

**Workshop on Consumer Engagement in Selected Patient Safety Topics  
("Chicago Patient Safety Workshop")  
Final Progress Report (filed November 2008)**

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**Submitted by**

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## Structured Abstract

**Purpose:** The workshop objective was to inform six selected topics THAT depend on consumer engagement to be optimally successful. The topics are:

1. Reporting medical errors and/or near misses;
2. Patient and family engagement in healthcare organization policymaking and operation via participation in safety, quality, or policy-making activities at the organizational level;
3. Active patient and family engagement in ensuring the safety of their own care or that of their loved ones;
4. Effectively responding when error occurs, and engaging patients in organizational learning from such events;
5. Prioritizing error prevention initiatives in Chicago; and
6. Improving communication between patients and clinicians.

**Scope:** The workshop emerged from developing work in the Chicago area to actively engage consumers in developing practical action plans that advance safe, patient-centered care. Workshop participants also became eligible to join the World Health Organization's international Patients for Patient Safety network.

**Methods:** The workshop adapted a group process methodology known as Appreciative Inquiry. Action planning was guided by an adapted Six Sigma DMAIC tool.

**Results:** Products include six topical action plans, a Challenge to Chicago; scholarly articles and public communications; and videotaped interviews.

**Key Words:** Action Planning; Communication; Disclosure; Error prevention; Patient Engagement; Patient Safety; Patient Reporting of Error

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### I. Purpose (Objectives of the Study)

The Workshop on Consumer Engagement in Selected Patient Safety Topics was a gathering of about 40 patients and family members – many of whom had experienced preventable harm due to healthcare systems failure – and an equal number of “other stakeholders.” The latter group was composed of physicians, nurses and other healthcare professionals; organizational administrators; researchers; philanthropists; government representatives; and facilitators and graduate school interns. This community of change agents came together with the common goal of expediting improvement in patient safety by developing measurable interventions that can be implemented in the Chicago region, and perhaps elsewhere.

The Workshop was jointly developed by three Chicago-based organizations: Consumers Advancing Patient Safety (CAPS), Partnership for Patient Safety (p4ps), and Northwestern Memorial Hospital (NMH). Other organizing partners who brought international perspectives and resources

included Patients for Patient Safety (PFPS), an action area of the World Health Organization's (WHO) World Alliance for Patient Safety, and the Pan American Health Organization (PAHO).

Our overall goal was to tap what Susan Sheridan, MBA, MIM, CAPS President and PFPS External Lead, calls "the wisdom of the consumer" and actively engage them in patient safety planning work together with healthcare providers and other dedicated persons interested in expediting ambitious patient safety improvement in the Chicago region. More specifically, the objective of the workshop was to inform six selected topics, which, to be optimally advanced, depend on consumer engagement with healthcare providers and policymakers: The topics are:

1. Reporting medical errors and/or near misses;
2. Patient and family engagement in healthcare organization policymaking and operation via participation in safety, quality, or policy-making activities at the organizational level;
3. Active patient and family engagement in ensuring the safety of their own care or that of their loved ones;
4. Effectively responding when error occurs, and engaging patients in organizational learning from such events;
5. Prioritizing error prevention initiatives in Chicago; and
6. Improving communication between patients and clinicians.

## **II. Scope (Background, Context, Settings, Participants)**

### **A. Workshop Development**

Most workshop participants were from the Chicago area. However, conscious that our approach of working *with* consumers—not just for them—was breaking new ground and could be adapted elsewhere, the workshop was designed to build bridges to other communities. Accordingly, participants were invited from Arizona, Colorado, Idaho, Indiana, Maine, Maryland, Massachusetts, Vermont, Washington, DC, the State of Washington, Australia, Canada, Ireland, and the United Kingdom.

The idea for the workshop emerged from two developing initiatives in the Chicago area. The first was leadership at NMH and the commitment of that organization to actively engage consumers in patient safety work. The second was the formation of CAPS, a Chicago-based non-profit organization that has been active in advancing the role of patient as partner. Although these efforts had been successful in developing an international network of motivated patient safety "champions" active in the WHO World Alliance, none had evolved to the point of developing practical action plans to advance actual safety of care in a local community.

