NATIONAL QUALITY FORUM

Patient Safety Quarterly

Meeting Series Agenda

Hardwiring Humanity into Healthcare: Protecting the Vulnerable and Preventing Harm Across the Board
Friday, October 3, 2014, 8:30am-3:00pm

Meeting Recording - Streaming Audio Online

- Direct your web browser to:
- http://nqf.commpartners.com/se/Meetings/Playback.aspx?meeting.id=366125

Objectives

1. Understand what "harm" encompasses from the viewpoint of patients and families
2. Create greater awareness of the needs and circumstances of vulnerable patients
3. Showcase national examples of innovation that lead to person-centered care, improved patient outcomes, and an organizational culture of dignity and respect
4. Generate and launch the next wave of action to prevent harm and protect vulnerable patients

Agenda

8:30am	**Light Breakfast** (provided by National Quality Forum)
9:00am	**Introduction and Meeting Overview** ***Martin Hatlie**, JD, Meeting Chair, Partnership for Patients Core Team Member* • Greetings and introductions ***Christine Cassel**, MD, CEO, National Quality Forum* • A Framework for Respect and Empathy ***Rachel Weissburg,** Project Manager, NQF* Warm-Up Exercise: Heard, Seen, Respected *"Empathy removes the blocks to action in a way that is inclusive. It creates power through partnership and cocreation, resolving what appears to be knotted and bound." – Dominic Barter*
10:00am	**Partnership for Patients Update** ***Dennis Wagner** and **Paul McGann**,MD, Partnership for Patients Co-Directors, **Jacqueline Kreinik**, Nurse Consultant* • Update on the progress of Partnership for Patients goals • Q&A
10:45am	**Break**

11:00am	**Creating Conditions for Safety and Humanity in Healthcare:** **Join these Fellow Attendees in Interactive Theater-in-the-Round Conversations** "A Mom and a Sheriff Partner to Create a Safe, Humane Environment for the Mentally Ill" ***Contra Costa Regional Medical Center*** • ***Teresa Pasquini**, Mother, Partner, Advocate, and **Lt. Jeff Moule**, Chief of Security* "The Power of Patient and Family Engagement to Make Hospitals Safer" ***Carolinas HealthCare System*** • ***Jason Byrd**, JD, Director of Patient Safety* "An Adverse Event, a Hospital Goes Public, a PFAC is Born . . Insights from Twelve Years of Culture Change" ***Providence Regional Medical Center Everett*** • ***Paula Bradlee**, Director of Organizational Quality* • ***Gary Linger**, Advisor/Past Co-Chair, Patient and Family Advisory Council* • ***Jennifer Smolen**, Co-Chair Patient and Family Advisory Board and Council*
12:45pm	**Networking Lunch** (provided by National Quality Forum) Storyboard: Heard, Seen, Respected
1:15-2:15	**Caring for the Caregivers: A Culture of Safety Starts from the Inside** ***Jo Shapiro, MD,** Chief, Division of Otolaryngology, Director, Center for Professionalism and Peer Support, Brigham and Women's Hospital* ***Cynda Hylton Rushton**, PhD, RN, FAAN, Professor, Anne and George L. Bunting Professor of Clinical Ethics, Berman Institute of Bioethics/School of Nursing, Professor of Nursing and Pediatrics, Johns Hopkins School of Nursing*
2:15-3:00	**Conversation Café: Sharing Solutions and Generating Action** *Martin Hatlie, Meeting Chair*
3:00pm	**Adjourn**

What is real is you and what is real is me; but what is really real is the experience of we.

- Martin Buber

Hardwiring Humanity into Healthcare: Protecting the Vulnerable and Preventing Harm across the Board

4th Meeting of the Patient Safety 2014 Quarterly Meeting Series
Supporting the Partnership for Patients

convened by the NATIONAL QUALITY FORUM

October 3rd, 2014

9th Floor Conference Center
1030 15th Street NW, Washington, D.C. 20005

Welcome and Introductions

Martin Hatlie
Meeting Chair
Partnership for Patients Core Team Member

Welcome and Introductions

Partnership for Patients Meeting Series

Since 2011, NQF has convened ten collaborative meetings -

…Connecting over 500 participants
…Spending 60 hours together
…Featuring over 100 presenters
…Sharing hundreds of stories and best practices

One goal: Improve patient safety

Is this Elephant in your room?

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Our Goals for Today

- Understand what "**harm**" encompasses from the viewpoint of **patients** and **families**
- Create greater awareness of the needs and circumstances of **vulnerable patients**
- Showcase national examples of **innovation** that lead to **person-centered care**, improved patient outcomes, and an **organizational culture of dignity and respect**
- Generate and launch the next wave of **action** to prevent harm and protect vulnerable patients

The Importance of Respect and Empathy in Healthcare

Christine Cassel
President and CEO
National Quality Forum

Empathy: The Human Connection to Patient Care
Cleveland Clinic

 http://www.youtube.com/watch?v=cDDWvj_q-o8

Warm-Up Exercise: "Heard, Seen, Respected"

"Empathy removes the blocks to action in a way that is inclusive. It creates power through partnership and co-creation, resolving what appears to be knotted and bound."

– Dominic Barter

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

National Quality Forum (NQF)

Patient Safety Quarterly Meeting Series:

Hardwiring Humanity into Healthcare: Preventing Harm and Protecting the Vulnerable

October 3, 2014

Dennis Wagner & Paul McGann, M.D.
Co-Directors, Partnership for Patients
Jacqueline Kreinik, M.S., R.N.
Kouassi Albert Ahondion, MBA, MHA, PMP
Jeneen Iwugo, MPA

U.S. Department of Health & Human Services
CMS Center for Medicare & Medicaid Innovation

Thank You

- For the hard work you are doing to improve our nation's healthcare system.
- For your active commitment to improve the care of patients and others.
- For your leadership and history of commitment and success on health care improvement, innovation and spread.

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Our Challenge to Leaders in the Room

Use today to generate your "to do" list of items to accelerate progress on Patient and Family Engagement in pursuit of reduced harm and 30 day readmissions:

1.
2.
3.
4.
5.

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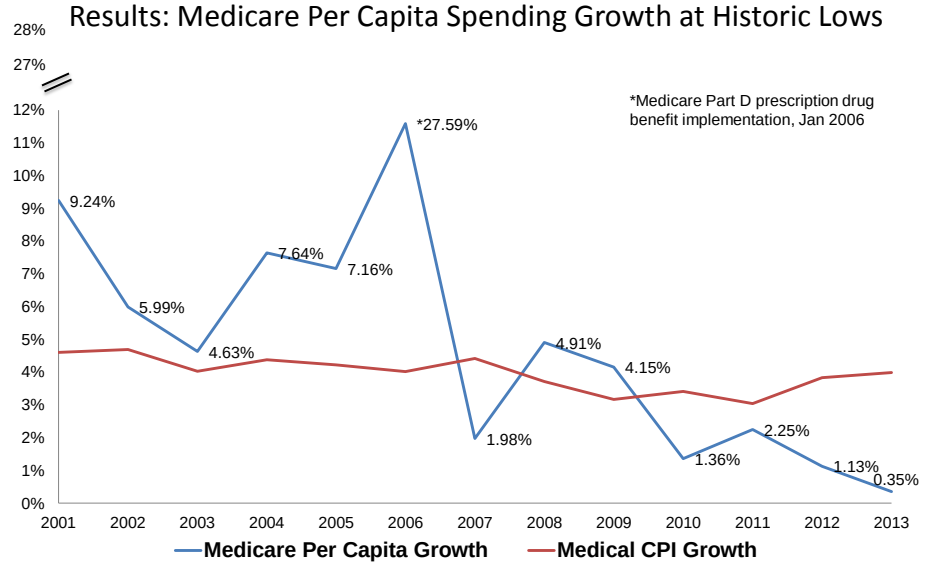
Questions to Run On

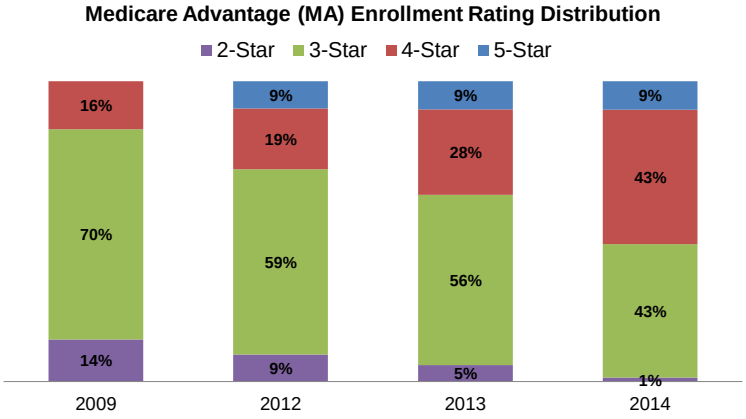
- What is happening overall and in the CMS Innovation Center with Healthcare Reform & results?
- Where are we with the Partnership for Patients (PfP) today?
  - What are our results so far?
  - What areas need increased action and attention?
- What is the PfP work on Patient and Family Engagement?
- What are the key learnings and results of this work on Patient and Family Engagement?
- How do we hardwire humanity into healthcare organizations to further accelerate patient safety efforts?
- ***What can each of us do to accelerate progress on the PfP aims and, specifically, the work on PFE?***
- What's next? How will this work be sustained/continued?

