



NATIONAL ACTION ALLIANCE
for Patient and Workforce Safety

Using Data for Real-Time Learning, Reporting, and Review

NAA National Webinar
March 10, 2026

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**Thank You for Your Commitment
to Advance Patient and Workforce Safety!**

Safe Care Everywhere—Zero Preventable Harm for All

Total Systems Approach to Safety Informed by Safety Self-Assessments

Strengthen
safety
competencies

Safety by
design

Empower the
patient's voice

Learning and Research Network

1. Advance Organizational Safety Strategies Using Safety Self-Assessments
2. Empower the Patient's Voice in Safety Strategy
3. Support Healthcare Workforce by Making Healthcare Safer by Design
4. Support Healthcare Workforce by Strengthening Safety Competencies
5. Facilitate Learning and Research Network

Best Practices of High-Performing Healthcare Systems

National Action Alliance for Patient and Workforce Safety


Best Practices to Strengthen Safety Culture, Leadership, and Governance Change Package: Technical Report

Final

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Agency for Healthcare Research and Quality

Authored by:
American Institutes for Research
Subcontractor to Ripple Effect Communications, Inc.

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NATIONAL ACTION ALLIANCE FOR PATIENT AND WORKFORCE SAFETY

Best Practices to Strengthen Safety Culture, Leadership, and Governance Change Package

Prepared for the Agency for Healthcare Research and Quality
Center for Quality Improvement and Patient Safety (DQIPPS)
by
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Questions to Run On

- What actions are you hearing from high performers that are most exciting?
- What are actionable takeaways from our presenters today?

Speaker Welcome



Kate Nesbitt, CPHQ, CPPS
Administrator, Patient Safety, Mayo Clinic



Walter "Chip" Harrison, R.N., CPHRM
Sr. Network Director, Clinical Risk Management,
St. Luke's University Health Network



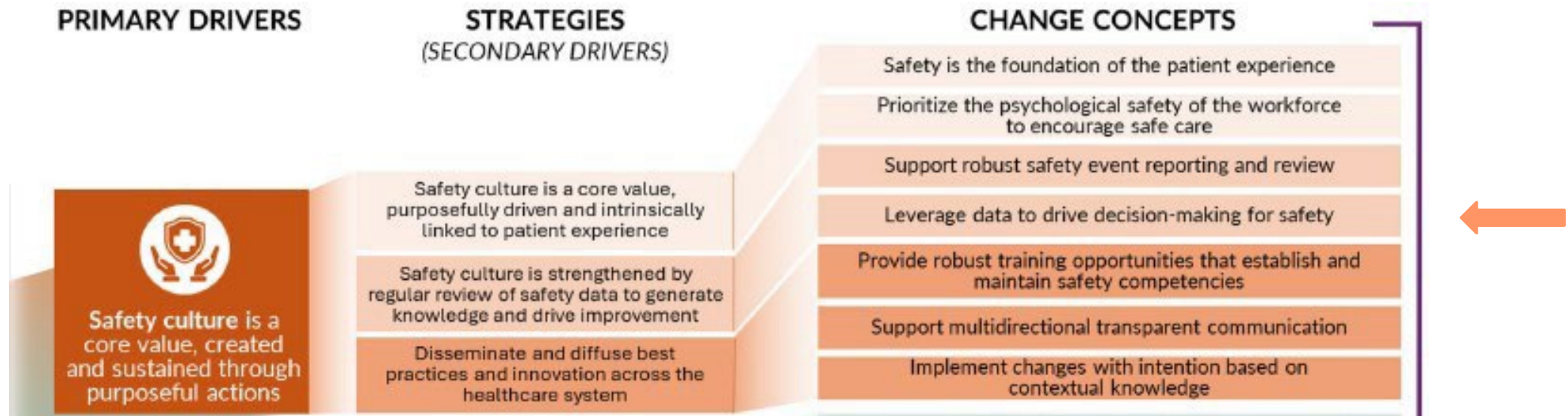
Quality

National Action Alliance for Patient and
Workforce Safety

Using Data for Real-Time Learning, Reporting, and Review

Kate Nesbitt, CPHQ, CPPS | March 10, 2026





- Develop and use data dashboards to transparently track baseline data and progress
- **Benchmark data internally and externally and establish standard metrics, definitions, and data sources that are shared across the healthcare system**
- **Maximize the use of real-time data and share data transparently to support clinical decision making**
- Use all available data to support structured quality improvement efforts

