The Intersection of Quality, Safety, and Patient and Family Engagement

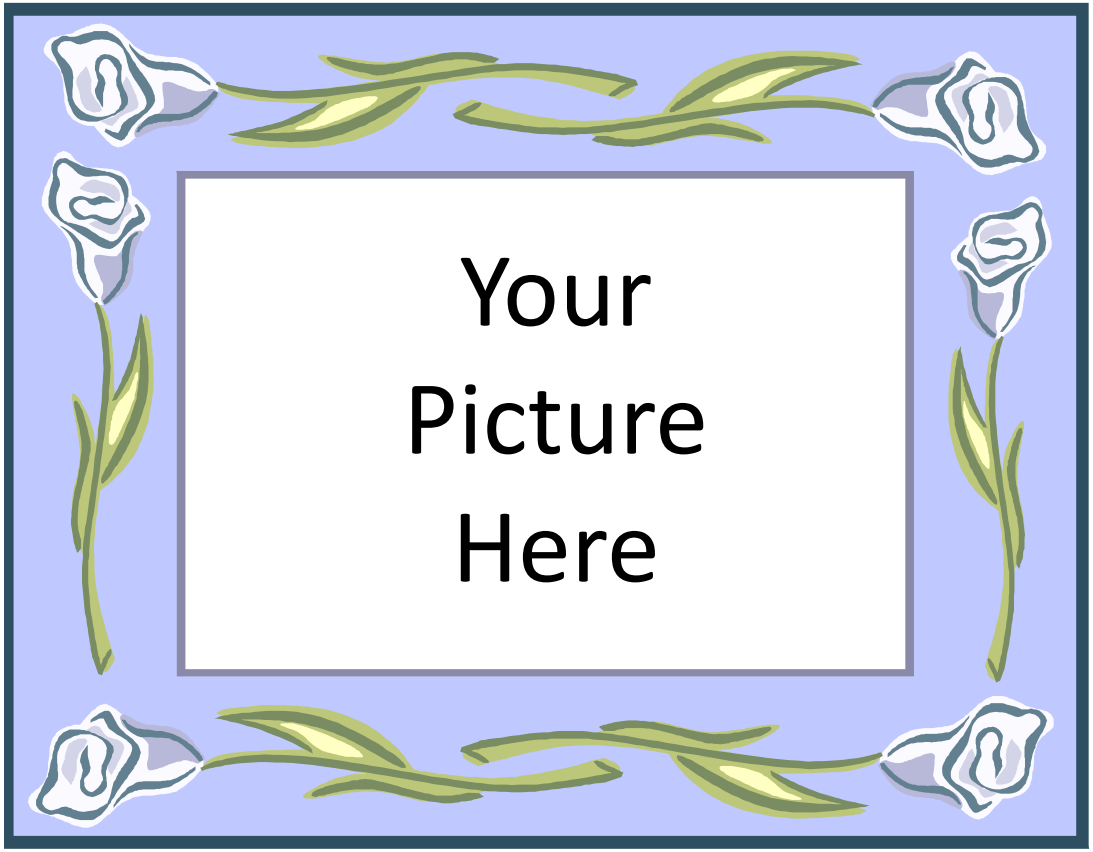
Safety Across the Board and Patient and Family Engagement

-Lisa Morrise, Co-Lead PFE Affinity Group, National Partnership for Patients

Why I Advocate for Quality & Safety

Who is your “one.”

