

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

AHRQ

The National Action Alliance to Advance Patient Safety Summer Webinar Series

Involving Patients and Families in Safety

July 25, 2023

2:00-3:00 PM ET

Special Guest Speakers

Sue Sheridan, MIM, MBA, DHL
Founding Member,
Patients For Patient Safety US

Jennifer Lundblad, PhD, MBA
President and CEO
Stratis Health

Lisa Juliar,
Director of Patient and Family Engagement
Minnesota Alliance for Patient Safety

Today's Call is Being Recorded

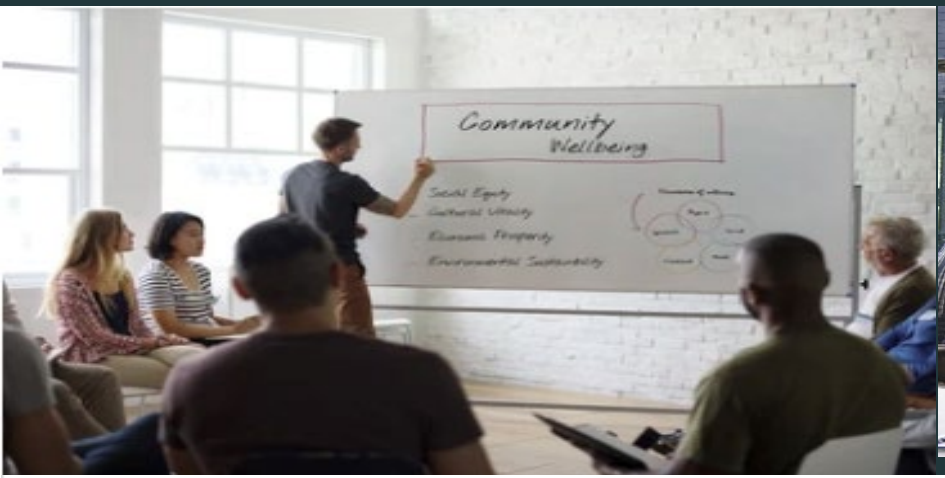
Questions to Run On

- What are the foundational elements of including patients and families in safety?
- What new opportunities exist to engage patients and families to make care safer, moving from advisory roles to inviting them to be part of codesign, building trusted relationships, and leading to action?
- How do we go about implementing patient and family engagement?

People Powered Patient Safety:

Democratizing patient safety for safer care

Sue Sheridan
Co-Founder, Patients for Patient Safety (PFPS) US
www.pfps.us



"Patient Engagement and Empowerment is Perhaps the Most Powerful Tool to Improve Patient Safety"

WHO Global Patient Safety Action Plan 2021-2022

WHO PATIENT AND FAMILY ENGAGEMENT STRATEGY

Engage patients, families, and civil society organizations in co-development of policies, plans, strategies, programs and guidelines

Learn from the experiences of patients and families exposed to unsafe care to develop more equitable, patient-centered solutions

Build the capacity of patient advocates and champions in patient safety

Establish the principle and practice of openness and transparency including disclosure to patients and families

Provide information and education to patients and families

PATIENT ENGAGEMENT AND EMPOWERMENT
AN EVOLVING LANDSCAPE

Patients and Families engage

During the Patient Journey

with health care professionals, health care facilities and other stakeholders

Patients, families and communities engage in

Co-producing Patient Safety Improvement Initiatives

with government, health care facilities and other stakeholders

Patients, families and communities engage in

Advocacy and Awareness Raising

with community, patient and civil society organizations

Patients and Families Engage in the:
Patient Journey

With Health Workers
participating in:

- Joint decision making
- Informed consent
- Self-advocacy
- Accessing medical records
- Escalation of care
- Patient education on safety
- Medication review

With Health Care Facilities
sharing and reporting unsafe care:

- Complaints and grievances
- Causal analysis (RCA)
- Patient safety reporting systems
- Patient reported experiences in safety surveys
- HCAHPS
- PROs
- Storytelling to boards and leadership

With Other Stakeholders
sharing and reporting to:

- National and state regulatory bodies
- National patient safety incident reporting systems
- Accreditors
- Licensing bodies
- Patient and civil society organizations

PATIENTS, FAMILIES, AND COMMUNITIES ENGAGE IN: CO-PRODUCING PATIENT SAFETY IMPROVEMENT INITIATIVES

Patient safety policies, plans, strategies, programs and guidelines

Patient safety research and QI programs

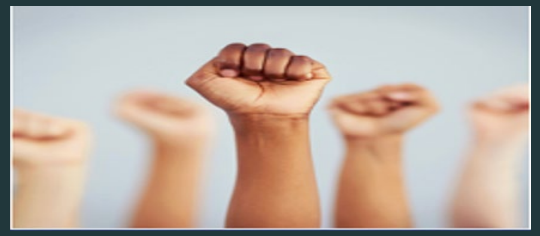
Mechanisms to learn from experiences of patients and families

