HMA

HANYS
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SINCE 1925

Leveraging Survey Findings and Strengthening Organizational Quality and Compliance

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HANYS Survey Readiness
Virtual Series 5 of 5

TODAY'S SPEAKERS

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LEARNING OBJECTIVES

- **Prioritize and sequence improvement efforts** based on risk, feasibility and organizational impact to avoid initiative fatigue and ensure lasting change.
- Move past **reactive fixes** by identifying system vulnerabilities to prevent recurrence.
- Design **sustainable** improvements.
- Establish **feedback loops** that connect post-survey improvement work with real-time monitoring, frontline engagement and leadership decision-making.
- Foster a **learning organization culture**.

WHAT MATTERS MOST?

POLLING QUESTION #1

When something lands on your post-survey to-do list, how does your team usually decide what gets tackled first?

1. The loudest issue gets the most attention
2. Whatever the surveyor emphasized
3. Going with the fastest fix
4. A structured approach to score and rank
5. It depends who's in the room

STRATEGIC PRIORITIZATION AND PACING

Start with structure

- Use tools to sort and sequence findings

Key drivers

- Severity of harm
- Frequency of occurrence
- Feasibility of correction
- Visibility to regulators or public

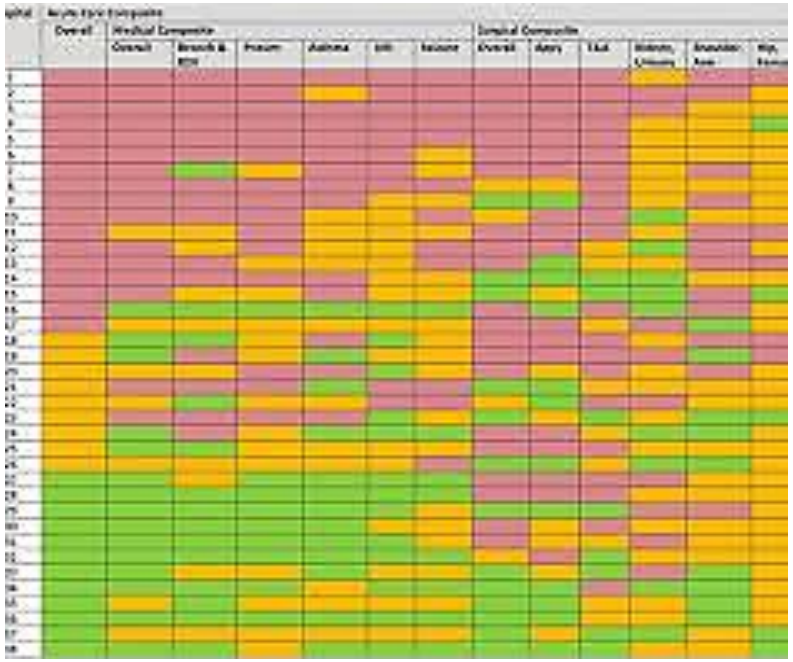
Balance urgency with feasibility

- Don’t try to fix everything at once
- Early wins build momentum

Sequence for success

- Tackle high-impact, actionable items first
- Defer complex, resource-heavy items until a plan is in place

PRACTICAL FRAMEWORKS TO ORGANIZE WORK



- **Prioritization matrix:** Weigh risk, effort and visibility
- **Regulatory heat maps:** Visualize areas of greatest compliance risk
- **Impact-effort grids:** Identify high-value, quick-win actions
- **Risk scoring:** Evaluate severity, occurrence, detectability
- **Tiering system:** Classify findings as immediate, near-term or long-term

AVOID INITIATIVE FATIGUE

Too Many Initiatives = Burnout + Missed Targets

Phase implementation

- Prioritize and sequence rollouts
- Pilot first, then scale

Communicate clearly

- Provide realistic timelines
- Keep staff informed and engaged

Build in recovery time

- Space out major changes
- Celebrate small wins before moving on

OWNERSHIP AND OVERSIGHT: WHO'S DRIVING CHANGE?