Results: Medicare Per Capita Spending Growth at Historic Lows



Source: CMS Office of the Actuary

Beneficiaries Moving to MA Plans with High Quality Scores



	2009	2012	2013	2014
4 or 5 Stars	**16%**	**29%**	**37%**	**55%**
2 or 3 Stars	**84%**	**71%**	**63%**	**45%**

The CMS Innovation Center

Identify, Test, Evaluate, Scale

The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

- The Affordable Care Act

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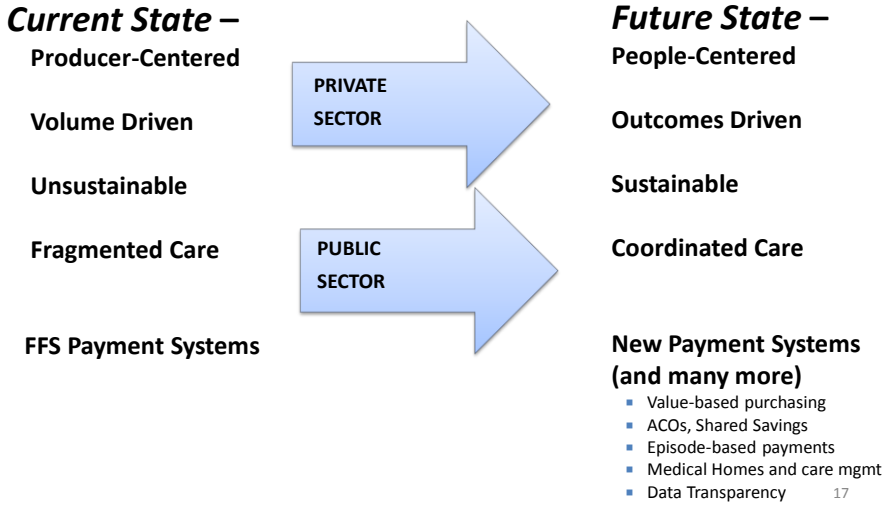
Delivery System and Payment Transformation



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CMS Innovations Portfolio: Testing New Models to Improve Quality

Accountable Care Organizations (ACOs)
- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

Primary Care Transformation
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

Bundled Payment for Care Improvement
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation
- **Partnership for Patients**
- Community-Based Care Transitions
- Million Hearts

Health Care Innovation Awards

State Innovation Models Initiative

Initiatives Focused on the Medicaid Population
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents

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Partnership for Patients Focused on 2 Breakthrough Aims

GOALS:

40% **Reduction in Preventable Hospital-Acquired Conditions**
1.8 Million Fewer Injuries | 60,000 Lives Saved

20% **Reduction in 30-Day Readmissions**
1.6 Million Patients Recover without Readmission

http://partnershipforpatients.cms.gov

PfP is Committed to Safety Across the Board

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

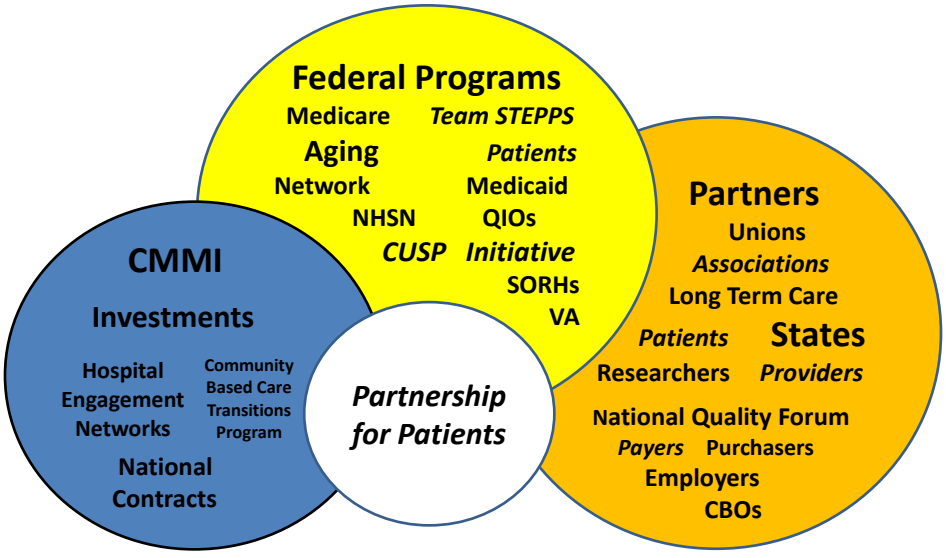
Base Topics

- Adverse Drug Event
- Catheter-Associated Urinary Tract Infections
- Central Line-Associated Bloodstream Infections
- Obstetrical Adverse Events
- Early Elective Deliveries
- Injuries from Falls
- Pressure Ulcers
- Surgical Site Infections
- Venous Thromboembolism
- Ventilator-Associated Pneumonia
- 30-Day All-Cause Readmissions

LEAPT Topics

- Severe Sepsis and Septic Shock (mandatory)
- *Clostridium difficile* (*C. diff*), including antibiotic stewardship
- Hospital Acquired Acute Renal Failure
- Airway Safety
- Iatrogenic Delirium
- Procedural Harm (Pneumothorax, Bleed, etc.)
- Undue Exposure to Radiation
- Results beyond 40/20 AIMs on HACs and readmissions
- Hospital Culture of Safety that fully integrates patient safety with worker safety

Partnership for Patients Achieves Results Through "3 Engines"



27 Hospital Engagement Networks (HENs) Achieving Results through 3,700+ Hospitals

System HENs

- Ascension Health
- Carolinas Health Care
- Dignity Healthcare
- LifePoint Hospitals, Inc.

Multi-State

- American Hospital Association
- Intermountain Healthcare
- Joint Commission Resources, Inc.
- eHEN
- Ohio Children's Hospital Solutions for Patient Safety
- Premier
- UHC
- VHA

Indian Health Service

State Hospital Associations

- Dallas-Fort Worth Hospital Council Foundation
- Georgia Hospital Association Research and Education Foundation
- Healthcare Association of New York State
- Hospital and Healthcare System of Pennsylvania
- Iowa Healthcare Collaborative
- Michigan Health and Hospital Association
- Minnesota Hospital Association
- New Jersey Hospital Association
- Nevada Hospital Association
- North Carolina Hospital Association
- Ohio Hospital Association
- Tennessee Hospital Association
- Texas Center for Quality and Patient Safety
- Washington State Hospital Association

Results Come From Many Contributors and Partnerships

- **Hospital Engagement Networks & Participating Hospitals**
- National Priorities Partnership and Many Private Partners
- American Nursing Association NDNQI
- NQF Maternity Action Team, American College of Obstetricians and Gynecologists, March of Dimes and Others Focused on Strong Start
- AHRQ Measurement Systems & Tools
- Office of Assistant Secretary of Health: Adverse Drug Event Action Plan
- HRSA Rural Health Programs
- States & Medicaid Programs
- Quality Improvement Organizations
- National Quality Strategy
- US OPM Federal Employee Health Benefit Plans
- ACL Aging Services Networks
- Reporting Programs
- Payment Penalties
- Indian Health Service
- Community Based Care Transitions Program
- …and many others

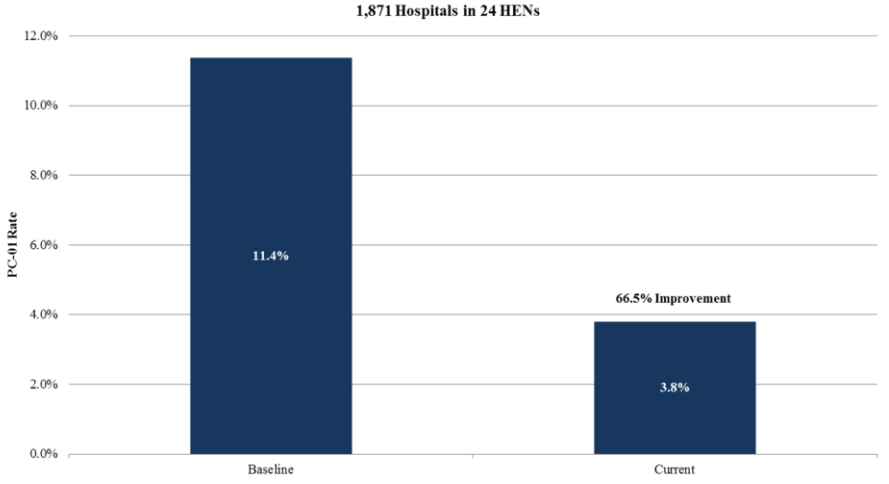
Partnership for Patients Uses 3 Major Data Streams for Formative & Impact Evaluation