Armed with this concept, the team approached two well-established supporters of patient safety. The Chicago-based Otho S. A. Sprague Memorial Institute has provided leadership and financial support for patient safety since it helped launch the Chicago Patient Safety Forum in 2001. The Agency for Healthcare Research and Quality (AHRQ) is the nation's lead federal

agency for research on healthcare quality, costs, outcomes, and patient safety. Both organizations agreed to partially support this effort. The Sprague Institute had a specific interest in assuring local engagement of the entire Chicago metropolitan healthcare community and helped to build relationships and bridges to involve providers, government, local associations, and others throughout the region. The interest of AHRQ was complementary, with strong emphasis on dissemination of results and development of a model for other communities and regions to replicate. In addition to these supports, NMH hosted the event in modern, welcoming meeting facilities and contributed many in-kind services.

Planning of the actual workshop agenda and logistics started early in 2008. To ensure that all aspects of the workshop were authentically patient centered, two dynamic leaders in consumer involvement in patient safety were approached to play leading roles. Dan Ford, vice president at the Furst Group, a healthcare search consultant, and Sue Sheridan agreed to participate on the Workshop Steering Committee. Both Dan and Sue have experienced health system failure that led to serious injury or death of a family member, and both are respected for their advocacy and perspective on the importance of partnership among all stakeholders. Their involvement was central to the success of the program and epitomized the constructive partnership that the workshop seeks to model and inspire.

In response to the commitment to the Sprague Institute to make the workshop truly a Chicago-wide initiative, planning was overseen by a Steering Committee composed of local healthcare providers, government representatives, and consumers active in the patient safety field. Letters of support were supplied by the Chicago Patient Safety Forum, Illinois Hospital Association, and the Metropolitan Chicago Healthcare Council. Outreach was done to all Chicago neighborhoods, with the goal of reaching a diverse pool of potential applicants.

We also acknowledge and thank the workshop participants (Table 1), who took time from family and work to contribute their experiences, ideas, and passion for making a difference in Chicago and beyond.

**Table 1: Workshop Participants**

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### **III. Methods (Study Design, Data/Sources/Collection, Interventions, Measures, Limitations)**

#### **A. Appreciative Inquiry**

The workshop adapted a group process methodology known as Appreciative Inquiry (AI), designed to tap participants' personal and professional successes in addressing challenges and creating inspired, positive change. The AI methodology is rooted in social constructionism—the theory that human beings co-create what is thought to be “reality” through language, thoughts, images, and beliefs about what is.<sup>1</sup> Change is energized, therefore, by the discovery of new

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<sup>1</sup> See, Beckhard, R. (1999, August). The past, present, and future of organization development. Symposium conducted at the annual meeting of the Academy of Management, Chicago, IL; Brittain, J. (1998). Do we really mean it? In S. A. Hammond & C. Royal (Eds.), *Lessons from the field: Applying appreciative inquiry* (pp. 216-229). Plano, TX: Practical Press Inc.; Cooperrider, D. L. (1990). Positive image, positive action: The affirmative basis of organizing. In S. Srivasta, D. L. Cooperrider, & Associates (Eds.), *Appreciative management and leadership - the power of positive thought and action in organizations*: 91-125.

thoughts, beliefs, and language that shift current mental models about what is (“patients who experience medical error are angry, potential litigants”) to what could be (“patients who experience harm are a unique resource to continuous learning systems”). AI searches for and builds on the best in people, their organizations, and the relevant world around them, thereby fostering collaboration and energy that can be transformative.

AI was developed and pioneered at the Cleveland Clinic in 1980 by David Cooperrider, PhD, and his associates as a new paradigm with the potential to replace the conventional problem-solving approaches that focus on analyzing deficits in order to make corrections. A central challenge to problem-based approaches is strong resistance to the guilt, shame, or disorientation that may attend the experience of concentrating on deficits. Appreciative Inquiry shifts this focus to a desired future or outcome, based on strengths and passions that are apparent or have been experienced in the past and present. AI does not ignore problems but recognizes and repositions them as a desire for something else, then works to identify and enhance that “something else.”

This positive change strategy is particularly well suited to challenges that require the formation of new and optimistic relationships. This can be challenging in the patient safety context, given the traumatic impact of medical error and negative feelings harbored by both consumers and healthcare professionals who have experienced system failure. This challenge is met by capturing stories that foster images of success, even if they arise from failure. Past tragedies are respected and losses are acknowledged and appreciated, but the focus is on what these painful experiences have produced that is positive and future oriented. What was discovered during the experience? Where was innovation demonstrated? Who worked together and how did that happen? What was remedied?