- Keep it real:

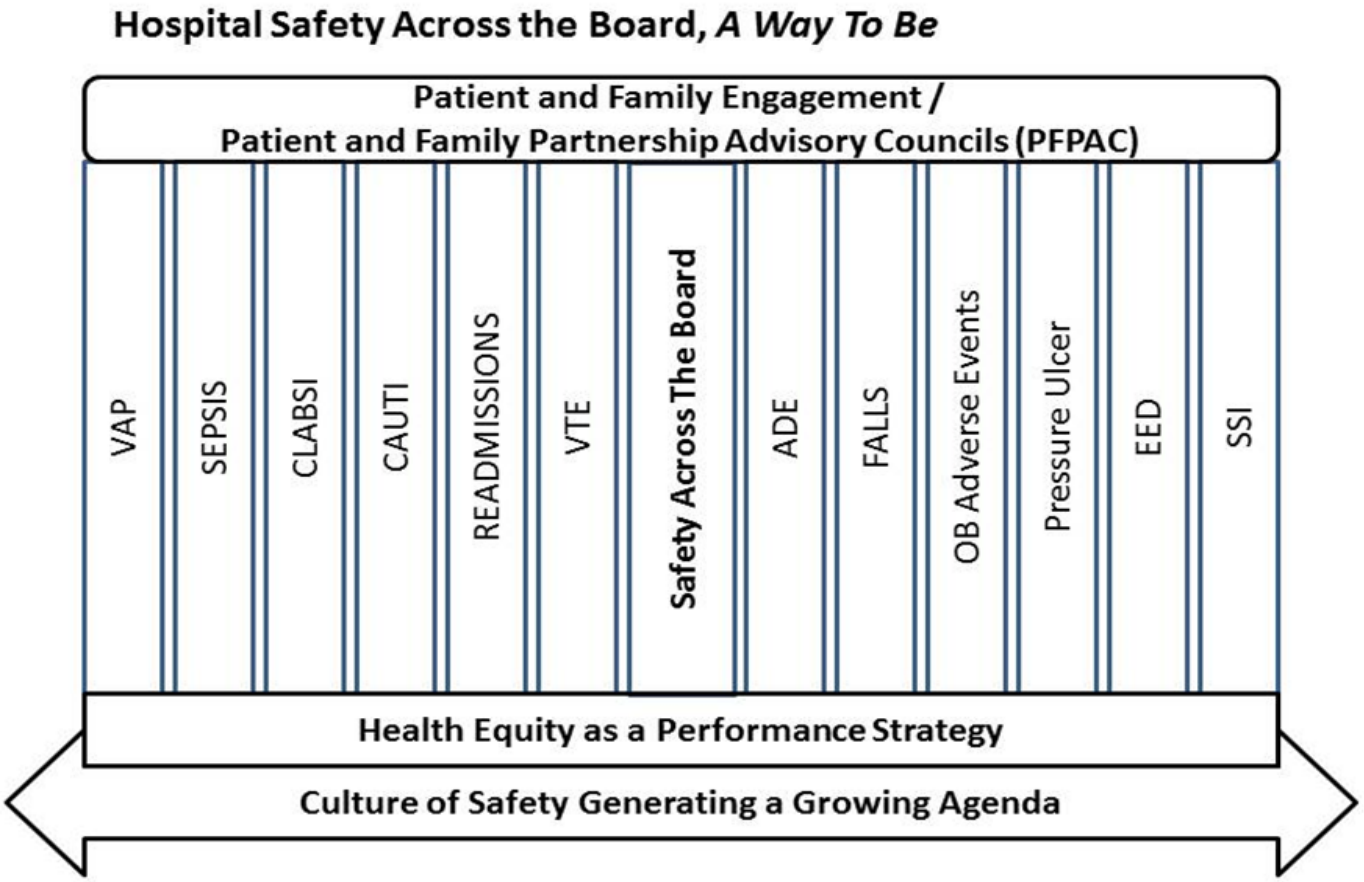


What is Safety Across the Board? (SAB)

Four Defining Principles

- Adoption of a ***culture of safety***, where safety is a strategic imperative and is interwoven into the fabric of all organizational priorities
- ***Composite scoring*** and reporting that includes all known forms of harm
- Inclusion of ***patient and family engagement*** throughout the health services continuum. Also inclusion and diversity as core principles of Patient and Family Partnership Councils development
- ***Health equity*** as a performance strategy. Hospitals operationalize strategies that identify and eliminate disparities in safety outcomes

What is Safety Across the Board? (SAB)



SAB Composite Scoring

"No Patient wants a hospital that is good at only preventing 3 harms."