Designate clear owners

- Define who is accountable for each action item and ensure they have decision-making authority

Identify department champions

- Trusted peers who can influence from within
- Support adoption and help remove barriers

Structure accountability

- Use trackers, dashboards, and defined timelines
- Schedule recurring check-ins to assess progress and recalibrate

Build cross-functional teams

- Engage nursing, medical staff, quality, and operations for shared ownership

ALIGNING QAPI AND RISK PLANS TO BUILD IMPROVEMENT

Integrate survey findings into QAPI and risk plans

- Tie citations to relevant QAPI priorities and annual goals

Shape internal audits, education and monitoring

- Use survey results to inform focused audits, policy refreshers and competency training

Connect improvements to strategic and board-level reporting

- Demonstrate how lessons learned influence long-term strategy
- Highlight progress in quality dashboards, board packets and governance updates

DIAGNOSE THE PROBLEM, DON’T JUST TREAT THE SYMPTOMS

FROM IMMEDIATE FIXES TO SYSTEMIC CHANGE

An Opportunity Behind Every Citation

- **Citations highlight systemic weaknesses, not one-off errors**
- **Quick fixes ≠ Long-term prevention**
  - Signage and checklists are helpful — but not sufficient
- **Use findings to probe for root causes**
  - Process breakdowns
  - Workflow inefficiencies
  - Communication failures
- **Reframe the mindset**
  - Every finding = a roadmap to improve safety, quality and reliability

POLLING QUESTION #2

You've just had a patient safety event or received a citation. What's your knee-jerk reaction?

1. Schedule an emergency training
2. Ask "Who was involved?"
3. Dust off the root cause analysis toolkit
4. Look for a policy to rewrite
5. Honestly… it depends on the day

UNDERSTANDING THE DIFFERENCE BETWEEN RCA AND FMEA

Aspect	Root Cause Analysis	Failure Modes and Effects Analysis
Purpose	Investigate past events to identify underlying causes of failures	Identify potential failure modes before they occur
Approach	Retrospective assessment	Prospective — anticipates possible failures in new or existing processes
When to Use	After an incident, error, sentinel event or near miss to prevent recurrence	Before implementing or modifying a process to mitigate potential risks
Focus	Understanding what happened and why	Examine each step for failure, severity and likelihood opportunities
Outcome	Actionable insights leading to system-level changes	Risk-prioritized action plans to address and prevent potential failures
TJC Expectation	Required within 45 days of a sentinel event	Recommended as a proactive risk assessment at least every 18 months

DEMYSTIFYING RCA: LOOKING BACK TO MOVE FORWARD

RCA = Retrospective tool

- Triggered by significant findings, near misses or adverse events

Focuses on systems, not people

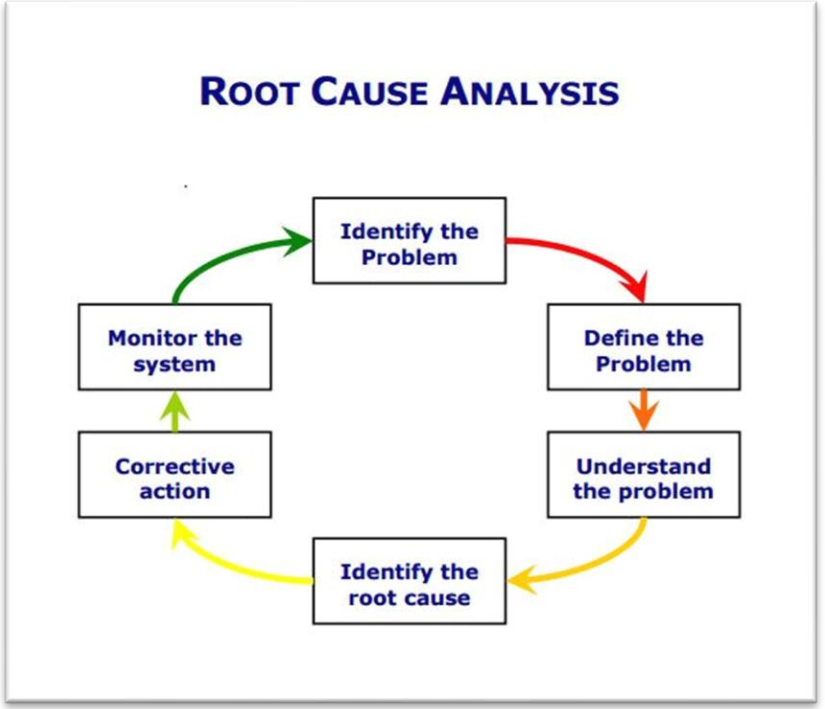
- Shifts conversation from “who” to “why”

