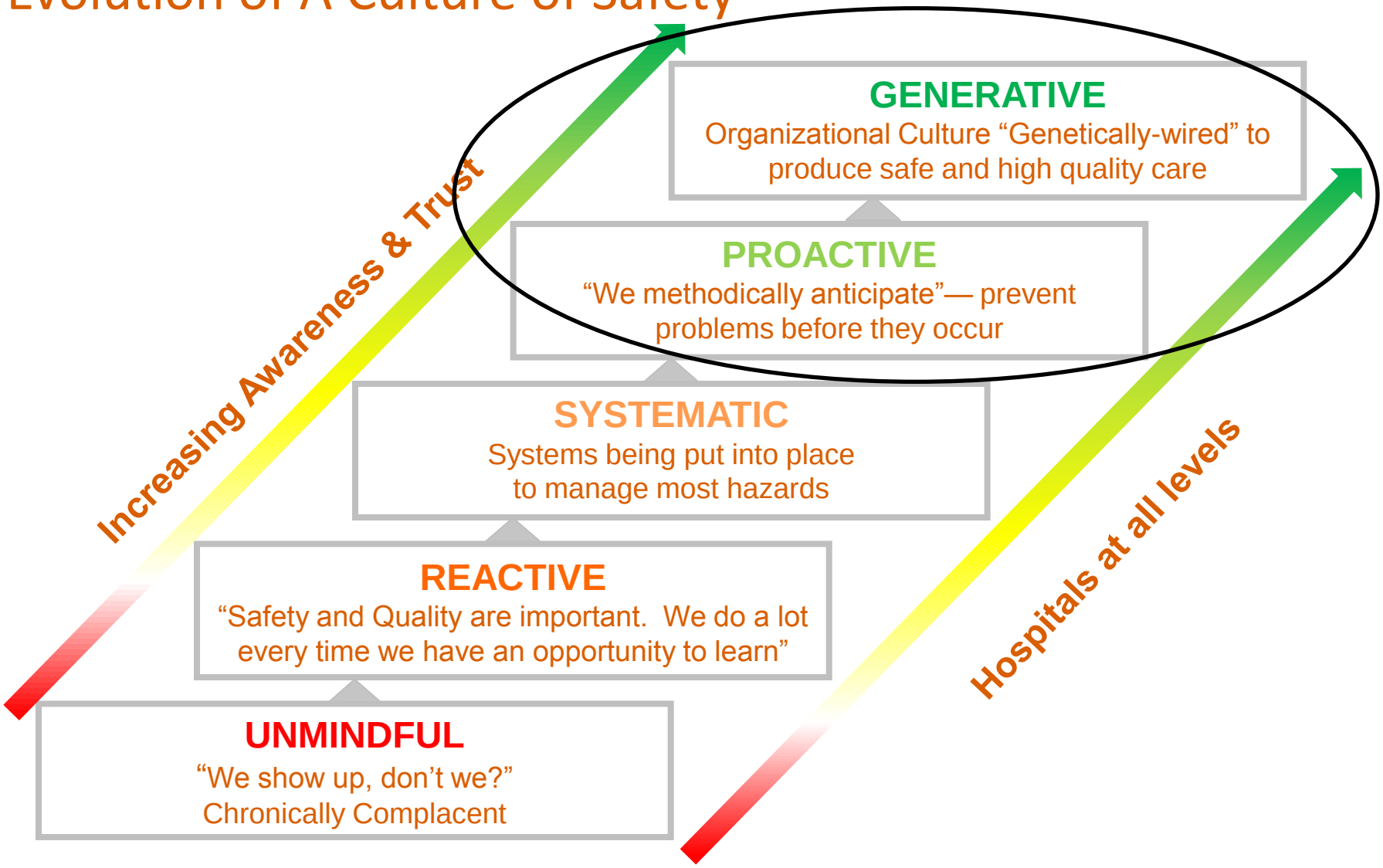




Perceptions of Hospital Safety Climate and Incidence of Readmission

Luke O. Hansen, Mark V. Williams, and Sara J. Singer

Evolution of A Culture of Safety



Structure / Leadership Engagement

Leadership Engagement ~ Starts at the Top

Bay Area Medicine Man

Fortune profiles Lloyd Dean, CEO of San Francisco-based Dignity Health, noting he has become one of the most connected Bay Area CEO's in the nation. Dean is well regarded by national and local constituencies, as well as his own employees. He has been an ardent supporter of Obamacare, despite being a CEO of a hospital corporation. Kathleen Sebelius, the U.S. Secretary of Health and Human Services, says Dean is in the constellation of 10 health care leaders she relies on our bounces ideas off of. The profile includes a look at Dean's upbringing and his career path.



Systematic Approach to a Culture of Safety



- Setting meaningful metrics
- Providing complete toolkits
- Coordinating with hospitals' leads
- Establishing a timeline
- Providing results/interpretation

System Leadership

- Providing access/results to units
- Identifying high/low performers
- Interpreting results
- Monitoring engagement
- Assuring strong leadership

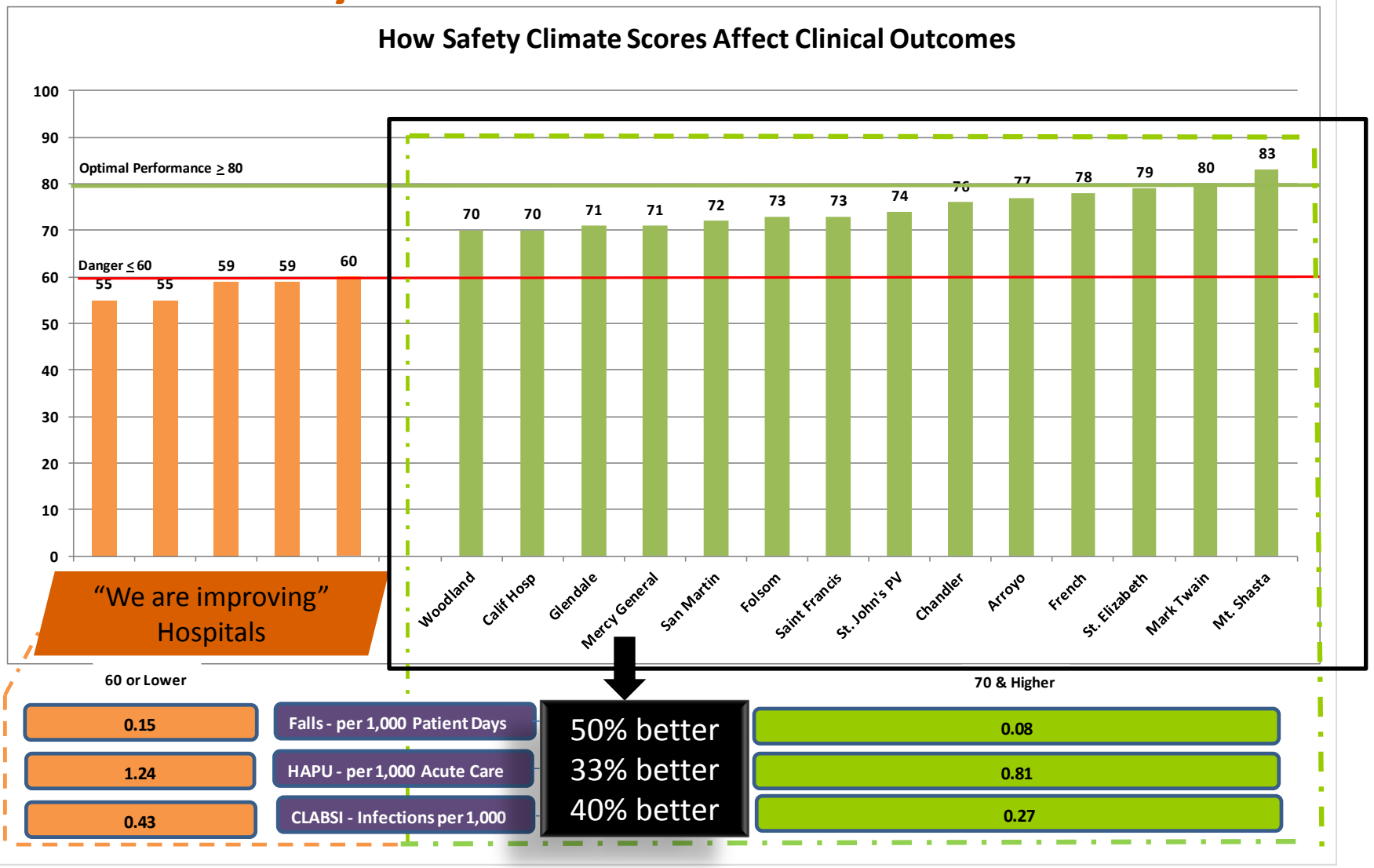
Hospital/Department Engagement

The right people might be outside the usual job categories

The right people are …

- ✓ Collaborative
- ✓ Creative
- ✓ Focused
- ✓ Unflappable
- ✓ Accountable
- ✓ Tenacious
- ✓ Cheerleaders
- ✓ Change agents

Safety Climate versus Patient Outcomes



Perinatal Safety Initiatives FY13

2013 Perinatal Safety Initiatives

Designed to:

Improve patient care:

- Early Elective Deliveries
- Oxytocin Pre/In Use Check List
- Obstetrical Hemorrhage
- Hyperbilirubinemia

Improve documentation:

