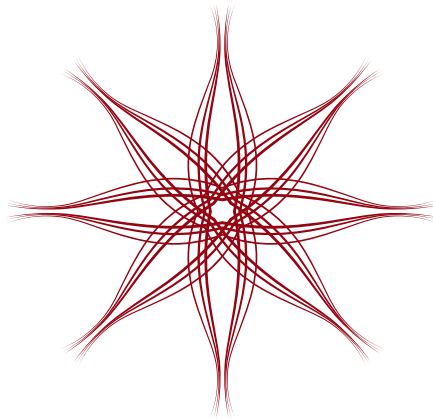


Celebrating Achievement: The 2022 John M. Eisenberg Patient Safety and Quality Award Winners



JOHN M. EISENBERG
PATIENT
SAFETY &
QUALITY
AWARDS

Presented by
The Joint Commission &
National Quality Forum

Feb. 21, 2023

The 2022 John M. Eisenberg Patient Safety and Quality Awards recognize those who have made significant and long-lasting contributions to improving patient safety and healthcare quality. Established in 2002 by The Joint Commission and the National Quality Forum (NQF), this annual awards program is named after former Agency for Healthcare Research and Quality (AHRQ) Administrator John M. Eisenberg.



“It is a true pleasure and privilege to honor these worthy recipients of the John M. Eisenberg Awards. Dr. Eisenberg was a tireless advocate for healthcare quality and patient safety. His vision and dedication inspired individuals and organizations throughout healthcare to continually strive to improve the quality of care, and undoubtedly saved or dramatically improved untold numbers of lives. His legacy continues to inspire us today and is carried on through achievements like those exemplified by this year’s honorees, Dr. Jason S. Adelman, North American Partners in Anesthesia, and Parkland Health. Their work has helped people live better, healthier lives, and I can’t think of a more fitting tribute to Dr. Eisenberg’s memory.”

**—Dana Gelb Safran, ScD, President and CEO,
National Quality Forum**



The 2022 Eisenberg Awardees are:

Jason S. Adelman, MD, MS — Individual Achievement

North American Partners in Anesthesia — Innovation in Patient Safety and Quality at the National Level

Parkland Health — Innovation in Patient Safety and Quality at the Local Level

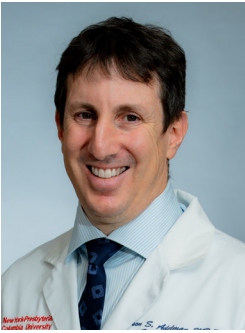
“The John M. Eisenberg Awards represent the enduring legacy of Dr. Eisenberg. They continue to showcase how innovation, dedication to process improvement, and trailblazing action can lead to sustainable solutions to some of healthcare’s greatest challenges. The recipients of this year’s Eisenberg Awards honor Dr. Eisenberg and his life’s work — as well as those who have come before them — in advancing the mission of improving patient safety and quality of care. Congratulations to Dr. Jason S. Adelman, North American Partners in Anesthesia, and Parkland Health for being the recipients of the 2022 Eisenberg Awards.”

David Baker, MD, MPH, FACP, executive vice president, Division of Health Care Quality Evaluation, The Joint Commission



Dr. Eisenberg's legacy

An impassioned advocate for health care quality improvement, John M. Eisenberg, MD, MBA, was a founding member of NQF's board of directors and the former AHRQ administrator (1997-2002). Dr. Eisenberg was a leader in health care quality, and he dedicated his life to ensuring care was based on a strong foundation of research and that it considered the patient's needs and perspectives.