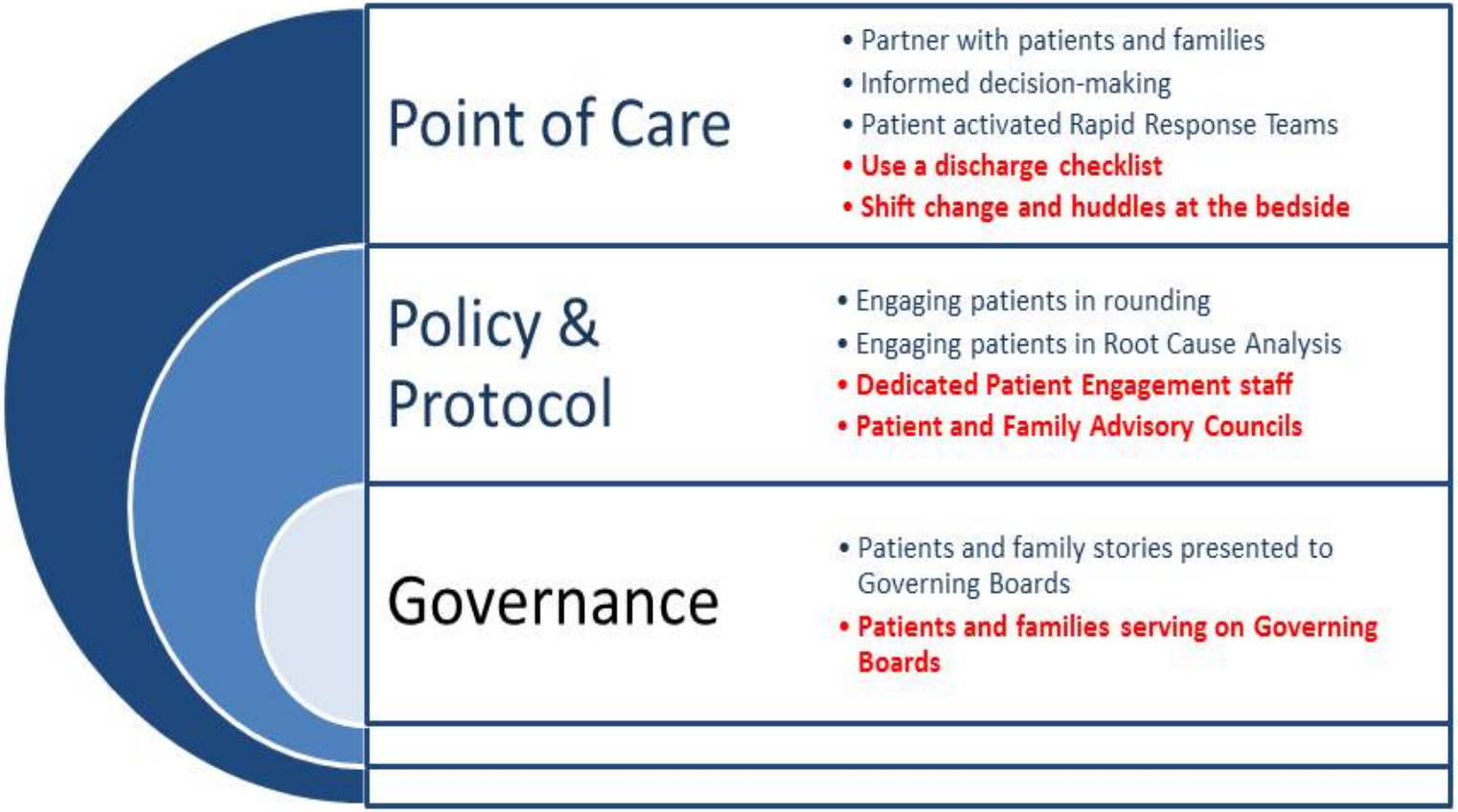
1. Adverse Drug Events (ADE)
2. Catheter-Associated Urinary Tract Infections (CAUTI)
3. Central Line-Associated Bloodstream Infections (CLABSI)
4. Early Elective Deliveries (EED)
5. Injuries from Falls
6. Obstetrical Adverse Events (OB-AE)
7. Pressure Ulcers
8. Surgical Site Infections (SSI)
9. Venous Thromboembolism (VTE)
10. Ventilator-Associated Pneumonia (VAP)
11. 30-Day All-Cause Readmissions
12. Other Areas of Harm as Identified