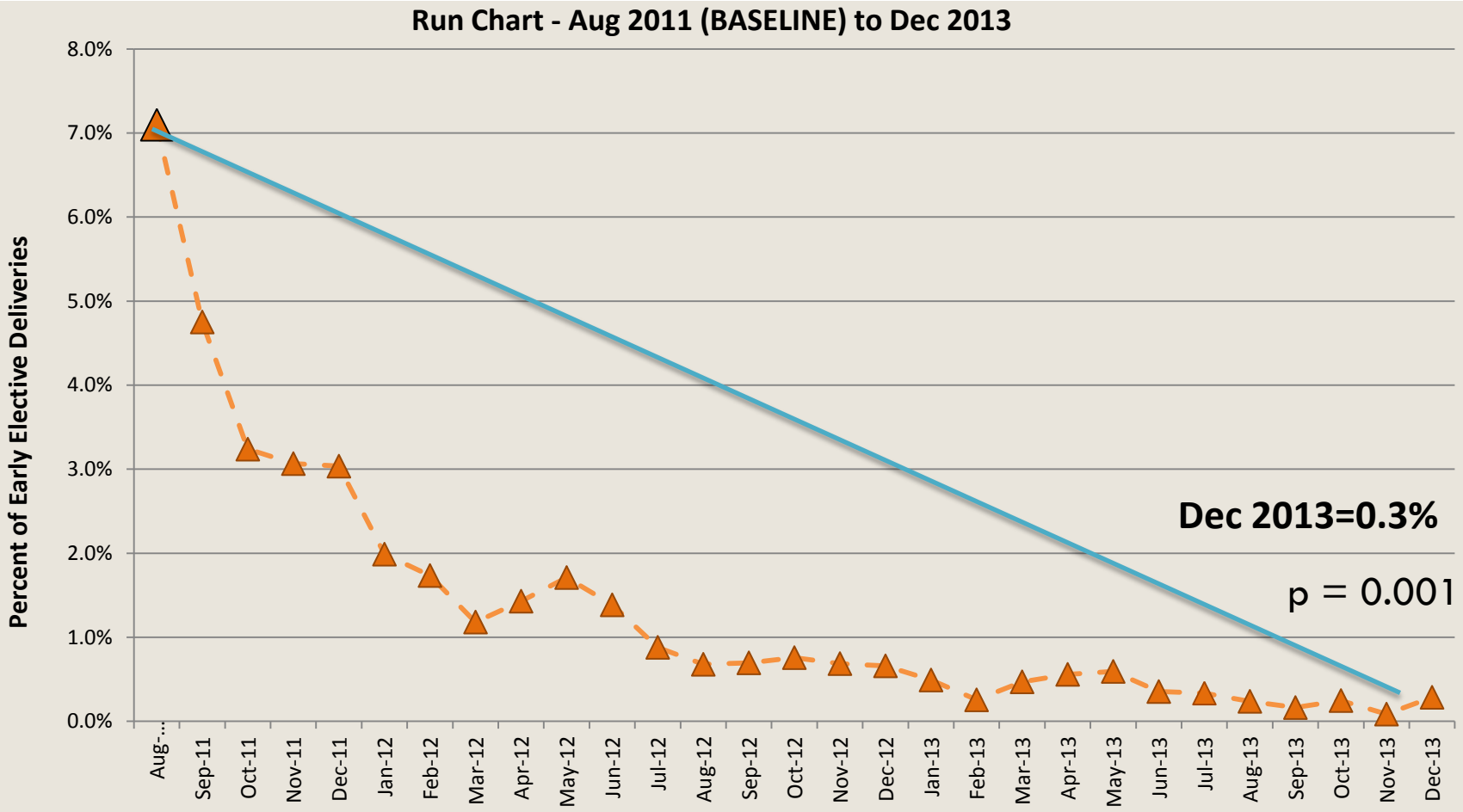
- Shoulder Dystocia

Improving patient care and documentation:

- Operative vaginal delivery
- Oxytocin Pre/In Use Check List

Reducing Early Elective Deliveries

Early Elective Deliveries



Exclusions-Medically Indicated Delivery
Dignity Health v. The Joint Commission

Criteria	Dignity Health	TJC	Comments
29. ≥ Three previous CS	YES	NO	Dignity Health Policy based on increase rate of adverse neonatal outcomes may be higher at ≥ 3 previous CS. • J Matern Fetal Neonatal Med. 2013 June. • J Matern Fetal Neonatal Med. 2013 Jan;26(1):10-2
30. Consultative Recommendation	YES	NO	Felt that there would be instances were guidelines could not be met but delivery is still indicated (i.e. initiation of chemotherapy, maternal surgery of another condition)

Dignity Health v. The Joint Commission

- Dignity Health:

$$\frac{\text{All Elective Deliveries}}{\text{All Deliveries 37-38w6d}}$$

- The Joint Commission:

$$\frac{\text{All Elective Deliveries}}{\text{(All Deliveries 37-38w6d)-Exclusions}}$$

Dignity Health v. The Joint Commission

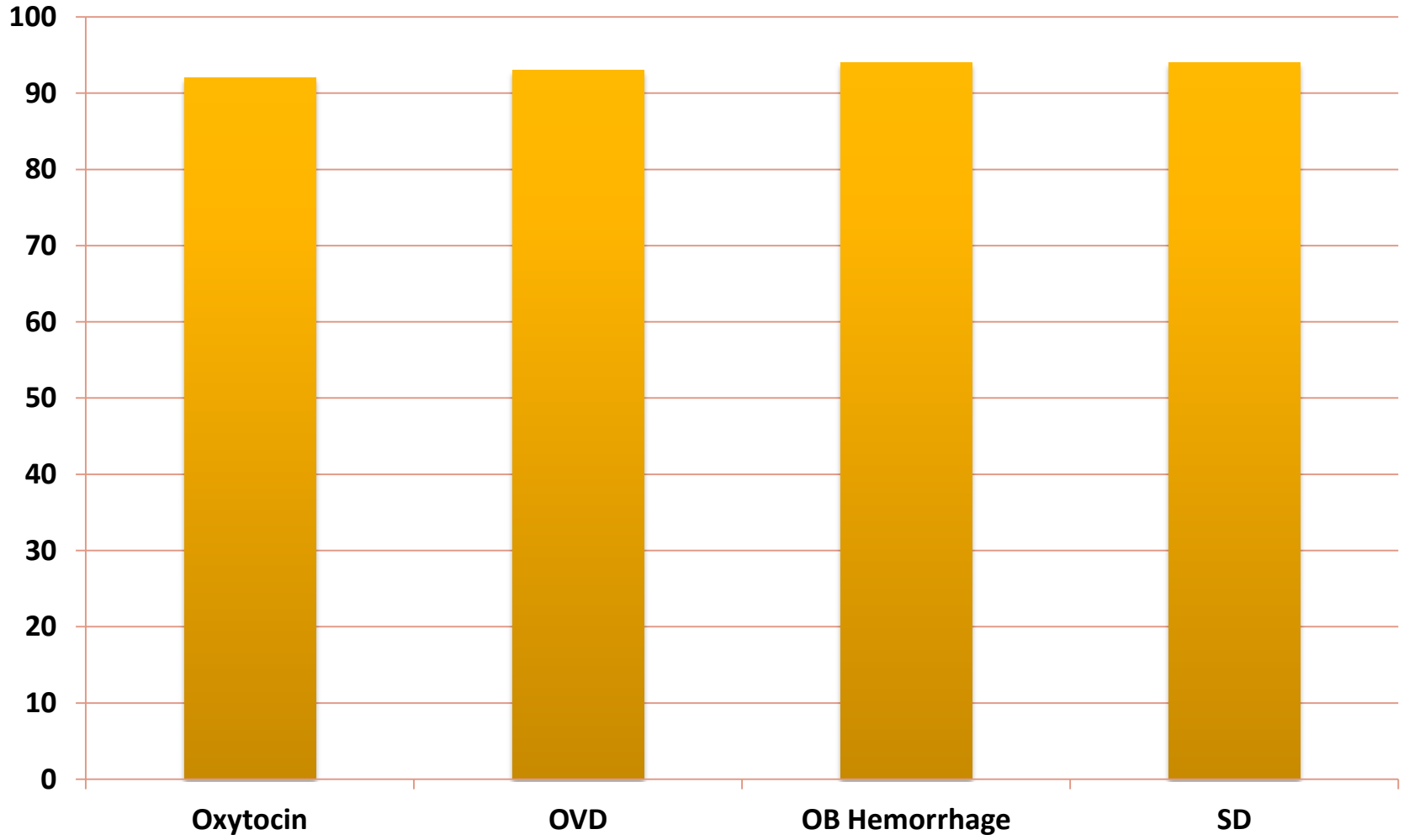
- Dignity Health:

$$\frac{\text{3 EED}}{\text{1000 (total 37-38w6d)}} = 0.3\%$$

- The Joint Commission:

