Coalition for Care
IHA's Hospital Engagement Network

Indiana Hospital Association
INDIANA PATIENT SAFETY CENTER

Implementing P&FE Organizational Strategies

July 10, 2013

Indiana Hospital Association

Indiana Hospital Association

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

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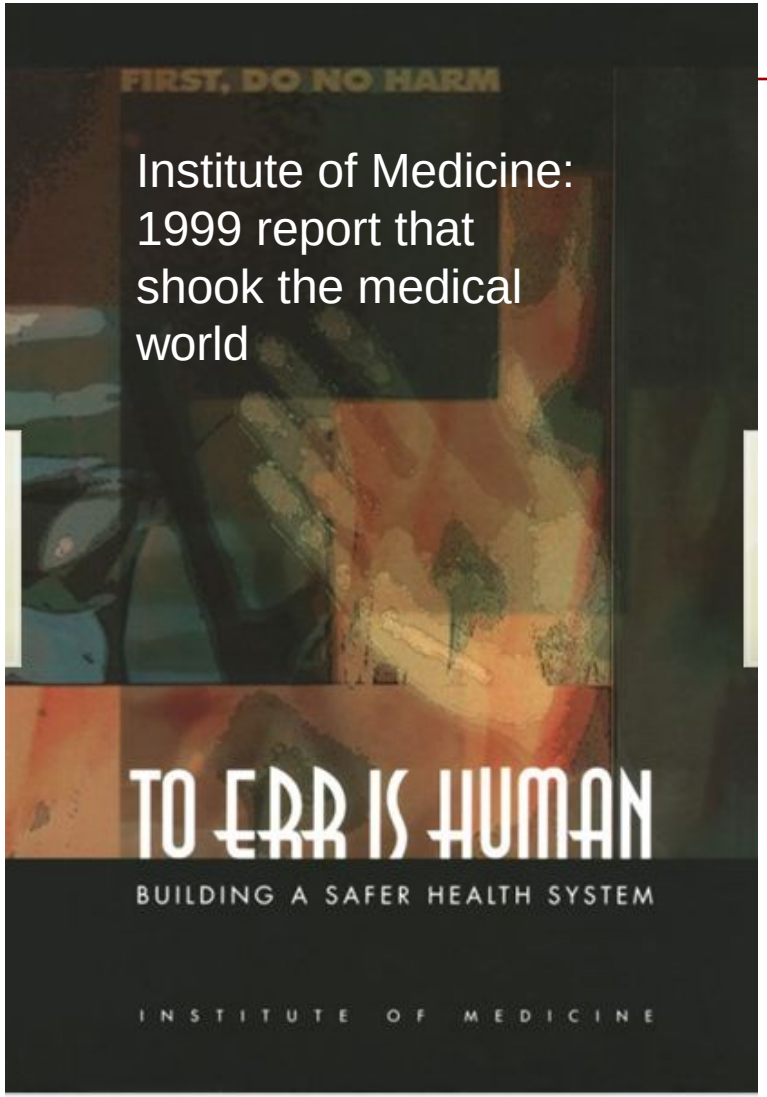
Evaluation

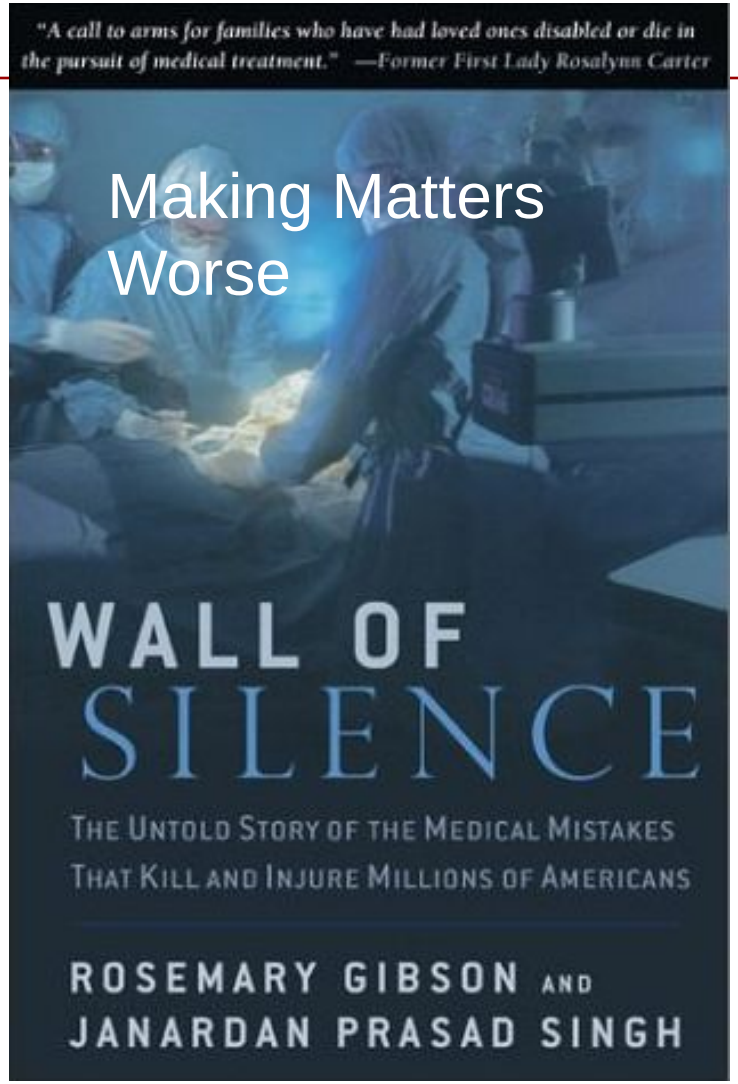
- Webinar funded by CMS through the *Partnership for Patients*
- CMS reviews results and wants 80% of participants to evaluate educational sessions
  - April evaluations – 21%
  - June evaluations – 48%
  - July evaluations - ??
- Please complete the simple three question evaluation by July 18, 2013: 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


FIRST, DO NO HARM
Institute of Medicine: 1999 report that shook the medical world
TO ERR IS HUMAN
BUILDING A SAFER HEALTH SYSTEM
INSTITUTE OF MEDICINE


"A call to arms for families who have had loved ones disabled or die in the pursuit of medical treatment." —Former First Lady Rosalynn Carter
Making Matters Worse
WALL OF SILENCE
THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS
ROSEMARY GIBSON AND JANARDAN PRASAD SINGH

Part of the problem

HealthAffairs

- February 2012, Volume 31, Issue 2

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

Expand

Lisa I. Iezzoni[1,*], Sowmya R. Rao[2], Catherine M. DesRoches[3], Christine Vogeli[4] and Eric G. Campbell[5]