Leveraging Safety Data at Mayo Clinic



Executive / Board

- Quarterly Reports
 - Patient experience
 - Patient safety
 - Mortality
- External Benchmarking
 - HCHAPS
 - Leapfrog
 - US News
 - CMS Overall Star Rating

Leadership

- Quarterly Reports
 - Additional detail
- External Benchmarking
- Committee Meetings
- Dashboard Access

Work Unit Level

- Dashboard Access
- Specific Reports
- Electronic Visual Management Boards
- Tiered Huddles

Performance Dashboard Navigator "Dashboard of Dashboards"

[Hospital Measure Matrix](#)

[Information](#)

Mayo Clinic Quality Index | Leadership Quality Reports | Leapfrog Safety Grade | CMS Care Compare | Mortality

MCVI 	Board of Governors 	CPC 	Quality KPI Tracker 	Leapfrog 	Care Compare 	CMS 30 Day Mortality 	Inpatient Raw Mortality 	Mortality Review Subcommittee Summary
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US News & World Report | Readmissions | Hospital Claims Based | Patient Safety

Leading Quality Indicators for USNWR 	USNWR Procedures and Conditions 	Outpatient Complications Solventum AMPPCs 	POE Note Performance 	30 Day Readmissions 	Hospital Acquired Conditions 	Patient Safety Indicators 	Patient Safety Reporting 	Patient Safety Inpatient Rates
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Patient Experience | Infection Prevention & Control | Ambulatory | Specialty Dashboards

Patient Experience 	CAUTI, CLABSI, Cdiff, MRSA, VAE 	SSI 	Hospital Acquired Infections 	Hand Hygiene 	Ambulatory Epic Metrics 	Primary Care KPIs 	Ambulatory eCQMs 	OCG Department Reports
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Hospital eCQMs | Core Measures

Hospital eCQMs 	HBIPS/IPFQR 	Outpatient Core Measures 	Perinatal Core Measures 	Sepsis Core Measures 	The Joint Commission Core Stroke Measures
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Putting Safety Data Into Action

- Patient event trends and responses
- Quality improvement projects
- Local and enterprise-wide initiatives
- Strategic planning and priorities