$$\frac{\text{3 EDD}}{\text{1000-750 (labor, PROM, exclusions)}} = 1.2\%$$

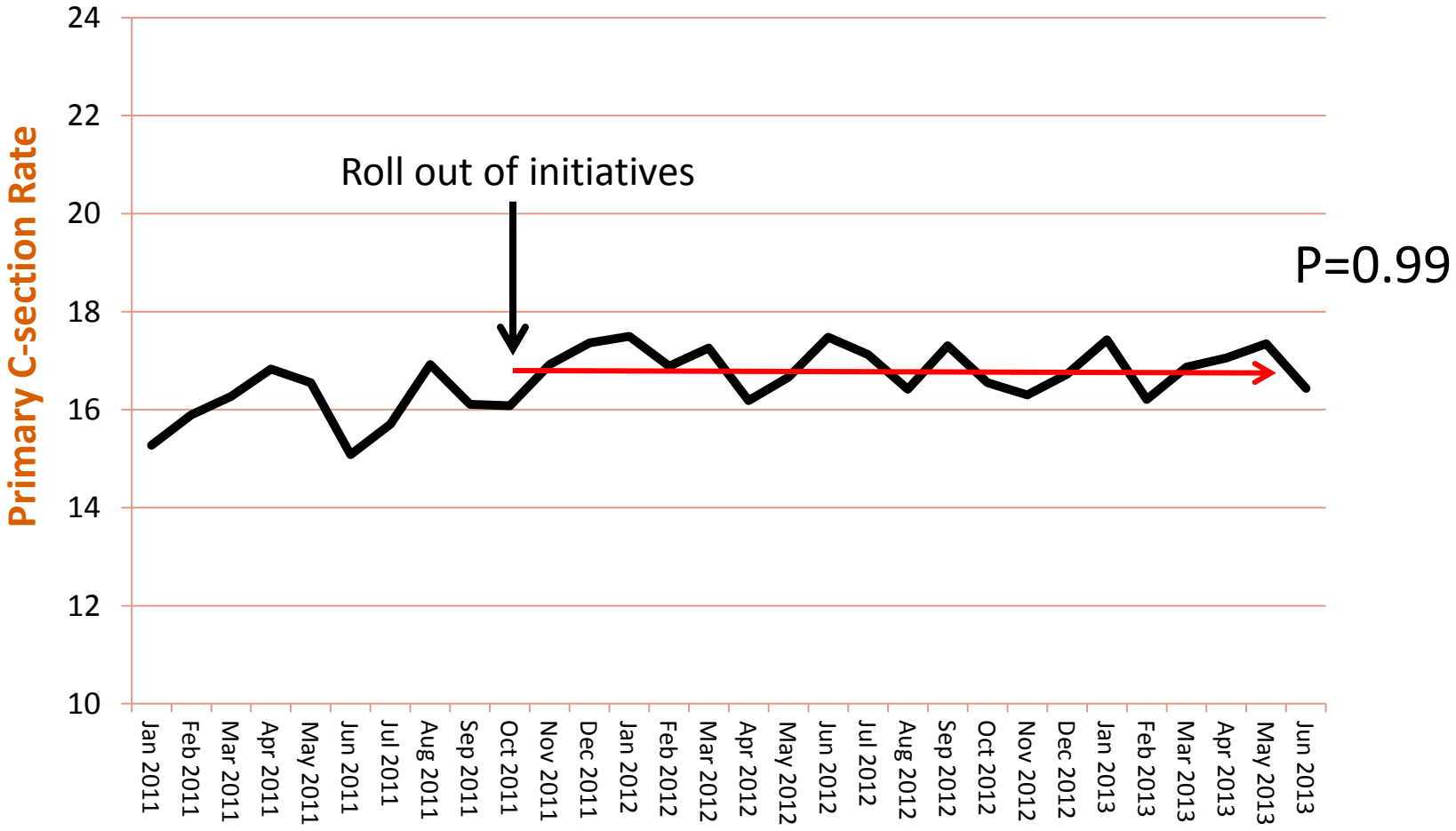
Perinatal Safety Results – Evidence-Based Practices



Did the Safety Initiatives make a difference?