SAB Culture of Safety

"The safety of culture of an organization is the product of individual and group values, attitudes, perceptions, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of an organization's health and safety management. Organizations with a positive safety culture are characterized by communication founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures."

Quality Safe Health Care, 2003

Patient & Family Engagement
PfP Campaign Metrics



What is Patient Engagement?

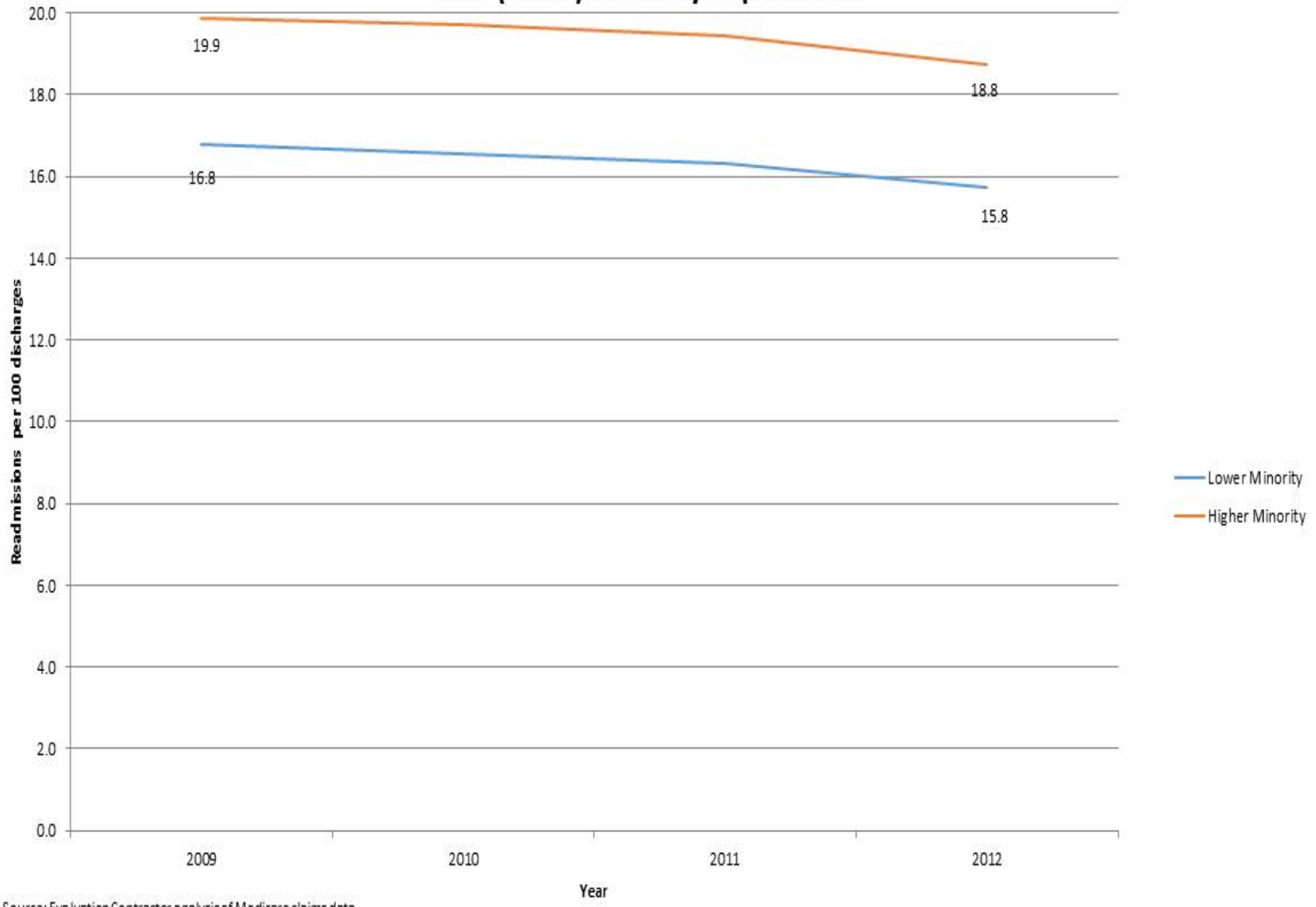
Four Levels of Engagement

The framework/declaration was originally developed for the World Innovation Summit for Health (WISH) 2013, an initiative of Qatar Foundation. See WISH Patient Engagement Report (available at www.wish-qatar.org/reports/2013-reports).