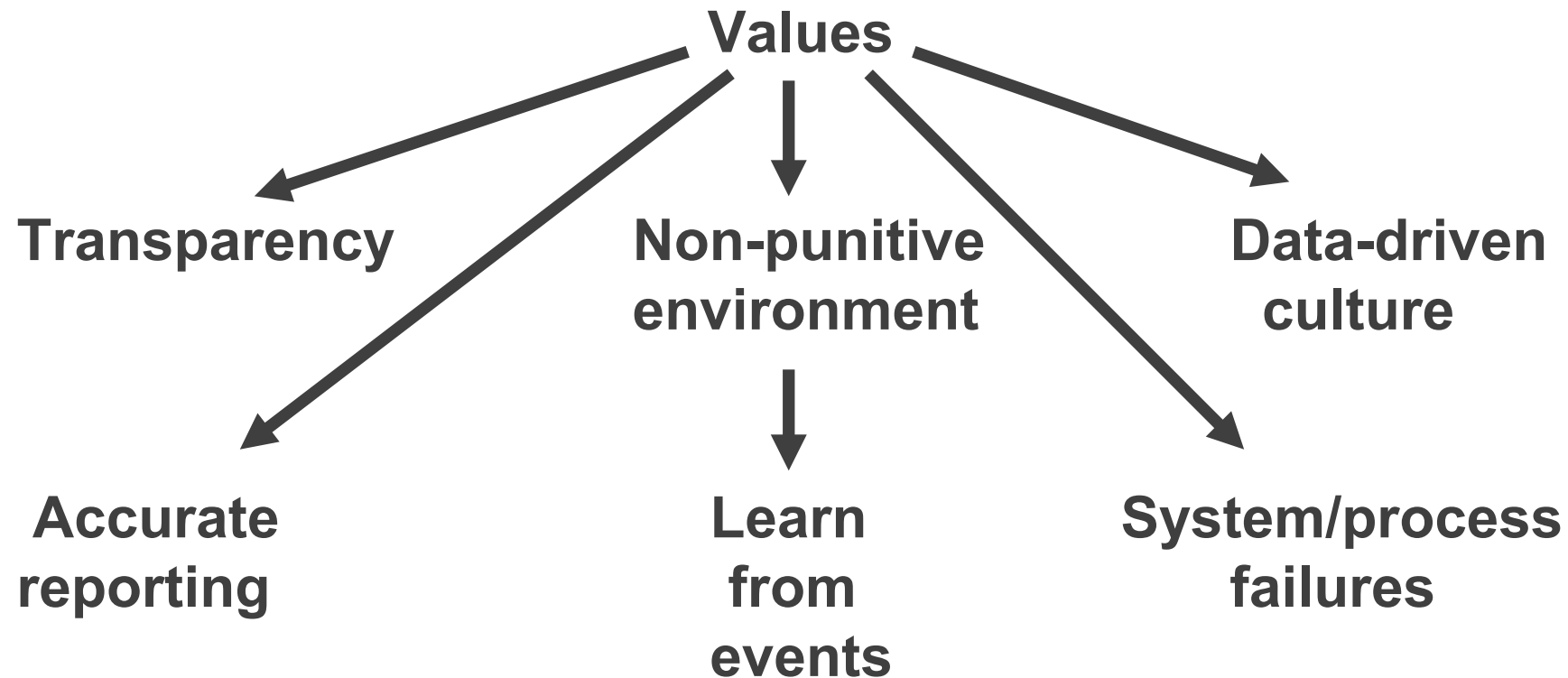
Quality

Real-Time Insights, Real-World Safety

Walter (Chip) Harrison, R.N., B.S.N., CPHRM
Sr. Network Director, Clinical Risk
Management