Medical professions education - “Patients as educators”

Patient education materials and information

Policies on disclosure, transparency, patient access to medical records and patient activated rapid response

Patients and Families Engage in Advocacy and Awareness Raising with Community, Patient and Civil Society Organizations and Other Stakeholders



Advocate

Patient safety as a national priority

Mandatory transparency

Inclusion of diverse patients in all patient safety improvement efforts

Raise Awareness

Harm from unsafe care

Patient safety reporting systems

The right to access medical records and informed consent

Organize

Recruit, build capacity and mobilize diverse patient safety advocates to be engaged in patient safety improvement

Develop

Develop and disseminate patient information and information on patient safety

Collect

Collect and curate patient stories/data of harm from unsafe care

ACTIONS YOU CAN TAKE TO ENGAGE AND EMPOWER PATIENTS AND FAMILIES

Secure	**Secure strong commitment from leadership**
Conduct	**Conduct a landscape assessment of PFE in your organization**
Establish	**Establish policies, strategies, budgets and structures that require and support PFE that is diverse and inclusive of the populations served**
Develop	**Develop alliances with community, patient and disease-based organizations**
Utilize	**Utilize effective engagement methods, capacity building, and principles to empower patients**
Design	**Design and implement mechanisms that effectively learn from patient experiences**
Create	**Create processes to monitor and evaluate the effectiveness of patient empowerment**

“It’s a question of will”

What is your #1 takeaway from what you just heard?

National Action Alliance to Advance Patient Safety

Jennifer P. Lundblad, PhD, MBA
President and CEO

July 25, 2023

Stratis Health

- Independent, nonprofit organization founded in 1971
- Mission: Lead collaboration and innovation to improve health
- Core services: Strengthening Organizational Capacity, Redesigning Care Delivery, Strengthening Connections Between Health Care and Community
  - Work at the intersection of research, policy, and practice
- Learn more: Stratis Health - We Make Lives Better!

Stratis Health and Patient Safety: A Sampling

Project	About the project	What our work focuses on
Adverse Health Events	A longstanding Minnesota project in partnership with MDH and with MN Hospital Association	Incident reporting, root cause analysis, health system coaching
Comprehensive Unit Based Safety Program (CUSP)	A national program in partnership with NORC and funded by AHRQ	Build a team and safety culture in hospitals and nursing homes which addresses safety -- antibiotic stewardship, infection prevention, telehealth
Adverse Drug Events	Part of our Medicare Quality Innovation Network-Quality Improvement Organization program serving Minnesota, Michigan, and Wisconsin funded by CMS	Appropriate prescribing
Opioid Prescribing Improvement Program (OPIP)	A Minnesota project part of our growing portfolio of opioids initiatives	Appropriate prescribing
Partnership to Advance Tribal Health (PATH)	A national program in partnership with Comagine Health and funded by CMS focused on the nation's 24 Indian Health Services hospitals	Build and sustain a Just Culture for IHS hospitals

MAPS: Brief Background

- MAPS was established as Minnesota's patient safety coalition in 2000, in the wake of "To Err is Human"
- Active as a coalition for 15 years
- Established as its own 501c3 nonprofit org in 2015
- Expanded from primarily hospital focused to "Safe Care Everywhere"

Stratis Health and MAPS

- Stratis Health has been a leader in MAPS since inception and was a founding member when MAPS incorporated
- Mission-aligned and collaborative safety work over many years
- MAPS sought an affiliation with a larger organization in 2016, Stratis Health was top choice
- MAPS became a Stratis Health subsidiary in 2017

Creatively Co-creating Safe Care with Patient and Families

Lisa Juliar, Director of Patient and Family Engagement

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Safe Care Everywhere:
Partnering and Co-designing with patients and families is the answer:

INVITE THEM IN

INCLUDE THEM THROUGHOUT

INVEST IN THEIR IDEAS

INCREASE THEIR INFLUENCE

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MAPS work:

- Statewide Network of Patients and Families
- Statewide Network of Safety Leaders
- Advocate and promote **in-person caregivers**
- **Adverse Event Reporting system**
- **Diagnostic Error Project**
- Community Advisory Boards in Assisted Living
- Create **patient story database** and formalize **storytelling coaching and training**
- **Provide opportunities for networking and brainstorming**

