The Role of Consumers, Families, and the Community in Patient Safety: Learning from Experience

2008 AHRQ Annual Meeting
Rockville, Maryland
September 8, 2008 ~ 3:00-4:30pm
The Journey
Session Objectives

- Identify the range of roles and responsibilities that consumers, patients/families play in efforts to improve patient safety in the health care environment.

- Describe how your organization currently includes consumers, patients/families in the planning, delivery, and evaluation of patient safety-oriented interventions.
Session Objectives

- Describe how you will plan to introduce the concept to your organization’s leadership.
- Identify resources for planning and implementing patient safety programs for consumers, patients/families.
Presentation Outline

- **Introduction**
  (3:00-3:15pm)
  Katherine Crosson, MPH, AHRQ

- **Patient/Family Perspective**
  (3:15-3:25pm)
  Jim Beveridge, Member, Patient/Family Advisory Council
  Aurora Health Care, Wisconsin

- **Range of Roles for Consumers, Patients/Families**
  (3:25-3:50pm)
  Cezanne Garcia, MPH
  Institute for Family Centered Care

- **Partners in Safety: The Aurora Health Care Journey**
  (3:50-4:10pm)
  Kathryn Leonhardt, MD, MPH
  Aurora Health Care, Wisconsin
Introduction
Magnitude of the Problem

- Medical errors result in annual:
  - Deaths of 44,000 – 98,000 hospitalized patients (US)
  - Injuries to approximately 1 million individuals (US)

- Surgical errors cost nearly $1.5 Billion annually

- World-wide recognition of the need to promote patient safety
  - Countries representing 78% of the world’s population have pledged to work together to reduce medical errors (World Alliance for Patient Safety)
Support for Patient/Family Engagement

Who supports a prominent role for the consumer, patient/family in patient safety?

- Consumer/Patient Organizations
- Government
- Professional Groups/Research Organizations
Consumer/Patient Organizations

- Consumer’s Advancing Patient Safety (CAPS)
- National Family Caregiver’s Association
- PULSE (Patient Safety Network Counsel)
- International Alliance of Patients’ Organizations
- Institute for Family Centered Care
Government

Department of Health and Human Services

- Agency for Healthcare Research and Quality
- Centers for Medicare and Medicaid Services
- Centers for Disease Control
- National Institutes for Health

Institute of Medicine
Academic Institutions

- **Patient Safety Curriculums**
  - Medical and Nursing Schools
  - Schools of Public Health
  - Allied Health Professionals

- **Continuing Education**

- **Board Certification**
Professional Organizations

- National Patient Safety Foundation
- The Joint Commission
- American Hospital Association
- Institute for Healthcare Improvement
- Institute for Family-Centered Care
- World Health Organization / Alliance for Patient Safety
Patient/Family Perspective

Jim Beveridge
Member, Patient/Family Advisory Council
Aurora Health Care, Wisconsin
Range of Roles for Patients and Families

Cezanne Garcia, MPH
Senior Program and Resource Specialist
Institute for Family Centered Care
Patient- and family-centered care is working with, rather than doing to or for.
Fostering the partnerships among patients, families, clinicians, and others to encourage constructive dialogue and further improvement when reporting quality data publicly.

- Reductions in mortality associated with intensive public reporting of hospital outcomes.
Focus groups and surveys are not enough!

Hospitals and health systems create a variety of ways for patients and families to serve as advisors and leaders.
Why Involve Patients and Families as Advisors in Safety Initiatives?