AI methodology presumes that stories can be transformative in two ways. First, they have the potential to create a relatedness of experience that is then shaped by conversation among meeting participants into a path to future change as a community. Second, reflecting on the stories of others or responding to others’ questions about one’s own story can lead to internal reframing of what happened—a shift of perspective that helps individuals move forward in a process of healing or overcoming their own resistance to change. In other words, the AI process inspires change at both the group level and for the individuals participating in the group. The process enables consumers, providers, and policymakers to generate fresh perceptions of one another, thereby allowing for the revitalization of the social bond and a heightened collective will to act. In its broadest focus, it involves systematic recovery of what gives “life” to a living system when it is most alive, most effective, and most constructively capable.

## **B. Objectives and “Subjectives”**

In addition to the objectives detailed in Section I, success in an AI process is dependent on subjective factors, such as trust and a sense of goodwill and common purpose. Strategies to

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Cooperrider, D. L., Barrett, F., & Srivastva, S. (1995). Social Construction and Appreciative Inquiry: A Journey in Organizational Theory. In D. Hosking, P. Dachler, & K. Gergen (Eds.), *Management and Organization: Relational Alternatives to Individualism*, 157-200, Aldershot, UK: Avebury Press; Cooperrider, D.L & Whitney, D. (2000). A positive revolution in change: Appreciative inquiry. In D. L. Cooperrider, P. F. Sorensen Jr., D. Whitney, & T. F. Yaeger (Eds.), *Appreciative inquiry: Rethinking human organization toward a positive theory of change* (pp. 3-27). Champaign, IL: Stipes Publishing.

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achieve these “subjectives” during the Chicago Patient Safety Workshop included:

- Requiring participants to fill out an application which probes readiness for change;
- Short pre-workshop paired interviews between consumer participants and provider participants, during which some common ground is almost always identified;
- Development of rules of engagement emphasizing mutual respect;
- Building a consumers-only session into the front end of the agenda to provide an opportunity to tell personal stories, express anger or frustration, identify and address feelings of inadequacy due to lack of expertise, and coach participants on what to expect as the workshop proceeds; and
- Opening presentations by inspiring leaders from both the consumer side of our community (Dan Ford, Susan Sheridan) and the provider side (Chuck Watts).

### C. DMAIC

The Chicago Patient Safety Workshop built on work done previously by CAPS and WHO’s PFPS initiative, using the same AI-influenced methodology to reconfigure “who talks to who about what” and build invigorated communities across the globe that are dedicated to achieving patient safety goals. However, these earlier events focused more on articulating mission and goals and achieving the pledge of partnership between consumers, providers and policymakers. In the Chicago Patient Safety Workshop, we sought to push the frontier forward by producing action plans that could be implemented in the Chicago region.

Action planning was guided by a tool adapted from the Six Sigma DMAIC methodology.<sup>2</sup> DMAIC consists of the following five steps: (i) *Define* process improvement goals that are consistent with customer demands and the enterprise strategy; (ii) *Measure* key aspects of the current process and collect relevant data; (iii) *Analyze* the data to verify cause-and-effect relationships, determine what the relationships are, and ensure that all factors have been considered; (iv) *Improve* or optimize the process; and (v) *Control* to ensure that any deviations from target are corrected before they result in defects. In adapting the DMAIC tool, the action plan elements presented to Workshop participants were charged to:

1. Develop a clearly articulated goal statement: ***In order to improve patient safety in Chicago, when this workshop is over we will have accomplished this:***  
\_\_\_\_\_;
2. ***In 5 to 7 steps, outline the actions needed*** to achieve this goal;
3. Discuss ***who needs to be involved*** at each step and ***why each step is important***; and
4. Determine ***short- and long-term benchmarks*** for progress, by completing the statement: ***Success looks like*** \_\_\_\_\_.

Participants divided into six groups, each with facilitators, and were given a briefing about what the research showed “we know or don’t know” on the six selected topics and how to use the

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<sup>2</sup> See, De Feo, Joseph A.; Barnard, William (2005). *JURAN Institute's Six Sigma Breakthrough and Beyond - Quality Performance Breakthrough Methods*. New York, NY: McGraw-Hill Professional; Pyzdek (2003). *The Six Sigma Handbook: A Complete Guide for Green Belts, Black Belts and Managers at All Levels*. New York, NY: McGraw-Hill Professional. ISBN 0071410155.



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adapted DMAIC tool. Graduate student interns took notes and developed summaries of the small group discussions. All action planning discussion also was audio taped and transcribed.