Jason S. Adelman, MD, MS

Jason S. Adelman, MD, MS, is Chief Patient Safety Officer and Associate Chief Quality Officer; Executive Director, Center for Patient Safety Research; Director, Patient Safety Research Fellowship, Columbia University Irving Medical Center and NewYork-Presbyterian; Associate Professor of Medicine (in biomedical

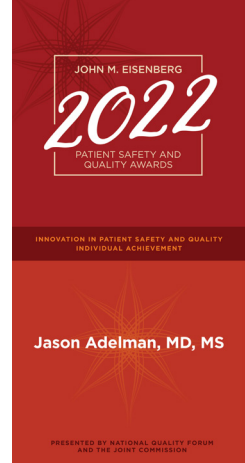
informatics) and Vice Chair for Quality and Patient Safety, Department of Medicine, Columbia University Vagelos College of Physicians and Surgeons

Jason Adelman, MD, MS, is a leader and innovator in the medical errors field and has developed novel methods to measure and prevent errors in health information technology (IT) systems. Improvement in safety events has been hindered by lack of systematic methods to measure safety events and evaluate system improvements. Dr. Adelman developed the first health IT safety measure endorsed by National Quality Forum (NQF), the Wrong-Patient Retract-and-Reorder (RAR) Measure that detects wrong patient orders in electronic health record (EHR) data (NQF #2723), which subsequently facilitated a large body of patient safety research. Dr. Adelman used the RAR method to develop a set of new medication error measures, demonstrating utility of this approach to capture a range of error types.

Using the Wrong-Patient RAR Measure, Dr. Adelman also demonstrated a significantly higher rate of wrong-patient orders in neonatal intensive care units (NICUs) versus general pediatric units, a greater risk for errors in the presence of multiple versus singleton births, and a significant reduction in errors using a distinct naming convention. This work influenced The Joint Commission to require all hospitals to use distinct methods of newborn identification as part of its National Patient Safety Goals (NPSGs).

As executive director and founder of the Center for Patient Safety Research, a multidisciplinary collaboration between Columbia University Irving Medical Center, Weill Cornell Medicine, and NewYork-Presbyterian, he has led several National Institutes of Health and Agency for Healthcare Research and Quality-funded projects to rigorously test safety interventions across the interventions' lifespans. Dr. Adelman's research has had far-reaching impact, leading to national and international safety recommendations.

Dr. Adelman is now leading safety culture transformation throughout the NewYork-Presbyterian enterprise, designing and conducting an interactive safety culture training program for senior leadership, management, and staff.



“It’s an honor to be presented with the individual Eisenberg Award from The Joint Commission and National Quality Forum, two organizations that define the standards and measures used to drive the nation’s performance in quality and patient safety. Receiving an award named after Dr. John Eisenberg is a particular honor for me as he is someone who opened doors for many of us in the quality and patient safety field. It is also truly a privilege to be named among the accomplished past recipients, leaders in quality and patient safety who have collectively been my role models throughout my career. To me, this award highlights the importance of using health IT to measure and improve quality and patient safety — my area of interest as a researcher and what I believe to be essential for achieving high reliability in healthcare.”

—Jason S. Adelman, MD, MS, Chief Patient Safety Officer and Associate Chief Quality Officer; Executive Director, Center for Patient Safety Research; Director, Patient Safety Research Fellowship, Columbia University Irving Medical Center and NewYork-Presbyterian; Associate Professor of Medicine (in biomedical informatics) and Vice Chair for Quality and Patient Safety, Department of Medicine, Columbia University Vagelos College of Physicians and Surgeons



North American
Partners in
Anesthesia®

North American Partners in Anesthesia

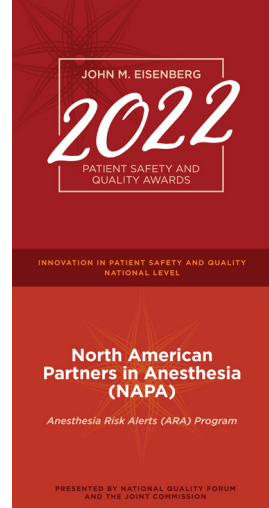
- John F. Di Capua, MD, Chief Executive Officer, NAPA
- Leo Penzi, MD, Chief Medical Officer, NAPA
- Julie Marhalik-Helms, BSN, RN, Vice President, Quality Improvement, NAPA
- Brent Lee, MD, MPH, FASA, Director, Clinical Excellence and Performance Improvement, NAPA

The Anesthesia Risk Alert (ARA) Program is a patient safety intervention under the North American Partners in Anesthesia (NAPA) Patient Safety Institute. ARA was implemented across NAPA's nearly 500 hospital and ambulatory surgery center (ASC) partners in March 2019. They conducted a systemwide review of serious adverse events using their anesthesia clinical outcomes database. Within this program, the strategies employed for complex patients included:

- Use of a standardized protocol incorporating risk assessment.
- Clinical collaboration.
- A defined decision-making process that optimizes analytical thinking.