Structure to uncover underlying issues

- Ask “Why?” 5 times
- Map out processes
- Identify contributing factors

Outcome = Actionable, system-level changes

- Policy updates, tech fixes, workflow redesign, training



RCA IN ACTION: STEPS TO A SUCCESSFUL RCA

Assemble a cross-functional team

- Include clinical staff, quality/risk, IT, support services and leadership

Map the event timeline

- Use flowcharts or process mapping to visualize the sequence of events

Apply RCA tools

- 5 Why's: Drill down into layers of contributing factors
- Fishbone diagram**:** Categorize causes (e.g., people, process, IT, environment)

Identify the true root causes

- Focus on system-level contributors, not just individual actions

Translate findings into actionable improvements

- Policy changes, tech updates, workflow redesign, targeted education

THE FISHBONE DIAGRAM: VISUALIZING ROOT CAUSES

Organize contributing factors

- People: Training, staffing, communication
- Process: Workflow design, handoffs, redundancies
- Environment: Physical layout, noise, interruptions
- Equipment: Functionality, availability, maintenance
- Policy: Procedures, protocols, clarity of expectations

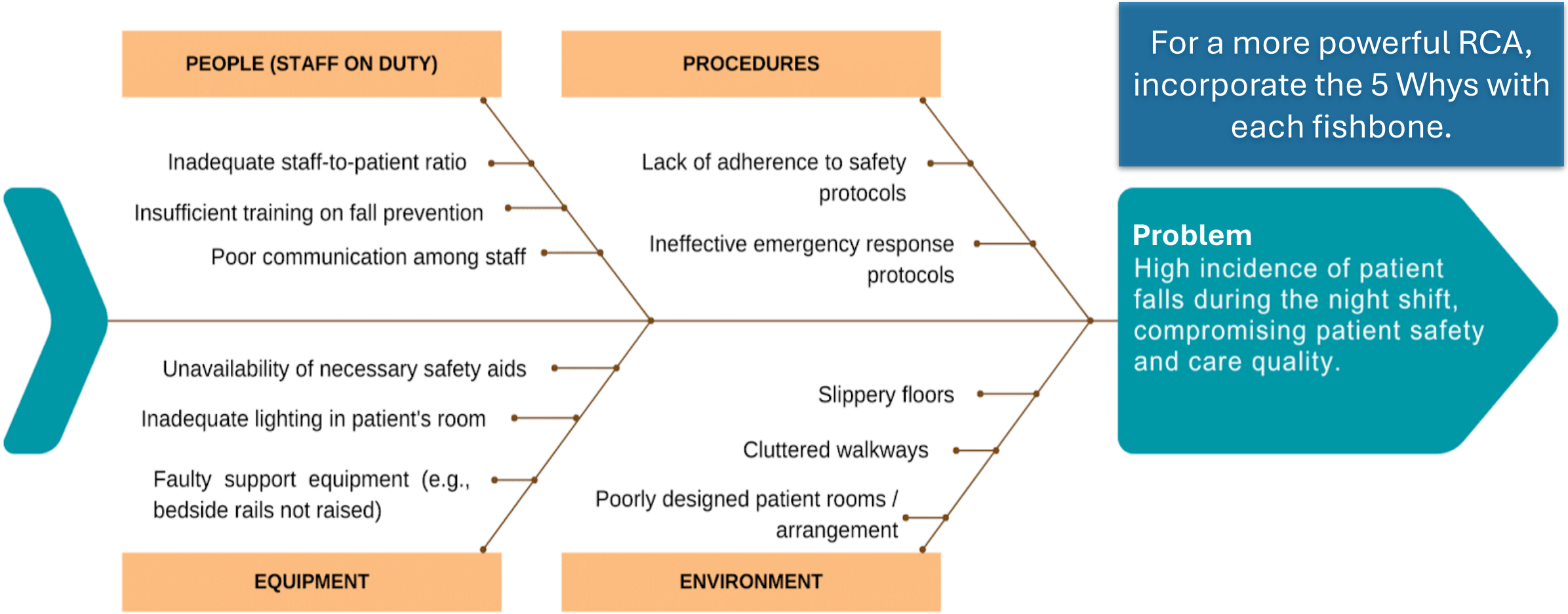
Best for collaborative brainstorming

- Used during RCA team meetings
- Encourages contributions from all disciplines

Reduces oversimplification

- Helps avoid defaulting to human error as the sole cause

FISHBONE EXAMPLE: PATIENT FALLS



For a more powerful RCA, incorporate the 5 Whys with each fishbone.

RCA OUTPUT: FROM FINDINGS TO FIXES

- Thorough documentation of root causes
- System-level corrective actions
- Clear, actionable recommendations
- Prioritized interventions with leadership buy-in
- Mechanisms for monitoring and reassessment

FAILURE MODE AND EFFECTS ANALYSIS (FMEA)

FMEA = Proactive risk assessment tool

- Used before launching or redesigning high-risk processes

Analyzes each process step

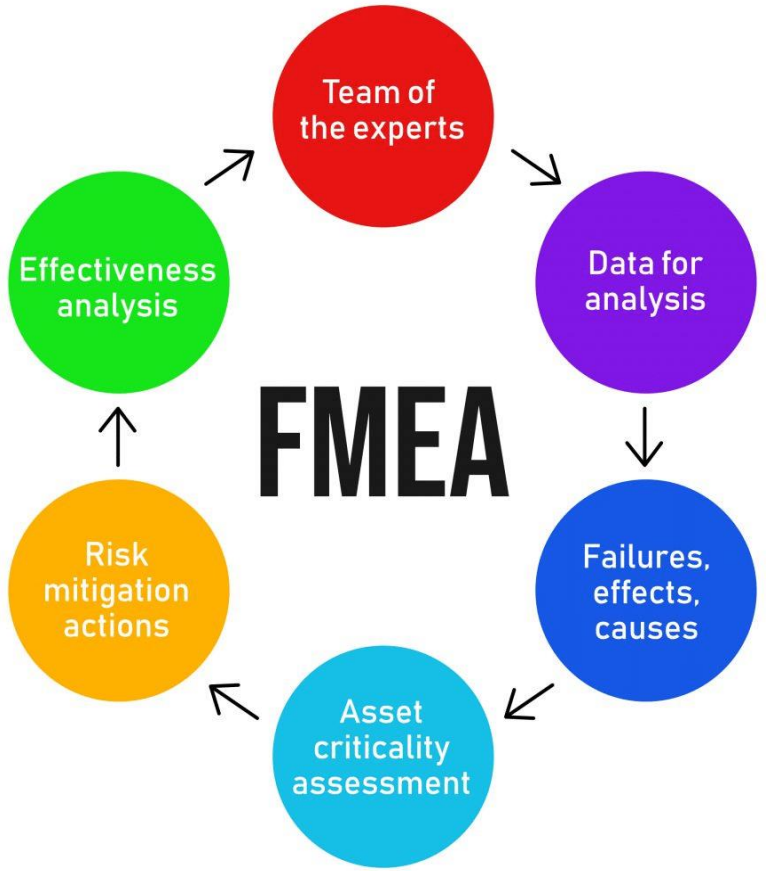
- Identifies where failures *could* occur and why

