Implementing P&FE Organizational Strategies

July 10, 2013
Webinar Agenda

• Overview & Introductions – Kathy Wallace
• Incorporating patients and families into patient safety, quality improvement and other hospital committees – How do you effectively bring them on?  
  – Dr. Tim McDonald
• Incorporating patient representation on a governing or leadership board – What does it mean?  
  – Carrie Brady
• Patient & Family Advisor Response – Bob and Barb Malizzo
• Wrap-up/ Questions
Evaluation

• Webinar funded by CMS through the Partnership for Patients

• CMS reviews results and wants 80% of participants to evaluate educational sessions
  – April evaluations – 21%
  – June evaluations – 48%
  – July evaluations - ??

• Please complete the simple three question evaluation by July 18, 2013:
  https://www.surveymonkey.com/s/PFEWebinar
Patient and Family Engagement Collaborative

Timothy McDonald, MD JD
University of Illinois Hospital and Health Science Systems
The Problem

Institute of Medicine: 1999 report that shook the medical world

Making Matters Worse
Part of the problem

Survey Shows That At Least Some Physicians Are Not Always Open Or Honest With Patients

Lisa I. Iezzoni¹,*, Sowmya R. Rao², Catherine M. DesRoches³, Christine Vogeli⁴ and Eric G. Campbell⁵
Impact on the medical malpractice community

Doctors Lie to Patients to Avoid Accountability Says Arkansas Personal Injury Lawyer

Little Rock, AR (Law Firm Newswire) April 11, 2012 – We trust our doctors to do what is right for us. Are they lying to us?
The UIC experience prior to 2004

- “Deny and Defend” approach to all patient harm
- Loss of patient and family trust
- Minimal internal or external transparency
- Non-existent learning from harm events or “claims”
- Progress in patient safety stymied
- Occurrence reports – only 1,500 per year
- Resident Patient Safety education confined to orientation
- No organized patient and family engagement at any level
Open and honest communication with patients and families

- Benefits
- Barriers
Extreme Honesty

Benefits
- Maintain trust
- Learn from patients
- Learn from family
- Learn from mistakes
- Improve patient safety
- Improve quality
- Employee morale
- Psychological well-being
- Accountability
- Money

Barriers
- Money
- Ego
- Reputation
- Loss of control
- Loss of job, license
- Uncertainty
- Regulatory abuse
Patient and family engagement: the “right” and “smart” thing to do

- In 2000-2004
- Medical liability crisis
- IOM Report – Patient Safety crisis
- Lack of learning
- “Perfect storm”
- Initial positive data – Michigan, VA-Lexington
Step 1: 2005 UIC Board approves “Patient Safety-Transparency” program

- Comprehensive
- Integration of safety, risk, quality and credentials
- Linkage to claims and legal
- Permission to engage of patients and families
- Longitudinal patient safety education plan
  - UGME
  - GME
  - CME
Next steps

- Create task force with subgroups to get buy-in and input into “process”
  - Physician – leadership, rank and file
  - Legal – inside and outside counsel
  - Hospital leadership
  - Financial
  - Create process
Next steps

- Create task force with subgroups to get buy-in and input into “process”
  - Physician – leadership, rank and file
    - Must have physician[s] champion
  - Legal – inside and outside counsel
    - And legal champion
  - Hospital leadership
  - Financial
  - Create process
The Seven Pillars: A “Principled Approach” to Adverse Patient Events

- Data Base
- Patient Communication Consult Service
- Event Investigation
  - Consider “Care for Care Provider” hold bills?
  - Yes
  - Unreasonable Care?
    - Yes
      - Full Disclosure with Apology and Remedy
    - No
  - No
- Concern or unexpected event reported to Safety/Risk Management
- “Near misses”
- Process Improvements
  - Activation of Crisis Management Team
A Comprehensive Response to Patient Incidents: The Seven Pillars.
McDonald et al \textit{Quality and Safety in Health Care, Jan 2010}

- Reporting
- Investigation
- Communication
- Apology with remediation
- Process and performance improvement
- Data tracking and analysis
- Education – of the entire process
The University of Illinois at Chicago
Comprehensive Approach to Adverse Patient Events

Data Base

Patient Harm? 🔄

Yes 🔄

Consider “Second Patient” Event Investigation
Hold bills

No 🔄

Appropriate care? 🔄

Yes 🔄

Full Disclosure with Rapid Apology and Remedy

No 🔄

Unexpected Event reported to Safety/Risk Management

“Near misses” 🔄

Process/Performance Improvements

Activation of Crisis Management Team

Patient Communication Consult Service
Areas for Patient and Family Engagement
The University of Illinois at Chicago
Comprehensive Approach to Adverse Patient Events

Data Base

Patient Harm?

