CPPS CE APPROVAL APPLICATION

- Complete the form below and attach requested program information
- Pay the applicable fee online here
- Submit via email to cpps@ihi.org

Only completed applications with payment can be processed. Please submit application information at least 6 weeks prior to your program.

Questions? Contact us at cpps@ihi.org or 617.391.9927

Name of Organization:_____

Staff Contact: _____ **Job Title:** _____

E-mail Address:_____ **Phone**: _____ _____ _____

Organization/Program website:_____

Program title: _____

Was a current CPPS involved in program planning/review? ◯Yes ◯No

If yes, please provide name, credentials, and contact email/phone:

_____

Has your program been approved by other CE providers? ◯Yes ◯No

If yes, please list and include hours approved:

If approved, would you like your program to be publicly listed on ihi.org/cpps? ◯Yes ◯No

If yes, please provide listing details (title, date, registration information and link (if applicable)):

Submission Requirements:

□ Organization/Program information (above)
□ Complete table and include supporting documentation (next page)
□ Online payment (https://my.ihi.org/portal/content/CPPS_Accreditation_Fee.aspx)

I hereby verify that the information contained in this application is true and accurate and affirm that my organization has responsibility for control over all aspects of the program(s) to ensure educational objectives and standards are met.

Print Name and Job Title: _____

Signature: _____ **Date**: ____ ____ _____

CE PROGRAM DOCUMENTATION

Title and Brief Description of Activity	Date of Activity Or Enduring	Content Code (1-4)	CE Requested	Documentation
				☐ Timed Agenda ☐ Objectives ☐ Faculty bios
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CPPS Content Codes

1 Culture
2 Systems Thinking, Human Factors Engineering, and Design
3 Safety Risks and Responses
4 Performance Measurement, Analysis, Improvement and Monitoring

CPPS Examination Content Outline

1. Culture

A. Culture of Safety

1. Organization Culture (e.g., Just, Non-hierarchical, Psychological Safety)
2. Organizational Infrastructure and Requirements
3. Safety Climate/Healthy Work Environment
4. Communication and Collaboration
5. Learning Culture
6. Event Response

B. Leadership and Outreach

1. Organizational Leadership and Outreach
2. Community/Group Leadership and Outreach
3. Individual/Team Leadership and Outreach

2. Systems Thinking, Human Factors Engineering, and Design

A. Systems Thinking

1. Systems Thinking Models (e.g., SEIPS) and Frameworks (e.g., Safety I & II, High Reliability)
2. System Complexity
3. Systems Approaches and Principles

B. Human Factors Engineering

1. Cognitive Bias
2. System Constraints/Barriers
3. Human Factors and Ergonomics
4. Human Capacity

C. Design

1. Usability/Functionality
2. Workflow
3. Resources (e.g., Supplies, Cost/Benefit)
4. Technology, Equipment, and Environment

3. Safety Risks and Responses

A. Risk Assessment

1. Escalations, Reporting Systems, and Communication Methodologies
2. Severity of Incident
3. Process and Data Analysis
4. Transitions of Care

5. Environmental Hazards
6. Settings/Care Location
7. Work Environment and Psychological Safety
8. Sociodemographic/Population-Specific Stratification and Assessment

B. Risk and Harm Recognition
1. Diagnosis
2. Medication Management and Use Process
3. Interventions, Surgery, Diagnostic and Therapeutic Procedures
4. Patient Deterioration
5. Health Care Acquired Conditions and Infections
6. Inequities (e.g., Sociodemographic, Population, Condition-Specific, and Workforce)
7. Physical and Non-Physical Violence and Incivility
8. Over/Under Treatment and Omissions
9. Emergency Preparedness

C. Barriers to Safety
1. Human/Financial Resources
2. Supplies and Shortages
3. Technological Factors (e.g., interoperability)
4. Inequities in Care (e.g., Access, Language, Technology, and Health Literacy)
5. Care Fragmentation/Transitions
6. Extra-organizational Challenges (e.g., pandemics, regulations, policies)

D. Patient and Workplace Safety Responses
1. Protocols and Checklists
2. Safety Systems (e.g., rapid response, proactive, environmental, EHR)
3. Risk Management
4. Peer/Team Support (e.g., safety huddles, debriefings, de-escalation)
5. Communication and Resolution Programs

4. Performance Measurement, Analysis, Improvement and Monitoring

A. Measurement
1. Process Mapping
2. Process, Outcome, and Balance Measurement Design
3. Data Collection and Analysis
4. Data Visualization

B. Review and Analysis
1. Analysis Tools

2. Analysis and Review Process (e.g., risk, events, hazards)
3. Approaches to Reviews and Analysis (e.g., proactive and reactive events)
4. Barriers to Review and Analysis

C. Improvement and Sustainability

1. Improvement Models
2. Design, Selection, and Implementation
3. Communication and Education
4. Evaluation of Event/Process Response
5. Hierarchy of Hazard Reduction
6. Change Management
7. Monitor Change