- 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

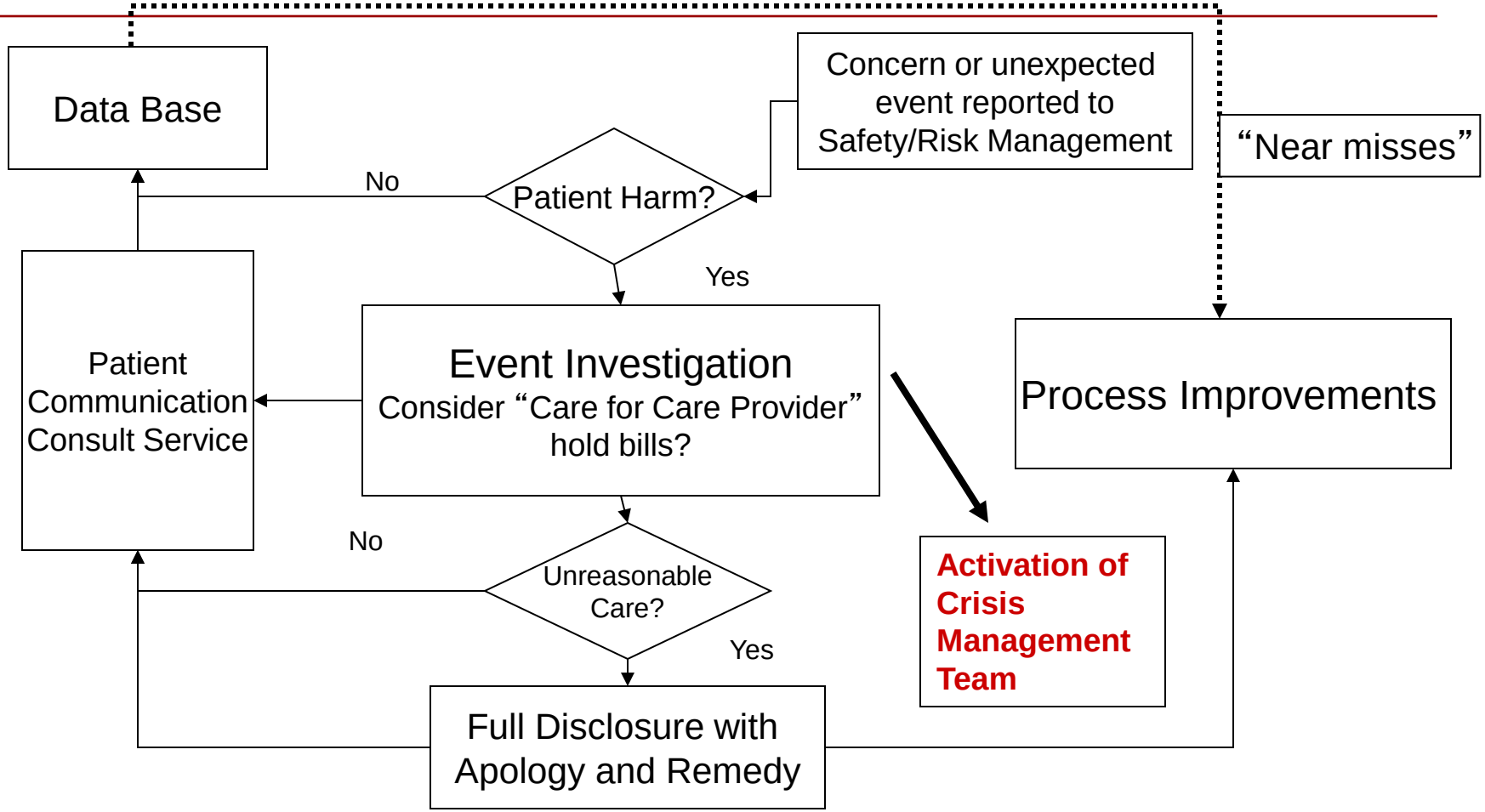
Next steps

- 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

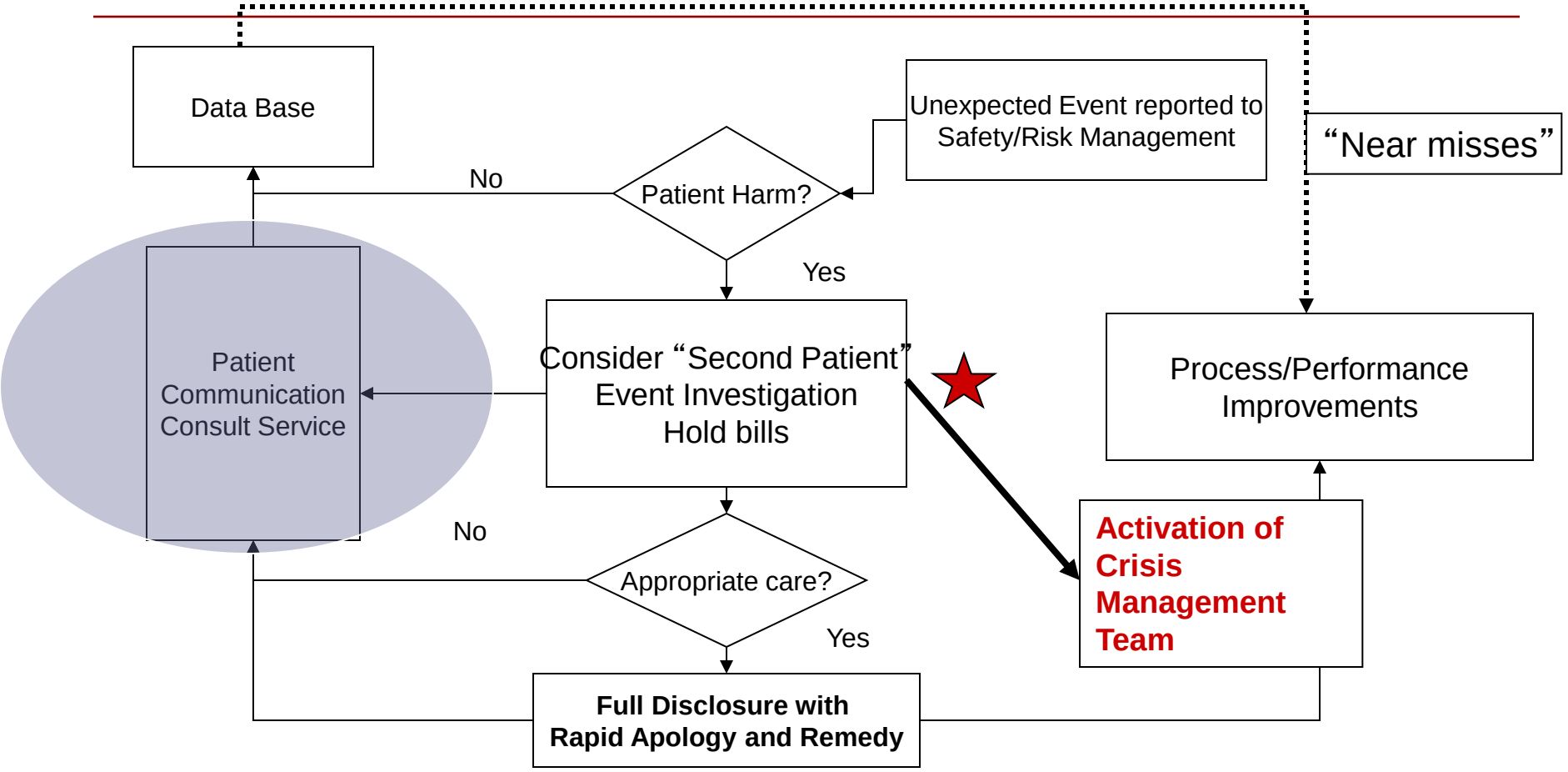


A Comprehensive Response to Patient Incidents: The Seven Pillars.

