

# Full Reports

Washington Patient Safety Coalition Inaugural Conference: June 13 & 14, 2002

## DEVELOPING A COALITION TO SET THE COMMUNITY AGENDA

### Group 1

DAY 1: June 13, 2002

Go forward from today: quickly implement with measured impact

#### Members

- CEO must have some
- Insurance forum
- WSMA
- 7 for HCQ

#### Steering committee

- separate groups responsible for each work issue

#### Tasks:

- Review and grade evidence [FHCQ, Qualis, UW]
- Prioritize most important for state
- Allocate across stakeholders & regions
- Develop business case: benefits/ costs/ \$\$ resources
  - Both qualitative and quantitative if possible

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- If regulatory requirement, everybody negative
- Hospital admin- how to balance if there is conflict between LF and other patient safety initiatives
- No 3<sup>rd</sup> set of mandates [JCAHO, State/Federal/ ]
- Employers and plans different than hospital doc
- Small providers disagree with evidence
- Voluntary?
- Think their own is better than others

-----COALITION-----

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- Regulators like as deal with outcomes/ DOH and CMS
- All stakeholders buy in
- Know what literature says
- Coalition = voluntary standards

- Buy-In from plans, employees and providers
- Buy in from larger provider groups

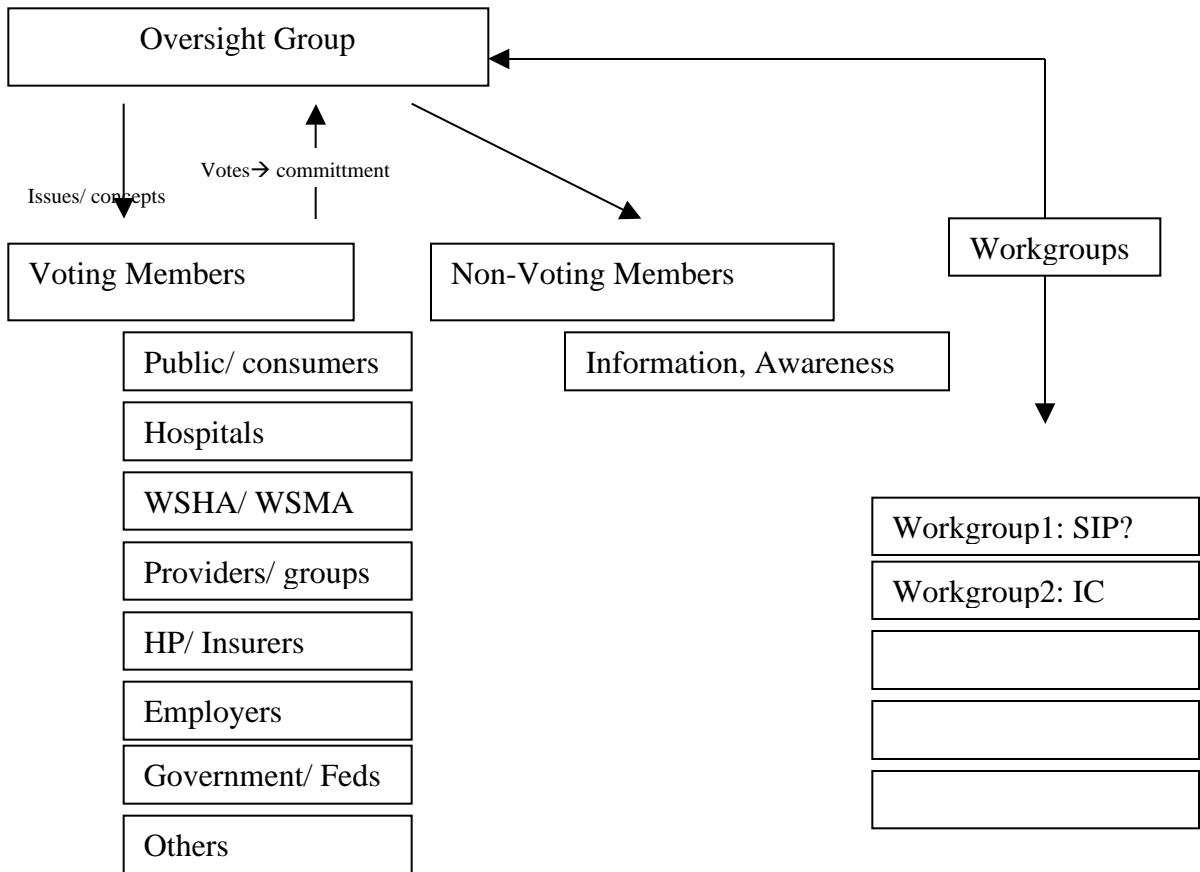
Imagine a patient safety coalition :**[bolded are 1s]**