Consider “Second Patient” Event Investigation
Hold bills

Patient Communication Consult Service

Yes

Appropriate care?

No

Yes

Full Disclosure with Rapid Apology and Remedy

Unexpected Event reported to Safety/Risk Management

“Near misses”

Process/Performance Improvements

Activation of Crisis Management Team
Goals of the Seven Pillars

- Reduce harm thru transparency and learning
- Reduce lawsuits through early, effective communication with all parties
- Resolve inappropriate care cases early, efficiently
- Support patient and family engagement
- Support care professionals following harm events
Putting it all together
Family lends hand after deadly error

Bob and Barb Malizzo, along with daughter Kristina Chavez and her son Adrian, visit their daughter Michelle Ballog’s grave at Graceland Cemetery in Valparaiso, Ind. Ballog died after a medical error at UIC Medical Center in Chicago.
Another communicating openly and resolving early

Death gives new life to friend

ORGAN DONOR | Daughter dies in surgery, dad offers kidney to pal

BY PIET LEVY
Post-Tribune

In death, Michelle Ballog has given new life to a family friend in need of a second chance.

On Sunday, Ballog's kidney was given to Lake County (Ind.) Police Chief Marco Kuyachich, who has been awaiting a transplant for two years. Ballog, 39, was the daughter of former Hobart Mayor Robert Malizzo.

“She was always there to help everyone,” Malizzo said. “Even in her death, she wanted to help, and that's why she’s a donor.”

Ballog, who had two daughters, died during liver surgery Saturday at the University of Illinois Medical Center.

Despite his grief, Malizzo remembered his friend Kuyachich needed a kidney. So, he called him.

“Sometimes there’s a bright side out of a bad situation,” Malizzo said. “My daughter gave [Kuyachich] the gift of life. What greater gift can you give anyone?”

Kuyachich said: “I'm hoping others will learn from this and follow her lead. You don't realize how much you can do for others until you have it done to you.”

Comment at suntimes.com.
Medical mistake spurs relatives to join hospital panel, not sue

Bob Malizzo and daughter Kristina Chavez attend a patient safety review committee meeting at UIC Medical Center in Chicago. They joined after the death of Michelle Ballog, his daughter and her sister.
The Seven Pillars: A Comprehensive Approach to Adverse Patient Events

Data Base

Patient Communication Consult Service 24/7 Immediately Available

Unexpected Event reported to Safety/Risk Management

Patient Harm?

Consider “Second Patient” Error Investigation Hold bills

Inappropriate Care?

Full Disclosure with Rapid Apology and Remedy

“Near misses”

Process Improvement

Activation of Crisis Management Team
Process improvement: Significant change in national guidelines

- July 1, 2011 ASA
- Specifically, in section 3.2.4 of the Standards for Basic Anesthetic Monitoring, the ASA states, "...During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment."
Lessons learned

- Engage all patients and families in their own care as much as possible
- When selecting patient/families for committees
  - Be selective – want advocates, not activists
  - Solicit, interview – tools are available
  - Mentor and hold hand thru the process
  - Meetings before the meetings with patients/families is critical and very valuable
Impact of comprehensive effort

- Increased reporting
- Rapid, effective ongoing communication
- Rapid cycle improvements and harm prevention
- Early resolution
Patient Safety metrics

- Large improvement in HCAPS
- Substantial reduction in SSEs
- Mortality
  - Was 50%-ile
  - Now in top 5% of UHC
Effect of 7P on Claims
University of Illinois Hospital and Health Sciences System

Time (Quarterly from July 2000 to September 2011)
Other data update

- Medical Malpractice Premium data
- Overall reduction on premium over past three years = $22MM
- FY 2014 shows another 9% reduction in premium
- $14MM less than FY 2010