The teams of participants moved from their “home” topics to the five other topics in succession. In each setting, the facilitators explained what the topic was and described the work that the “home” and rotating teams had completed so far to define goals and actions to advance the topic. This exercise was designed to engage participants as creative partners, perhaps prompting them to re-examine their own thoughts and belief structures. Another goal was to build shared ownership of all topics while advancing mutual respect as the teams continued to get to know each other. By the end of this segment, all participants had “touched” all six topics—either as a home topic or one that they visited. This process was meant to develop agreement about the future direction of the Chicago area patient safety community.

Each participant then returned to their “home” topic and team and asked to:

- Finalize the action plan for their home topic by:
  - Using the input of all rotations, crisply stating the goal or accomplishment that is targeted; and
  - In 5 to 7 steps, outlining the action plan to achieve this goal.
- Identify a timeline;
- Define who needs to be involved;
- Define short- and long-term benchmarks for progress; and
- Evaluate: How will we know we are successful? Can it be measured?

During the final session of the Chicago Workshop, each of the home teams presented their action plans in a plenary session.

#### **IV. Results (Principal Findings, Outcomes, Discussion, Conclusions, Significance, Implications)**

##### **Topic 1 Action Plan: Patient Reporting of Patient Safety Event**

###### **Goal statement:**

Establish in Chicago a mechanism for consumers to report medical errors that has these key attributes:

- Available in all healthcare settings, not just hospitals;
- The reports can be analyzed and mapped to the patient safety reporting/learning systems maintained in Chicago that providers report to;
- There is feedback to consumers who report about how their report is analyzed and used; and
- A subset of data analyzed thematically should be publicly reported.

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**Actions steps:**

1. Design a reporting system accessible by patients, families, and other consumers in Chicago that has the key attributes outlined above.
2. Establish a reporting mechanism that is web based and that includes an “800” number with a trained workforce (nurses, for example) who will accept reports by telephone in English and Spanish.
3. Use a classification system as the back end that allows consumer reports to be analyzed in the same way provider reports to PSOs (Patient Safety Organizations) are analyzed, so comparisons can be made.
4. Use the data reported for learning purposes, for example, to analyze risks and thematic factors in health system failures; complaints seeking accountability should be triaged elsewhere (for example, state agencies or The Joint Commission).
5. When themes are identified, corrective strategies are implemented.
6. Data are continually monitored to see if corrective strategies are making a difference in place.

**Who needs to be involved?**

- Healthcare organizations, although hospital-only reporting may be too circumscribed. National or regional reporting systems should be considered.
- Patients and families who will report.
- Patient and family educators.
- Trained report receivers, such as nurses, who can triage learning reports from patient satisfaction reports or complaints that need to be handled by state agencies, The Joint Commission, or others.
- Report analysts who are trained in using classification systems, such as the quality improvement staff of healthcare organizations.
- The Joint Commission and Illinois state agencies.
- Lawyers, to address questions of what is protected from discovery.

**Measures (what will success look like?)**

- Healthcare settings have processes in place to make sure patients know about the reporting system and are invited and encouraged to use it.
- Consumer reporters can see what has been done about the report they made. (It may work something like this: After a report is made, it gets sent to the place of care, and it becomes the responsibility of the healthcare facility to report back to the patient via email what has been done or to send a form email that states “we have received your complaint and added it to our data, and we are working toward a resolution of the problem.”)
- Majority view: The mechanism is used to improve healthcare outcomes, not for comparisons. (Minority view: Reports should be used for accountability as well.)
- Reports and their analyses are used by researchers and providers to study and cost effectiveness.
- Corrective strategies are recommended for implementation throughout Chicago.

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- Implementation of corrective strategies is monitored over time.
  - Over time, consumers are surveyed to determine if they know what the reporting system is for, and what it is *not* for.

## **Topic 2 Action Plan: Engaging Patients/Families in Quality Improvement & Patient Safety Policy Development**

### **Goals Statement:**

Establish in Chicago the perspective that these key outcomes are important:

- Patients should be “at the table” in all settings in which patient safety and quality policies are developed:
  - In healthcare organizations, for example: patient safety committees, complaint committees, adverse event review committees, infection control committees, clinical program leadership, quality and safety committees;
  - In the Chicago region, for example: patient/family advisory panels for the region, Chicago Patient Safety Forum, government, other policy groups.
- The region needs a model toolkit that addresses the roles of consumers and includes a recruitment process for engaging them;
- We need to drive fear out of our work and prepare to manage conflict; and
- It’s important that we evaluate what we have learned via a survey of perceptions, measures of each project’s success and the spread of good ideas.