McDonald et al *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

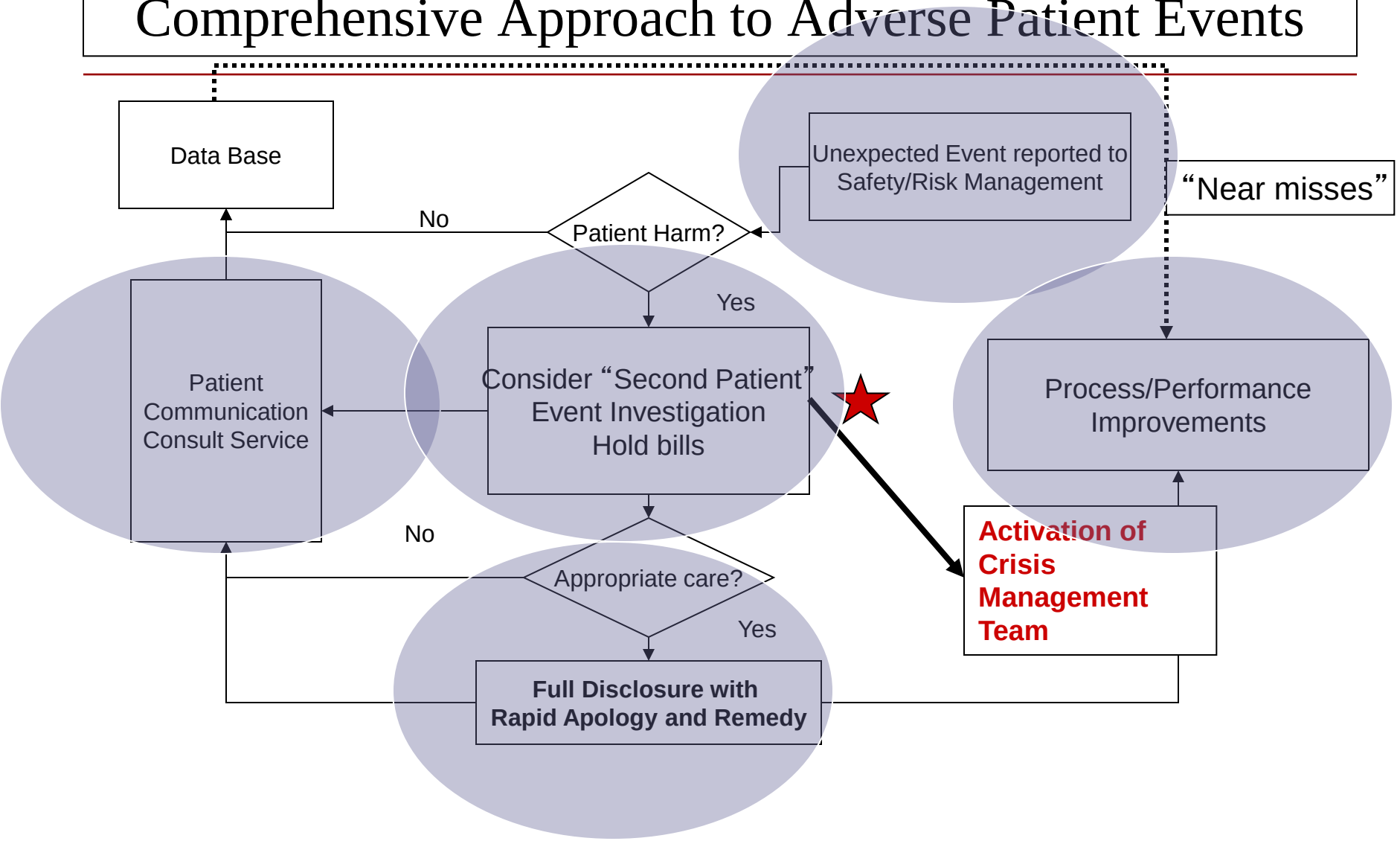
The University of Illinois at Chicago
Comprehensive Approach to Adverse Patient Events



Areas for Patient and Family Engagement

The University of Illinois at Chicago

Comprehensive Approach to Adverse Patient Events



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

Michael Phillips' review in A+E

Chicago Tribune

Questions? Call 1-800-Tribune | Friday, October 7, 2011 | Breaking news at chicagotribune.com

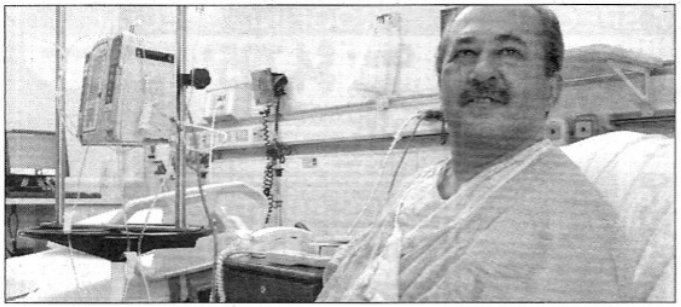
October 7, 2011

HEATHER CHARLES/TRIBUNE PHOTOS

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.

Family lends hand after deadly error

Another communicating openly and resolving early



Marco Kuyachich recovers from transplant surgery Monday at Northwestern Memorial Hospital. He received the kidney after the death of a family friend.

MICHAEL MCARDLE ~POST-TRIBUNE

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 tranplant 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."

Michelle Ballog

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.