Scores each potential failure mode

- Severity: How bad is the outcome if it happens?
- Occurrence: How likely is it to happen?
- Detectability: How easy is it to catch before?

Outcome = Prioritized action plan

- Build safeguards before errors reach the patient



CONDUCTING A FMEA: ANTICIPATE FAILURE

- Define the full process in detail
- Identify potential failure modes at each step
- Score each failure mode
  - **Severity:** Impact if it occurs
  - **Occurrence:** Likelihood of it happening
  - **Detectability:** Likelihood of catching it before harm
- Prioritize based on risk scores
- Build targeted preventive interventions

FROM DOCUMENTATION TO IMPLEMENTATION

Strong actions = System change, not surface fixes

- Go beyond policy edits and reminder memos

Integrate improvements into operational infrastructure

- Update training, workflows, clinical decision support and audit routines
- Embed changes into the EHR to reduce variability

Link implementation to measurable outcomes

- Define what success looks like and how it will be tracked

Sustain change over time

- Use dashboards, leadership check-ins and frontline feedback to reassess

DESIGN IMPROVEMENTS THAT STICK

Images: Reddit, Pintrest.

FAILED INTENTIONS

POLLING QUESTION #3

What is your most common experience with organizational changes?

1. Occurred as intended and is still in place
2. Lasted a while but went back to the old way of doing things
3. Staff received training, but changes were not implemented
4. Saw change, but different than intended

STRENGTH OF ACTIONS

Weak Actions

- Double Checks
- Warnings
- New procedure, memo, policy development
- Training

Intermediate Actions

- Redundancy
- Balance workload
- HIT enhancements
- Education methods: simulation, application, refreshers, observations
- Checklist, cognitive aids
- Standardized communication tools
- Enhanced comms and documentation

Strong Actions

- Architectural, physical environment changes
- Human factors controls/engineering
- Simplify process
- Standardize process
- Tangible leadership involvement

STRENGTH OF ACTIONS: WEAK ACTIONS

Double Checks

- One person doing the work and another person checking their work

Warnings/Alerts

- Equipment alarms, EHR alerts, posted signs

New procedure, memo, policy development

- Creating a new policy, new procedure, or sending out a memo or email

Training

- One -time, informational training

STRENGTH OF ACTIONS: INTERMEDIATE ACTIONS

Redundancy

- Example: Two people calculate separately and compare results

Balance workload

- Example: Instead of the provider giving the PHQ-9 Screen, have the intake care team member give the screen
- Example: one week prior to the visit, have a care team member ensure needed labs have been completed and are ready for the provider

HIT enhancements

- Example: Implement a new Transitional Care Management template that provides outreach, timing and frequency fields for required documentation such as medication review and key scripting to be used by staff.

STRENGTH OF ACTIONS: INTERMEDIATE ACTIONS

Education methods: simulation, application, refreshers, observations

- Example: Describe and demonstrate, integrate role-play/demonstration into annual training, routinely shadow to provide feedback on implementation fidelity

Checklist, cognitive aids

- Example: Create a checklist for Care Coordination to use

Standardized communication tools

- Create a huddle report for identifying and communicating patient/client needs on the schedule for the day

Enhanced documentation, communication

- Example: Highlight patient names in the EMR that have the highest risk scores; highlight patients that haven't had their labs completed as ordered

STRENGTH OF ACTIONS: STRONG ACTIONS

Architectural/physical environment changes

- Example: Main entrance door replaced with powered sliding doors to reduce falls