- Bring important perspectives about the experience of care
- Insights on how systems really work
- Inspire and energize staff
- Keep staff honest and grounded in reality
- Provide timely feedback and ideas
- Lessen the burden on staff to fix the problems...staff don’t have to have all the answers
- Bring connections with the community
- Offer an opportunity to “give back”
Domains of Care to Improve Strategies and Tools for Safer Practices

- **Clinician - Patient and Family Care Interaction**
  - Patient and Family
  - Clinician

- **Clinical Microsystem**
  - Team interaction
  - Access to care
  - Clinical information systems
  - Patient feedback

- **Healthcare Macrosystem**
  - Coordination of care across care settings
  - Public information on practices

Thomas Bodenheimer’s Improving Primary Care Strategies and Tools for a Better Practice (2007)
Selecting Patient and Family Partners

- Two or more
- Representative of the Ethnic Diversity of Your Patient Population
- Key Qualities
  - Able to Share Ideas Constructively
  - Speaks Up

Operationalizing Transparency with Legal Protections

- HIPAA training for volunteers
- Sign Confidentiality Agreements
Once You’ve Started: Preparing Patient, Family and Staff Partners

- **Orientation to Safety Initiatives**
  - Orientation/Training
  - Mentors

- **Encourage participatory styles**
  - Offer facilitation training to middle managers and supervisors in PFCC initiatives.
  - Jargon and key concepts resources

- **Reinforce value of patient/family input and concrete suggestions of how this information will influence practice and policy**
Gauge Your Strengths for Partnering with Patients and Families in Getting Your Patient Safety Program Started

- Conduct an environmental scan
  - Priority initiatives
  - Culture assessment
- Develop a high level outline for a program.
- Secure approval to move forward.
- Draft a formal plan with goals, objectives, time lines, and responsibilities.
- Commitment to resources for implementation and evaluation.
Key Readiness Domains to Engage in Patient-and Family-Centered Safety

- Data transparency
- Flexibility around aims and specific changes of improvement project
- Underlying fears and concerns
- Perceived value and purpose of patient and family involvement
- Senior leadership support for patient and family involvement
- Experience with patient and family involvement
- Collaboration and teamwork
Strategy: Safety and quality work is patient- and family-centered

- Work with legal department to establish framework for patient and family advisors serving as team members.
- Educate leaders, front line staff, and families about patient- and family-centered care.
- Establish that patient and family experiences are drivers for quality improvement.
- Board provides leadership for quality and safety.
- Physicians are engaged in patient safety and quality as partners.
5-Year Quality Plan – Prioritizing Key Initiatives

- Process of leadership rounding.
- Patients and families serve on quality teams.
- Family involvement in Rapid Response Team implemented across University Health System.
- Create a patient- and family-centered “model” unit at each hospital.
- Hold an annual physician safety/quality summit.
5-Year Quality Plan – Culture Change

- Patients tell stories at Board meetings.
- Patients and families serve on root cause analysis teams.
- Patients and families share stories at the Medical Executive level.
- Leverage technology to customize and enhance communication with patients and families.
- Expand patient- and family-centered units.
Our Partnership Pledge

At Hopkins, we take a team approach to your safety. We invite you and your family to join us as active members of your care team.

We pledge to:
• Coordinate your care
• Explain your care and treatment
• Listen to your questions or concerns
• Ask if you have safety concerns and take steps to address them
• Ask about your pain often and keep you as comfortable as possible
• Check your identification before any medication, treatment or procedure
• Label all lab samples in your presence
• Clean our hands often

We ask you, or a loved one, to:
• Ask questions
• Speak up if you are concerned about a test, procedure or medication
• Check the information on your ID bracelet for accuracy
• Be clear and complete about your medical history, including current medications
• Clean your hands often and remind your visitors to do the same
• Remind us if we do not carry out our pledge to you

We welcome your involvement and feedback. The unit manager is available to hear concerns about your care and safety.

From the doctors, nurses and staff of The Johns Hopkins Hospital
Adoption: Build Strategies to Support Patient and Family Active Roles in Care

Closer Look

- Have you noticed a recent change in your loved one?
- Have you asked the nurse to assess this change?
- Has a physician or nurse followed up with your concern?
- Are you still concerned?

Ask your nurse to contact the Rapid Response Team for a prompt “Closer Look” or Dial 1-3893 and ask the operator to page the Rapid Response Team to your room.