### **Action steps:**

1. Learn how to select/prepare patients and staff to be effective as partners
2. Locate and recruit patients/families
  - Outreach through existing groups (e.g., MRSA, advocacy, patients, clinicians, advertisements, etc.)
  - Patients who have been harmed
  - Patients who have had excellent experiences
  - Screening
3. Develop formal orientation, training, support
  - Target: 2+ patients per committee (not just one)
4. Identify role models
  - IRB, IFCC, Australia
  - UK resources and research
5. Identify settings/committees/progressive process
  - Diversity
  - Include non-hospital settings
6. Collaboratively define the process of involving patients—the “job description”—broad involvement

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7. Prepare the healthcare teams
    - Prepare to manage conflict
    - Address expectations
    - Accountability—the committee has to come to some form of closure
    - Accountability—for follow up and action
  8. Work to drive out fear
  9. Share results, for example with WHO, CPSF, Northwestern Memorial Hospital website and other websites, through publications, by holding a conference in the Chicago area.

### **Who needs to be involved?**

- Consumers Advancing Patient Safety
- Chicago Patient Safety Forum
- The Joint Commission
- “Real” Patients and Families
  - Harmed patients
  - Patients/families who have had good experiences
  - Those with special expertise in systems, etc.
- Providers

### **Measures (what will success look like?)**

- Within a year, at least five hospitals in Chicago will have meaningful involvement on committees, including:
  - Patient safety committees
  - Infection control committees
  - Quality committees
  - Patient/family advisory committees
- There will be a toolkit for other organizations to start similar patient involvement programs
- Measurable evidence of meaningful improvement, including better safety outcomes after implementation of patient engagement strategies.
- Measures that identify barriers to engagement, for example, via stories and monitoring of continuous improvement.
- Measures of actual patient/consumer involvement, for example:
  - Actually have representatives on relevant committees
  - Orientation/training, expenses, time
  - Principles of engagement—partnership
  - Measure the engagement by asking them!
  - Pre-/post-involvement measures?
  - Evaluate the “spread” of good ideas

**Table 2**  
**Action Plan Goals Side-by-Side**

<b>Selected Topic</b>	<b>Action Plan Goals</b>
<b>1. Patient Reporting of Medical Error</b>	<p><b>Goal:</b> <i>Establish in Chicago a mechanism for consumers to report medical errors that has these key attributes:</i></p> <ul style="list-style-type: none"> <li>• <i>Available in all healthcare settings, not just hospitals</i></li> <li>• <i>The reports can be analyzed and mapped to patient safety reporting/learning systems maintained in Chicago that providers report to;</i></li> <li>• <i>There is feedback to consumers who report about how their report is analyzed and used.</i></li> </ul> <p><i>A subset of data analyzed thematically should be publicly reported.</i></p>
<b>2: Engaging Patients/Families in QI &amp; Patient Safety</b>	<p><b>Goal :</b> <i>Establish in Chicago the perspective that these key outcomes are important:</i></p> <ul style="list-style-type: none"> <li>• <i>Patients should be “at the table” for in all settings where patient safety and quality policies are developed:</i> <ul style="list-style-type: none"> <li>○ <i>In healthcare organizations, for example: patient safety committees, complaint committees, adverse event review committees, infection control committees, clinical program leadership, quality and safety committees;</i></li> <li>○ <i>In the Chicago region, for example: patient/family advisory panels for the region, Chicago Patient Safety Forum, government, other policy groups.</i></li> </ul> </li> <li>• <i>The region needs a model toolkit, that addresses roles of consumers and a recruitment process for engaging them;</i></li> <li>• <i>We need to drive fear out of our work, and prepare to manage conflict;</i></li> </ul> <p><i>It’s important that we evaluate what we have learned, via a survey of perceptions, measures of each project’s success and the spread of good ideas.</i></p>
<b>3: Patient and Family Involvement in their Own Care</b>	<p><b>Goal:</b> <i>To ensure complete and accurate medical info for every patient in Chicago, through shared goals and responsibility of the care team and patients across the continuum of care, where patients are:</i></p> <ul style="list-style-type: none"> <li>• <i>Valued;</i></li> <li>• <i>Listened to AND understood;</i></li> <li>• <i>An integral and equal part of the team;</i></li> <li>• <i>Allowed access to advocates (interns, relatives); and</i></li> </ul> <p><i>Communicated with especially about medications and procedures</i></p>
<b>4: Effective Patient/Clinician Communication</b>	<p><b>Goal:</b> <i>Develop a team-oriented, patient-centric, reciprocal communications model that is transparent, truthful, respectful, reliable, systemic, and accountable (aka Optimal Tools and Strategies for Patient Clinician Communications)</i></p>
<b>5: Preventing Error through Patient/Provider Partnership</b>	<p><b>Goal 1:</b> <i>Ensure complete and accurate medical information for every patient in Chicago (3-5 years)</i>  <b>Goal 2:</b> <i>Provide information for patients to improve safety (6-12 months)</i>  <b>Goal 3:</b> <i>Curriculum for education for Chicago area on the principles and practices for safety (2-4 years)</i>  <b>Goal 4:</b> <i>Determine healthcare processes for which standardization would be appropriate (1.5 years+)</i>  <b>Goal 5:</b> <i>Create a mechanism for involving the patients in error prevention – refer to other groups (Patient Involvement in Policy, Patient Involvement in Own Care, Communication Practices)</i></p>
<b>6: Disclosure, RCA, Learning &amp; Emotional Support</b>	<p><b>Goal:</b> <i>To establish a meaningful best practice for response after error throughout Metropolitan Chicago for responding to an adverse event, using evidence-based research</i></p>