1. Aggregate quality improvement data reported by Hospital Engagement Networks (monthly)

2. Leading Indicators Databases like Medicare Fee for Service claims, CDC's NHSN, American Nursing Association NDNQI (quarterly)

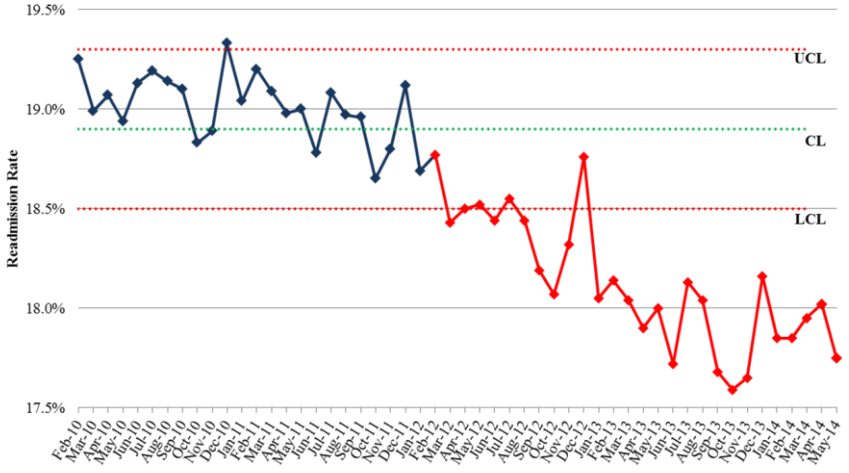
3. AHRQ National Scorecard of 30,000 annual chart reviews for 2010 baseline year & each subsequent year of PfP (annually)

Early Elective Delivery (EED) Rate (PC-01) per 100 Deliveries, Improvement from Baseline



Source: HEN-reported data submitted July 2014.
Note: Baseline and current periods vary by HEN. Baseline and current period rates are rounded for presentation, while the percent improvement is calculated using unrounded data.

Medicare FFS 30-Day All-Cause Readmission Rate, 2010 – May 2014, All Short-Term Acute Care Hospitals Nationally



Source: Health Policy and Data Analysis Group in the Office of Enterprise Management at CMS. October 2013-May 2014 readmission rates are projected based on early data, with 95 percent confidence intervals as shown for the five most recent months.

AHRQ National Scorecard 2010 Baseline & Results to Date

2010: 145 Harms/1000 Discharges

2011: 142 Harms/1000 Discharges
2012: 132 Harms/1000 Discharges

2013: Preliminary Results not yet final
126 Harms/1000 Discharges is Goal

2014: Still to come

Partnership for Patients AHRQ National Scorecard 2012 Annual Hospital Acquired Condition (HAC) Data Compared to 2010 Baseline

- 8.8% Reduction in Measured HACs
  - from 4,757,000 to 4,337,000
  - from 145 per 1,000 discharges to 132 per 1,000 discharges
  - ***Data meets pre-launch HAC reduction goal for 2012***
- $3.1B in 2012 Associated Cost Savings
  - $4.0B for 2012 and 2011 combined
- Estimated Associated Reductions in Deaths Due to HACs
  - ~12,000 for 2012
  - ~16,000 for 2012 and 2011 combined

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Pause for Reflection

1. What do you like about this work? How do you or could you "lean in" to achieve bold goals?

2. As we gear up to learn more about national and regional results…

…what improvements and results in your work do you want to share with CMS and others?

Links to Public Reports on Partnership for Patients Measurement & Results

- HHS May 7 Press Release and Initial Report: http://innovation.cms.gov/Data-and-Reports/index.html
- Journal of Patient Safety: "*An Overview of the Measurement Activities of the Partnership for Patients*" http://journals.lww.com/journalpatientsafety/Abstract/2014/09000/An_Overview_of_Measurement_Activities_in_the.2.aspx
- Preliminary Evaluation Report http://innovation.cms.gov/Data-and-Reports/index.html

PfP and QIO are Committed to Patient & Family Engagement

"A world in which patients are treated as partners in efforts to prevent all avoidable harm in health care. PFPS calls for honesty, openness, and transparency, and aims to make the reduction of health-care errors a basic human right that preserves life around the world".
World Health Organization-Patients for Patient Safety (PFPS)

- It is the right thing to do
- Patients and families have significant impact on outcomes – urgency, breaking through barriers, more.
  - Growing evidence proved that PFE generates more positive patient outcome

QIO Goals: Avoiding Readmissions

- Nearly 1 out of every 5 hospitalized Medicare patients is readmitted within 30 days of discharge.[1]
- This problem affects approximately 2.6 million seniors annually at an estimate cost of over $26 billion.[2]
- Nearly 64% of these readmitted patients receive no post-acute care between discharge and readmission and the Medicare Payment Advisory Commission estimated that up to 76% of these readmissions may be preventable.[3]

"Do My PART"

A Campaign to Activate Patients & Families to Avoid Hospital Readmissions

- *Core Messages of "Do My PART:*
- **P = Prepare for your hospital stay.**
- **A = Ask questions and clarify what you don't understand.**
- **R = Respond to what is being asked of you.**
- **T = Transition from one care setting to another or home.**

HealthInsight
a partnership for the future of health care

"Do My PART"

A Campaign to Activate Patients & Families to Avoid Hospital Readmissions

- *Implementation Channels*

- Patient Advocacy Program
  - Targeted patients who filed appeals
  - Coached patient, Immediate Advocacy with staff
  - Provided educational materials (soft & hard copies)
  - Follow-up after discharge
- Promotional Campaign
  - Online resource center
  - Radio (PNR) advertising
  - Social Media Outreach
  - Educational presentations to senior community centers
    - www.DoMyPART.org

"Do My PART"

A Campaign to Activate Patients & Families to Avoid Hospital Readmissions

Patient Barriers

- Uncertainty leads to discharge appeal and readmission.
- Caregiver uncertainty about gaps in care after discharge.
- Social needs (meals on wheels, transportation) after discharge are great.

Successes

- Improved information sharing to reduce uncertainty.
- Increase in patient and caregiver request for information and participation.
- Revelation of new concerns to Patient Advocate.

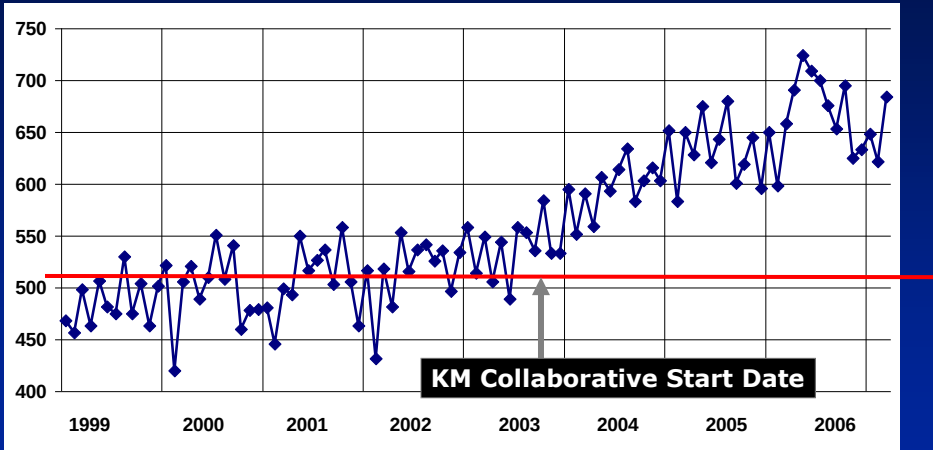
10th Statement of Work

Patient & Family Engagement Campaign *Special Innovation Projects*

Jeneen Iwugo, Director
Division of Beneficiary Healthcare Improvement & Safety
CCSQ, Quality Improvement Group
Jeneen.Iwugo@cms.hhs.gov

Alexa's Mother Chose to Make Things Better for Others…and Made Monumental Contributions

Major National Increases in Number Of Organ Donors Per Month



Increasing Organ Donation in USA
Jan 1999 – Apr 2007 (Monthly)