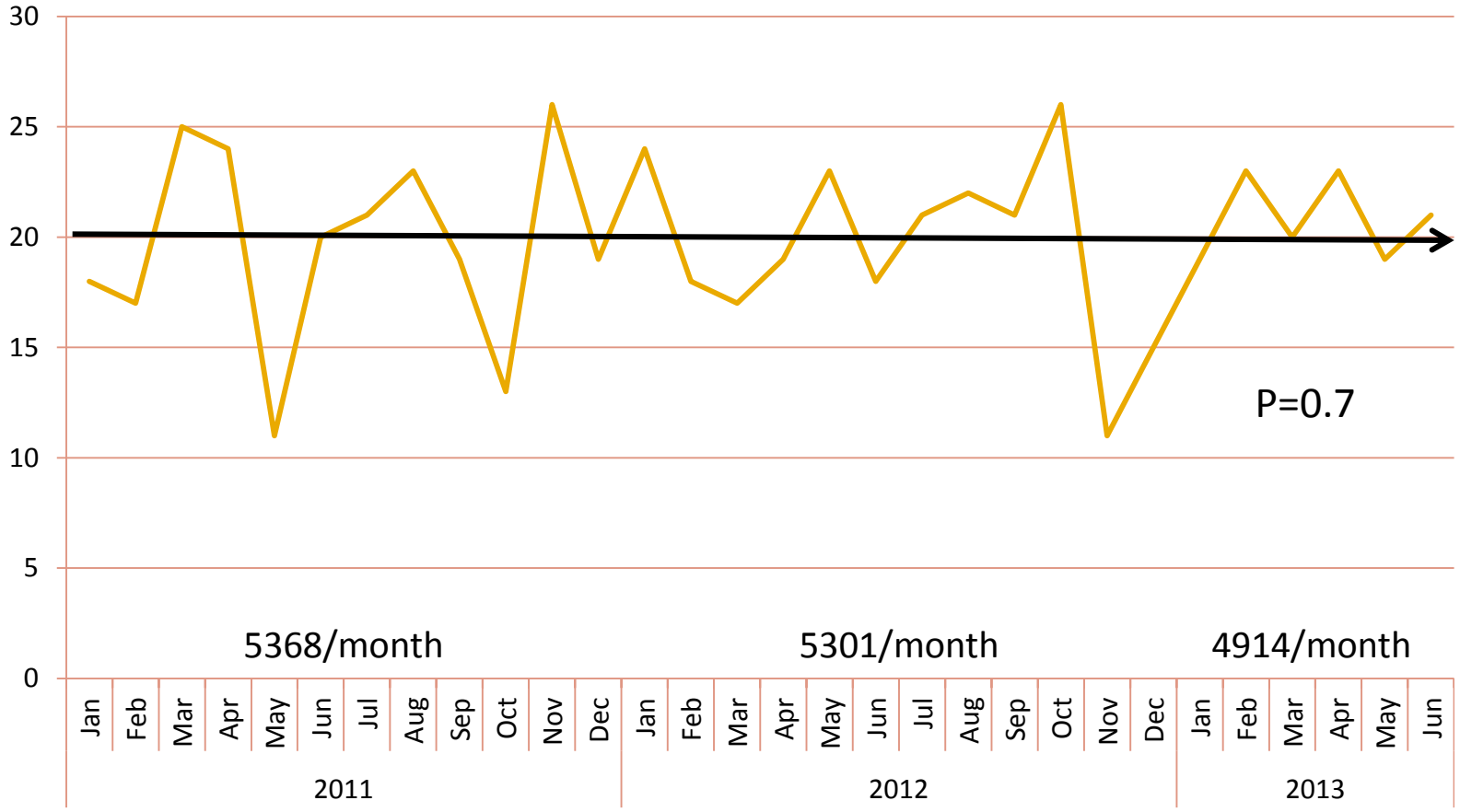
Dignity Health

Primary C-Section Rate 2011 to 6-2013



Dignity Health

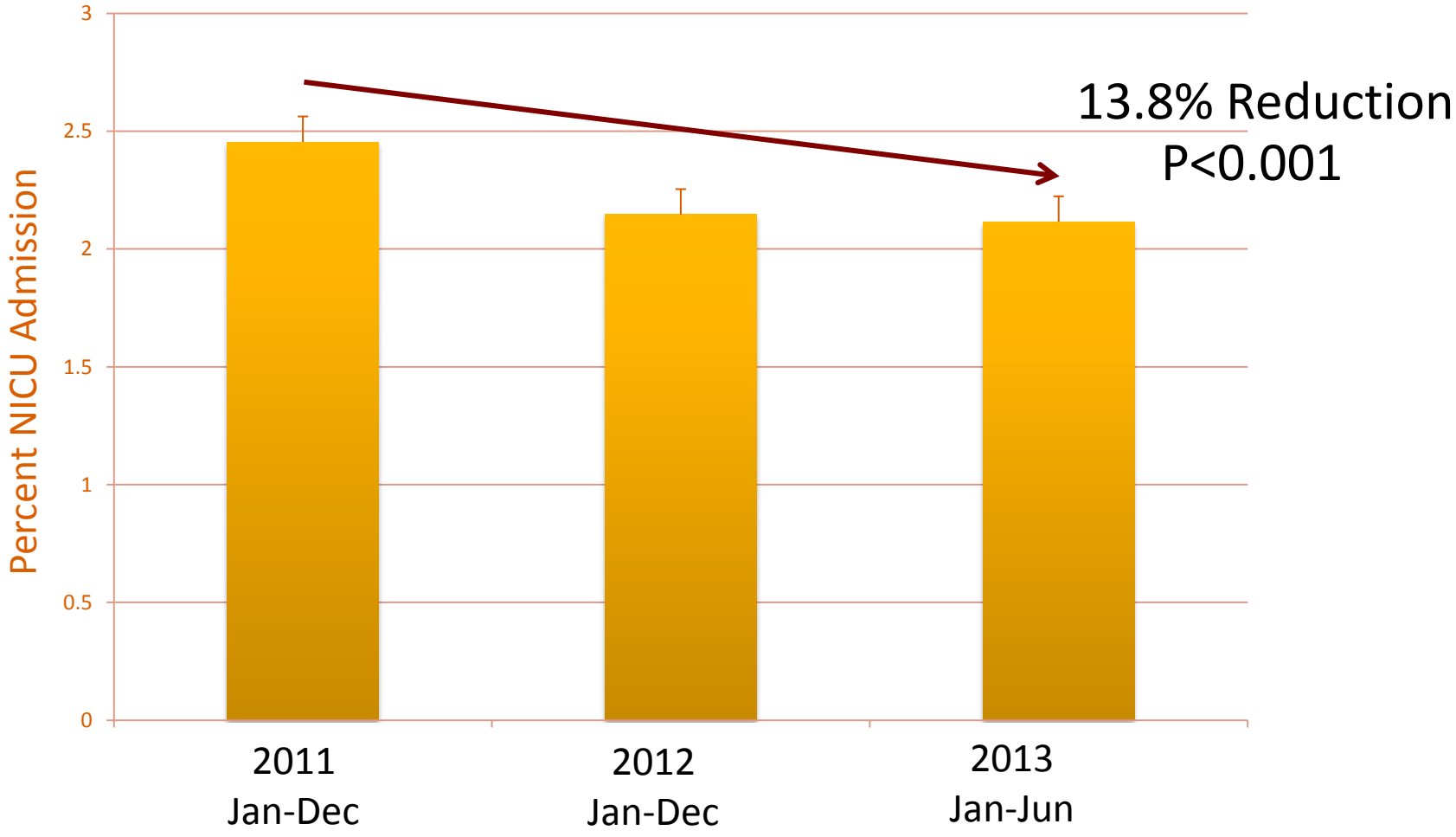
Frequency of Stillbirths per Month



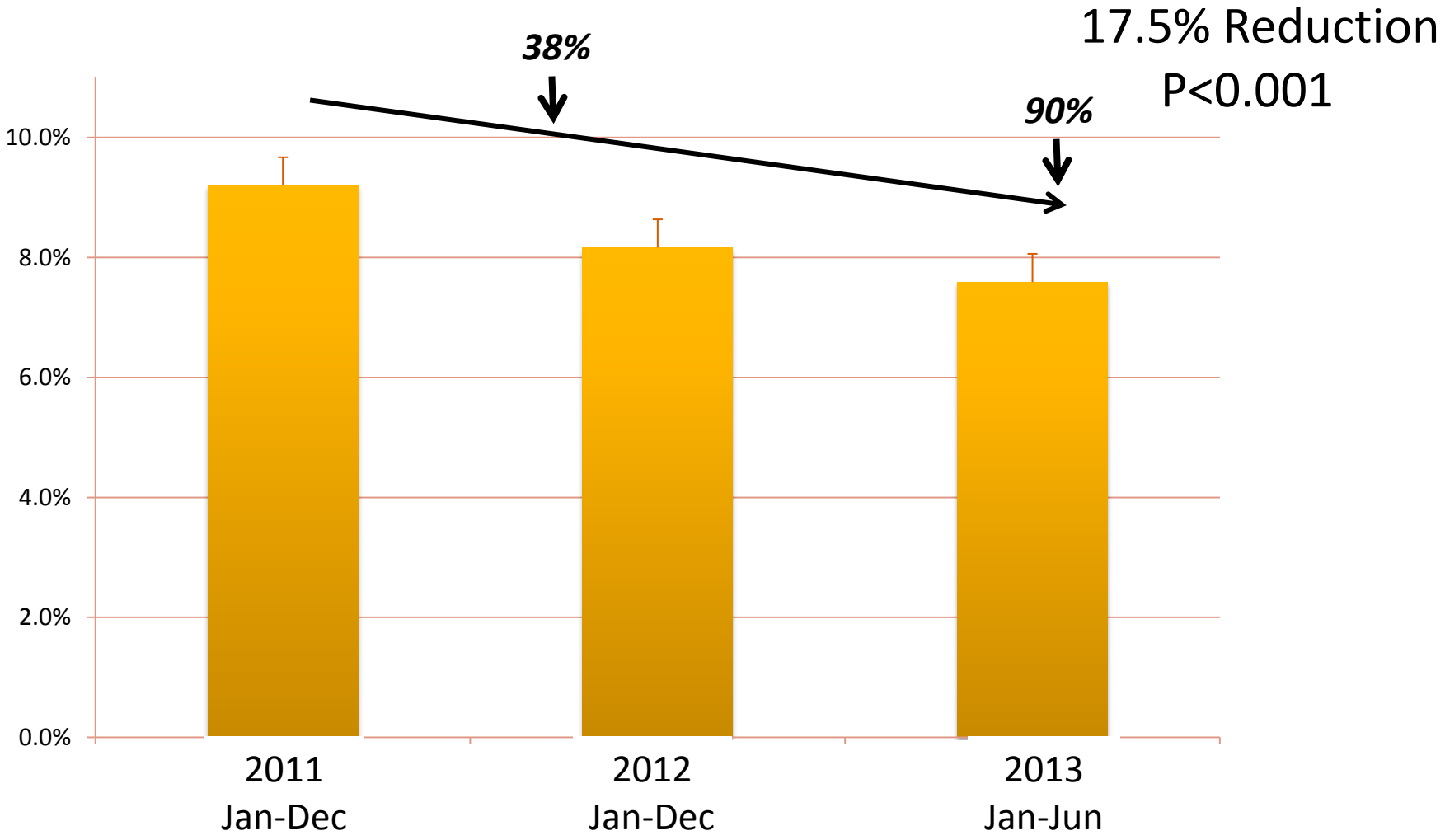
Dignity Health

AJOG 2013;208:s323

Percent of Infants >2500 gms Admitted to NICU

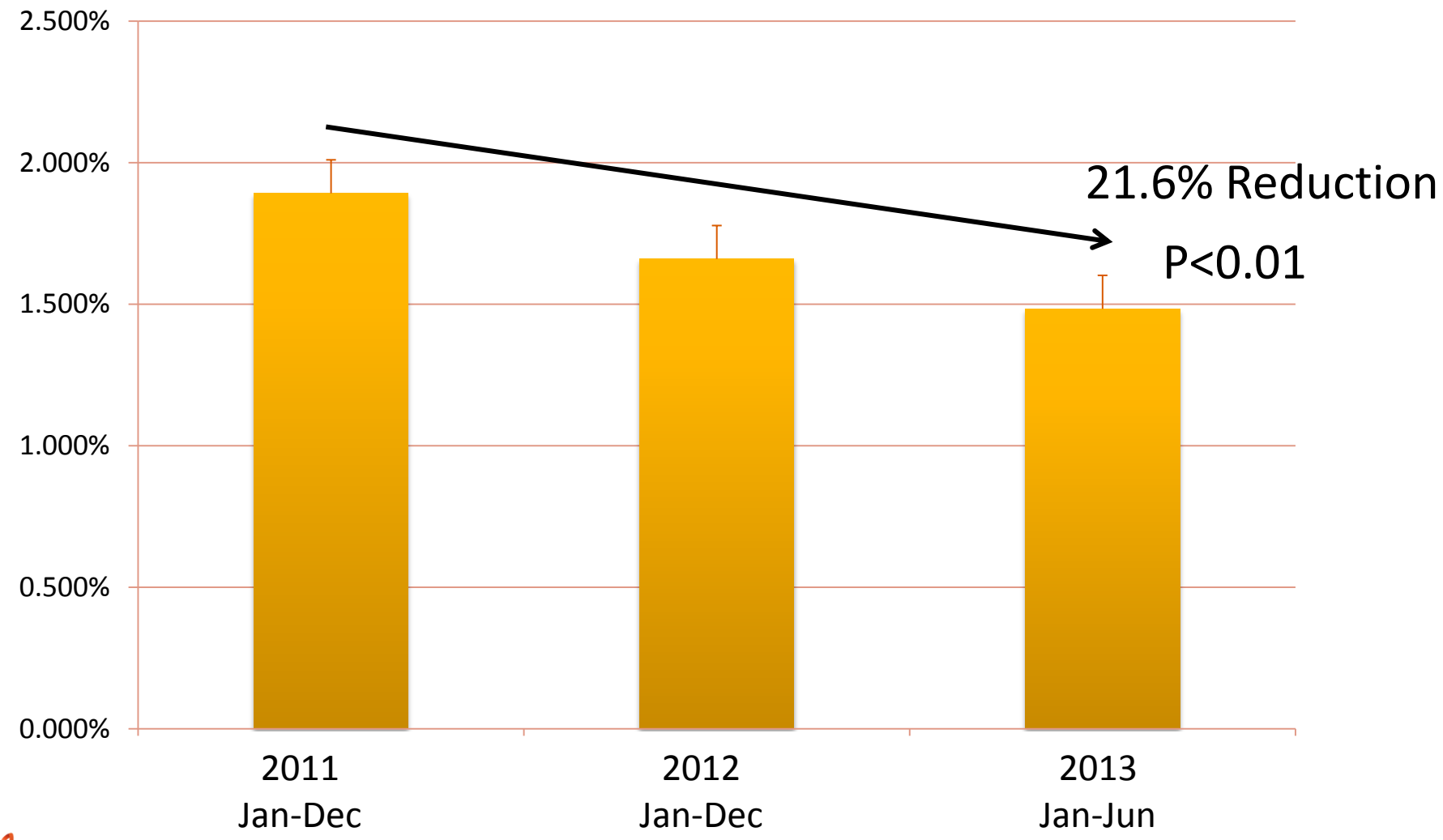


Operative Vaginal Delivery Rate



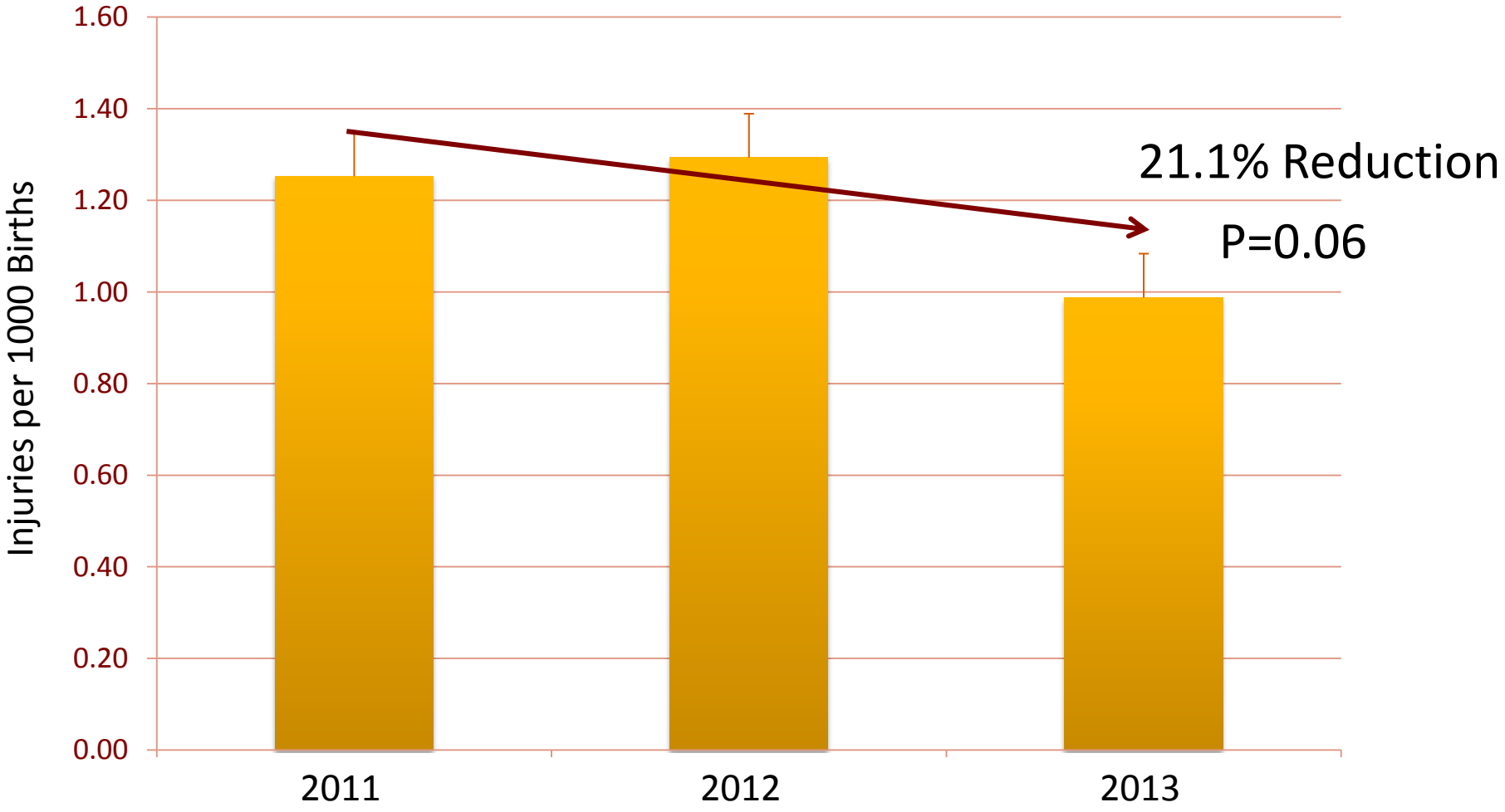
Dignity Health

Rate of Shoulder Dystocia per 100 Vaginal Deliveries



Dignity Health

Rate of Birth Trauma Per 1000 Births



Dignity Health

Obstetrical Hemorrhage

	Baseline Nov-Dec 2011	Assessment May-Jun 2012	Assessment Sep-Oct 2013	Change
Deliveries	10,433	10,457	11,169	
Hysterectomy	20	11	14	*- 30%*
pRBCs	232	180	197	*-15%*
FFP	35	24	56	+60%
Platelets	65	37	26	*-60%*
Cryoprecipitate	43	18	18	*-58%*
All Blood Products	375		297	*-20.8%*

Perinatal Safety Initiatives – System-Wide Outcomes

- Successfully reduced non-indicated EEDs to < 1%
- Reduced NICU admissions for term infants by 3.8%
- No change in stillbirths or primary C/S rate
- Reduced percentage of Operative Vaginal Delivery by 17.5%
- Reduced incidence of Shoulder Dystocia by 21.6%
- Reduced birth trauma by 21.1%
- Reduced utilization of blood and peripartum hysterectomy



Perinatal Adverse Event Reviews

- Evidence-Based Practice (EBP) Evaluations
  - Completed by the Perinatal Safety Specialist and Perinatal Manager/Director
  - Reviewed and signed by the Risk Manager and uploaded to the event reporting system
  - Identifies areas of compliance / non-compliance with EBP's
  - What triggers an EBP Evaluation?
    - Unanticipated clinical event / adverse outcome
    - Examples: Apgar < 7 at 5 minutes, unexpected NICU admission, shoulder dystocia with neonatal injury, *obstetrical hemorrhage requiring blood transfusion (rolled out January 2014!)*

Evidence Based Practice Evaluation for Obstetrical Hemorrhage Event
This is a Patient Safety Work Product

Facility Name		Date of Review	
Medical Record #		ERS #	

Instructions: This Obstetrical Hemorrhage Event evaluation will be completed for all patients who receive a blood transfusion in relation to an **obstetrical hemorrhage event**. The evaluation provides an opportunity for a systematic review of the event in order to identify opportunities for process improvement. Upon completion of the Evidence-Based Practice Evaluation, the document will be placed in the Events Reporting System (ERS). The EBP Evaluation is designated as a Patient Safety Work Product.

Part One: History and Delivery Summary

Patient History	Gravida		Para		Gestational Age	
	Weight		Height		BMI	
Did this mother receive any prenatal care?	☐ YES ☐ NO ☐ Unknown					

Pregnancy Complications: Select all that apply: (click on box to check):
☐ Preterm ☐ Hypertension ☐ Diabetes ☐ Multiple Gestation ☐ Previous C/S Delivery
☐ Accreta ☐ Previa ☐ Bleeding, Unknown Cause
Other :

Part Two: Admission/ Intrapartum/Delivery

Admission Date		Admission Time	

Why was the patient admitted? (ROM, Labor, Induction, Scheduled C/S):

What was the OB Hemorrhage Risk on Admission?	☐ Low ☐ Medium ☐ High ☐ Unknown
Was the appropriate blood bank specimen ordered per protocol?	☐ YES ☐ NO ☐ N/A

What were the CBC results on admission?	☐ Not Available				
	HGB		HCT		Platelets
Type of Delivery	☐ Vaginal ☐ OVD ☐ Cesarean				

If **CESAREAN DELIVERY**, what was the indication? Describe below:

What was the infant's birth weight?	Grams
Was the placenta sent to pathology?	☐ YES ☐ NO

Dignity Health Confidential Patient Safety Work Product

Evidence Based Practice Evaluation for Obstetrical Hemorrhage Event
This is a Patient Safety Work Product

Part Three: Hemorrhage Event Details

What was the EBL at delivery? (e.g. 450ml)	ml
What was the total blood loss for the event? (e.g. 2500ml)	ml
Which uterotonics were administered? (check all that apply): ☐ Oxytocin ☐ Misoprostol ☐ Methergine ☐ Hemabate	
Was the blood loss weighed/quantified per protocol?	☐ YES ☐ NO
Was the OB provider called to the bedside in a timely manner?	☐ YES ☐ NO