Secondary Classifications – Tasks

1. Target domains of safety culture/climate for improvement
2. Address patient and workforce safety through a unified strategy to eliminate harm
3. Identify and use validated surveys to assess culture/climate of safety
4. Interpret safety culture/climate survey results
5. Ensure dissemination of safety culture/climate survey results across all levels of the organization
6. Use safety culture/climate survey results to create a course of action
7. Leverage data from other surveys (e.g., workplace engagement, patient experience) to improve safety
8. Apply ongoing proxy measures of safety culture/climate (e.g., near-miss reporting, targeted surveys, follow-up plans)
9. Create, implement, measure, and monitor improvement action plans
10. Engage patients, care partners, and healthcare team in patient safety initiatives
11. Educate patients, care partners, and healthcare team about the value and process of reporting safety incidents
12. Educate patients, care partners, and healthcare team on the importance of timely communication, disclosure, and resolution programs about adverse events and unexpected outcomes
13. Promote transparency through sharing information across the organization regarding patient and workforce safety
14. Address intended/unintended patient safety implications associated with operational or other changes
15. Identify and apply principles of a fair and just culture
16. Recognize opportunities to mitigate harm from inequities for patients, families, and the workforce
17. Promote principles of diversity, equity, and inclusion
18. Advocate for health care access and equity in patient safety
19. Advocate for culturally sensitive care and address issues of health literacy
20. Collaborate with diverse parties to improve safety
21. Advocate for a healthy work environment
22. Assess workforce safety to develop and implement a plan to prevent and mitigate physical, non-physical, and psychological harm to the workforce
23. Identify and address contributing factors to physical, non-physical, and psychological harms for patients, care partners, and visitors

24. Promote training to provide workforce with tools to de-escalate conflicts or challenging situations
25. Engage with leadership to communicate needs to support patient and workforce safety
26. Align safety strategies with organizational mission, vision, values, and goals
27. Identify and apply practices to learn from everyday practice
28. Develop operational plans to improve safety
29. Advocate for resources required to support the operational safety plans
30. Foster transparent communication with patients and their care partners
31. Create opportunities for interdisciplinary safety conversations and problem solving
32. Promote the application of principles of high reliability at all levels of the organization
33. Use storytelling as a mechanism to engage interested parties and drive change
34. Provide safety expertise for situational and crisis readiness and prevention
35. Promote compliance with requirements related to reporting serious occurrences and reportable events to appropriate organizations
36. Report, review, and respond to safety risks and hazards
37. Perform activities to identify gaps and risks (e.g., failure modes and effects analysis (FMEA), walk-arounds)
38. Ensure support for staff affected by safety-related adverse events
39. Recognize populations with a high likelihood of patient safety events (e.g., chronic conditions, extremes of age, social determinants) to prevent harm and improve care
40. Perform root cause analysis (RCA)
41. Perform apparent cause analysis
42. Use a risk-based prioritization to rank severity hazards, risks, and events
43. Identify solutions and corrective actions based on risk-based priorities
44. Identify the strongest interventions for effective and sustained improvement
45. Evaluate the degree to which proposed solutions match root causes
46. Share finding and action items from safety reviews with appropriate parties
47. Monitor execution of safety action plans
48. Perform critical evaluation of evidence for suitability of safety interventions to programs and initiatives
49. Evaluate evidence-based practices for organizational implementation of processes, simulations, tools, training, and techniques
50. Evaluate technology solutions and devices to promote safety
51. Monitor safety outcomes following the implementation of new or modified technology
52. Identify how technology and technology systems may contribute to safety events
53. Identify how the interface between technology and users may contribute to safety events
54. Recognize cybersecurity threats to patient safety
55. Identify and use qualitative safety data sources (e.g., walk-arounds, event reporting, patient feedback, patient, and family advisory council)
56. Identify and use quantitative safety data sources for internal and external reporting
57. Implement a systematic approach to respond to data sources (e.g., safety alerts, product recalls, industry alerts)
58. Analyze safety data using statistical techniques (e.g., statistical process control)
59. Use stratification of data to inform and close gaps in care
60. Compile and communicate results of data analysis
61. Select and apply improvement methodologies to promote measurable improvement
62. Use structure, process, outcome, and balancing measures to evaluate system performance
63. Use project management skills

64. Employ facilitation skills
65. Identify normalized deviance (e.g., drift) in processes and systems
66. Recognize rule violations as an indicator of potential system design or performance flaws
67. Differentiate between unintended human error and behavioral choices as they apply to safety
68. Use systems thinking (e.g., theory, total system thinking, total systems safety, sociotechnical considerations) when considering safety and process improvement
69. Identify relevant system elements (e.g., people, tools/technology, tasks, environment, organizations and their interaction, other performance shaping factors)
70. Apply human factors principles to systems analysis and design
71. Identify and address factors that negatively impact human performance
72. Identify and enhance factors that support human performance
73. Identify and plan for unintended consequences and consequences of change
74. Outline the workflow and capacity as it applies to safety
75. Analyze the complexity of workflows and capacity as it applies to safety
76. Identify barriers to safety improvements
77. Incorporate regulatory/accreditation requirements in safety improvement
78. Recognize occupational-related health hazards and contributing factors that may impact or harm the workforce
79. Collaborate with interdisciplinary teams to improve safety
80. Promote the involvement of patients and care partners to advance patient safety
81. Advocate for patients and care partners to participate in shared decision making
82. Advocate for person-centered care
83. Advocate for the inclusion of the principles and science of safety within initiatives
84. Provide formal and informal education to staff and leadership on applying safety principles
85. Promote a collaborative work environment
86. Facilitate a systems approach to address disruptive workplace behaviors
87. Recognize the safety implications of over or under treatment of patients (e.g., polypharmacy)
88. Identify risks to patient and workplace safety as it relates to resources (e.g., supply chain) and human resources (e.g., staffing)
89. Foster teamwork and teams to support safety outcomes
90. Recognize the impact of financial considerations on patient safety
91. Advocate for training, competency validation, and credentialing that optimizes patient safety