Partnership for Patients Strategy to Support Patient & Family Engagement

1. **Authentically engage** patients in the work and model best practices
2. **Identify** organizations that reflect best practices
   i. Vidant Health-NC
   ii. RARE Campaign-MN
   iii. Wexner Medical Center-OH
   iv. Many others…
3. **Replicate** and spread effective practices
4. **Track** progress on PFE across 3700+ hospitals and increase transparency
5. **Team** with and support others involved in leading this work
   i. National Partnership for Women and Families, Institute for Patient and Family Centered Care, Institute of Medicine, Gordon & Betty Moore Foundation, many others
   ii. Support 236 patient advocates who are working with 27 HENs and 3714 hospitals throughout the United States
   iii. AHRQ's 7 Pillars Initiative, QIOs and other Federal Partners

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Culture Change: PFE at Tipping Point

Then	Now (2013+)
Patients seen as ***receivers*** of care	Patients increasingly viewed as ***partners*** in care
Limited hospital staff focused on PFE and fostering a culture of safety	Patient experience officers and teams in hospitals playing a role in Safety Across the Board
Few, if any, PFACs in place and limited PFE metrics in hospitals	Established National PFE Metrics in place with monthly reporting
Patients have limited resources to equip them as advocates	Many tools, conferences and resources now available for patient advocates
Limited focus on PFE in hospitals or among associations and outside organizations	Hospitals showcase PFE leadership as core activity and PFE awards programs in place nationally

PfP helped drive the focus on Patient and Family Engagement through PFE metrics, Masters Classes, the PFE Affinity Group and Vulnerable Population Working Group, and partnerships

PfP Supports a Vibrant Network of 236 Patient and Family Advocates Like Helen Haskell in Our Improvement Work with 3700+ Hospitals

Helen Haskell, President of Mothers Against Medical Error

- Her healthy 15-year-old son, Lewis, developed severe upper abdominal pain while on NSAID and narcotic pain regimen following elective surgery
- Nurses and residents failed to act upon increasing signs of instability, including 24 hours with no urine output and four hours with no BP
- Four days post-op, Lewis died. Autopsy showed a giant duodenal ulcer and 2.8 liters of blood and gastric secretions in the peritoneal cavity

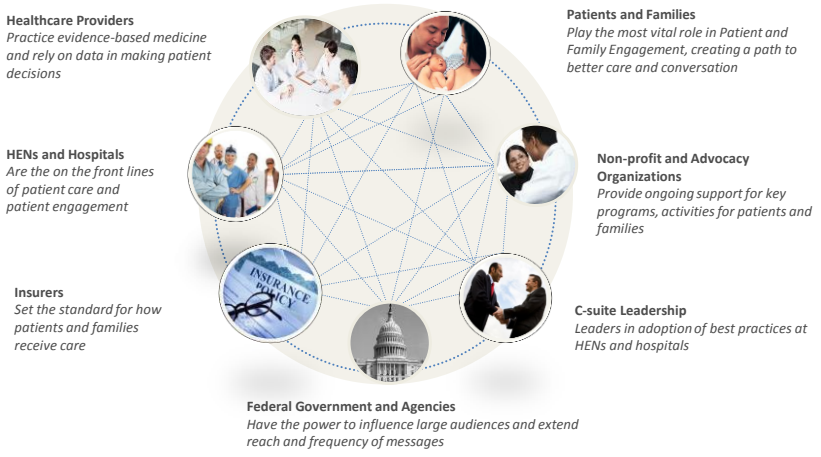
Since the medical error death of her young son in 2000, Ms. Haskell has been active in many areas of healthcare quality and safety.

Hardwiring Humanity means sharing our humanness

"Compassion is willingness to be close to suffering. To simply listen to someone, to 'be with' suffering, or bear witness to it, is honestly the greatest gift we can give someone."

NWH NORTHERN WESTCHESTER HOSPITAL

Mobilizing a Diverse Network on PFE



Working to Spread and Sustain PFE

Patient advisors and advocates work to share information and catalyze action to advance PFE. Along with Hospital Engagement Networks, hospital staff, leaders in national patient and consumer organizations and other stakeholders, they ensure that the patient voice is a part of every PfP activity and help spread best practices and innovations in PFE.

Core Activities

- PFE monthly Master Classes via the PFE Affinity Group
- Vulnerable Populations Working Group (2+ years)
- Listserv on Communities of Practice/PfP website
- Weekly emails
- Patient profiles (100+)
- Infographics, videos, one-page summaries illustrating PFE programs and strategies (30+)
- Case studies and best practices in PFE (150+)

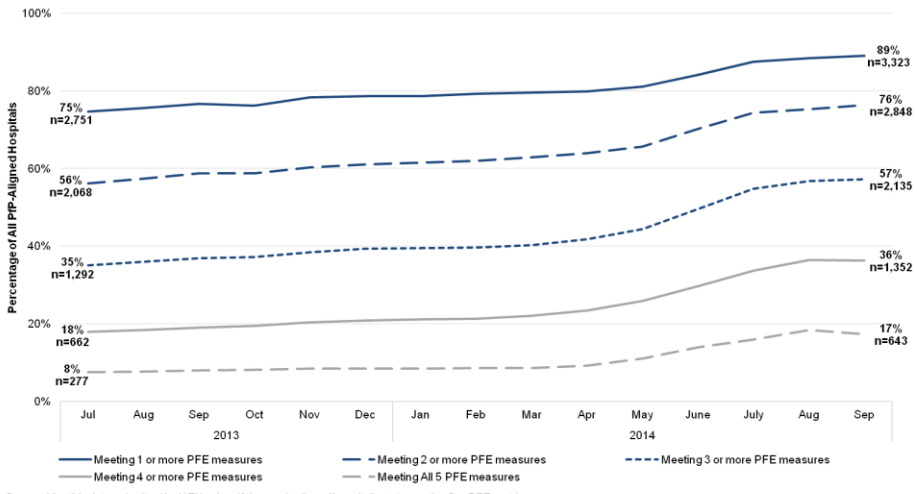
Hospitals Meeting PFE Metrics

PFE Metrics	Number of Eligible PfP Hospitals Meeting PFE Criteria	Percent of Eligible PfP Hospitals Meeting PFE Criteria
PFE 1: Planning Checklist	2,117	56.62%
PFE 2: Shift Change Huddle	2,648	70.82%
PFE 3: Leader Assigned	2,107	56.35%
PFE 4: Committee/Representative	1,790	47.87%
PFE 5: Committee Representative on Board	1,637	43.78%

Source: HENs' August Z-5 hospital list spreadsheets.

PFE 1 - Prior to Admission, hospital staff provides and discusses a **planning check list** with every patient that has a scheduled admission, allowing for questions or comments from the patient or family.
PFE 2 - Hospital conducts **shift change huddles** and **bedside reporting** with patients and family members in all feasible cases.
PFE 3 - Hospital has a **person or functional area**, who may also operate within other roles in the hospital, that is dedicated and proactively responsible for Patient & Family Engagement and systematically evaluates PFE activities (i.e. open chart policy, PFE trainings, establishment and dissemination of PFE goals).
PFE 4 - Hospital has an active **Patient & Family Engagement Committee** OR at least one former patient that serves on a patient safety or quality improvement committee or team.
PFE 5 - Hospital has at least one or more patient(s) who serve on a **Governing and/or leadership board** and serves as a patient representative.

Increase in HEN-Aligned Hospitals Meeting 5 PFE Metrics, July 2013 – September 2014



Source: Monthly data submitted by HENs classifying each aligned hospital's status on the five PFE metrics.

Sustainability Into the Future

- Align with Overarching Priorities for 2014:
  - Safety Across the Board
  - Expanded Reporting; Expanded Improvement
  - Broader Scope on ADEs
  - Expanded Work on OB Harm
  - Leadership Engagement and Commitment
  - Continued Expansion of Patient and Family Engagement
  - Reverse the National Trend on CAUTI
- Generate Results: Nothing Increases Opportunities for Sustainability as Much as Results
- Commit to Improvements in Safety and Reduced Readmissions for the Long Term
- Address Advance Practice Harm Areas

Sustainability Beyond 2014

What is happening next with the Partnership for Patients

- Preliminary Evaluation – The evaluation has found clear evidence for decreased rates of harm.
- Next Phase of Evaluation – Determining the linkage between the significant results we are seeing, and the contribution of PfP to the results.
- Determination from CMS Office of the Actuary- In order to proceed as a model appropriate for national expansion and fund PfP as a regular program of CMS. To be determined a successful test, the OAct assessment must document one of the following:
  - Quality Up, Cost Constant
  - Quality Constant, Cost Down
  - Quality Up, Cost down

Our Challenge to Leaders in the Room

Use today to generate your "to do" list of items to accelerate progress in pursuit of reduced harm and 30 day readmissions:

- **What situations and opportunities are each of us presented with now?**
- **How do we embrace change with every challenge we face?**
- **What can each of us do to promote transparency, accountability and create a learning environment?**
- **What can each of us do in our work to *hardwire humanity into healthcare?***

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Questions to Run On

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- Where are we with the Partnership for Patients (PfP) today?
  - What are our results so far?
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- What is the PfP work on Patient and Family Engagement?
- What are the key learnings and results of this work on Patient and Family Engagement?
- How do we hardwire humanity into healthcare organizations to further accelerate patient safety efforts?
- ***What can each of us do to accelerate progress on the PfP aims and, specifically, the work on PFE?***
- What's next? How will this work be sustained/continued?