Questions Are the Answer
Get More Involved With Your Health Care
Best Practices Examples of Engaging Patients and Families as Partners

- Defining safety policy
- Developing and supporting evidence-based safety initiatives
- Patient safety-related training of staff and providers
- Designing and testing interventions
- Promoting and disseminating best practices
- Developing safety dashboards
Defining Safety Policy

- University of Washington Medical Center - Advisor membership on safety committees
  - Patient Safety Committee
  - Falls Prevention Committee
  - NICU Quality Leadership Team

- SUNY Upstate Medical University PFCC Policy Development Worksheet - Patients and families participate in policy/procedure development
Developing and Supporting Evidence-based Safety Initiatives

- Improve Care by Public Posting of Quality Data
- Translate new Patient Safety Goals
- Participate in National and Regional Collaboratives
- Partner with Patients and Families in Patient Liaison Safety Rounds
- Engage in Priority Safety Initiatives: Hand Hygiene
Translate new Patient Safety Goals

Rapid Response Team (RRT): Transforming Clinician-Only Activation to Family Activation

- **Condition H**
  - Parents can alert a similar team who will come and assess the situation.

- **Family-Activated RRT**
  - Over 50 Hospitals
    - N.C. Children’s Hospital in Chapel Hill
    - Cincinnati Children’s
    - Shands Jackson Medical Center
    - Yale-New Haven Hospital

2007 Socius Award

Condition H

Josie King Call Line
# 3-3131

UPMC
University of Pittsburgh Medical Center

National Patient Safety Foundation

North Carolina Children's Hospital
Developing evidence-based programs/resources

Involving Patient and Family Advisors in Learning-Based Collaboratives

- Vermont Oxford Network
  - Monitoring to Excellence: Quality Indicators
  - Safety Audits: Infection Control
  - Central Line Bundle

- Build Safety Dashboard

- Benefits
  - Increased credibility
  - Transparency
  - Momentum at stages of inertia
  - Advisors are best messengers
  - Power of stories
Training Staff and Providers

- **Patients and Families as Co-Leaders**
  - Facilitator
  - Content Expert
  - Faculty

- **Keys to Success**
  - High level of involvement
  - Related work/educational experience valuable
  - Engage experienced, effective advisor
  - Advisable that level of involvement may necessitate hiring as staff/consultants
Patient Safety Rounds

Traditional Staff-Led Patient Safety Rounds

- Interdisciplinary Team
- Ask questions that probe about safety
- Effectively identifies:
  - Adverse events
  - Near-miss occurrences
  - Design ideas for systemic interventions to effect change

Patient and Family Safety Liaisons Rounds

- Focus of Patient/Family Liaison: patient feedback on safety concerns
- Patient and Family Advisors involved in designing program
Developing Interventions: Educational Tools and Learning Aids

Growth in Patient and Family Resources that Identifies Roles for Patients/Families to Avert Errors

- Partner with patients and families as co-authors reviewers
- Include safety standards descriptions of what health care providers are doing to help ensure patient safety
- Standardized safety messages for patient and family education materials
- Importance of health literacy

Transforming Culture

- Why before how. Philosophy is important, identify core values.
- Remain focused and start small and plan long term.
- Measure what matters. Don’t get consumed with minutiae. Identify key benchmarks for success.
- Leadership actions/behaviors are key to develop culture, reinforce norms and allocate resources.
- Embrace patient safety culture shift: there is no doing without mistakes. Learn from it - intentionally move from shame and blame to openness and learning.
- Engage stories to make lessons more personal and powerful.
Quality is more than technical quality.

The patient’s and family’s experience can be a driver for quality improvement.
Migrating patient and family involvement in improvement and transforming the care experience from an exception to an expectation.

Paradigm shift: patient and families in an entirely new position within our operational and care structures.
“To wait for all the evidence is to finally recognize it through a competitor’s product.”