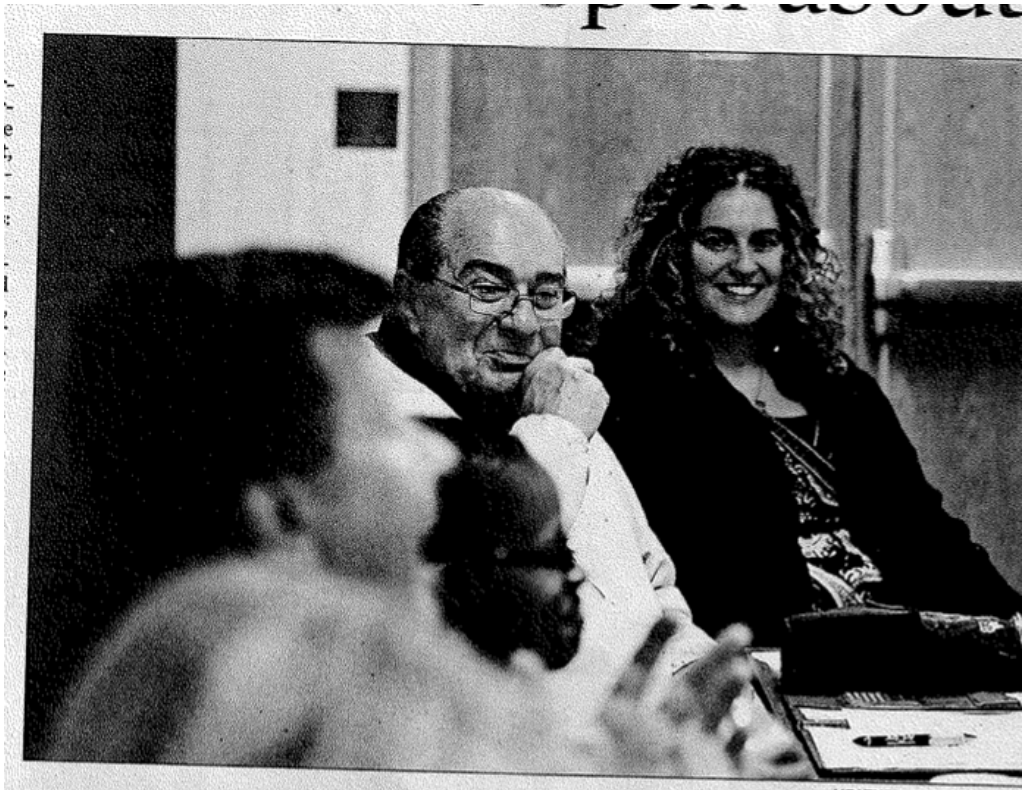
"Sometimes there's a bright side out of a bad situation," Malizzo said. "My daughter gave [Kuyachich] the gift of life. What greater gift can you give anyone?"

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.

October 7, 2011

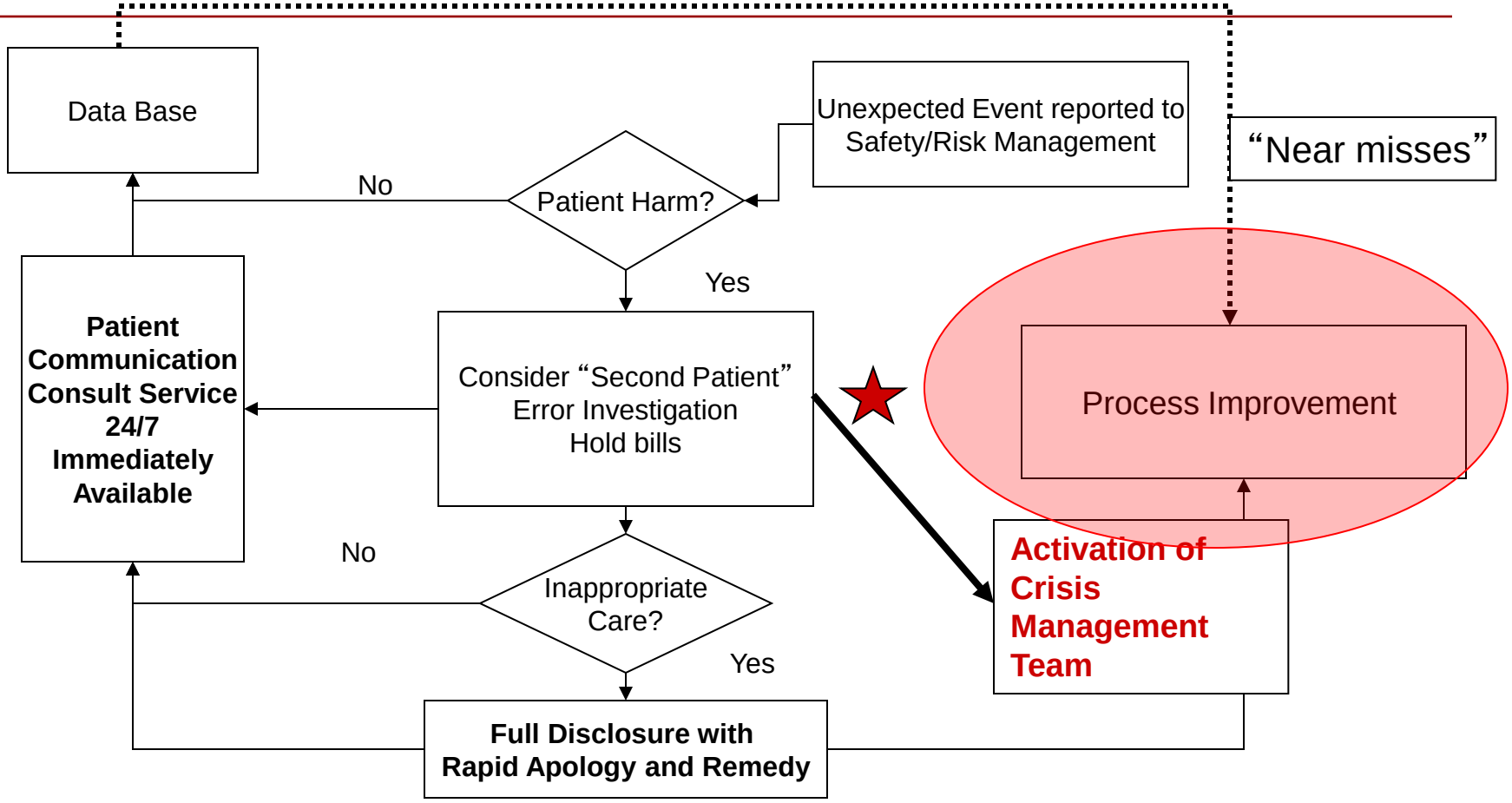
Medical mistake spurs relatives to join hospital panel, not sue



HEATHER CHARLES/TRIB

Bob Malizzo and daughter Kristina Chavez attend a patient safety review committee meeting at UIC Medical Cer
Chicago. They joined after the death of Michelle Ballog, his daughter and her sister.