Was the OB Hemorrhage cart utilized per protocol?	☐ YES ☐ NO
Was a DIC panel ordered per protocol?	☐ YES ☐ NO
Which conservative interventions were done to control hemorrhage? ☐ B-Lynch Suture ☐ Interventional Radiology ☐ Bakri Balloon ☐ D&C ☐ Other:	
Was definitive surgical intervention (hysterectomy) required to control hemorrhage?	☐ YES ☐ NO
Was a Rapid Response / OB Alert or Code Blue initiated?	☐ YES ☐ NO
Were blood products administered per protocol?	☐ YES ☐ NO

What were the TOTAL blood products administered (units)?

PRBC's		Platelets		FFP		Other	

What was the reason for the hemorrhage event?
☐ Atony ☐ Laceration ☐ Hematoma ☐ Coagulopathy ☐ Previa ☐ Accreta ☐ Fibroids
☐ Retained Placenta ☐ Other:

Was there an opportunity to alter outcome?
☐ Strong ☐ Good ☐ Some ☐ None
Comments:

What was the patient outcome?
☐ Stabilized ☐ Transferred to ICU ☐ Maternal Death

What was the overall length of stay (LOS)? (days)	days

Comments:

Reviewers Signatures

Perinatal Manager/Director		Date	
Perinatal Safety Specialist		Date	
Risk Manager / PSO		Date	
Other		Date	

Dignity Health Confidential Patient Safety Work Product

Perinatal Safety Goals for FY14

Dignity Health

Perinatal Safety –Top 10 Goals for FY14

	Title	Baseline	Goal
1	Sustain Low Rate Early Elective Deliveries	0.4%	<1%
2	Maintain Success with Oxytocin, OVD, Hemorrhage and Shoulder Dystocia	85%	90%
3	Improving Neonatal Care and Documentation - *Neonatal Therapeutic Hypothermia* - *Cord Gases/Placental Pathology* - *Magnesium Sulfate for Neuroprotection*	varies	100%
4	Initiatives to Reduce Maternal Morbidity & Mortality - *CMQCC Preeclampsia Toolkit* - *Maternal Sepsis Screening* - *Development of an Early Warning Trigger System*	varies	100%
5	Standardized Online Learning – APS Modules FHR, SD, hemorrhage (RN)	36%	95%
6	Standardized Online Learning – APS Modules FHR, SD, hemorrhage (MD)	8%	50%
7	Culture of Safety – Improve "Climate of Safety" Results	69%	75%
8	Culture of Safety – The "Team Work" Results *(Cost of Silence)*	62%	75%
9	Improving Safety and Teamwork - Drills Involving Perinatal High Risk Scenarios	33%	90%
10	Patient Experience – Improve HCAHPS for Medication *(purpose/side effects)*	unknown	TBD

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4	Initiatives to Reduce Maternal Morbidity & Mortality - *CMQCC Preeclampsia Toolkit* - *Maternal Sepsis Screening* - *Development of an Early Warning Trigger System*	varies	100%
5	Standardized Online Learning – Completion of APS PPMs (RN)	36%	95%
6	Standardized Online Learning – Completion of APS PPMs (MD)	8%	50%
7	Culture of Safety – Improve "Climate of Safety" Results	69%	75%
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Childhood Outcomes after Hypothermia for Neonatal Encephalopathy

- Assessment at age 6-7
- Long term follow-up of RTC of 208 infants
- 122 survivors

	Hypothermia	Control	P
Death	28%	44%	0.04
Death + Severe Disability	38%	60%	0.03
Death of IQ<70	47%	62%	0.06

N Engl J Med 2012; 366:2085-2092

Cord Blood Gases and Placental Pathology

Implementation / Ideal Situation:

- Standard criteria for collection
- Cord Sample obtained at every delivery and used if needed
- Placenta to be sent in all cases if criteria met
- List posted on labor and delivery and part of standard order set
- *Supported buy all malpractice insurance carriers*

Meta-Analyses Magnesium Sulfate Protocol

- All 3 separate meta-analyses *Same* conclusion
- ~30% Reduction in cerebral palsy by age 24 months
  - (RR 0.71; 95% CI, 0.55-0.91)
- No statistical increase in fetal or infant death
- Benefit appears to confined to neuromuscular protection

Doyle LW, et al. Cochrane Database Syst Rev 2009;1:CD004661
Costantine MM, et al. Obstet Gynecol 2009;114:354-64
Conde-Agudelo A, Romero R. Am J Obstet Gynecol 2009;200:595-609

- 23w0d – 33w6d gestational age
- Preterm labor with cervical change and the high likelihood of delivery within 12 hours
- Preterm premature rupture of membranes
- Planned delivery for medical indications or obstetric complications that can safely be delayed for magnesium therapy

Does the patient meet exclusions?