Statewide Network of Patients and Families

- Established during Covid when PFACS were not meeting
- “What is missing in the Covid discussions that could impact safety?”
- Quickly and unanimously landed on creating a document outlining the need for an in-person care partner to ensure safe care
- Met weekly for 6 months
- Began each meeting with a story
- MAPS In Person Care Partner Updated 08_24_2020.pdf (mnpatientsafety.org)
- Endorsed by multiple healthcare organizations in MN

In-person Care Partner

- Most people who receive care are in a vulnerable state
- This is the best way to encourage patient and family engagement at the point of care and to establish a trusting relationship
- Extra set of eyes and ears: additional layer of safety
- Assist with cares
- Allows care partner to understand and implement care upon discharge

Statewide Network of Patients and Families

- Partners were so engaged, we continue to meet monthly
- 3 workgroups meet 1-3x/mo
- Partnered with
    1. Minnesota Department of Health,
    2. Minnesota Medical Association,
    3. Shared Decision-Making Collaborative
    4. MAPS conference planning
- Work continues to expand

Diagnostic Error project

- To decrease *diagnostic error* by *co-designing* the process of diagnostic test management in the rural health care system.
- The study will identify the optimal team (patients, families, clinicians, and health care systems) and their roles in managing diagnostic test follow-up in high-risk transitions of care, focusing on discharge from a rural emergency department

Co-design

Use existing structures whenever possible:

- Patient Family Advisory Council
- Food Farmacy
- Occupational Health Partnership
- Grievances
- Errors

Be creative!

- Surveys
- Quilting club
- Rotary club

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Best Practices

- Utilize patient partners from the beginning to the end
- Aim for equal numbers of staff and partners in meetings
- Strive for diversity: patient partners should represent your community
- Look for the stories and be willing to use them for improvement
- Be real- no need to be “non-medical” with patients in the room