Human factors controls/engineering (Don't rely on memory to take the correct action)

- Example: mandatory fields in the EMR to ensure required questions are answered

Simplify process

- Example: Remove unnecessary steps in a process

Standardize process

- Example: Patients receive care management based on a CM policy and procedure

Tangible involvement by leadership

- Example: Purchase needed equipment; ensure staffing/workload are balanced, speak publicly about monitored data trends and performance

MAKING WEAK ACTIONS STRONGER

Double checks

- Action: One person calculates a dosage, another person reviews the calculation
- Stronger: Two people calculate the dosage separately and compare results

Sending a memo or email

- Action: Send a memo reminding staff to screen for depression using Patient Health Questionnaire (PHQ-9)
- Stronger: Designate a screening champion (e.g. a nurse or medical assistant) responsible for ensuring that patients are screened during their visit (standard work) based on a new policy

Training

- Action: During a provider meeting, educate all staff and providers on the importance of using the screening
- Stronger: Host interactive workshops that include role-playing or case studies to help staff practice integrating PHQ-9 into patient care

HARDWIRING CHANGE INTO POLICY AND WORKFLOW: MAKING IT STICK

Update and re-approve key documents

- Standard operating procedures, protocols, policies and job descriptions

Train staff on new standard, don't just inform

- Hands-on training, skills validation and scenario-based reinforcement

Integrate changes into tools and expectations

- Update audit forms, rounding checklists, huddles and daily assignments

Build Change into routines, not the exception

- Embed into EHR, handoff templates and onboarding

USING A CROSSWALK TO STAY ALIGNED WITH REGULATORS: TRANSLATING INTERNAL CHANGES TO EXTERNAL STANDARDS

- Create policy-to-standard crosswalks
- Demonstrate active alignment with external requirements
- Support transparency and survey readiness
- Use as a living document
- Supports leadership transitions and staff education