~David Whyte
Partners in Safety: The Aurora Health Care Journey

Kathryn Leonhardt, MD, MPH
Patient Safety Officer

Aurora Health Care®
Partners in Safety: Research

- **Theory:** Engaging consumers at the community level will improve safety
  - Patient-centered care
  - Community-based participatory research (CBPR)

- **Goals/objectives:**
  - Establish a *community-based* patient:provider advisory council
  - Identify and implement interventions to *improve medication safety* throughout the community

- **Partners**
  - Consumers Advancing Patient Safety
  - Midwest Airlines
  - AHRQ grant support, 2005-2007
Partners in Safety

Walworth County Patient Safety Council

- 11 Patients/Caregivers and 12 Healthcare Providers
  - Patients, doctors, nurses, retail pharmacist, parish nurse, Medicare benefits specialist, social worker
- 5 Aurora Clinics and 4 Aurora retail pharmacies
Q: How do you create an accurate medication list for patients 55 years and older in the outpatient setting?

- (2) Focus groups: 22 patient participants
- Patient Interviews (n=21)
- Provider Interviews (n=21)
- Literature review on accurate medication lists in the outpatient setting
Identifying the Problem: Patient Perspective

Q: Does your physician ask you to bring in your medicines to your appointment for review?
Q: Are your patients asked to bring in their current medications or list at each visit?
Developing Interventions: Engaging the Community

- Create the tools
  - Evaluations provided by 300 community members

- Enlist the consumers in the community
  - Active role of Advisory Council members
  - Use existing community programs and organizations

- Educate and disseminate
  
  Medication Lists: 16,000
  Medication Bags: 7,300
  Community Education programs: 80+
  Patient and Community Participants: 2,300
Developing Interventions:
Provider Interventions

- **Clinic Flow Analysis**
  - Best practices identified
    - Reminder call/letter to patient; dictation process
  - Defined staff roles and responsibilities

- **Forms revised**
  - Standardization

- **Education and training**
  - Outside Speakers
  - Physician engagement through targeted data feedback
Measuring the Results: Accurate Medication List

Accuracy of medication lists:

- **AMG Overall**
  - 2005: 63% accurate
  - 2007: 56% accurate
  - N = 2154
  - N = 2053

- **Walworth Co. AMG (Grant Project Sites)**
  - 2005: 55% accurate
  - 2007: 72% accurate
  - 5 Clinics with N charts reviewed
  - N = 596
  - N = 594

Accuracy of clinic medication list defined as: the clinic medication list contains the same list of prescription medications as the patient’s list/bag of prescription medications.

Statistical significance:
- P < .001
- P < .001
Measuring the Results: Patient use of Medication Lists

AMG Overall: 49% in 2005, 49% in 2007
Walworth Co. AMG (Grant Project Sites): 51% in 2005, 61% in 2007

P < .001

2007: 31% used Partners in Safety list
The medication list/medication bag helped facilitate communication between you and your patients.

Survey response rate 57% (52/92)
Integrating ‘partners in safety’ into organizational goals:

- Patient-centered care
- Patient safety
- Regulatory requirements
- Patient loyalty
- Staff retention
- Financial goals and incentives
- Health promotion and education
- Community engagement
Leadership support is the necessary (but not sufficient) first step

- Patient safety is part of the organization’s mission
- Strategic plan built around ‘patient at the center’
- Board committee meetings begin with patient safety story
Partners in Safety
Dissemination and Replication

- Patient-Centered Care
  - Planetree philosophy

- Patient safety
  - Organizational structure and function

- Regulatory Requirements
  - Medication Reconciliation (TJC)
    - Patient survey questions regarding medication safety
  - NPSG #13: Patient involvement in own care for safety (TJC)
    - Patient/family educated/engaged in hand hygiene, fall prevention, RRT activation
Partners in Safety
Dissemination and Replication

The Meaning of “Quality”