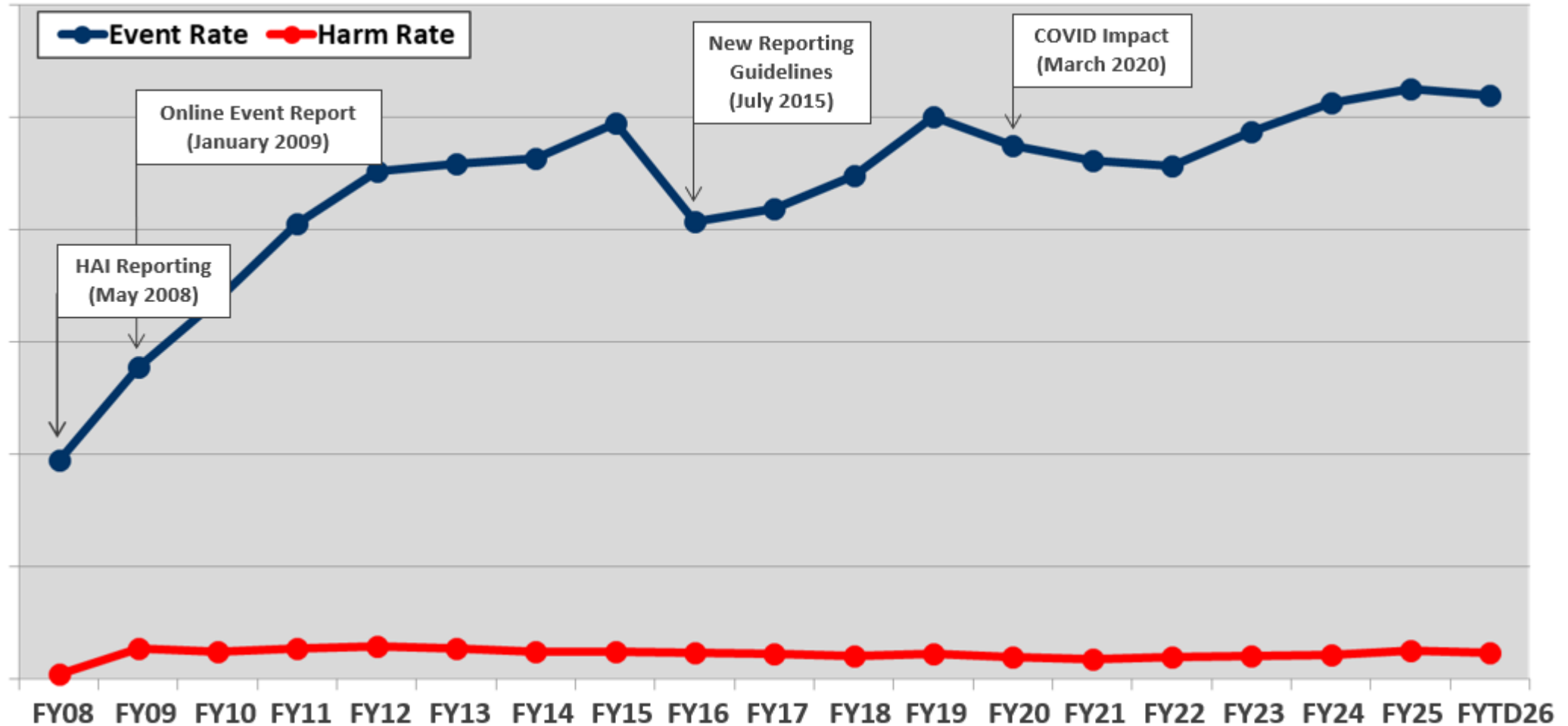


Culture of Safety



Patient Safety Event Reporting

Rate per 1,000 Adjusted Patient Days



Diagnostic Imaging Excellence

Radiology Peer Review Process

- RadPeer – ACR Gold Standard
- Image reviews are embedded in radiologist workflows
- Significant discrepancies are reviewed by a panel of radiologists
- Ensures a structured peer review and feedback process

Performance Measure	CY2025	CY2024
Studies Reviewed (#)	67,582	49,587
Agreement Rate (%)	98.4%	97.9%
Serious Events Discovered (#)	1	2