The NAPA Patient Safety Institute identified five, high-risk clinical scenarios, and through the improvement project, identified and implemented specific mitigation strategies:

1. Known or suspected difficult airway: Second practitioner present to assist for induction and emergence for all general endotracheal anesthetics.
2. Body mass index (BMI) greater than or equal to 45: Second practitioner present to assist for induction and emergence for all general anesthesia cases.
3. Pulmonary hypertension: Consultation about the case with a second clinician.
4. Risk category American Society of Anesthesiologists (ASA) status 4 or 5: Consultation about the case with a second clinician.
5. Operating room fire risk: Follow fire mitigation protocols as prescribed by the local institution.



Within this program, every patient is assessed by the anesthesia clinician for these five scenarios prior to undergoing an anesthetic. If one or more risks is identified, a specific mitigation strategy paired to that clinical scenario is recommended to prevent patient harm. Continually leveraging their clinical database permits NAPA to track compliance and provide performance feedback to facilities and practitioners. Since launching the ARA program, analyses of critical adverse events related to both high-BMI patients and patients presenting as ASA status 4 or 5 significantly decreased the number of relevant critical events over time. Data shows the incidence rate of critical events for patients with a BMI greater than or equal to 45 and under general anesthesia decreased by approximately 42%.

“The ARA program exemplifies how NAPA strives to bring the highest level of care to every patient, every day. NAPA clinicians nationwide have embraced the ARA protocol, as evidenced by a compliance rate that exceeds 95%. This success validates the infrastructure investments that NAPA has made in its dedicated Quality and Patient Safety team, as well as the clinician training and data analytics feedback regularly provided to our clinicians in support of the program and ensures the continuation of ARA at our approximately 500 partner facilities where ARA is measurably reducing the incidence of critical events in high-risk patients.

“Winning the Eisenberg Award is a great honor to all the NAPA clinicians who take the extra time every day to ensure compliance with the ARA protocol, and in doing so save lives. This award also honors the hard work of NAPA’s dedicated QI team, which created and maintains the ARA program and works daily to advance clinical education and our culture of safety. Their work is enhanced by the organizational infrastructure, our Patient Safety Organization designation, and many individuals who support QI research and innovation. These include the quality nurses who provide ARA education and ongoing feedback to clinicians, our many data analytics experts, marketing communications professionals, and the human resources team that supports our clinicians’ well-being so they can deliver the best patient care. The Eisenberg Award acknowledges that by reinvesting in quality, NAPA is making meaningful contributions to improving patient safety for all.”

**—John F. Di Capua, MD, Chief Executive Officer, North American
Partners in Anesthesia**



Parkland Health

- Marjorie Quint-Bouzid, DNP, MPA, RN, NEA-BC, Sr. Vice President of Nursing, Women and Infant's Specialty Health, Parkland Health
- David B. Nelson, MD, FACOG, Chief, Division of Maternal-Fetal Medicine, Associate Professor, Maternal-Fetal Medicine, Department of Obstetrics & Gynecology, University of Texas Southwestern Medical Center
- Tammy Turner, MS, RNC, Sr. Director of Nursing, Women and Infant's Specialty Health, Parkland Health

Parkland Health's Extending Maternal Care After Pregnancy (eMCAP) program provides postpartum access to care for 12 months after birth for women with the highest social needs and limited access to physical clinic locations, impacting mostly minority women. Initiated in October 2020, this program:

- Utilizes community health workers, nurse home visits, scheduled virtual visits, and an in-person mobile van unit deployed to different community locations in Dallas County.
- Is staffed by advance practice providers, medical providers, social workers, and pharmacy services.
- Enhances care for diabetes, hypertension, and behavioral health services.

Evidence-based approaches are utilized to target gaps in screening and improve follow-up care, including culturally and linguistically appropriate services (CLAS) guidelines, social determinants of health (SDOH) screening based on the U.S. Office of Disease Prevention and Health Promotion Healthy People 2030, mental health screening using Edinburgh Postnatal Depression Scale, and generalized anxiety disorder screening instruments.