Percentage of Respondents Selecting Proxy

- Physician Reputation: 63%
- Patient Safety Record: 48%
- Hospital Reputation: 39%
- Cutting Edge Technology: 37%
- Center of Excellence: 26%
- Clinical Outcomes Data: 24%
- Nursing Reputation: 22%
- Hospital Rank: 20%
- Participation in Research: 9%
- Academic Affiliation: 8%
- Other: 4%
Partners in Safety
Dissemination and Replication

- didn’t
- responded to patient’s
Aurora Health Care InPatient Satisfaction and Employee Pulse Survey Oct 2007
Y-Axis Patient Satisfaction, X-Axis Employee Pulse, $r=0.458$, $p<=0.005$

33 Staff took steps to keep you safe from medical errors

Q55 I have the materials and equipment I need to serve our customers effectively
## Partners in Safety Dissemination and Replication

<table>
<thead>
<tr>
<th>Medication Safety</th>
<th>Measure: Patient leaves the hospital with a complete list of their medications Methodology: HCAHPS Survey July, Aug, Sept.</th>
<th>95 – 100%</th>
<th>90 – 94%</th>
<th>85 – 89%</th>
<th>&lt; 85%</th>
<th>Hospitals</th>
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<tbody>
<tr>
<td>Improve medication management (TJC) – HOSPITAL</td>
<td>96 and &gt; (WI Benchmark) Measure: Complete medication reconciliation form within 48 hrs of admission Methodology: WHA CheckPoint chart reviews</td>
<td>90 – 95</td>
<td>85 – 89</td>
<td>&lt; 85</td>
<td>Hospitals</td>
<td></td>
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<tr>
<td>Improve medication management (TJC) – CLINIC</td>
<td>Measure: Accurate medication list on the clinic chart Methodology: Patient interviews</td>
<td>80%</td>
<td>65 – 79%</td>
<td>50 – 64%</td>
<td>&lt; 50%</td>
<td>AMG</td>
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## Patient-Centered Care

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<tr>
<th>Increase the level of patient participation in quality/safety projects (Aurora Long Term Strategy) – HOSPITAL, CLINIC, AVNA, RETAIL PHARMACY</th>
<th>Measure: Patients participate in quality/safety projects Methodology: Number of projects with patient involvement</th>
<th>1 project per hospital</th>
<th>1 project - AMG</th>
<th>1 project – AVNA</th>
<th>0 projects</th>
<th>Hospitals</th>
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<td>AMG</td>
<td>AVNA</td>
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Partners in Safety
Dissemination and Replication

- Health promotion
  - Medical Home model in clinics
  - Patient-centered care: patient empowerment

- Community Engagement
  - Community programs through out Wisconsin
Redefine- and redesign- the health care provider role
- Patient-centered care is a collaborative relationship
- Workflow and delivery systems will need to be modified

Apply scientific rigor to your efforts
- Evaluate, quantify, systems analysis, and measure

Engage your community
- Patient safety is a public health concern

Align with your strategic goals

Apply lessons from other fields: behavioral economics; marketing.
Remember: the patient is at the center of all we do
Engaging Patients and Families in Patient Safety: A Primer

Classic Patient Safety Texts

- Institute of Medicine Quality Chasm Series
  - To Err is Human: Building Safer Healthcare Systems (1999)
  - Preventing Medication Errors (2006)


- Partnering with Patients to Prevent Medical Errors (2006) American Hospital Association


Key Sources for Tools, Techniques, Best Practices:

- American Hospital Association (http://www.aha.org)
- Consumers Advancing Patient Safety (http://www.patientsafety.org)
- Federal Government
  - Agency for Healthcare Research and Quality (http://www.ahrq.gov)
  - Veterans Administration (http://www.va.gov)
- Institute for Family-Centered Care (http://www.familycenteredcare.org)
- National Patient Safety Foundation (http://www.npsf.org)
- World Alliance for Patient Safety (http://www.waps.int)
Questions & Answers

Thanks!