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APPENDIX

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Links to Previous Master Classes

- Classes 1&2: Patient and Family Advisory Councils
- Class 3: Shift Change Huddles at Bedside
- Class 4: Staff Assigned to Oversee PFE
- Class 5: Patients on Governing Boards
- Class 6: PFE and Discharge Planning Checklists
- Class 7: Engaging the Family Caregiver at the Point of Care
- Class 8: Health Literacy
- Class 9: Medication Management and Readmissions
- Class 10: Engaging Staff to Deliver PFCC
- Class 11: Educating and Engaging Patients and Caregivers
- Class 12: Informed Consent

**To access the hyperlinks, right-click on the blue text and select "open hyperlink"

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A New Tool Helps Reduce Patient Falls Wexner Medical Center in Ohio

Areas of Focus

- Patient previously deemed low-fall risk suffered serious head injury
- Hospital involved patients and families in effort to identify fall and injury risks
- Examined current materials used to educate and alert patients
- Offered suggestions on how to improve fall/injury risk
- A simple, highly visible tool was created for each patient
  - Fall wheel created
  - Located on door of each patient's room
  - Updated every 8 hours by nursing staff

Results

- 30% overall reduction in falls
- 5 months without a fall in targeted safety areas where patients are at highest risk

Patient and Family Engagement helped develop the Falls Wheel

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Caregiver Action Network Advancing Excellence

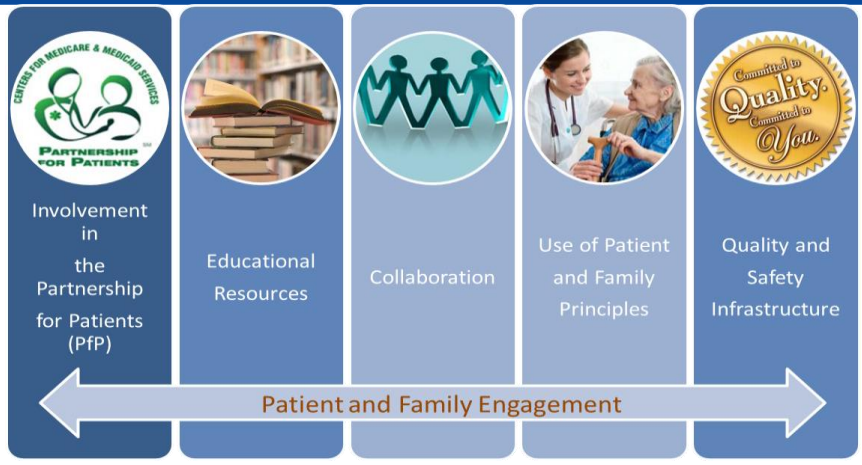
Nominations in three categories:

- Patients and Caregivers
- Hospital Staff
- Hospital Systems / Healthcare Leadership

External committee of evaluators

- How adaptable and replicable is the program?
- How does it impact vulnerable populations?
- What are the measurable results?
  - **Share successful programs to inspire replication**

Driving PFE Innovation Through



PA-HEN PFE Approach

A THREE-STEP APPROACH

The PA-HEN/HAP has taken three important steps to help hospitals actively engage patients in their care:

1 Developed a HEN-level Patient and Family Advisory Council

PA-HEN/HAP formed the first state hospital association sponsored Patient and Family Advisory Council (PFAC) in the United States, consisting of patients, family members, health care professionals and community leaders from across Pennsylvania.

2 Created a Patient and Family Centered Care Guidebook

The guidebook, *Patient and Family Centered Care* is a comprehensive on-line resource that explains concepts, identifies the role of leaders in implementing PFE strategies and offers case studies that demonstrate best practices.

3 Developed an Electronic PFE Needs Assessment Survey

This needs assessment survey provides a means for hospitals to identify areas where they have the greatest need for educational, networking and technical support.

PFE woven into PA-HEN Program and Project Designs

ACHIEVING more TOGETHER
Pennsylvania Hospital Engagement Network

HAP
THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

57

References

- 1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare Fee-for-service Program. *NEJM*. Apr 2 2009;360(14):1418-1428.
- 2. CMS Community-based Care Transitions Program Web page. Centers for Medicare & Medicaid Services website. Available at: http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html. Accessed July 28, 2014.
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15-minute Break

Creating Conditions for Safety and Humanity in Healthcare

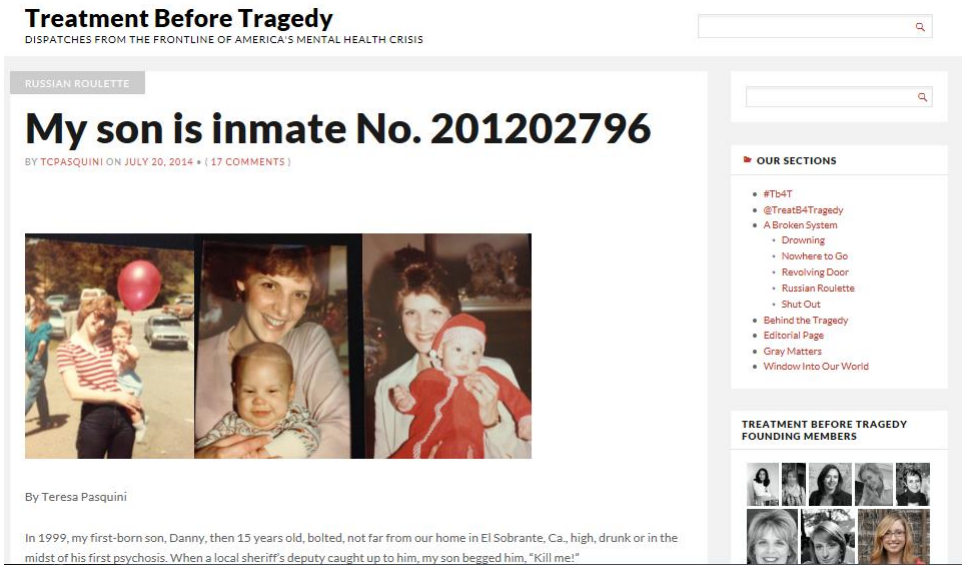
interactive theater-in-the-round conversations

Creating Conditions for Safety and Humanity in Healthcare

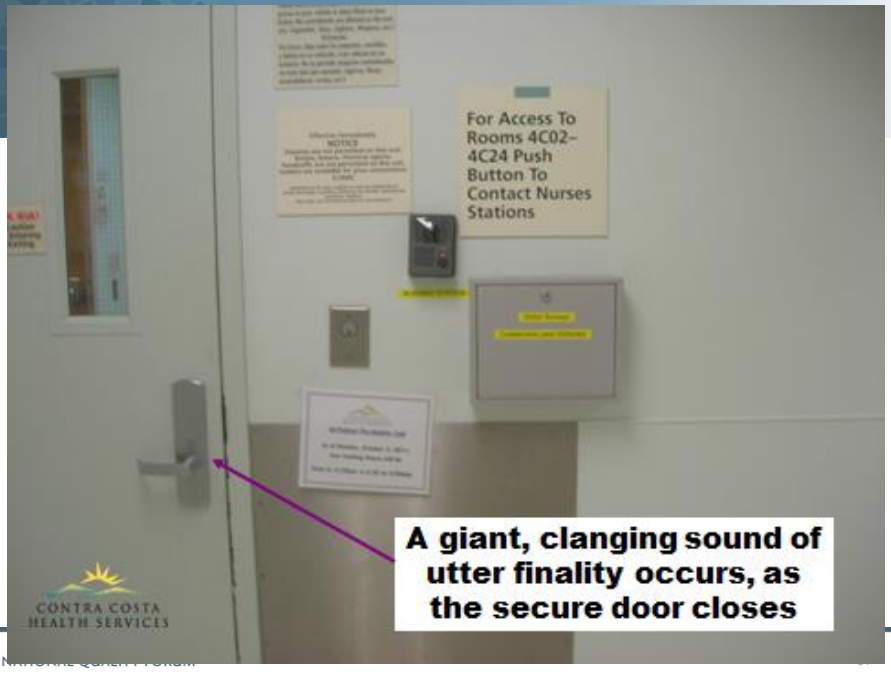
Teresa Pasquini
Mother, Partner, Advocate
Chair of the Behavioral Healthcare Partnership