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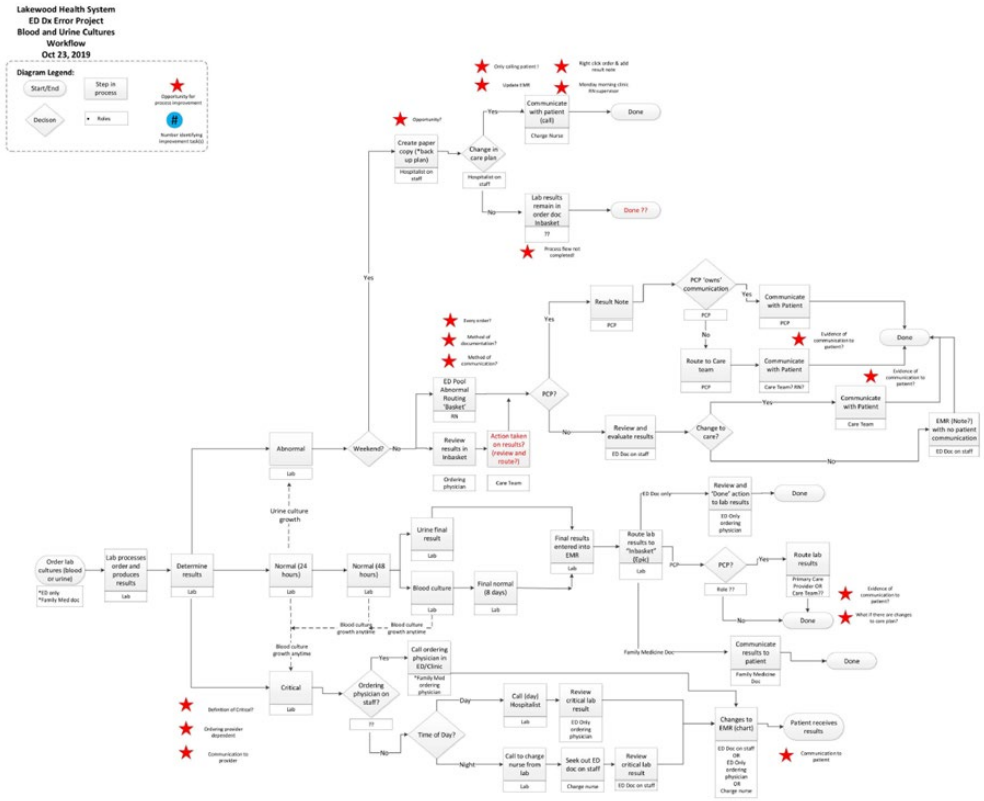
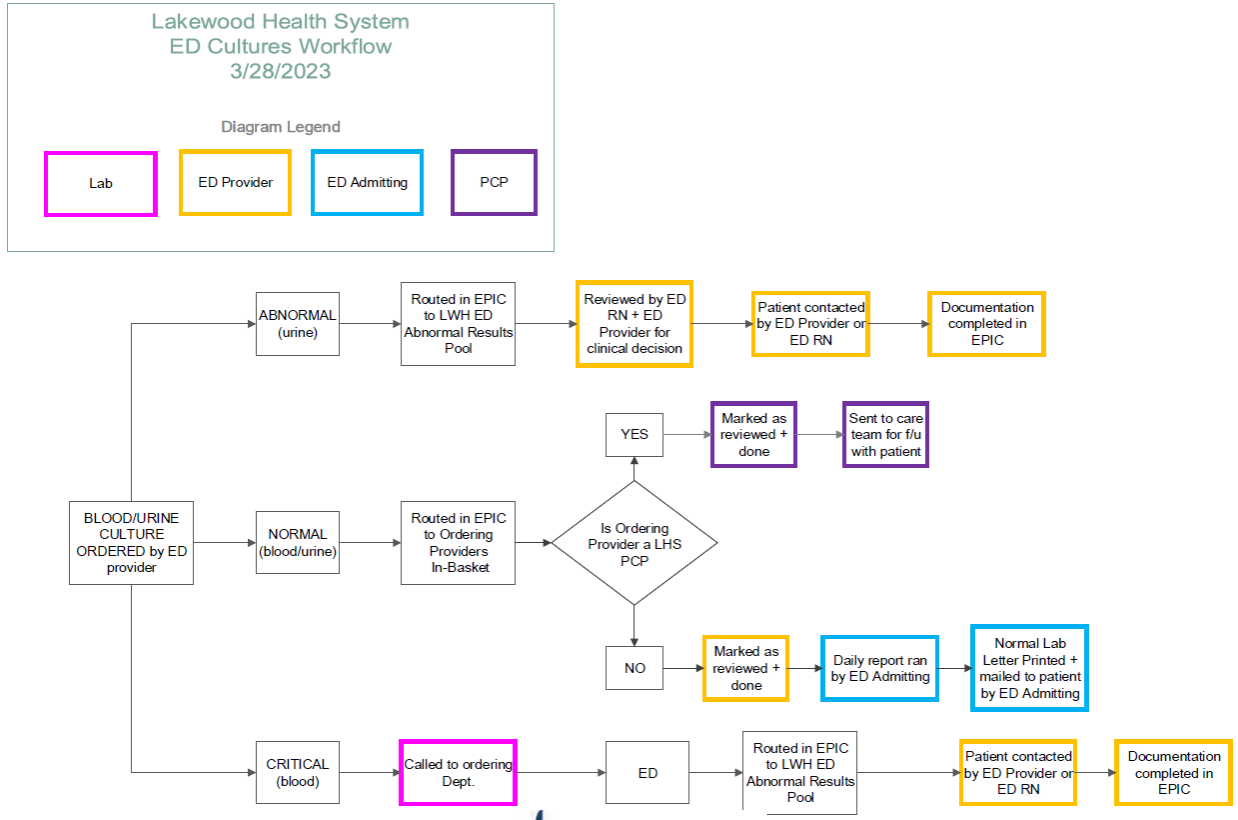
Future State: Cultures





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What we learned:

Most hospital follow-up systems in health care systems are **designed around** the **providers**, **not** the **patients**. This contributes to the follow-up system failures and highlights the importance of **co-designing** a **follow-up system** with **patients** and **community members**.

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Feedback:

- “We turned a disaster into something I can understand.” – Leader
- “Having time and the key people in the room was key”- staff manager
- “Fueling collaboration in this way is something we need to do more of”- Administration
- “As an outsider, it was great to see that nobody was embedded into what is currently”-Researcher/Doctor
- “Staff did a phenomenal job advocating for other teams that weren’t in the room”- Leader
- “This is one of the best process mapping processes I have been part of. I loved the collaboration and honesty. It was facilitated fabulously”- Patient Partner
- “This totally filled my bucket. Patients provided us with incredible input- it is so important to have them in the room. Each patient added value” Administration
- “My favorite part was to see the messy cultures chart transform into an actual flow chart that was easy to follow”- Patient Partner
- “This can be a model for future work”- Doctor