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## **Topic 3 Action Plan: Patient/Family Involvement in Their Own Care, Driving the Plan of Care, and Transitions in Care**

### **Goals Statement:**

The goal is to ensure complete and accurate medical information for every patient in Chicago, through shared goals and responsibility of the care team and patients across the continuum of care, where patients are:

- Valued;
- Listened to AND understood;
- An integral and equal part of the team;
- Allowed access to advocates (interns, relatives); and
- Communicated with especially about medications and procedures.

### **Action steps:**

1. Establish a patient-centered personal health record.
2. Provide information to patients to improve safety, with the information developed to meet their needs and tested before and after implementation.
3. Develop a best practices demonstration project among Chicago providers:
  - a. Find the best practices;
  - b. Implement the best practices;
  - c. Create focus groups to guide implementation; and
  - d. Work together to support multidisciplinary adoption in all levels of care.
4. Develop an educational curriculum for practitioners (MD, PharmD, RN).
5. Standardize core healthcare practices and involve patients in planning and implementing standardization.

### **Who needs to be involved?**

An identified team needs to be formed, possibly with an executive sponsor to ensure delivery and follow through.

### **Measures (what will success look like?)**

- The patient is respected as a partner and a teacher.
- Care team and patient share responsibility for goals and the continuum of care.
- Patients are invited to use care partners/advocates.
- Clinicians and patient use teach-back techniques.
- Evaluation: patient/staff satisfaction, better outcomes, decreased harm/complications, fewer errors.
- Treatment outcomes are measured continuously after implementation.

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## Topic 4 Action Plan: Techniques for Effective Patient Clinician Communication

### Goal Statement:

Develop a team-oriented, patient-centric, reciprocal communications model that is transparent, truthful, respectful, reliable, systemic, and accountable (aka *Optimal Tools and Strategies for Patient Clinician Communications*).

### Action steps:

Our Key Strategies to achieve the goal are:

1. Build on what current knowledge exists - don't reinvent the wheel; but make sure the view is balanced and really reflects the patients' needs.
2. Clarify what the optimal patient experience looks like in each clinical setting from a patient's perspective – the doctor's office, the outpatient clinic, the inpatient experience, and on discharge – and adapt the tool to each setting.
3. Define the tools: common rules of communication engagement between patient and caregivers that are likely to be effective for the patient – the do's and don'ts – based on courtesy, respect, mutual listening, and using simple, nonclinical language; create an understanding of those communication styles that are *not* productive among clinicians.
  - a. Develop or adopt an existing clinician/patient communication intro/framework (using a tool like SBAR, SEGUE) to shape the dialogue between patient and physician and to address the issue of communication; all care team members need to work together to address this issue.
  - b. Develop or adopt an existing clinician/patient glossary so that language becomes less of an obstacle and everyone is on the same page.
  - c. Develop/adopt an existing medication FAQ so that there is a standard way to approach the issue of existing medications and to ensure there is a process to capture these at the point of care.
  - d. Develop or adopt an existing 'trigger phase' to allow patients to challenge in a nonconfrontational manner – the patient needs to feel comfortable enough to do this and the physician needs not to take this personally.
  - e. Consider using visual multimedia (dvds, web, print) to reinforce these messages effectively – using effective adult learning practices to bring them to life.
  - f. Identify opportunities/contexts in each clinical setting to utilize a patient advocate – when and where does it belong, how does this role get staffed, voluntary vs. caregiver role, who does it, how is it paid for.
4. Pilot the model in multiple Chicago inpatient and outpatient settings using these *Optimal Tools and Strategies For Communications Between Patients and Caregivers* for validation, re-alignment and impact on patient and caregiver satisfaction.
5. Measurement is key – primarily in pre and post patient satisfaction studies, likelihood to recommend, etc.