- **Where all players are at the table**
- **All players want to be there**
- Has high level executive attendance or endorsement
- Includes CFOs
- Has \$ on the table
- That other states emulate
- That encourages the UW to develop a masters degree in patient safety
- That makes WA state the safest place to get healthcare
- That sponsors tort reform because trial lawyers are at the table
- That produces an environment where there are no reasons for lawsuits
- Where patients understand systems and their role in healthcare
- **Where partnerships spring up in unexpected places**
  - **McDonalds is a partner**
- In 2012 we celebrate 10 years of no wrong site surgery
- Where health care premiums decrease due to safer care, and we fully insure the population
- Where money shifts from liability to prevention/ shifts from ICU costs to care outside of facilities
- **Where CFOs are engaged**
  - **Where a focus on results and ROI drive us towards patient safety**

Models:

1. Volunteer Committee of Interested Parties
  - Similar to this coalition meeting
  - Leaders but not selected nor representative
  - Ability to commit organization or stakeholder group?
  - Where is expertise and how does it flow to group?
  - Who leads and who follows?
2. Membership Group with Elected Board
  - Who can be a member?
  - Who can be a board member/ role of board?
  - How to ensure diversity vs. power?
  - Where is expertise and how does it flow to group?
  - Who lead and who follows?
3. Forum Model: Voting Membership with Oversight Committee
  - Oversight committee formed from key stakeholder groups
  - Voting membership approves [and endorses/ accepts] recommendations
  - Work groups provide expertise
4. State Sponsored with Appointed Members

- Executive or legislative? Political or thoughtful?
- Where is expertise and how does it flow to group?
- Commitment of members and ability to commit organizations/  
stakeholders



## PROCEDURAL SITE INFECTION

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- *Costs more upfront*
- *Requires a change in facility practice*
- *Is intrusive to surgeons and anesthesiologists*
- *Requires additional nursing time*
- *Risks more pre-surgery allergic reactions*

## -----PROCEDURAL SITE INFECTION PREVENTION -----

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- *Decreases cost of litigation*
- *Decreases requirement for infectious disease internist*
- *Enhances patient/ family satisfaction, decreases lost work days*
- *Lower cost for health plans and self insured employers*
- *Decreased allergic reactions from post-op antibiotics*
- *Decreases time in acute [primary and readmit] and post-acute settings*

Imagine a world where:

- *patients receive the most cost effective and best antibiotics for every procedure*
- *Patients receive such care with buy in from all providers*
- *MDs beg to be champions [for PIP work]*
- *Drug companies shift \$ from advertising to surgical patient safety, and all their ads are for safety*
- *[some] Funding for medical management of surgical patients comes from drug companies*
- *There is a state-wide system to share patient medication history*
- *Surgical safety procedures are integrated into the normal course of business in procedure areas and operating rooms*
- *Infection Control and Surgical Quality departments are abolished because each health team in the OR knows the methods and incorporates them into all aspects of work*
- *Surgical infection prevention/ patient safety is part of a training curriculum for surgeons and anesthesiologists*
- *Patients choose a hospital with the lowest rates of avoidable infections*
- *Employers and payors change benefit structures to reward performance in surgical infection rates*
- *We know antibiotic resistance rates are down due to our interventions*
- *A rapid response team is available when rate shift or for rural/small hospitals needs*
- *SIP started with CV surgery but then extended to other surgical procedures*
- *Surgery was a 'highly reliable' area with multiple layers of safe care*
- *We ask and tell patients about surgical infection rates both absolute and at our facility*

# DEVELOPING A COALITION TO SET THE COMMUNITY AGENDA

Group 1

DAY TWO: June 14, 2002

## Reactions to the model from Day 1:

- Forum model has high overhead costs
- Need projects that are not '1-shot wonders'- a project should be worth doing longterm
  - Some AHRQ topics are limited interventions [subglottic aspiration] that may not be appropriate for long term data collection. Others- surgical infections, informed consent= participatory disclosure are longer term
  - A large cumbersome structure will doom effectiveness
  - Representation not at the oversight level but at some forum meeting like this coalition meeting
- Long-term funding of this coalition needs to be part and parcel of the structure as it is set up, not added later. Don't expect charity
- Need quality assessment of current service levels, and of interventions and of sustained activities
- Determine whether coalition is "narrow" [only applies to hospitals or urban or whatever] or "broad" [may have some topics that are limited but has some which apply pretty much everywhere healthcare is delivered]

Back to the basics! What is the role of the Coalition?