The Seven Pillars:
A Comprehensive Approach to Adverse Patient Events



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

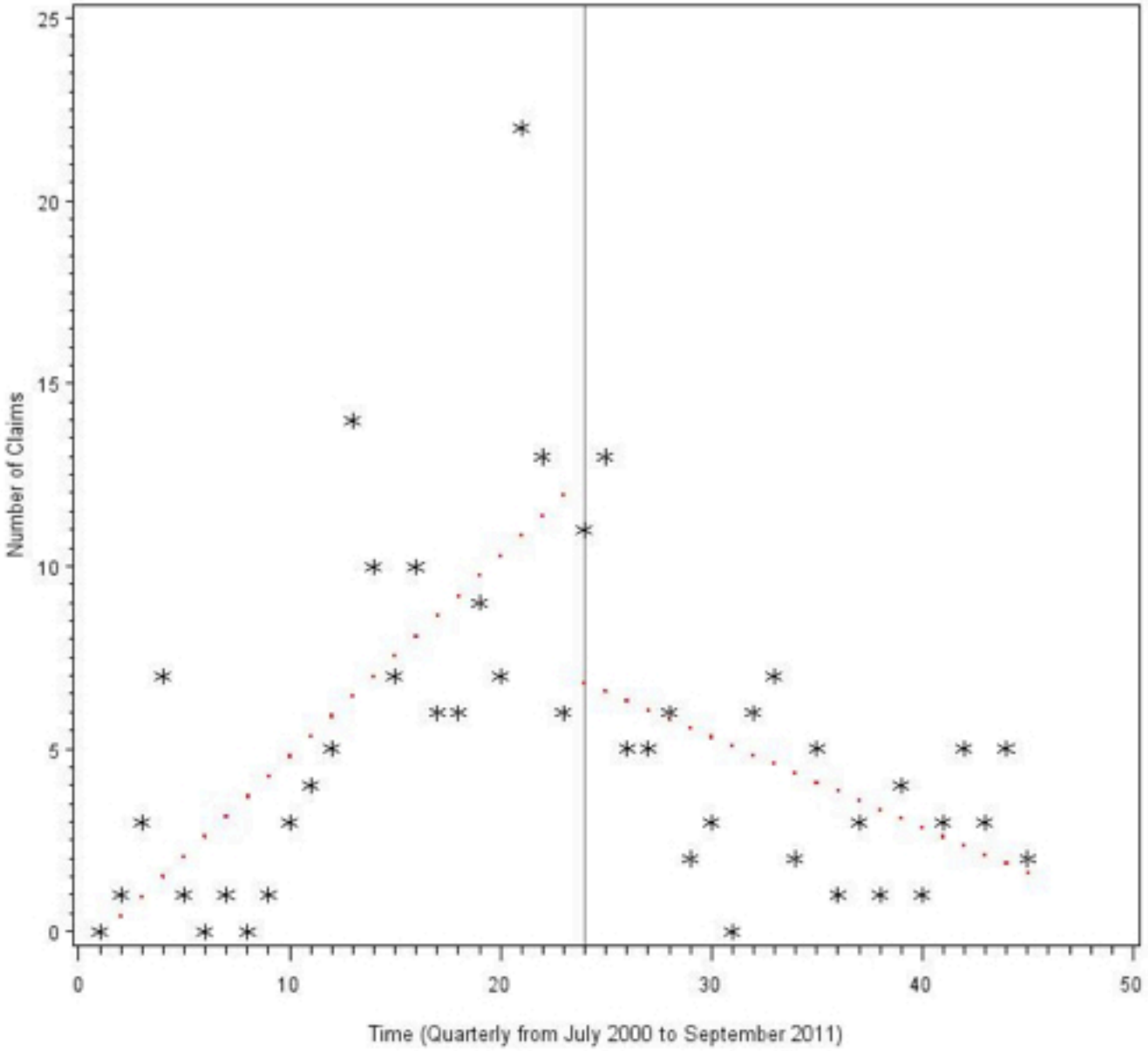
- Increased reporting
- Rapid, effective ongoing communication
- Rapid cycle improvements and harm prevention
- Early resolution

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

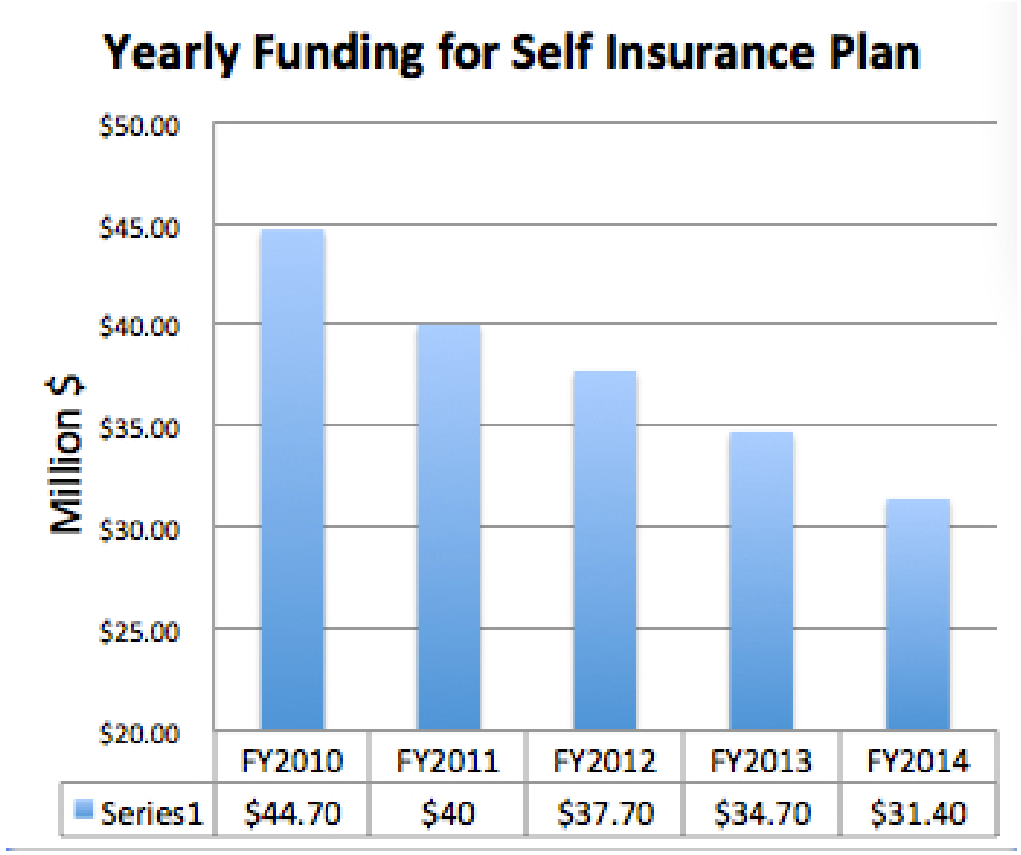
University of Illinois Hospital and Health Sciences System



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

	FY13	FY2012	FY2011	FY2010
Total Funding	$34,680,000	$37,327,112	$39,996,393	$44,743,090
Change Over Prior Year	($2,647,000)	($2,669,281)	($4,746,697)	$5,513,862
% of Change	-7%	-6.7%	-10.6%	14.1%
Change Over Fy2010	($10,062,978)	($7,415,978)		
% of Change	-23.0%	-16.6%		

