Greeley
A CHARTIS COMPANY

Quality, Safety and High Reliability:

Leading the Transformation High Reliability as an Operating Model for Quality and Safety

3 Day National Agenda

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Steve is a partner of Patient Safety & External Peer Review with Chartis. He brings more than 25 years of healthcare experience in emergency medical services, quality, safety, and high reliability organizing principles.

Greeley has confirmed that none of the faculty/presenters or contributors has any relevant financial relationships to disclose related to the content of this educational activity.

COURSE DESCRIPTION

The essential promise of healthcare – helping people at their most vulnerable – has never been more challenging to deliver. Our approach to high reliability offers a path forward for healthcare organizations who aspire to provide consistently excellent, equitable care, supported by hardwired capabilities to detect and avoid harm.

Achieving high reliability will result in more equitable clinical outcomes and greater patient and employee engagement. And, by extension, it will also improve public rankings and pay for performance program outcomes and produce significantly greater financial return. This course will provide high reliability tactics as well as the operating model's component structures, processes, and supporting functions required to embed reliability in your organization.

PROGRAM GOAL

Introduce a comprehensive framework to help healthcare executives and leaders understand high reliability and the critical elements required to build and sustain an effective, integrated quality and safety enterprise.

LEARNING OBJECTIVES

Upon completion of this program, participants should be able to:

- Understand the current healthcare climate and challenges healthcare providers face
- Describe the essential characteristics and capabilities of a high reliability organization
- Understand the importance of structure and alignment in an effective quality and safety enterprise
- Appreciate the elements of a comprehensive quality and safety program in both the inpatient and ambulatory environments
- Articulate a high-reliability approach to performance management that can be used for medical staff and employees more broadly
- Understand how HRO enables reliable detection of inequitable care and implementation of practical solutions
- Describe the role of leadership in becoming a high reliability organization
- Articulate the business case for becoming a high reliability organization

AGENDA

Quality, Safety and High Reliability | 3 Day National Agenda
Scottsdale, AZ | October 15-17, 2026

DAY 1 - OCTOBER 15, 2026	
7:00 – 8:00 AM	**Breakfast**
8:00 – 10:00 AM	**The Healthcare Crisis and Why Change Can't Wait** The intersection of high reliability and disruptive healthcare challenges (e.g. pandemics, AI, workforce challenges, the great resignation, health inequities, and capacity challenges) – The impact of the current healthcare climate on quality and safety – Staff response to the crisis – the problem of burnout - Why now? – Health equity as a core component of reliability

DAY 1 - OCTOBER 15, 2026	
10:00 – 10:15 AM	**Break**
10:15 – 12:15 PM	**What is a High Reliability Healthcare Organization?** Defining high reliability – the goal state; beyond safety – High reliability concepts and capabilities – Hardwiring Quality and Safety processes – Developing a culture of safety **Aligning Quality, Safety and Operations Through an Intentional Structure** Establishing a unified quality, safety, and operations governance and accountability model from the board to the bedside – Unit-based team structure - Front line dyad/triad model – Integration with leadership, physician enterprise, and nursing – Domain team structure - aligning best practice with execution – Patient Safety / Reliability management - integrating risk, safety, grievances
12:15 – 1:15 PM	**Lunch**

DAY 2 - OCTOBER 16, 2026	
7:00 – 8:00 AM	**Breakfast**
8:00 – 10:00 AM	**Developing a Comprehensive Approach to Quality (Workshop Style)** Adoption of best practices for domains: mortality, readmissions, LOS, patient experience, HAIs and other HACs – Clinical pathways for reduced variation, improved quality, and cost – Building best practice programs - Palliative care / Hospice – Creating effective stewardship programs
10:00 – 10:15 AM	**Break**
10:15 – 11:15 AM	**Developing a Comprehensive Approach to Patient Safety** Best practices for detecting harm and potential harm – Creating a culture of safety, psychological safety, and just culture – Managing organizational vulnerabilities – classifying and tracking – Understanding the science of human error – Data considerations: Event reporting and common cause analysis
11:15 – 12:15 PM	**Ambulatory Quality and Safety** Chronic disease management and prevention – measure landscape – Ambulatory safety – hidden risks – Missed and delayed diagnosis – safety net programs, closed loop referral management
12:15 – 1:15 PM	**Lunch**

DAY 3 - OCTOBER 17, 2026	
6:00 – 7:00 AM	**Breakfast**
7:00 – 8:00 AM	**Health Equity – An Essential Part of Quality and Safety Improvement** Health equity as a quality and safety issue and opportunity – Building equity into quality measurement – Identifying equity issues in risk and harm evaluation – Drivers for integrating safety and equity
8:00 – 9:00 AM	**High Reliability People Management – HR and the Medical Staff Office** Performance and behavior-based evaluation and improvement pathways – The role of HR in a high reliability organization – Credentialing and privileging as the first step in physician performance management – Using OPPE/FPPE and peer review to manage and improve physician performance
9:00 – 9:15 AM	**Break**
9:15 – 11:00 AM	**Leading for Reliability: Your Role as an Leader** Making the case for investing in high reliability – Components of a comprehensive high reliability program – Identifying and mitigating drift in improvement – Establishing a culture of transparency and learning

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