Exclusions from Protocol:
- Intrauterine fetal demise
- Fetuses with lethal anomalies or palliative care planned for newborn
- Maternal contraindications to magnesium sulfate (e.g. Myasthenia gravis, renal failure).

YES

Do not initiate Magnesium Therapy

NO

Special Circumstances:
- **Impaired Renal Function**: evaluation of creatinine levels may be necessary in order to provide for the safest dosing.
- Maternal **severe preeclampsia** (these patients are placed on magnesium for seizure prophylaxis)

Implementation:
- Load the patient with a 4-gram bolus of magnesium sulfate IV over a total of 20-30 minutes.
- Run a maintenance infusion of 2 grams per hour until delivery or 12 hours have elapsed.

The patient returns with risk of preterm delivery and meets the above criteria. Has the patient been off magnesium for more than 6 hours?

Yes

- Load 4-gram bolus of magnesium sulfate IV over a total of 20-30 minutes.
- Continue infusion of 2 grams per hour until delivery or 12 hours have elapsed.

No

- Restart magnesium at 2 grams per hour IV until delivery or up to 12 hours

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine (SMFM)

CDC

Division of Reproductive Health

HRSA

Maternal Child Health Branch (MCH-B)

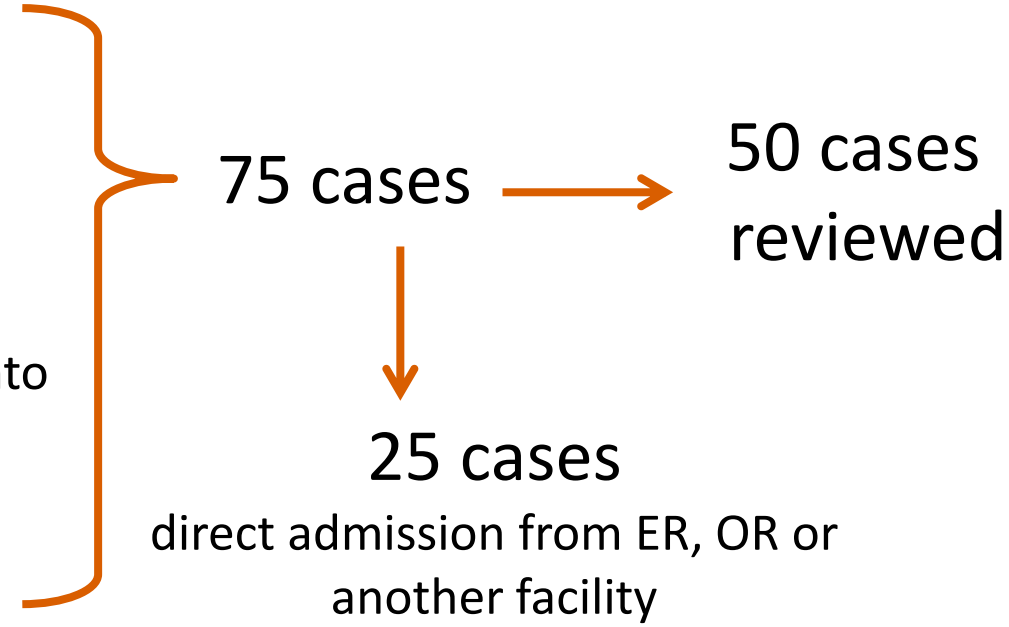
"What every birthing facility in the US should have…"

- ☑ ***Obstetric Hemorrhage Safety Bundle***
- ☐ ***Severe Hypertension Safety***
- ☐ ***Maternal Early Warning Criteria***

  (Critical Care Assessment)
- ☐ ***VTE Prevention Safety Bundle***

Review of Maternal ICU Admissions

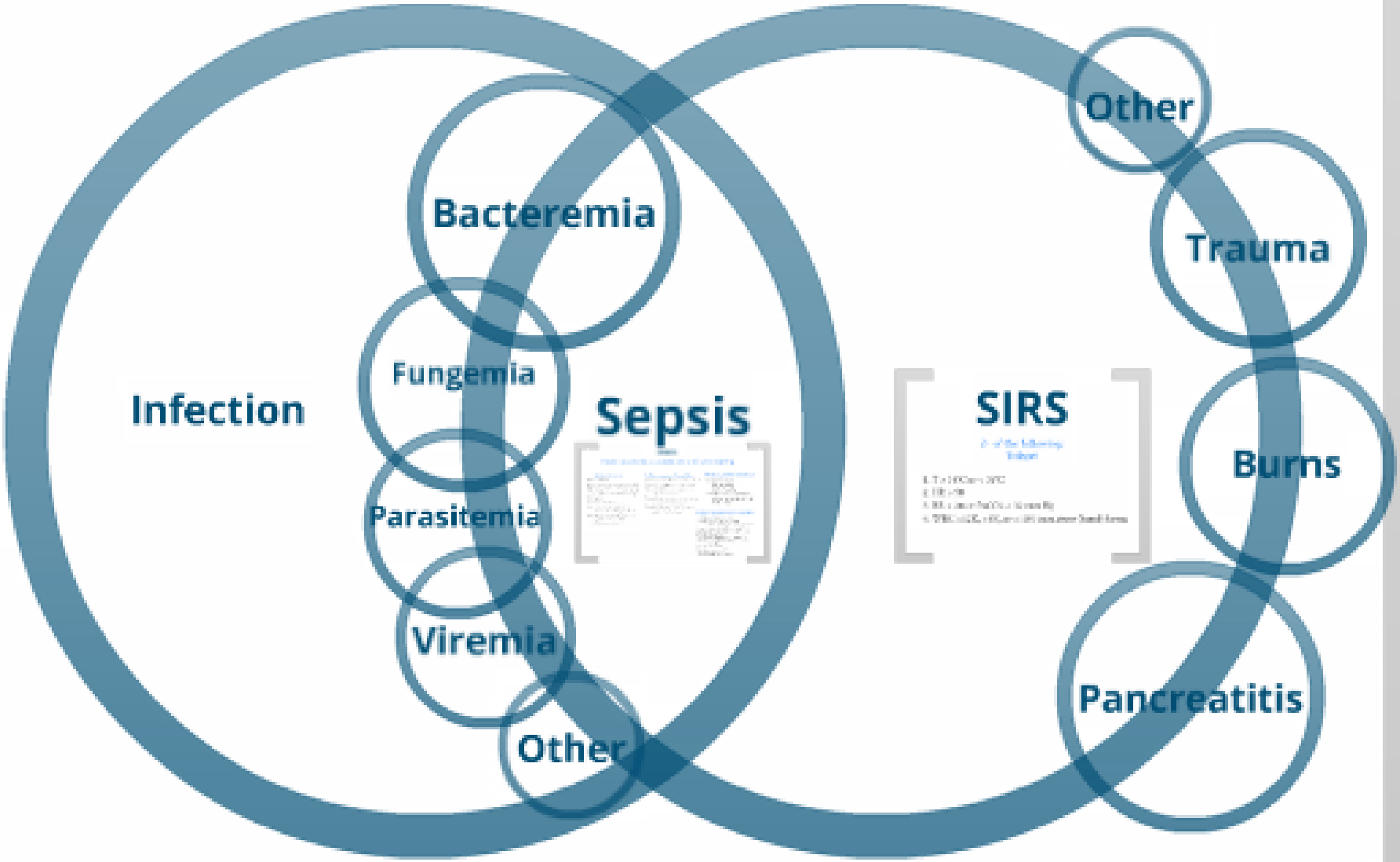
- 266 obstetrical patients admitted to the ICU
- Case review from:
  - Mercy San Juan
  - Mercy Folsom
  - Mercy General
  - Methodist Hospital Sacramento
  - St Josephs Phoenix
  - Marian Regional MC
- 50 normal controls