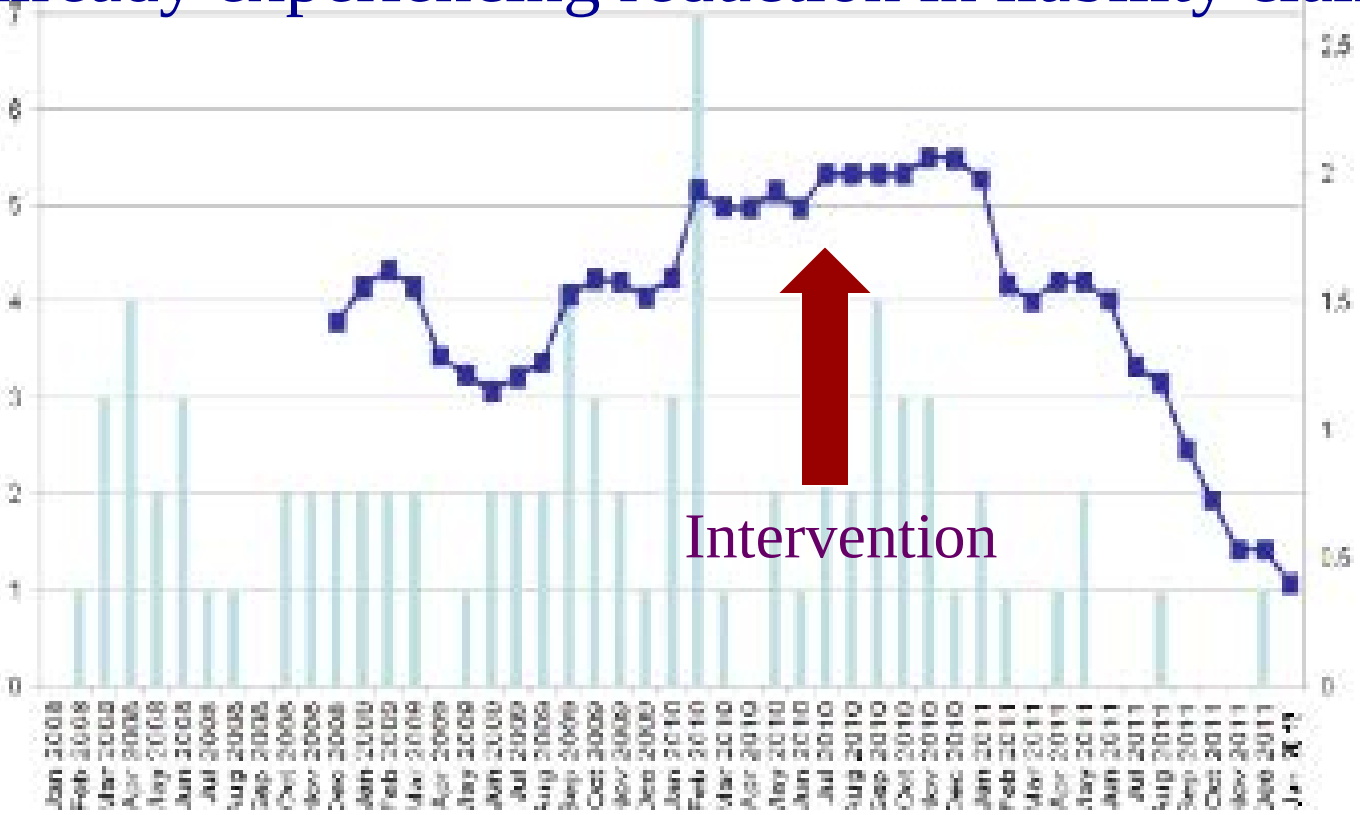

Yearly Funding for Self Insurance Plan
Million $
$50.00
$45.00
$40.00
$35.00
$30.00
$25.00
$20.00
FY2010
FY2011
FY2012
FY2013
FY2014
Series1
$44.70
$40
$37.70
$34.70
$31.40

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

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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.

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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

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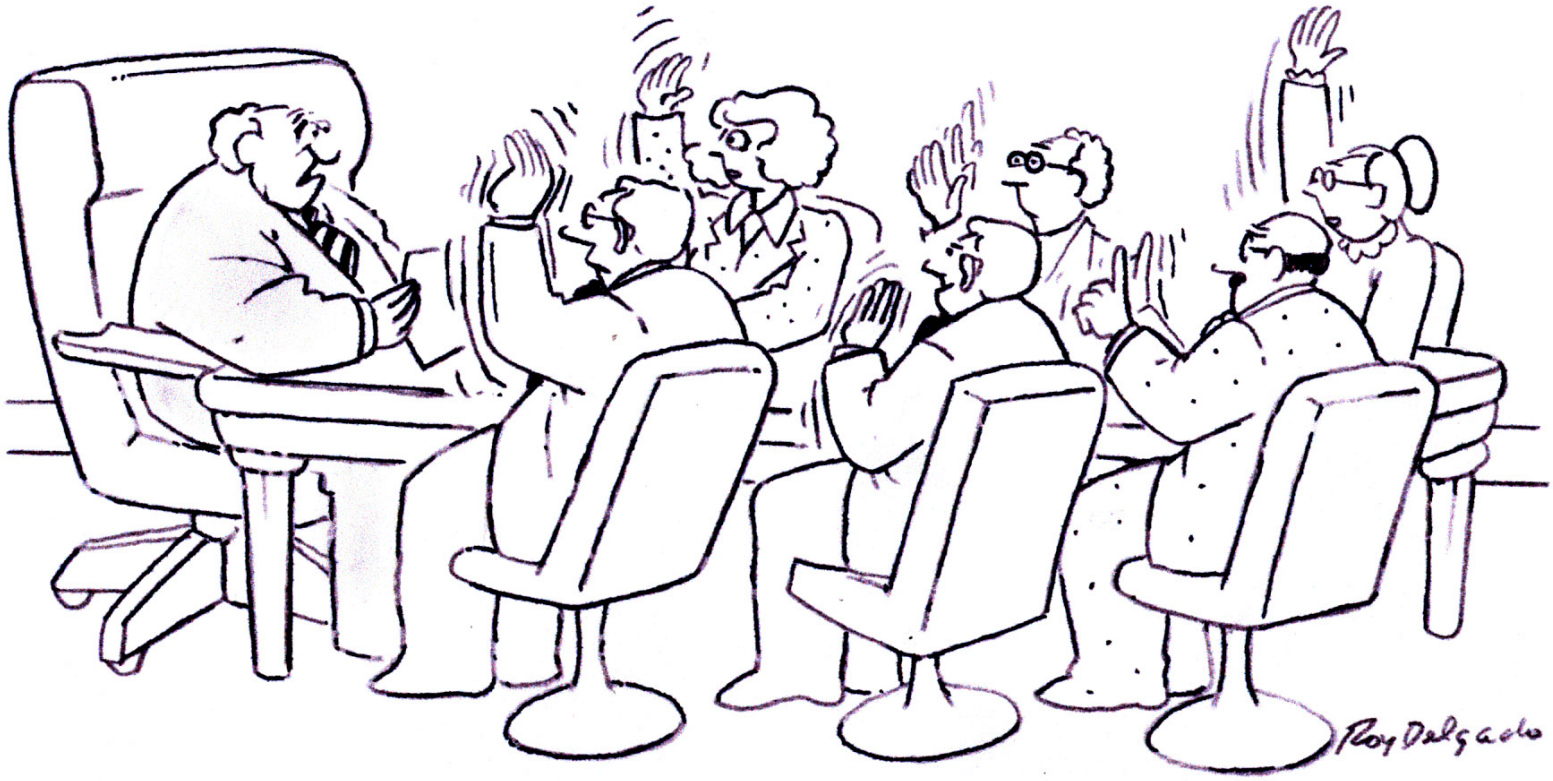
Why Engage at the Board Level?