Equity as a Performance Strategy

- Treat the Whole Person
- Optimize Authentic Patient and Family Engagement
- Add REAL Data to Clinical Integration Model Reporting
- Identify Performance Gaps
- Build Formal Platforms to Support Transparency and Sharing
- Build Quality Improvement Initiatives Targeting the Gaps
- Improve Discharge Planning
- Improve Care Coordination
- Increase Availability of Culturally and Linguistically Appropriate Services (CLAS)
- Create Strategic Partnerships with Community

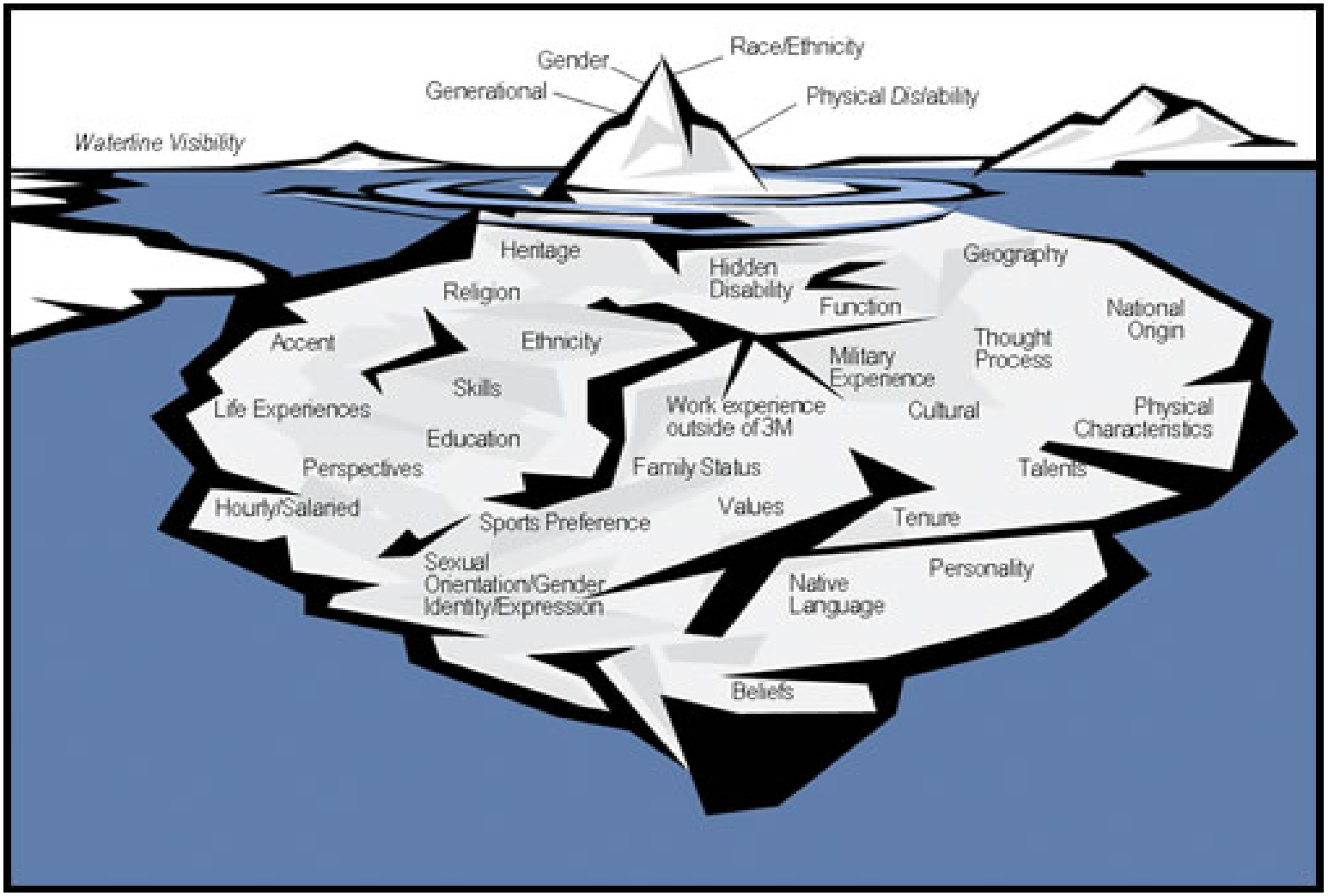
Medicare FFS 30-day, All-Cause Readmission Rates for Hospitals with High (>16%) and Low (<16%) Minority Populations