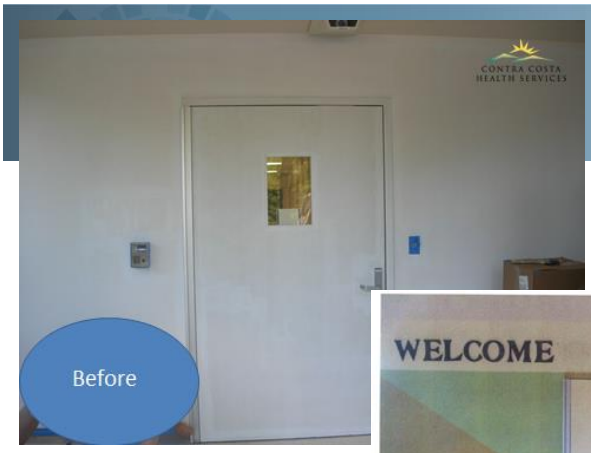
Lt. Jeff Moule
Chief of Security

Contra Costa Regional Medical Center (CA)




CONTRA COSTA
HEALTH SERVICES
Psychiatric Emergency Services
HOPE
RECOV


For Access To Rooms 4C02–4C24 Push Button To Contact Nurses Stations
A giant, clanging sound of utter finality occurs, as the secure door closes
CONTRA COSTA
HEALTH SERVICES



Contra Costa Regional Medical Center Nationally Recognized for Welcoming Policy

CONTRA COSTA HEALTH SERVICES

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Press Release

Contra Costa Regional Medical Center Nationally Recognized for Welcoming Policy

Contra Costa Hospital Part of National Campaign to Eliminate Restrictive Visiting Policies

Like 1 Tweet 3

Tuesday, June 24, 2014

Contra Costa Regional Medical Center (CCRMC) in Martinez is one of only 12 hospitals being recognized nationwide for supporting families as partners in care by eliminating restrictive visiting hours.

CCRMC is hailed as an exemplar hospital by the Institute for Patient- and Family-Centered Care (IPFCC) which launched its Better Together campaign today. IPFCC's campaign calls on all hospitals to welcome families 24 hours a day and to transform their approach to care so that patients' families and loved ones are included in care and decision-making, based on patient preferences.

CCRMC Chief Executive Officer Anna Roth said it was an honor to be selected, and the county hospital implemented a "welcoming" policy nine months ago, eliminating restrictive visiting policies and

Press Contact
Kate Fowle, CCRMC 925-370-2371

Videos
June 24, 2014 Revolutionizing Visitor Policy at CCRMC
June 24, 2014 Better Together: Partnering with Families
June 24, 2014 Process for Change

Community Living Room

Community Living Room

Dream Day Summit

Creating Conditions for Safety and Humanity in Healthcare

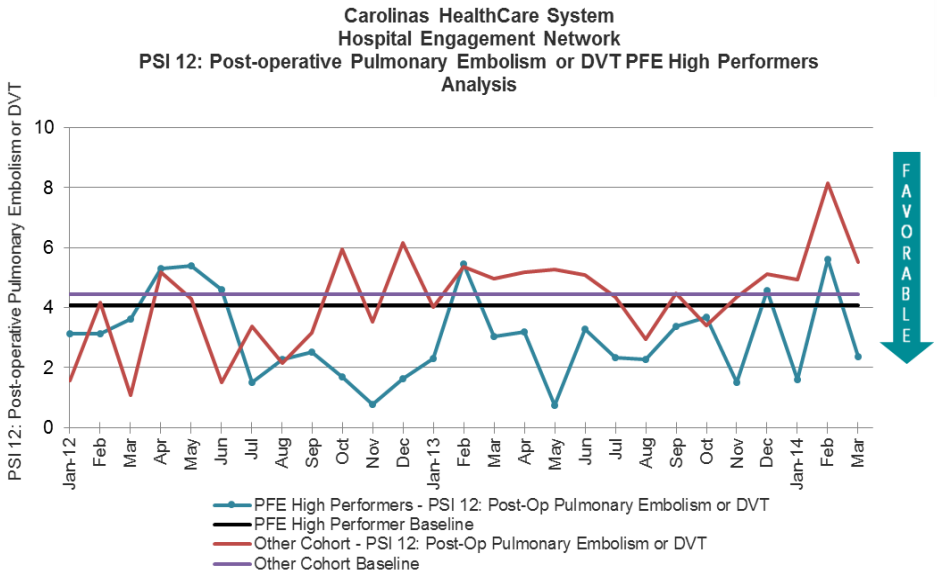
Jason Byrd
Carolinas HealthCare System
Director of Patient Safety

Carolinas HealthCare System HEN Patient & Family Engagement

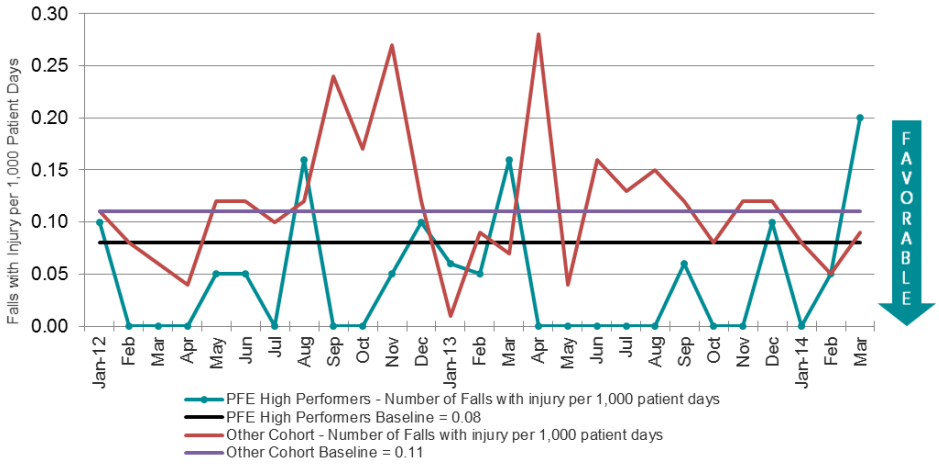
Jason Byrd, JD
Director of Patient Safety

Sample of Results

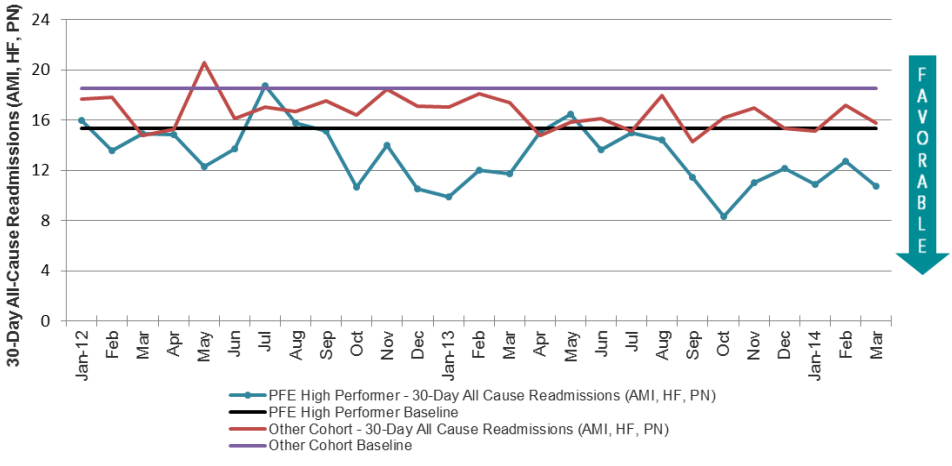
Measure	CHS P&FE High Performers Baseline (2010)	CHS P&FE High Performers Results (Jan 2012-Mar 2014)	CHS P&FE High Performers Reduction Percentage	Other CHS Hospitals Baseline (2010)	Other CHS Hospitals Results (Jan 2012-Mar 2014)	Other CHS Hospitals Reduction Percentage
Number of falls with injury per 1,000 patient days (NDNQI)	0.08 (19/226,467)	0.05 (25/505,993)	**- 41.1%**	0.11 (51/462,415)	0.11 (166/1,520,790)	**+ 1.0%**
PSI 12: Post-operative Pulmonary Embolism or DVT	4.09 (58/14,191)	2.99 (103/34,498)	**- 27.0%**	4.44 (147/33,115)	4.22 (291/68,947)	**- 4.9%**
Early Elective Delivery (PC-01)	3.54% (42/1,188)	1.03% (23/2,235)	**- 70.9%**	11.32% (474/4,188)	3.11% (199/6,393)	**- 72.5%**
PSI 17: Birth Trauma – Injury to Neonate	1.68 (10/5,953)	1.00 (15/15,049)	**- 40.7%**	2.11 (37/17,530)	1.67 (61/36,573)	**- 21.0%**
Rate of 30-day all-cause readmissions (AMI, HF, PN)	15.35 (575/3,747)	12.55 (1,285/10,236)	**-18.2%**	18.50 (2,247/12,148)	16.19 (4,784/29,551)	**-12.5%**