" Please STOP . . I'm getting MOTION SICKNESS. "

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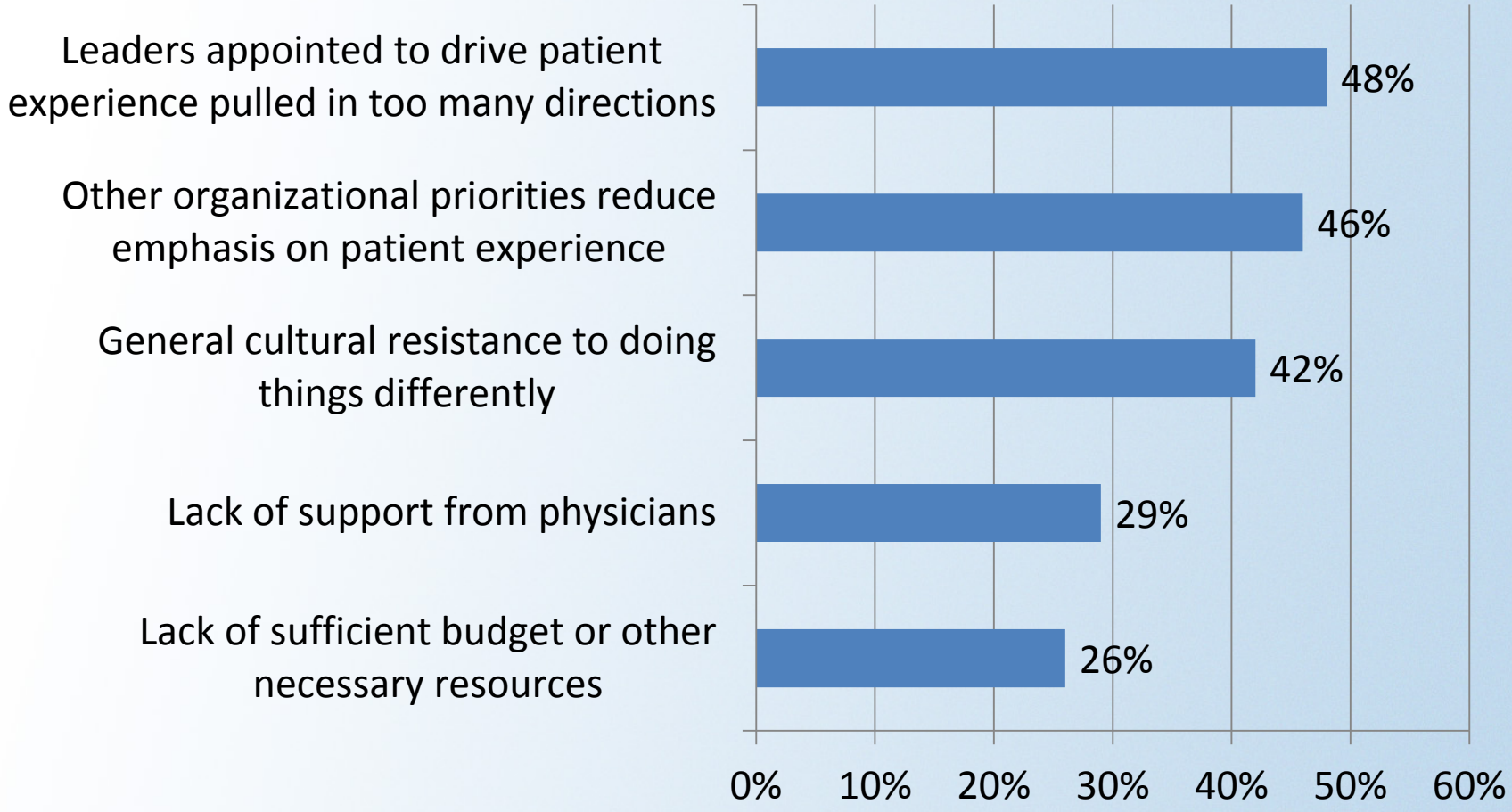
Common Roadblocks to Patient Experience Improvement