### STEERING COMMITTEE ROLES

Clearinghouse for safety issues Develops process to: Grade evidence Prioritize Collect ongoing data Identify costs Money already being spent Cost of not improving
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DEVELOP A RELATIONSHIP BETWEEN INCENTIVES AND INITIATIVES AMONG ALL STAKEHOLDER/ INTEREST GROUPS

INCENTIVES	DISINCENTIVES
<ul style="list-style-type: none"> <li>• UW and other research groups get projects</li> </ul>	<ul style="list-style-type: none"> <li>• May not be sexy</li> <li>• AHRQ has concepts but no support</li> </ul>

<ul style="list-style-type: none"> <li>• Program development at UW-graduate degree?</li> <li>• Statewide spinoff better than small local/ facility projects- better for federal funding</li> <li>• Find good models for statewide interventions- where is it going on already, and how to publicize it. Models include diabetes collab and COAP</li> <li>• AHRQ charisma/ reputation valuable</li> <li>• Where is the master data set for all interventions and opportunities?</li> </ul>	<p>structures, standard methodology and not sure if such would work in all locations</p>
<ul style="list-style-type: none"> <li>• Professional liability organizations- offer incentives for engagement and participation to hospitals and MDs [esp re informed consent issues]</li> <li>• Local foundations- marketing tools for donations?. “Partner for a Safer Washington” seal of approval</li> </ul>	<ul style="list-style-type: none"> <li>• Uncertain model for future- what is the next crisis coming down the pike?</li> <li>• Liability insurers may not want to pay for good outcomes</li> <li>• Leapfrog competition issues. Will Microsoft want to fund multiple ventures?</li> </ul>
<ul style="list-style-type: none"> <li>• Develop long-term funding out of the provision of the service itself</li> <li>• Develop ‘real’ vs. proxy ROI for projects</li> <li>• Start with a project where there is already funding—Surgical Infection Prevention</li> <li>• Develop a COAP-like model for topics chosen- ‘blinded’ initially but expectation of use of data beyond just reporting</li> <li>• Projects need to be operationally ‘do-able’</li> <li>• Recommend two clinical issues launched early with successes- need both short term intervention and sustainability</li> <li>• GET GOING!</li> </ul>	<ul style="list-style-type: none"> <li>• Collaboratives cost \$\$-- about \$100/k/yr for statewide level</li> <li>• Administrative costs for steering committee and for meetings</li> <li>• Current groups are using scarce resources [COAP, CV]</li> <li>• Too large a topic is dysfunctional, but the list contains several</li> <li>• Need both time and will power</li> <li>• Big project may die of its own weight</li> </ul>
<ul style="list-style-type: none"> <li>• How do you figure out CFO’s ROI for topics like CPOE</li> <li>• Include CIOs</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• ROI requires proactive measurement to avoid squishiness</li> <li>• CMO/VPMA/Medical Directors are critical even for non-clinical projects</li> </ul>