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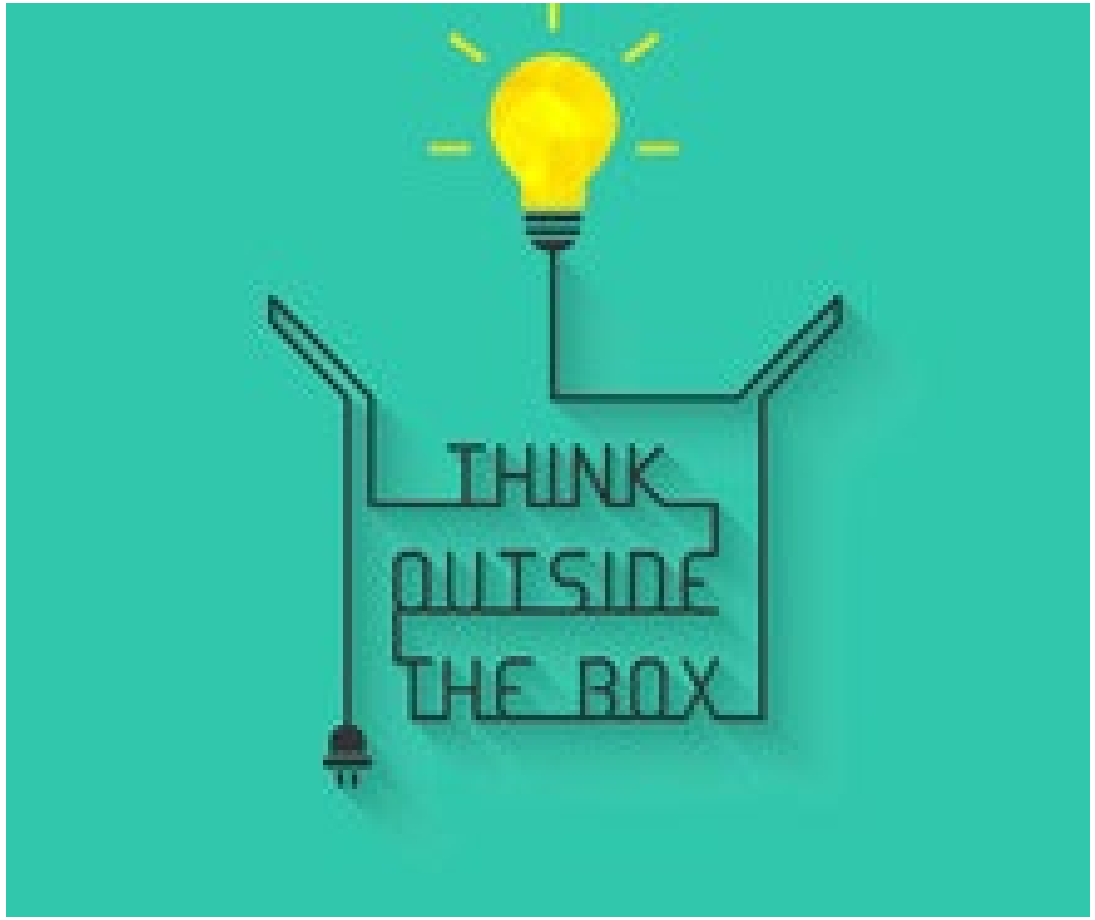
Community Advisory Boards

- Staff intentionally invited residents and families to partner with them through a new venue- CAB
- The organizations included the residents and family in the planning, the meetings and the follow-ups
- They found ways to invest in the resident's ideas- even if the idea was small
- As they found success, they increased the resident's role

The possibilities for partnership are endless!



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Processing Together

What are some of the benefits of engaging patients and families in safety?

What was one NEW thing you learned about how to meaningfully engage patients and families in safety?

AHRQ Resources and Tools

Improving Healthcare Safety by Engaging Patients and Families

Overview

Research has shown that involving patients, as well as their families and caregivers, in the planning, delivery, and evaluation of their healthcare can improve safety and quality. Since 2000, AHRQ has supported 53 patient safety projects related to increasing patient and family engagement. This publication summarizes AHRQ's investments in this promising pathway toward better care, including examples of project findings and products, collective outputs, and impacts of this work. Details about each AHRQ-supported project are available in the Appendix.

Scope of AHRQ Investments

53 projects

163 publications*

13,250 citations*

AHRQ-Funded Patient Safety Project Highlights

Agency for Healthcare Research and Quality

Search all AHRQ sites

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SHARE:

Patient Safety

- Patient Safety Research Summaries
- Patient Safety

Engaging Patients and Families in Their Health Care

Other

- Ques
- 20 Ti

The Action Alliance Summer Webinar Series

Next Summer Webinar…

August 22, 2-3 p.m. ET: Engaging Boards and Executive Leadership in Safety (sponsored by the Centers for Medicare and Medicaid Services)

Registration is OPEN: The National Action Alliance To Advance Patient Safety | Agency for Healthcare Research and Quality (ahrq.gov)