Source: Evaluation Contractor analysis of Medicare claims data

Note: Higher-minority hospitals are defined as those with >=16 percent of discharges accounted for by minority patients; lower-minority hospitals are all other hospitals. Includes all U.S. acute care, Maryland, cancer, and critical access hospitals

Authentic Patient Engagement Considers the Whole Patient



Patients and Families as Partners in Safety

- Hospitals have been called upon to adopt patient centered models of care
  - Institute of Medicine
  - Agency for Healthcare Research and Quality
  - 5 Steps for Safer Care
  - The Joint Commission-Speak Up and National Patient Safety Goals
  - NQF-Safe Practices for Better Healthcare, 2010 A Consensus Report

Patients and Families as Partners in Safety

- Many patient safety initiatives have been brought about through family involvement
  - Lewis Blackman - Helen Haskell (South Carolina)
  - Josie King - Sorrel King (John Hopkins)
- Programs Patient Advocacy has advanced include
  - Rapid Response Teams (Condition H at UPMC Shadyside)
  - Increased safety training in medical education
  - Greater transparency in reporting Quality & Safety

Ways Patients and Families May Partner in Safety

- On PFACs
  - Address specific Quality and Safety Initiatives
  - Offer insight into efficacy of protocols and procedures
- Serving on Committees including Quality and Safety, Ethics, Root Cause Analysis, Unit and Area Staff Committees
- On Boards of Trustees

Ways Patients and Families May Partner in Safety

- Provide real time insight into what really occurs at the patient level
- Assist in development of culturally appropriate and understandable educational materials and tools (patient portals)
- Collaborate in development of safe design
- Collaborate in developing programs that lead to actual adherence – programs that work
- Collaborate at the bedside – work together to achieve a plan of care and desired outcomes

Patients Offer Perspective

- What you see, What I see
- What you take for granted that I as a patient may not understand – how your efforts may miss the mark
- An understanding of how the patient experience can alter one's perspective – how do I respond when I'm sick, stressed, unsteady v. when I am well
- What efforts work to help me understand and increase my adherence to treatment, etc.
- Caregivers can increase safety through assisting in assessment and monitoring of the patient and in helping the patient to understand and adhere to treatment – how do you support the Caregiver

We're all on the same team!

- **T**ogether
- **E**veryone
- **A**chieves
- **M**ore

Discussion – Ideas for Implementation

THANK YOU

For follow-up information please contact:

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