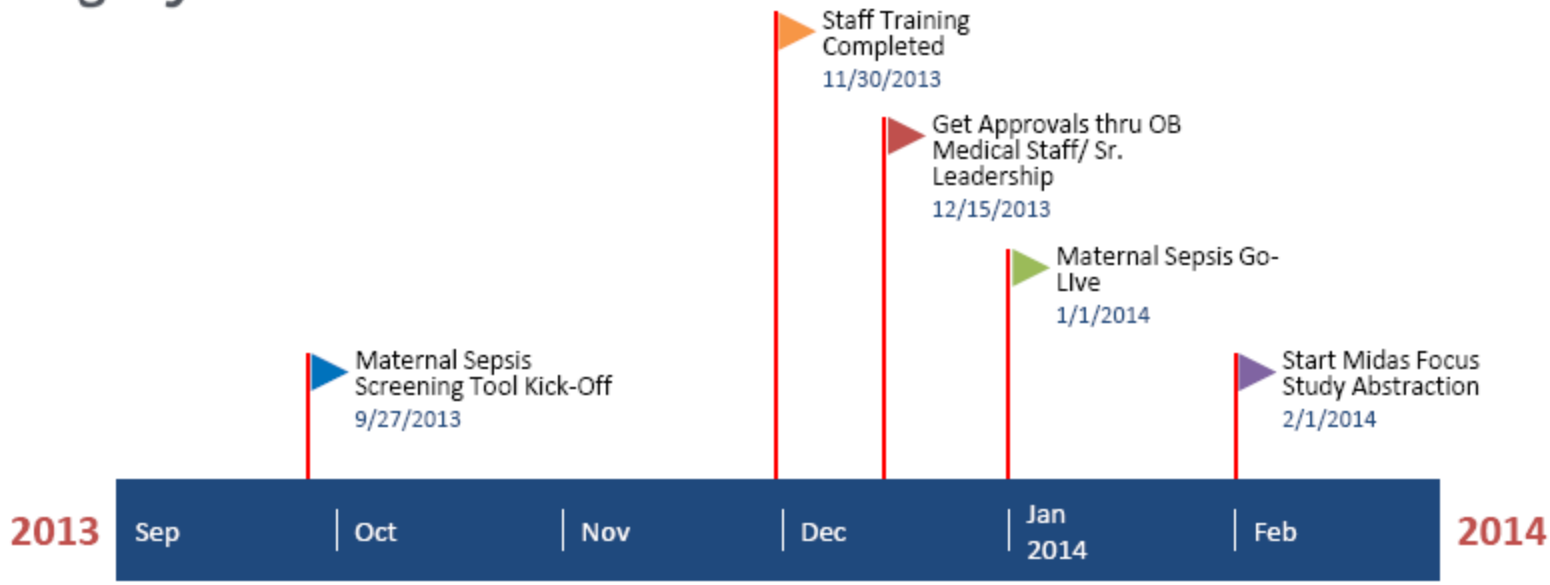
Primary Indications for ICU Admission

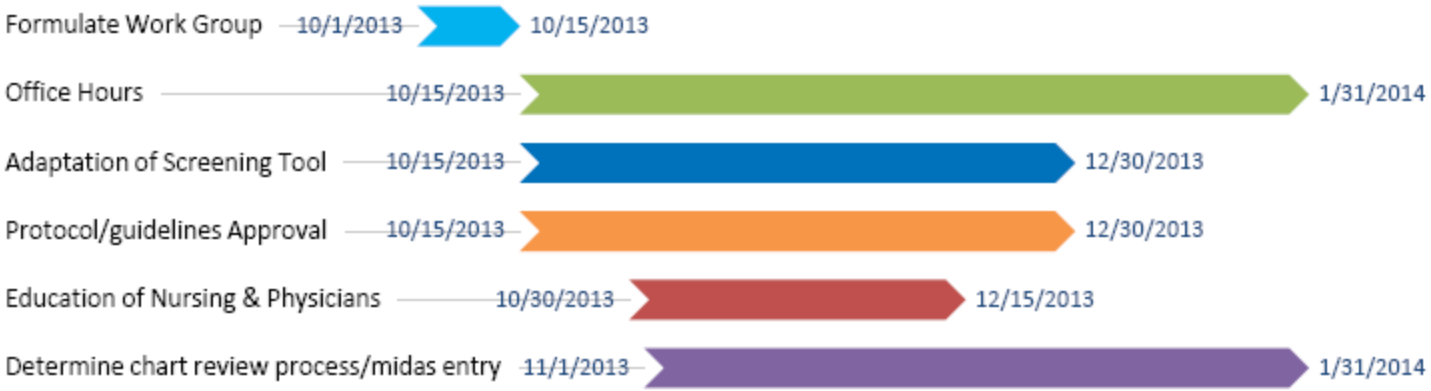
ICU admission rate: 4.5/1000 births		
Hemorrhage	15/50	30%
Sepsis	12/50	24%
Cardiac Dysfunction	8/50	16%
Preeclampsia	6/50	12%
Other	9/50	18%
Totals	41/50	82%

Surviving Sepsis Campaign: 2012 Guidelines



Dignity Health





Maternal Sepsis Screening Tool Timeline

8-16-13 bd

Hypertensive Disorders of Pregnancy

- Revised definitions from ACOG-2013
  - Changes in definitions and recommendations
- CMQCC toolkit -2014
  - Guidelines and recommendations for care based on ACOG and outcomes from review of maternal mortality in CA 2002-2005.
- Hospital Engagement Networks (HENs)
  - Two areas of interest for 2014
    - Preeclampsia
    - Obstetrical Hemorrhage

A California Toolkit to Transform Maternity Care

Improving Health Care Response to Preeclampsia: A California Quality Improvement Toolkit

THIS COLLABORATIVE PROJECT WAS DEVELOPED BY:

THE PREECLAMPSIA TASK FORCE

CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE

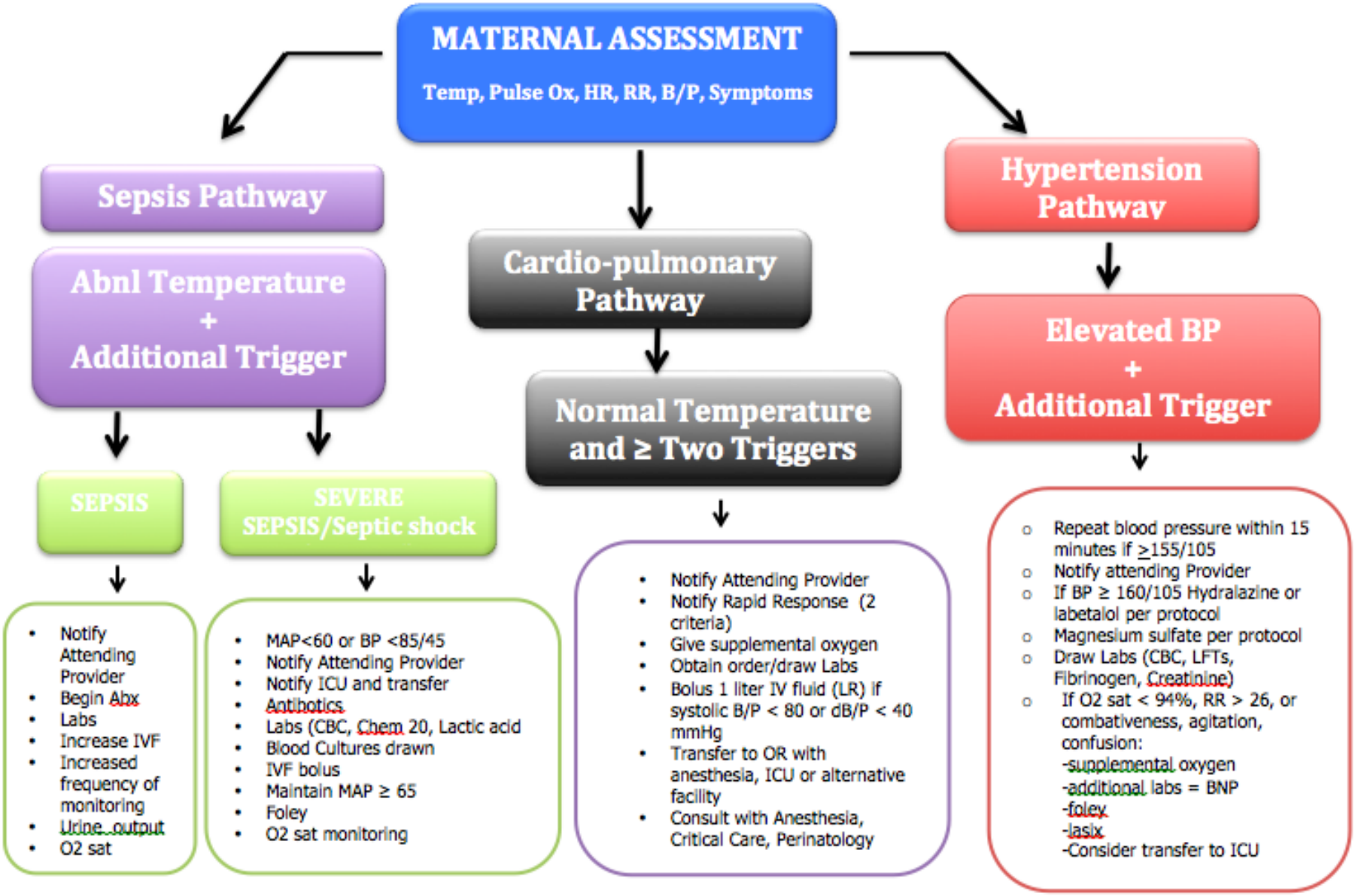
MATERNAL, CHILD AND ADOLESCENT HEALTH DIVISION: CENTER FOR FAMILY HEALTH

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

Monitored Elements for Preeclampsia

- Acute treatment of BP >155-160/105-110 with in 1 hour of verification
- Adopt a uniform policy for acute treatment of critical BP
- Adopt a uniform criteria for use of magnesium sulfate
- Discharge recommendations for follow-up within:
  - 7-14 days if diagnosis of preeclampsia
  - 3-7 days if the patient required BP treatment*
- Other Key elements:
  - Adopt program that improves identification and evaluation of subjective symptoms or “severe features”

Trigger-Critical Care Assessment



Perinatal Safety –Top 10 Goals for FY14

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1	Sustain Low Rate Early Elective Deliveries	0.4%	<1%
2	Maintain Success with Oxytocin, OVD, Hemorrhage and Shoulder Dystocia	85%	90%
3	Improving Neonatal Care and Documentation - *Neonatal Therapeutic Hypothermia* - *Cord Gases/Placental Pathology* - *Magnesium Sulfate for Neuroprotection*	varies	100%
4	Initiatives to Reduce Maternal Morbidity & Mortality - *CMQCC Preeclampsia Toolkit* - *Maternal Sepsis Screening* - *Development of an Early Warning Trigger System*	varies	100%
5	Standardized Online Learning – APS Modules FHR, SD, hemorrhage (RN)	36%	95%
6	Standardized Online Learning – APS Modules FHR, SD, hemorrhage (MD)	8%	50%
7	Culture of Safety – Improve "Climate of Safety" Results	69%	75%
8	Culture of Safety – The "Team Work" Results *(Cost of Silence)*	62%	75%
9	Improving Safety and Teamwork - Drills Involving Perinatal High Risk Scenarios	33%	90%
10	Patient Experience – Improve HCAHPS for Medication *(purpose/side effects)*	unknown	TBD

APS ADVANCED PRACTICE STRATEGIES

Advancing Knowledge, Empowering Caregivers.