CONNECTING IMPROVEMENTS TO ORGANIZATION STRATEGY

Corrective actions should advance enterprise goals

- Link improvements to broader safety, quality, and operational targets

Integrate findings into system-level structures

- Feed into QAPI plans, strategic initiatives, and board quality dashboards

Track cross-departmental themes

- Identify patterns in findings and use them to inform risk mitigation

Drive strategic investment and resource allocation

- Use trends to support decisions about staffing, technology and training

Build a continuous feedback loop

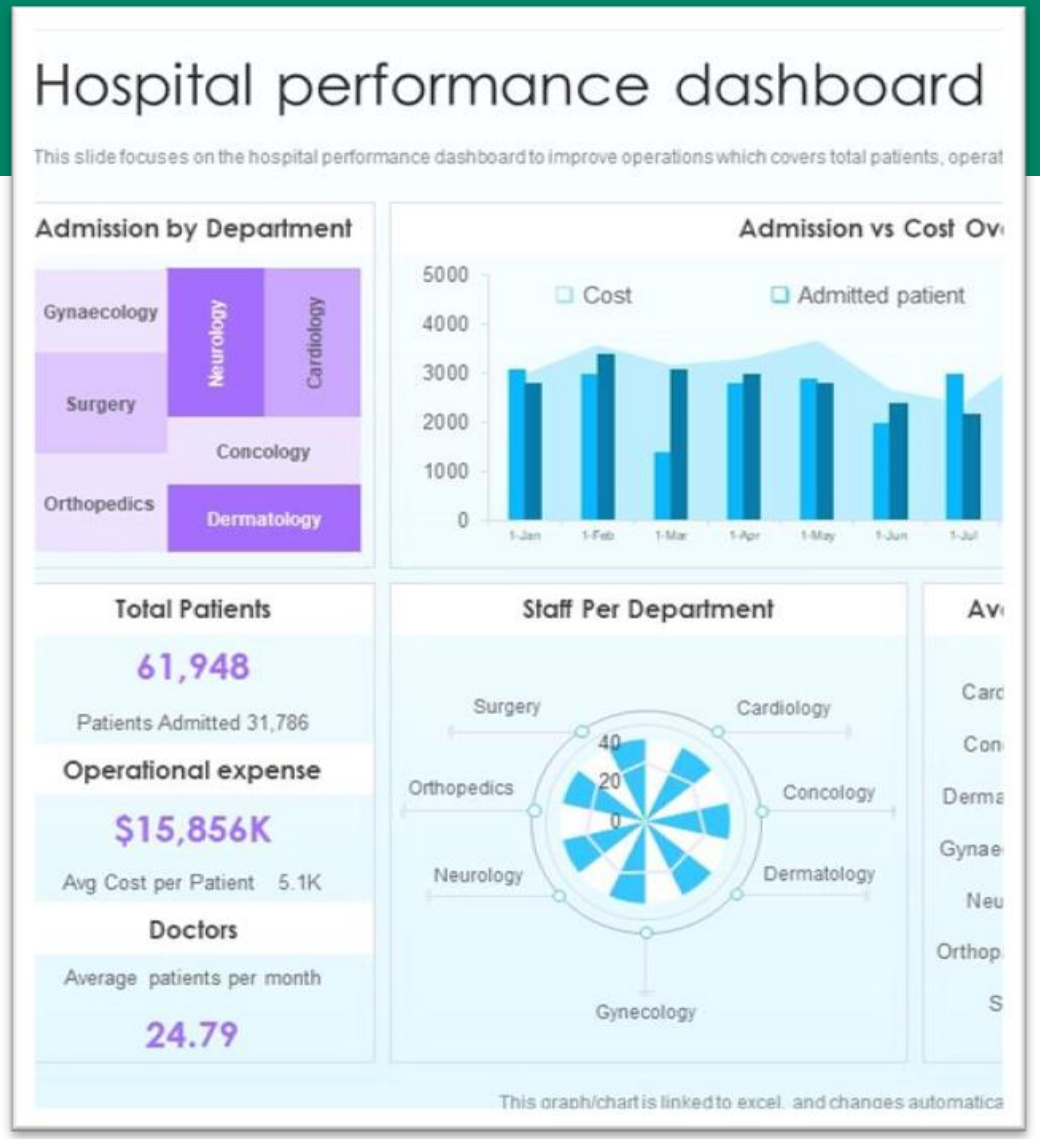
- Align improvement data with organizational KPIs and future planning cycles

MONITOR, ADJUST AND ENGAGE

MONITORING IN REAL TIME

From Dashboard to Daily Action

- Use visual tools to drive daily awareness
- Tie monitoring to recent findings and corrective plans
- Track process and outcome measures
- Make data the routine, not a report



EMPOWERING STAFF: FEEDBACK AND FOLLOW-UP

Frontline input = System intelligence

- Invite suggestions during huddles, rounds and team debriefs

Feedback is only valuable if it’s acknowledged

- Use “You said, we did” updates to build trust and transparency

Elevate ownership and visibility

- Recognize contributions publicly and show how feedback is driving improvement

Refine implementation in real-time

- Be willing to tweak based on how changes play out on the ground

ENGAGED LEADERSHIP DRIVES IMPROVEMENT

Round with purpose and curiosity

- Open-ended questions: “What’s working?” and “What’s getting in your way?”

Shift from oversight to coaching

- Use real-time observations as teachable moments, not performance reviews

Share what you learn across the organization

- Highlight wins and lessons from one unit to spark improvements in others

Be present to build psychological safety

- Create trust through consistency, follow-through and empathy

DATA DRIVING ACTION: REPORT, REFLECT AND RESPOND

Avoid metric overload

- Focus on the indicators that directly support your improvement plan

Tie data to actionable goals

- Connect metrics to real behaviors, outcomes and change priorities

Make data digestible and visual

- Simple formats: red/yellow/green signals, spark lines, top-three trends

Embed brief trend reviews into daily and monthly routines

- Incorporate into shift huddles, manager meetings and QAPI discussions

Summarize with “What now?” not just “What’s new?”