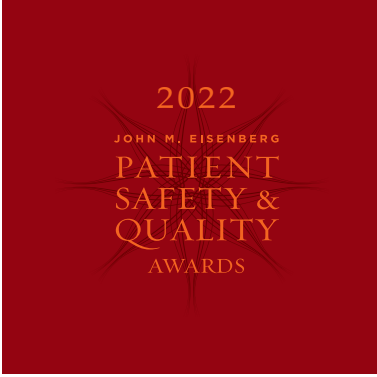
Compared to matched controls, follow-up postpartum attendance for eMCAP patients with chronic hypertension was significantly better at two weeks, one month, three months, six months, nine months, and 12 months (all $P < 0.001$). Women with diabetes management (DM) had significantly better follow up at two weeks ($P = 0.04$), one month ($P = 0.002$), and three months ($P = 0.049$) resulting in HbA1c values for DM being significantly lower ($P < 0.05$). Finally, women with abnormal mental health screening scores were successfully referred (71%) for behavioral therapy and completed sessions with licensed mental health counselors (72%), with 80% accepting therapeutic intervention.



“The program has continued to prevent the worsening of severe maternal morbidity and even preventable maternal deaths in that it proactively identifies postnatal mothers with severe range blood pressures outside of their traditional postpartum window when they would not have access to a medical provider because of loss of medical insurance.

“We are humbled to receive this award and we are proud that it recognizes the work we do in partnership with UT Southwestern Medical Center. With the goal of advancing health equity through excellence as a public health system, the eMCAP program is a prime example of our commitment to our community. Winning this award solidifies our commitment to advancing health equity, addressing the existing disparate outcomes in maternal mortality and severe morbidity that exist for Black and Latina mothers in Dallas County. Eliminating barriers to healthcare access as was done with this program bolsters healthcare quality in that maternal deaths and severe pregnancy-related complications are avoided. While we in the medical community acknowledge social determinants exist, it remains a daunting issue to address. This program demonstrates that the healthcare community needs only to start somewhere to begin to tackle the issue and simple, low-cost meaningful changes that incorporated the lived experiences of the mothers being served will make deep inroads in addressing health inequities in the postnatal space. The issue of social equity and health inequality cannot be approached as a program to be achieved. Instead, it must be embedded within an organization’s operational framework through strategic planning, strategic implementation and strategic resource allocation allowing managers to make daily decisions from an equity lens. This program did just that.”

—Marjorie Quint-Bouzid, DNP, MPA, RN, NEA-BC, Parkland Health, and David B. Nelson, MD, FACOG, University of Texas Southwestern Medical Center



The 2022 Eisenberg Award Panel

Carolyn M. Clancy, MD, MACP, Department of Veterans Affairs

Richard Christopher Antonelli, MD, MS, Boston Children’s Hospital, Harvard Medical School

Brent C. James, MD, MStat, Stanford University School of Medicine

Meika Neblett, MD, MS, Robert Wood Johnson Barnabas Health

Lisa C. Patton, PhD, JBS International, Inc.

Barbara Pelletreau, RN, MPH, CommonSpirit Health

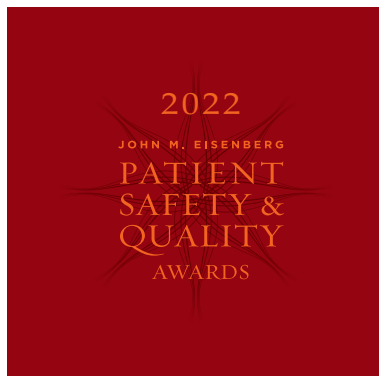
David M. Shahian, MD, Harvard Medical School

Charleen Tachibana, DNP, RN, FAAN, Virginia Mason Franciscan Health



“Working closely with leaders from very different healthcare systems with a shared commitment to improving quality, safety and equity has been a consistently awesome experience. The opportunity to learn how many systems are ‘pushing the envelope’ in all three areas is inspiring. Dr. Eisenberg would be proud.”