### Who needs to be involved?

- Focused groups of clinicians and patients
- Marketing professionals
- Patient advocates

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**Measures (what will success look like?)**

- Tools are developed and distributed to clinicians and patients
- Patients show up with advocates more frequently
- Inpatient pilot study: model is being used, and patient feedback is positive (measured by exit interviews or surveys)
- Patients are asking questions about their medication (measured by interviews with staff or surveys of patients)
- Trigger phase use is measured by staff interviews or patient surveys
- Tools are well used in Chicago and adopted by communities beyond Chicago
- Pre and post benchmark study of patient behavior when they use advocates

**Topic 5 Action Plan: Preventing Error through Patient/Provider Partnership****Goal Statements:**

This working group developed goals, each with an action plan, and incorporated a fifth, developed by other small groups. (See table on following page for summary.)

1. Ensure complete, accessible, and accurate medical information for every patient in Chicago
2. Provide information for patients to improve safety
3. Implement standardized curriculum/education for Chicago-area healthcare providers on principles and practices for safety
4. Determine healthcare processes for which standardization would be appropriate and begin to implement them
5. Create a mechanism for involving patients in error prevention (adopted from groups 2 (Patient Engagement in Policy), 3 (Patient Involvement in their own care), and 4 (Effective communication practices))

**Who needs to be involved?**

- Physicians
- Nurses
- Pharmacists
- Insurers
- Companies
- Patients
- Families
- Organizations involved in curriculum development, including American Association of Medical Colleges (AAMC), American Association of Colleges of Pharmacy (AACP), nursing schools



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## Action Steps and Measures (what will success look like?)

These Action Steps and Measures numerically track the goals and action steps above:

1. Ensure complete, accessible and accurate medical information for every patient in Chicago (3-5 years).

Action steps:

- 1.1 Determine what information ought to be included
  - 1.1.1 Measure (short term): Multidisciplinary committee is developed
  - 1.1.2 Measure (long term): Repository for patients is fully operational
- 1.2 Determine the sponsor for this type of product (web-based or ?)
  - 1.2.1 Measure (short term): Identify a potential sponsor
  - 1.2.2 Measure (long term): Secure a deal
- 1.3 Implementation (books on wheels, partner with local companies, libraries, etc.)
  - 1.3.1 Measure (short term): Roll out the program, where feasible, through companies and patient groups
  - 1.3.2 Measure (long term): 30% of population reached in 5 years

2. Provide information for patients to improve safety.

Action steps:

- 2.1 Define what information is to be provided
  - 2.1.1 Measure (short term): Organize the committee
  - 2.1.2 Measure (long term): Have the definitions established
- 2.2 Delivery of information (DVDs, videos, PSAs)
  - 2.2.1 Measure (short term): Delivery of information vehicles
  - 2.2.2 Measure (long term): Actual implementation

3. Develop curriculum from education for Chicago area on principles and practices for safety.

Action steps:

- 3.1 Develop a committee
  - 3.1.1 Measure (short term): Develop a committee
  - 3.1.2 Measure (long term): Charge a group to develop the curriculum
- 3.2 Develop the curriculum
  - 3.2.1 Measure (short term): Develop the curriculum
  - 3.2.2 Measure (long term): Implement the curriculum in schools

4. Determine healthcare processes for which standardization would be appropriate.

Action steps:

- 4.1 Develop a forum
  - 4.1.1 Measure (short term): Develop the forum
  - 4.1.2 Measure (long term): Establish criteria

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- 4.2 Set definitions and benchmarks
    - 4.2.1 Measure (short term): Set up first set of definitions and benchmarks
    - 4.2.2 Measure (long term): Doing this continuously

5. [Goal 5 referred to other groups – no action steps or measures specified here.]

## **Topic 6 Action Plan: Disclosure, Root Cause Analysis, Learning, and Emotional Support**

### **Goal statement:**

The goal is to establish a meaningful best practice for response after error throughout metropolitan Chicago for responding to an adverse event, using evidence-based research.