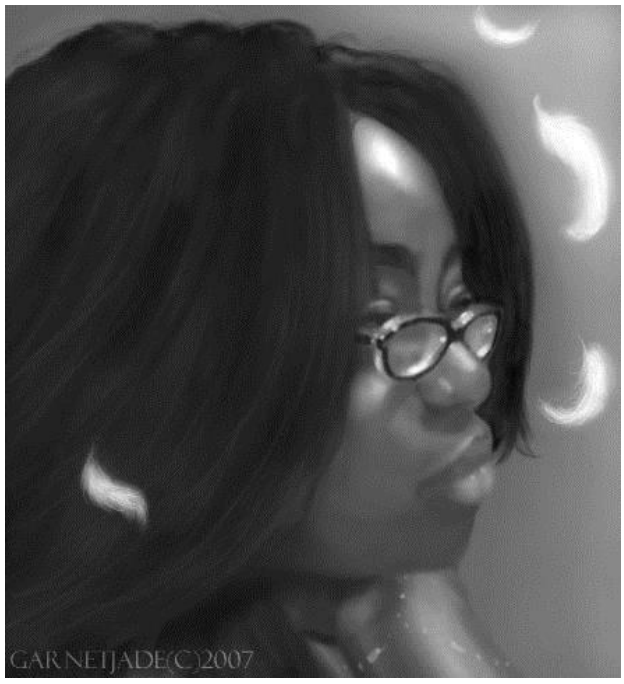


Carolinas HealthCare System
Hospital Engagement Network
Falls with Injury per 1,000 Patient Days - PFE High Performers Analysis



Carolinas HealthCare System
Hospital Engagement Network
Readmissions (AMI, HF, PN) - PFE High Performers Analysis

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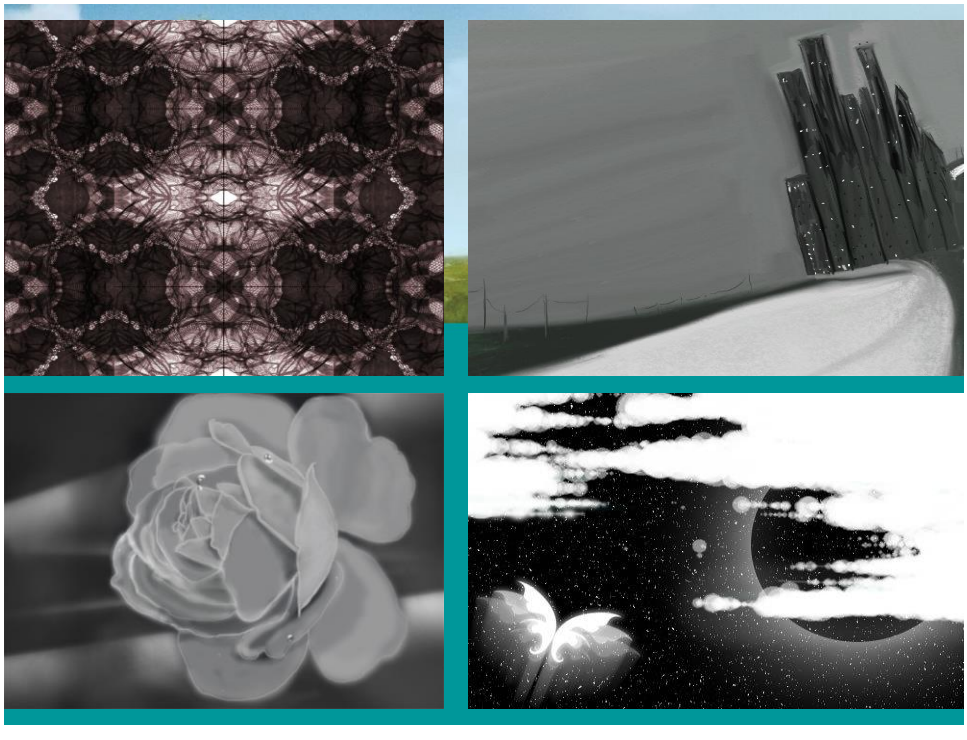


Creating Conditions for Safety and Humanity in Healthcare

***Paula Bradlee**, Director of Organizational Quality*

***Gary Linger**, Advisor/Past Co-Chair, Patient and Family Advisory*

***Jennifer Smolen**, Co-Chair Patient and Family Advisory Board and Council*

Providence Regional Medical Center Everett (WA)

HeraldNet
Everett, Washington

Published: Sunday, August 6, 2006

Often, hospitals reluctant to talk

By Sharon Salyer / Herald Writer

Hospital vows to cure its ills

Providence CEO pledges response to critical state report

By Todd C. Frankel
Herald Writer

Hospital seeks safety advisers

By Sharon Salyer
Herald Writer

EVERETT — Spurred by the death of a patient due to medical error last year, Providence Everett Medical Center will soon appoint a Patient Safety Advisory Council.

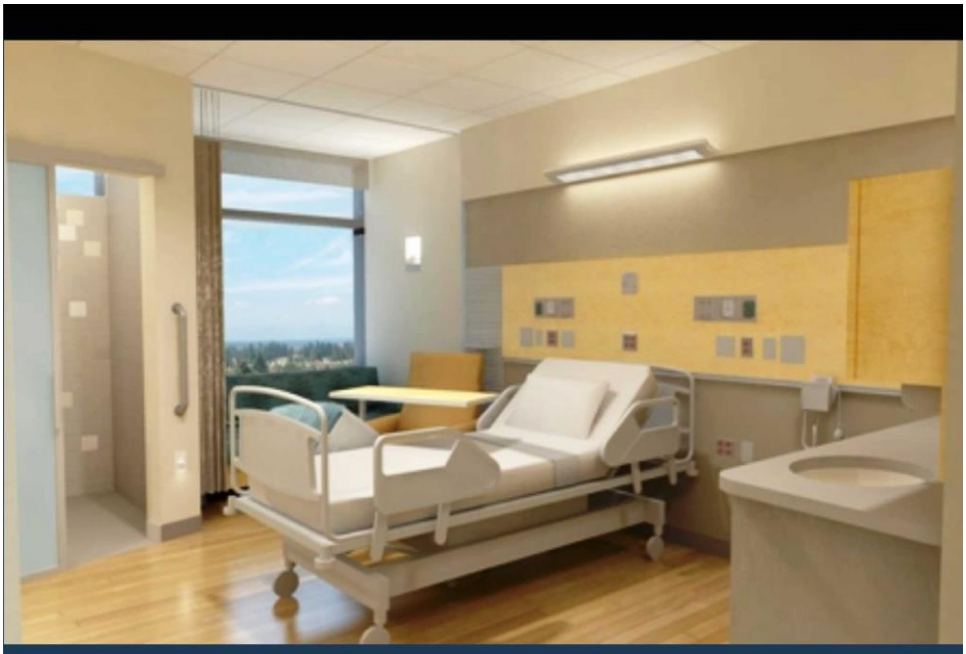
"The family members asked for an accountability group ... ensuring that (safety) procedures put in place by the hospital are followed," hospital spokeswoman Cheri Russum said.

Patient Safety Advisory Council

For more information, call 425-261-3924.