GNOSIS™ identifies opportunities for clinical improvement, weights them by error risk, and maps out a personalized curriculum path, in 2-5 minute modules, to rapidly improve clinician performance while eliminating the need to go through training where the user is already proficiency

Step 1: Assessment: content includes EFM, Shoulder Dystocia, and Hemorrhage

Step 2: Reports scores based on assignment of textbook type material “knowledge and the application of “knowledge” in clinical scenarios “judgment”

Step 3: Review: based on answers review of specific areas (i.e. risk factors for SD)

Perinatal Safety –Top 10 Goals for FY14

	Title	Baseline	Goal
1	Sustain Low Rate Early Elective Deliveries	0.4%	<1%
2	Maintain Success with Oxytocin, OVD, Hemorrhage and Shoulder Dystocia	85%	90%
3	Improving Neonatal Care and Documentation - *Neonatal Therapeutic Hypothermia* - *Cord Gases/Placental Pathology* - *Magnesium Sulfate for Neuroprotection*	varies	100%
4	Initiatives to Reduce Maternal Morbidity & Mortality - *CMQCC Preeclampsia Toolkit* - *Maternal Sepsis Screening* - *Development of an Early Warning Trigger System*	varies	100%
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10	Patient Experience – Improve HCAHPS for Medication *(purpose/side effects)*	unknown	TBD

Perinatal Standardized Drills



What is a high-risk scenario drill?

- High-risk drills include the following:
  - Briefing
  - Simulation with hands-on participation
  - Chain-of-command situation
  - Debriefing
    - What went well? What did not go well? What can we improve?
  - Documentation and signature by each participant to confirm attendance and that all learning objectives were met



Teams that train together to effectively collaborate, recognize strengths, and uncover weaknesses can have a profound effect on patient safety…

Hansen & Arafeh, 2012, JOGNN, 41, pp 559-571

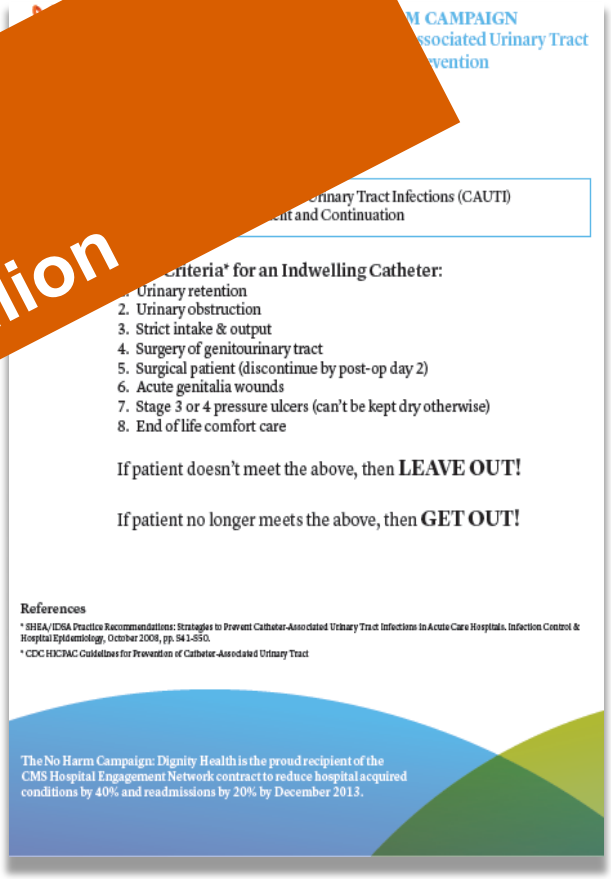
Good results
but do
patients benefit?

No Harm Campaign

Contract with CMS

- 40% reduction in hospital-acquired conditions
- 20% reduction in pr
  re-admissions
- $8 Million

10,000 patients and $25 to $30 million



Focus Areas

- Adverse Dru
- Catheter Urina
  Infection
- Central Line Infe
- Falls
- Obstetrical Adverse Events
- Pressure Ulcers

Infections

hromboembolism

- Ventilator - Acquired Pneumonia
- Readmissions
- ED Throughput
- Culture of Safety

Dignity Health

Culture, Strategy and Accountability dine together.

Dignity Health.

A Checklist for Culture of Safety, Quality Care & Patient Results

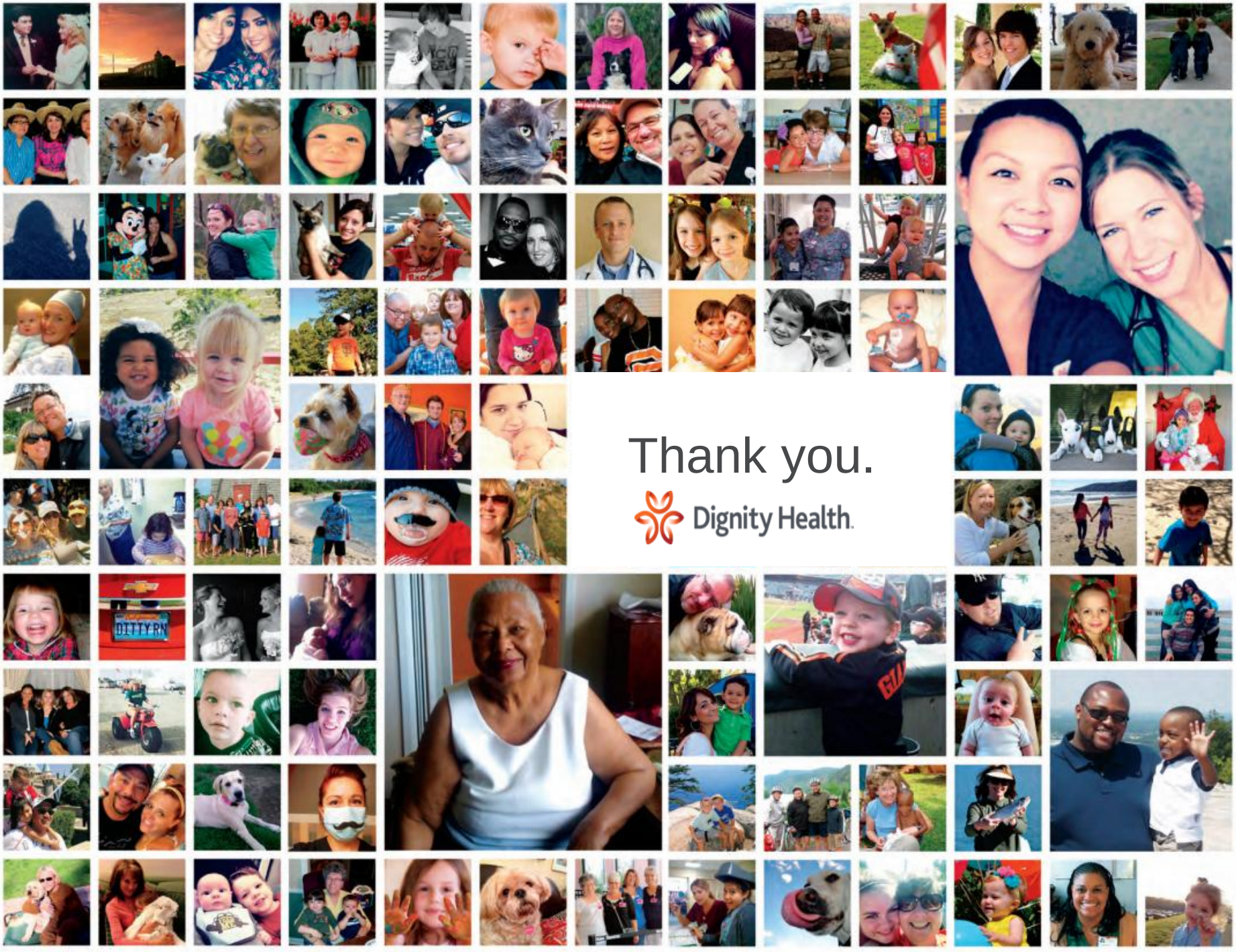
- ❑ 1. Does your leadership round daily at the bedside and units?
- ❑ 2. Can each of your senior leaders articulate the top ten safety and quality goals across your system?
- ❑ 3. Are your results available by hospital, easy to access and presented real time across all hospitals?
- ❑ 4. Can your organization easily identify the low performers and dedicate additional resources for improvement?
- ❑ 5. Does your hospital adopt evidence based practices (or create proven practices to share)?
- ❑ 6. Does your hospital support accountable and effective leaders at a department level?
- ❑ 7. Does your hospital engage councils, leadership groups, physicians, champions to implement and drive change?
- ❑ 8. Does your EHR team align with your clinical, safety and quality leaders?
- ❑ 9. Does your hospital adopt proven strategies like MV from other learning organizations to improve outcomes?
- ❑ 10. Does your hospital drill down and share your adverse events?



Need More Information?

Barbara Pelletreau, RN, MPH
Office (415) 438-5567
barbara.pelletreau@dignityhealth.org

Suzanne Wiesner MBA/HCM, RN, C-EFM
Office (916) 851-2789
suzanne.wiesner@dignityhealth.org


Thank you.
Dignity Health.