### **Action steps:**

1. Standardize the process.
2. Drive implementation of the process by getting buy-in from all key stakeholders.
3. Regulate the process through a central “go-to” group established with resources to aid implementation.
4. Provide training to clinicians on disclosure and support with coaching.
5. Establish a cadre of counselors available to patients, family members, and providers who are grieving.
6. Develop a toolkit that stays free of jargon and buzzwords.
7. Pilot the program before extensive roll out.
8. Define an end point for implementation and use evaluation measures to assess short- and long-term success; suggested: 80% of hospitals in Chicago in 5 years have process in place.

### **Who needs to be involved?**

A governing board composed of representatives from the following organizations and stakeholder groups (among others):

- Consumers Advancing Patient Safety
- Chicago Patient Safety Forum
- Illinois Hospital Association\
- Metropolitan Chicago Health Council
- Midwest Business Group on Health
- Hospital workers unions
- Illinois Trial Lawyers Association
- Medical societies
- Medical and law school deans
- Illinois Department of Public Health
- CHARMS

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### **Measures (what will success look like?)**

- Key allies are engaged, including Chicago Patient Safety Foundation, Illinois Hospital Association, Metropolitan Chicago Health Council
- Number of organizational participants is a measure, including Illinois Trial Lawyers Association, hospital worker's unions, medical societies, CMS, deans of medical & law schools, CHARMS, Midwest Business Group on Health, Department of Public Health, among others
- Reports from various types of hospitals – academic med centers & other communities
- Fully established and operational governing board that is funded
- Best practices for the Chicago community are identified
- A “full change” package of tools is developed and endorsed
- Publication of an article & presentation at an international patient safety meeting
- Toolkits are developed, continually monitored, and adapted as the practices change
- Patient surveys
- Hospital standards are in place, including perhaps a significant penalty (up to \$50K?) if an event is not disclosed and/or a report to the National Practitioner Data Bank (However, there should also be a “just culture” or these penalties will not be seen to be fair. Just culture = does not tolerate reckless disregard for the consequences of an action.)
- Nursing or social work can help with evaluation through interviews.

### **Action Plan Synergies**

Across the six topics, two platforms for change work emerged again and again.

- First, that healthcare organizations in Chicago “open the doors” and integrate consumers into their existing safety and quality committees, processes and other infrastructure
- Second, that healthcare organizations in Chicago engage in collaborative projects to implement change initiatives and measure progress.

A notable contribution made by Workshop participants of African ancestry was that they raised the theme of racial discrimination in healthcare and its impact on the safety of minority patients.

### **Other Workshop Products**

In addition to action plans, 20 videotaped interviews of workshop participants were produced that will be thematically analyzed using interpretive research methodology. Papers will be submitted to peer-reviewed publications on both the action planning process and the interpretive research project. Articles and stories will be disseminated via non-peer-reviewed publications as well, including those targeted to consumer audiences.

A final product of the workshop is the following Challenge to the Chicago community.

## **Our Challenge to Chicago**

We were privileged to be engaged in developing the Chicago Patient Safety Workshop in June 2008. We were struck by the energy and commitment of everyone who attended. As patients, family members and healthcare professionals shared their stories of loss suffered as a result of medical error, they expressed a great deal of pain and anguish, along with much enthusiasm and hope.

Our hope now is that the workshop was not just a momentary acknowledgment of the human toll of medical error but the launch of a new community of committed change agents in Chicago. Workshop participants want to make a difference. They demand and volunteer to help build a healthcare delivery system that is:

- Rigorously well designed
- Scientifically based
- Reliable
- Respectful
- Dignified
- Honest and trustworthy
- Open and transparent
- Collaborative
- Fair and nondiscriminatory
- Caring and compassionate

It is our wish that the proceedings published here will advance that goal as soon as possible, in the Chicago area and beyond. We seek to inspire transformation here as a model for other communities. Chicago—city of broad shoulders, the city that “makes no small plans”—and its metropolitan area can make this vision a reality.

The six work plans developed during the Chicago Patient Safety Workshop *can* be implemented, and indeed they must be. We, the Steering Committee, stand ready to work with dedicated people and organizations who want to take on this challenge.

Accomplishing this goal will require tremendous leadership from the provider and patient/family/consumer communities. We thank the representatives of the Chicago Patient Safety Forum and the Illinois Department of Public Health, in particular, for their interest in this work. Now we must act, and together move the workshop plans forward.



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