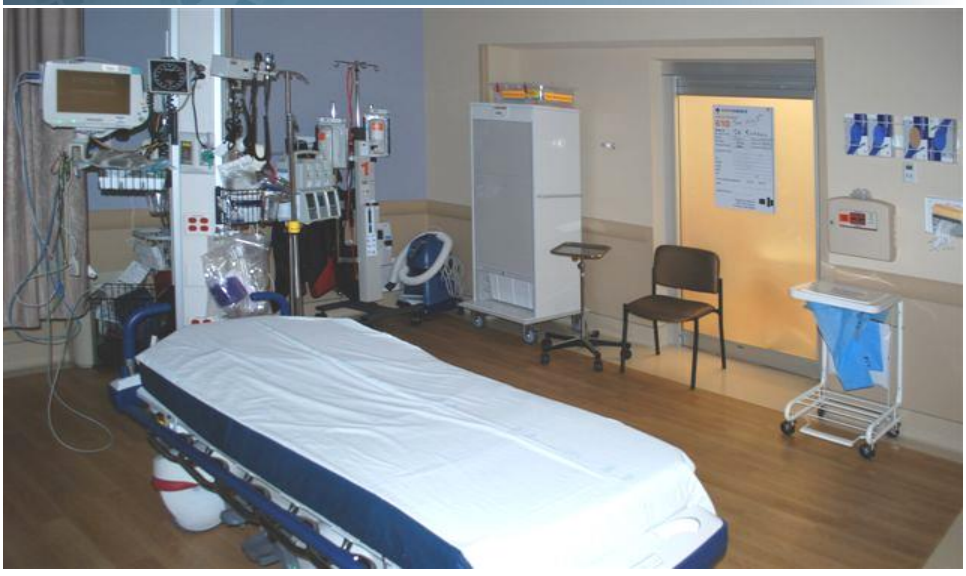
The patient death, which occurred in January 2002, was recently disclosed as part of an investigation by the state Health Department. The agency has suspended the license of a registered nurse who cared for the patient.

Early PFAC



White Boards

Emergency Department: Adjoining Patient Rooms



Tower Pre-Opening Simulation

Jennifer
Vision for the Future

- My story
- PFA goals: promote & educate
- Transition of Care model
- Collaborate
  - Volunteer Services
  - Diversity Council

Providence Regional Medical Center Everett

Lunch Exercise: Heard, Seen, Respected

"What is real is you and what is real is me; but what is really real is the experience of we."

– Martin Buber

Caring for the Caregivers: Safety Starts at Home

Cynda Hylton Rushton PhD, RN, FAAN
Anne and George L. Bunting Professor of Clinical Ethics
Berman Institute of Bioethics/School of Nursing
Professor of Nursing and Pediatrics
Johns Hopkins University

Jo Shapiro, MD
Chief, Division of Otolaryngology
Director, Center for Professionalism and Peer Support
Brigham and Women's Hospital

Institutions are…

"where the human heart either gets welcomed or thwarted or broken."

Parker Palmer. Quoted in Living the Questions, Jossey-Bass, San Francisco, CA,2005.

This is, fundamentally, a *culture* change

"The organization's culture consists of patterns of relating that persist and change through ongoing interaction."

- Tony Suchman, MD

Emotional impact of errors on clinicians

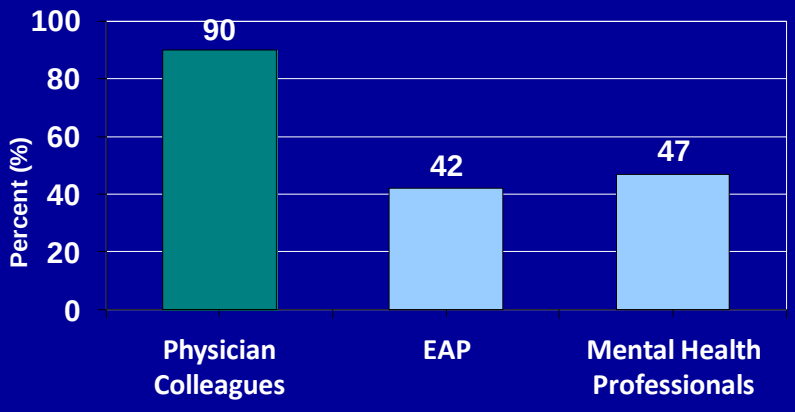
- Sadness
- Shame
  - Incompetence
- Fear
- Isolation

Impact of the impact

Discussing and learning from errors

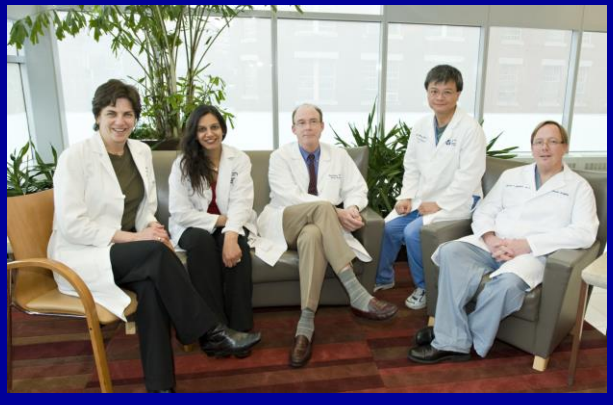
Disclosure and apology

Sources of support



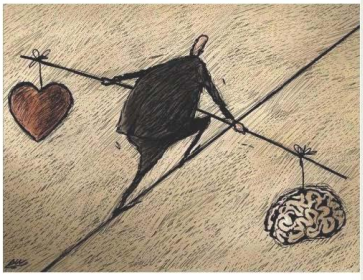
Hu J, Fix M, Hevelone N, Lipsitz S, Greenberg C, Weissman J, Shapiro J. Attitudes and needs of physicians for emotional support: The case for peer support Arch Surg 2012

Group peer support
1:1 peer support
Disclosure coaching



Shoulders

"You cannot give what you do not possess"



Cynda Hylton Rushton PhD, RN, FAAN

Anne and George Bunting Professor of Clinical Ethics

Professor of Nursing & Pediatrics

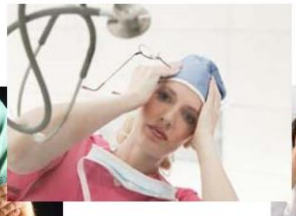
Johns Hopkins University

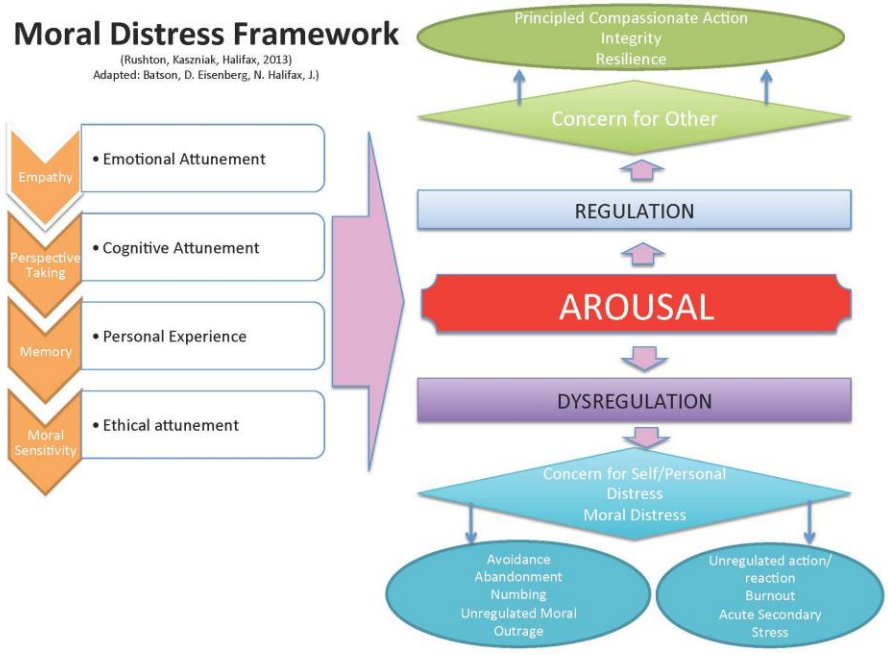
Berman Institute of Bioethics

School of Nursing

Evidence of Clinician Suffering

Burnout
Secondary Traumatic Stress
Compassion Fatigue
Cumulative Grief
Conscience violations
Moral distress
Soul Pain



Clarity and Calm

Columbine Lake, San Juan Mountains, CO – Jack Brauer Photographer - www.widerange.org/photo/columbine-lake-reflection/

Regaining Balance

- Engage in contemplative practices
- Cultivate moral sensitivity
- Modulate emotions
- Care for yourself so you can care for others
- Reconnect to meaning
- Build your "resilience muscle"
- Be generous and kind to self and others
- Develop institutional systems

Conversation Café: Sharing Solutions and Generating Action

- Where do you have discretion and freedom to act?
- What can you do **without** more resources or authority?
- If there are resources in this room (like the person sitting next to you or across from you), what or who are they and how can you work with them?
- **What is your 15% contribution to creating conditions for humanity in healthcare?**

"You cannot cross the sea by standing and staring at the water"

Evaluation of the Day

Survey Monkey link will be sent to you after today's meeting

Please respond by **Friday, October 10**

Meeting Materials Available Online

Meeting materials will be available on www.qualityforum.org shortly, including:

- Today's presentation
- A recording of today's meeting
- A meeting summary

Thank You for Participating in Today's Meeting

Now go, and

"Be the change that you wish to see in the world."

- Mahatma Ghandi