Beryl Institute 2013 Benchmarking Study

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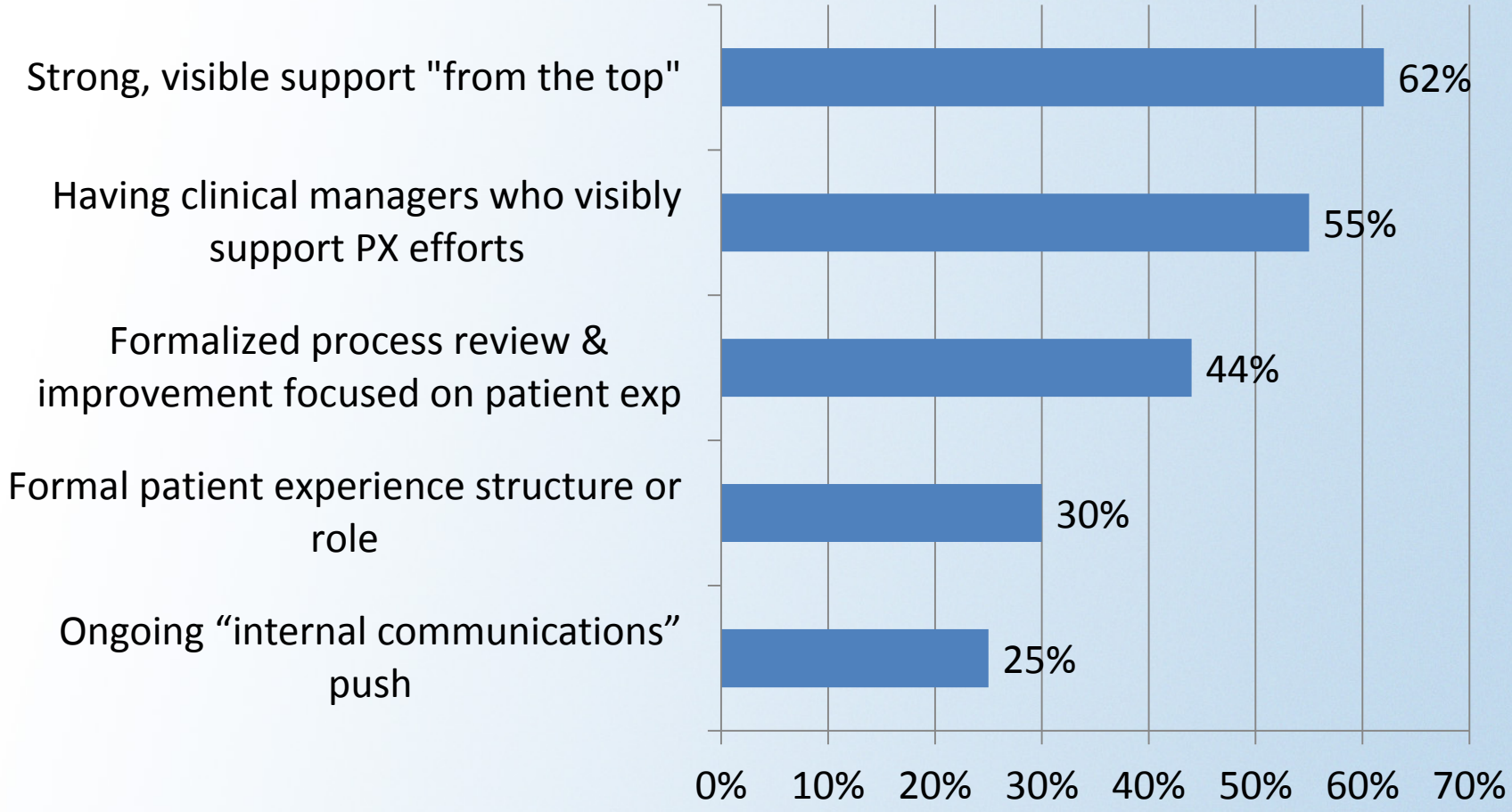
Key Drivers of Success for Patient Experience Improvement



Beryl Institute 2013 Benchmarking Study

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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

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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

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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?

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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?

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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

http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/patfamilyengageguide/

- Institute for Healthcare Improvement How-to Guide: Governance Leadership (Get Boards on Board)

http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideGovernanceLeadership.aspx

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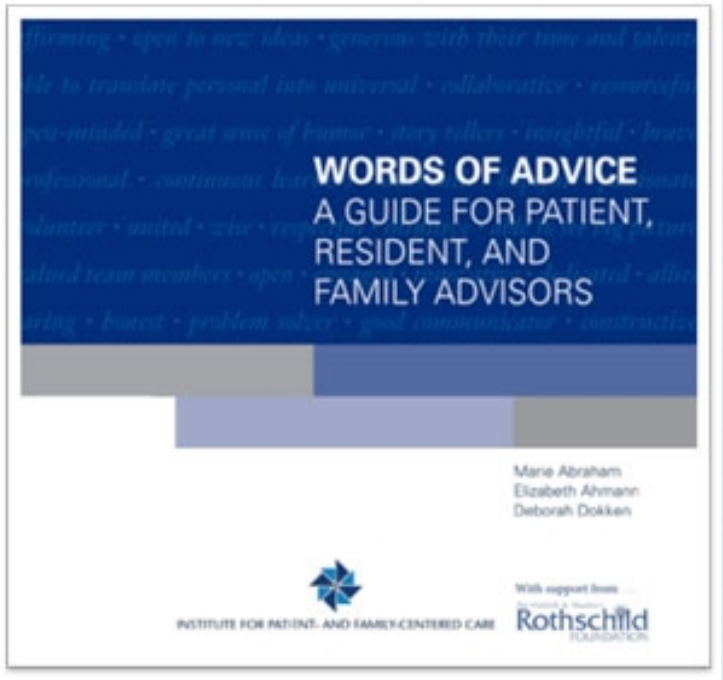
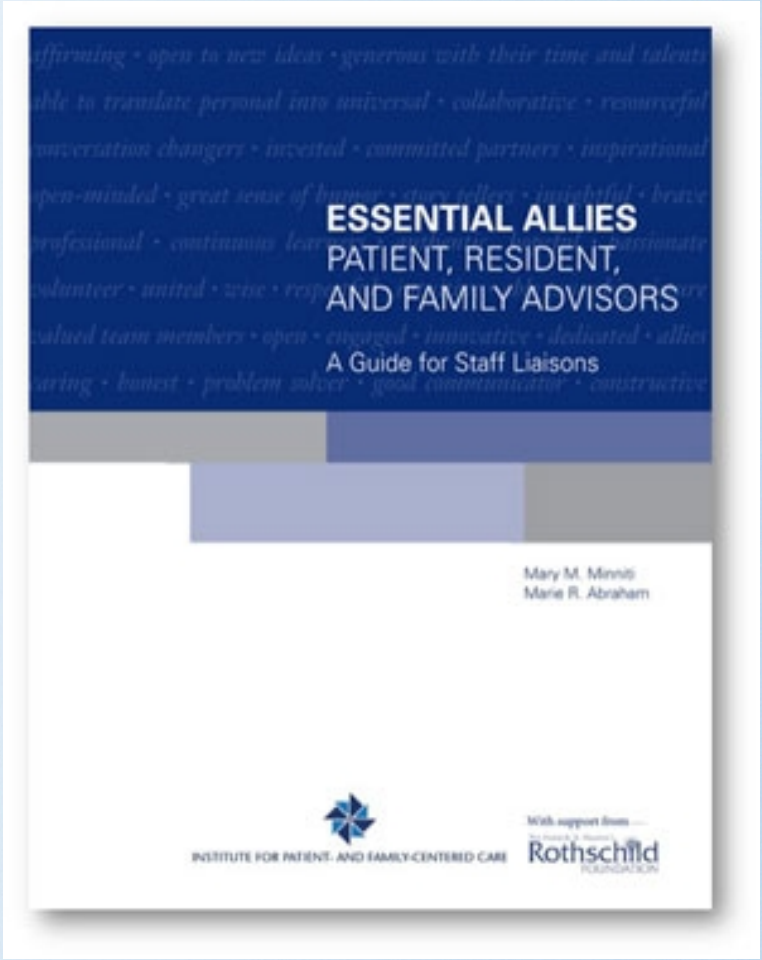
Detailed Guides





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

http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/patfamilyengageguide/strategy3/index.html

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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?

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Thank you