- End each review with a clear next step or focus area

MAKING LEARNING THE CULTURE

POLLING QUESTION #4

Which of these would give your culture a serious upgrade if you nailed it?

1. A fearless feedback loop (people actually speak up!)
2. Leaders who admit they don't have all the answers
3. Turning findings into long-term fixes — not band-aids
4. Making data useful — not just available
5. A clear, shared sense of priorities

LEARNING IS THE DEFAULT, NOT THE EXCEPTION

Everyday structures for reflection

- Shift debriefs, safety huddles, end-of-day check-ins

Incorporate micro-learning moments

- “Learning minutes”
- Mock scenarios
- 60-second safety tips

Learning in daily practice beyond a crisis

- Don’t wait for a near miss or survey

Normalize curiosity and continuous inquiry

- What surprised us today?
- What should we revisit?

JUST CULTURE AND PSYCHOLOGICAL SAFETY: STARTS WITH FAIRNESS

Different types of behavior

- *Human error*: slips, lapses, unintentional mistakes
- *At-risk behavior*: shortcuts, workarounds, normalized deviance
- *Reckless behavior*: conscious disregard of safety protocols

Respond with the right approach

- Use coaching and system fixes for human error
- Escalate only when behaviors are repeated or intentional

Protect and promote reporting

- Create non-punitive pathways for speaking up
- Reinforce confidentiality and leadership follow-up

Lead with empathy and accountability

- Fair doesn't mean lenient — it means consistent, informed and supportive

TEACH FROM WHAT'S REAL: FINDINGS AS EDUCATIONAL TOOLS

Transform citations into learning opportunities

- Use real examples for mock surveys, simulations and tabletop reviews

Share the story, not just the standard

- Highlight what happened, why it mattered and how it was addressed

Bring survey learning into orientation and ongoing education

- Use findings to teach new hires about expectations and high-risk areas

Make learning relatable, memorable and action-oriented

- Embed findings in newsletters, huddles and department debriefs

Learn from near misses, not just harm

RECOGNIZE GROWTH, NOT PERFECTION

- Celebrate improvement, not just outcomes
- Acknowledge those who speak up
- Make recognition meaningful and visible
- Tie recognition to organizational values and mission
- Create rituals around progress

LEADERSHIP MODELS LEARNING BEHAVIOR

Reflective leaders build reflective organizations

- Model vulnerability and learning in action
- Create safe space by owning missteps
- Set and share leadership learning goals
- Lead with curiosity, not just control
- Reinforce that learning is everyone’s job — including yours

WHAT'S NEXT STARTS NOW: SERIES WRAP UP

1. Accreditation readiness is not a project — it's a mindset
2. Risk mitigation, quality and compliance must be continuous
3. Staff engagement, strong systems and learning culture drive sustainability
4. From readiness to response to resilience — you're building more than survey preparation
5. Use these tools to lead confidently, adapt quickly and improve consistently

QUESTIONS

REFERENCES

- CMS QAPI Toolkit
- DNV NIAHO Standards
- IHI Framework for Safe, Reliable, and Effective Care
- NYSDOH Clinical Guidelines
- TJC Root Cause Analysis Framework

SURVEY READINESS: PREPARE, RESPOND, SUCCEED

Webinar Topic	Date
Survey readiness 101: Overview and getting started	4/2
Preparation: How to mitigate risk and prepare for upcoming surveys	4/9
They’re here: Establishing a survey response and management protocol	4/16
Responding to survey findings: How to develop a strong plan of correction and knowing your options	4/23
What’s next: Leveraging survey findings and strengthening organizational quality and compliance	4/30

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