— **Carolyn M. Clancy, Assistant Under Secretary for Health for Discovery, Education & Affiliate Networks, Department of Veterans Affairs, John M. Eisenberg Award Panel Chair**



The Joint Commission

Founded in 1951, The Joint Commission seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. The Joint Commission accredits and certifies more than 22,000 health care organizations and programs in the United States. An independent, nonprofit organization, The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care. Learn more at www.jointcommission.org.



National Quality Forum

The National Quality Forum (NQF) works with members of the healthcare community to drive measurable health improvements together. NQF is a not-for-profit, membership-based organization that gives all healthcare stakeholders a voice in advancing quality measures and improvement strategies that lead to better outcomes and greater value. Learn more at www.qualityforum.org.


2021

Hardeep Singh, MD, MPH
Prime Healthcare Services
Kaiser Permanente Northern California
Mark R. Chassin, MD, FACP, MPP, MPH

2020

David M. Gaba
Veterans Health Administration
Northwestern Medicine

2019

Gordon D. Schiff, MD
HCA Healthcare
WellSpan Health

2018

Brent C. James, MD
The Society of Thoracic Surgeons
BJC HealthCare

2017

Thomas H. Gallagher, MD
Children's Hospitals' Solutions for Patient Safety
LifePoint Health's National Quality Forum

2016

Carolyn M. Clancy, MD
I-PASS Study Group
Christiana Care Health System

2015

Pascale Carayon, PhD
Premier, Inc.
Mayo Clinic-Rochester

2014

Mark L. Graber, MD, FACP
American College of Surgeons
Northshore-LIJ Health System

2013

Gail L. Warden
Institute for Clinical Systems Improvement
Minnesota Hospital Association
Stratis Health
Anthem Blue Cross
National Health Foundation
Hospital Association of Southern California
Hospital Association of San Diego & Imperial Counties
Hospital Council of Northern & Central California
Vidant Health

2012

Saul N. Weingart, MD, PhD
Kaiser Permanente
Memorial Hermann Healthcare System

2011

Kenneth I. Shine, MD
Jerod M. Loeb, PhD
Henry Ford Health System
New York Presbyterian Hospital
The Society of Hospital Medicine

2010

John H. Eichhorn, MD
James L. Reinertsen, MD

The Children's Hospital at Providence Newborn
Intensive Care Unit
Washington State Hospital Association

2009

Gary S. Kaplan, MD
Virginia Mason Medical Center
Tejal Gandhi, MD
Dr. Noreen Zafar, MD
Mercy Hospital Anderson
Michigan Health & Hospital Association Keystone
Center for Patient Safety & Quality

2008

Michael S. Cohen, RPh, MS, ScD
Institute for Safe Medication Practices Research
Dennis O'Leary, MD, president emeritus of The
Joint Commission
The RAND Corporation and University of California
at Los Angeles School of Medicine
National Coordinating Council for Medication Error
Reporting and Prevention
Anthem Blue Cross and Blue Shield of Virginia
New York City Health and Hospitals Corporation

2007

Flaura Koplin Winston, MD, PhD
Darrell A. Campbell, Jr., MD
Eric J. Thomas, MD, MPH
Beth Israel Deaconess Medical Center
Harvard Medical School
Evanston Northwestern Healthcare

2006

Donald Berwick, MD, MPP, KBE
Jerry H. Gurwitz, MD
Minnesota Alliance for Patient Safety
Pennsylvania Patient Safety Authority
Wichita Citywide Heart Care Collaborative

2005

Audrey L. Nelson, PhD, RN
Maryland Patient Safety Center
Meridian Health
Sentara Healthcare

2004

Lucian L. Leape, MD
Peter J. Pronovost, MD, PhD
Major Danny Jaghab, MS, RD
Kaveh G. Sojania, MD and Robert M. Wachter, MD
University of Pittsburgh Medical Center

2003

Jeffrey Cooper, PhD
The Leapfrog Group
Lehigh Valley Hospital and Health Network
Abington Memorial Hospital

2002

Julianne Morath, RN, MS
David W. Bates, MD, MSc
Veterans Affairs Medical Center
Concord Hospital
Veterans Affairs National Center for Patient Safety