Diagnostic Excellence

PI Project: Acute Pancreatitis

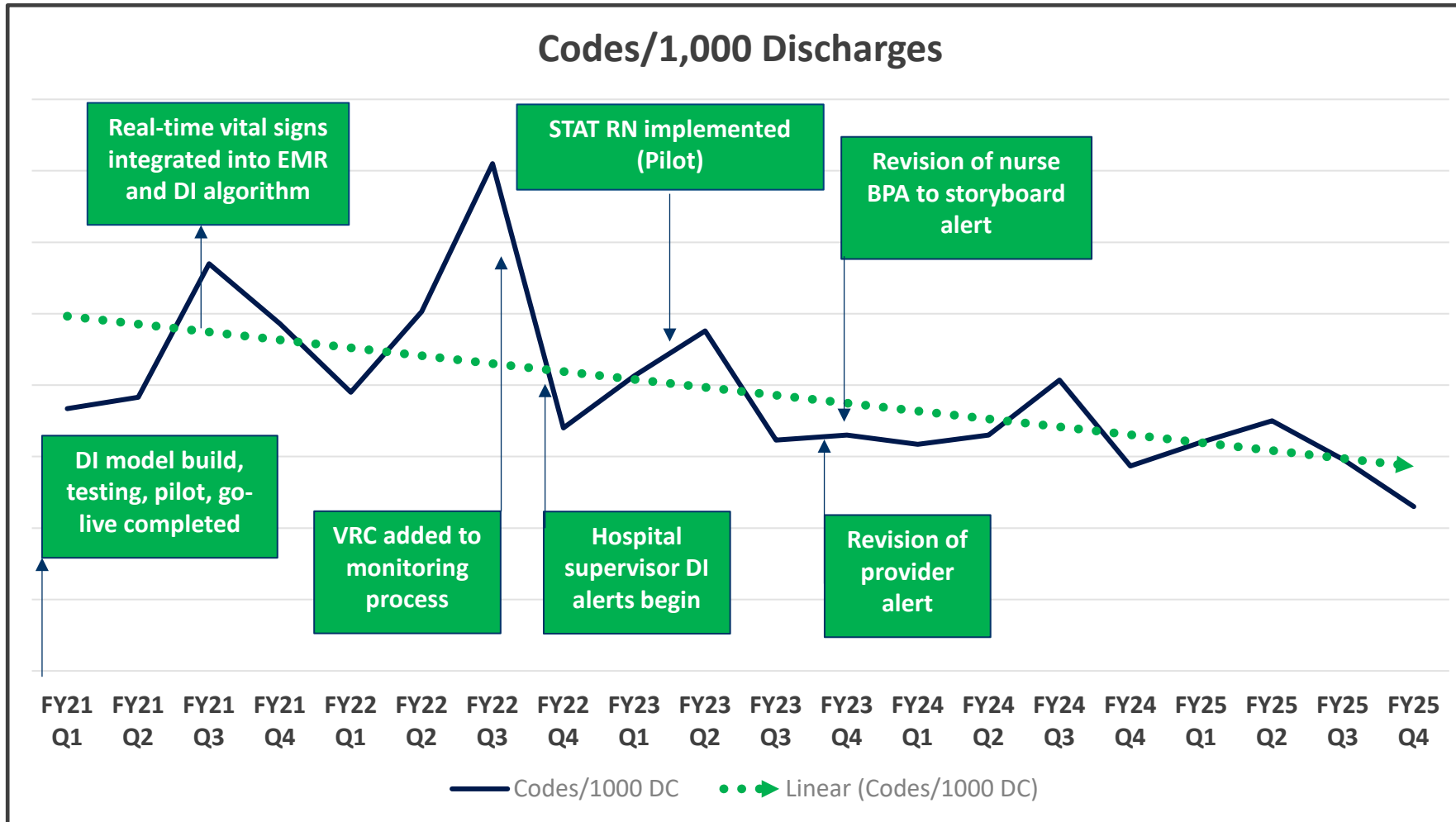
- Etiology: Gallstones or alcohol (80% of cases)
- Presentation: Sudden onset severe abdominal pain, nausea & vomiting
- Treatment: Supportive care, may require antibiotics or surgical intervention
- Severe acute pancreatitis occurs in 20% of cases and has high morbidity/mortality

	Baseline (CY24)		FYTD2026		Peer
SLUHN	Actual	Index	Actual	Index	Index
ALOS	4.0	1.10	3.7	1.01	1.17
Readmissions	14.2%	1.33	12.9%	1.22	1.19
Mortality	1.0%	1.48	1.1%	0.91	1.42