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Data from grant hospitals

- Hospital and physician leadership fully engaged
- Gap analyses completed
- Communication training complete
- On-line occurrence reporting begun
- Disclosures, early offers have occurred
- Data being analyzed
Data from one grant hospital

- Huge reduction in serious reportable events
- Already experiencing reduction in liability claims
Stakeholder buy-in prior to grant submission

- Medical Societies
- Professional liability companies – hospital and physician
- Hospital Association
- Legal groups
- Consumers Advancing Patient Safety
- Project Patient Care
- Individual hospital boards, medical staffs
Engaging Patients in Leadership

Carrie Brady, JD, MA

CMS Metric: Hospital has one or more patient(s) who serve on a Governing and/or Leadership Board and serves as a patient representative.
Engaging Patients in Leadership

• Changes the dialogue
• Has the power to transform organizations

• Must be done well
  – Token representation is ineffective and detrimental.

“[F]amily members bring a totally different point of view to the board and committee discussions and they change the dynamics of the meeting in a very positive way.”

Lee Carter, Member Board of Trustees, Former Chairman, Cincinnati Children’s Hospital Medical Center
Why Engage at the Board Level?

"Please STOP . . . I'm getting MOTION SICKNESS."
Common Roadblocks to Patient Experience Improvement

- Leaders appointed to drive patient experience pulled in too many directions: 48%
- Other organizational priorities reduce emphasis on patient experience: 46%
- General cultural resistance to doing things differently: 42%
- Lack of support from physicians: 29%
- Lack of sufficient budget or other necessary resources: 26%

Beryl Institute 2013 Benchmarking Study
Key Drivers of Success for Patient Experience Improvement

- Strong, visible support "from the top" (62%)
- Having clinical managers who visibly support PX efforts (55%)
- Formalized process review & improvement focused on patient exp (44%)
- Formal patient experience structure or role (30%)
- Ongoing “internal communications” push (25%)

Beryl Institute 2013 Benchmarking Study
The Conundrum

• Board members are asked to put their personal interests aside and act collectively to serve the organization

• But, many Board members have been hospitalized or have loved ones who have been hospitalized and can offer invaluable perspectives based on personal experience
Tap the Gold Mine

• Encourage every community Board member to function as patient and family representatives
• Review your Board member orientation materials and the expectations you set for Board members
• Create time for reflective dialogue
• Consider engaging Board members in rounding
• Share patient and family stories
A Quiz

How comfortable are you with the patient and family experience in your organization:

- Are there any special processes in place for Board members who are hospitalized? If so, what are those processes designed to prevent or to improve?
- If a Board member was admitted and no one from the hospital was aware of the patient’s Board role, would anything be different about their care?
Call to Action

• Review the process for identifying and selecting Board members.
  – Is patient and/or family experience one of the factors considered?
• As talented patient advisors gain credibility within the organization, consider future Board opportunities.
• If you already have advisors in place, would any of them be effective Board members?
Key Resources

- New AHRQ Guide to Patient and Family Engagement in Hospital Quality and Safety
  - *Strategy 1: Working with Patients and Families As Advisors* includes a detailed implementation handbook and 14 tools

- Institute for Healthcare Improvement How-to Guide: Governance Leadership (Get Boards on Board)
Available for purchase through the Institute for Patient and Family-Centered Care at http://www.ipfcc.org/resources/index.html
A New Resource for Bedside Shift Reporting

• In our June webinar, we encouraged you to implement or improve bedside shift reporting.

• AHRQ’s new guide to patient and family engagement also includes resources on bedside shift reporting, specifically:
  – Implementation handbook
  – Staff training tools
  – Patient information brochure
  – Checklists

Patient and Family Perspective

Bob and Barbara Malizzo
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Next Webinar

Meaningful Use Requirements for Patient & Family Engagement
August 15, 11 a.m. – 12 p.m. ET

• Finalizing national and state speakers who will talk about meaningful use requirements surrounding patient and family engagement
  – What are the considerations for a Hospital Portal versus Community Portal?
  – Will and should the patient be able to document in their record?
  – Will the information need to be made available across providers?
  – What tools will need to be available to patients electronically?
Thank you