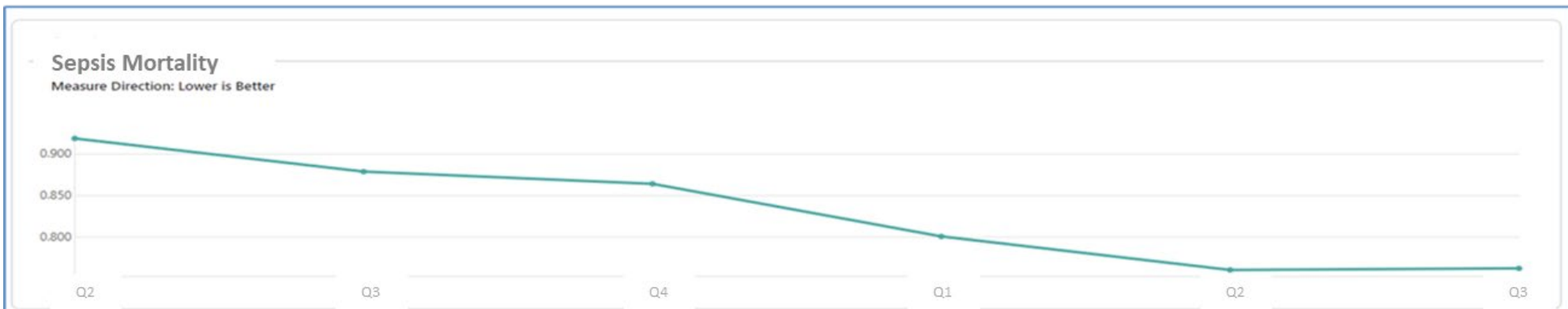
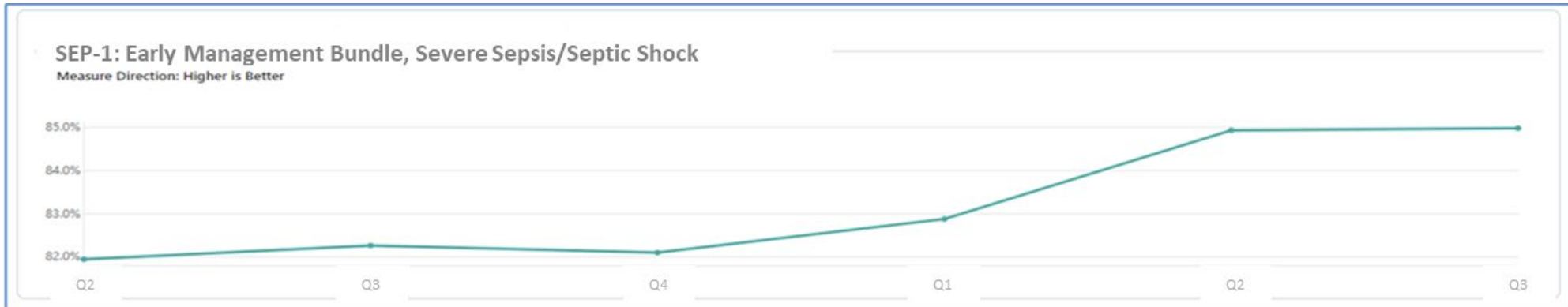
Deterioration Index (AI)

Inpatient Codes per 1,000 Discharges



Sepsis Performance

Cognitive Computing Model



Real-Time Insights, Real-World Safety

Effective Practices

- Quantify and prioritize true opportunities
- Establish reliable data sources
- Incorporate reporting in common workflows
- Embrace transparency
- Robust review processes
 - Service-line peer review and multidisciplinary RCAs
 - Address root causes
 - Closed-loop communication to Sr. Leadership AND staff



Questions and Answers

Share With Us!

Based on what you have learned today:

- What most excites you about what you heard?
- What are 1–2 key actionable takeaways?

***Please submit your response in the chat**

Thank You!

Announcing the Next NAA Monthly National Webinar

Leadership That Drives Safety

Tuesday, June 9, 2026 (3–4 p.m. EST)

Register here – <https://www.ahrq.gov/action-alliance/webinars/index.html>

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