	<ul style="list-style-type: none"> <li>• Will be considered one more thing in list of 'requirements'.</li> </ul>
<ul style="list-style-type: none"> <li>• Medicare funding issues may cause problems or perhaps opportunities. For VTE- develop concept of episode of care that doesn't violate Medicare regs- generate pool of resources to pay for innovative care delivery</li> <li>• Thromboembolism vs. observation. Would not choose observation for test case</li> </ul>	<ul style="list-style-type: none"> <li>• Misaligned Medicare Part A&amp;B [esp in VTE]</li> <li>• Medicare waivers for projects crossing regulations</li> <li>• Alignment between hospitals and Fis, outpatient and patient costs... all are losing \$</li> <li>• Intensivists in rural areas- reimbursement, loss of revenue of practicing docs</li> </ul>
<ul style="list-style-type: none"> <li>• Share data with employers to identify opportunity costs</li> <li>• Consultants [e.g. Mercer] need data as well</li> <li>• Get employers to recommend reimbursement for participation, and get insurers to agree</li> <li>• Hospitals are employers as well.</li> <li>• Test ideas with health plans</li> <li>• Small employers are more incentivised if there is a change in utilization/ workloss</li> <li>• Reduce costs to employer/ change rates</li> <li>• Labor contracts- use coalition to create a new agenda for membership on the quality of healthcare</li> <li>• Employees/ labor are advocates for patient safety</li> </ul> <p>Develop thoughtful dialog on where current system fails</p>	<ul style="list-style-type: none"> <li>• Where does data go once it gets to employers? Does it affect changes?</li> <li>• Employer recommendation sounds like Leapfrog</li> <li>• Difference between healthcare delivery and business of healthcare finance</li> <li>• How to meet consumer requirements? Who are the consumers?</li> <li>• Hard sell to stockholders who are in short cycle mode</li> <li>• Labor wants to pay less with more access/ services. In opposition?</li> <li>• Labor interests may be at odds with management</li> </ul>
<ul style="list-style-type: none"> <li>• Oversight body/ steering committee to include consumers</li> <li>• Make belonging to steering committee 'easy'</li> <li>• Identify needs and then ask people to form groups</li> </ul>	<ul style="list-style-type: none"> <li>• Steering Committee does not need to represent everybody</li> <li>• Too frequent meetings will raise too many issues</li> <li>• Virtual meetings may not be as effective for stickiness</li> <li>• Who moderates small working groups on clinical/ other topics?</li> </ul>

REPORT- OUT



Principles:

- This has been a great conference with a diverse group talking together, perhaps for the first time
- \$ money was spend for this conference
- \$ money is limited from sponsors, unless there is a real product and ROI to meet their interests
- The topics presented were abstract. Evidence-basis does not imply ease of implementation
- A short term fix is not needed. Sustainability of topics is key.
- There are time/ interest/ applicability competing priorities for stakeholders
- There is a lack of statewide coordination/ presentation of topics

So- how to take this work and move it into the future with ongoing measurement, assessment and documentation of improvement?

We have identified multiple issues for improvement. How do we coordinate future work with a non-short-term perspective?

- Analogy to COAP/ semi-mandatory. Protected environment for sharing data. Initially just data reporting and measurement, now moving into improvement
- Analogy to WA Diabetes Collab/ voluntary participation. Ongoing, iterative, sharing of data, improvement focus

We used two topics [clinical] to help focus our analysis of what to do:

- Surgical Infection Prevention
- Venous thromboembolic precautions

We also looked at the current structure of the Steering Committee-

- Planning for this meeting >6months of weekly conferences
- Recruitment of key members and staff
- Solicitation of resources to put on conference
- Not truly representative- did include healthplan, medical directors, state but not business, consumer, hospital or practitioner

In discussing these two topics, we generated thoughts and ideas about the structure of the Coalition going forward, in particular the steering committee

*RECOMMENDATIONS:*

1. Expand the steering committee to include some additional representation, particularly of business and consumer/media groups
2. Promote a conference like this one on an annual basis to set priorities
3. Use those priorities to spin off workgroups overseen by the steering committee which would produce specific products: measurement tools to identify gap and improvement, some stab at ROI for an intervention, an assessment of whether or not the intervention is statewide and sustained [meaning that there is an expectation of ongoing data collection and improvement] or limited to an intervention [meaning that the intervention is

promoted to the appropriate site which then will determine how and what to do].

4. Ensure that priorities set by this group do not become regulatory mandates- e.g. that the hospital licensing survey should ask “what are you doing on this topic” but also allow for facilities to determine their degree of importance. No regulatory mandate for these topics unless a significant gap is identified.

*DELIVERABLES:*

1. In the minutes from this conference, the Planning Group will propose membership of the Steering Committee for input
2. The Steering Committee will meet twice this summer to launch investigative committees for the topics identified by the Coalition meeting. Those committees will meet by this Fall. Out of those topics will be determined which are simple interventions and which are topics for ongoing continuous measurement and improvement.
3. The Steering Committee will decide this Fall on the time and location of the next Coalition meeting.
4. The Steering Committee will investigate the Qualis Health [formerly PRO-West] Surgical Infection Collaborative as a means to initiate initial measurement and improvement at hospitals and surgical centers. . Qualis Health will launch the statewide collaborative in the Fall/Winter. ROI will be determined for this intervention, and the collaborative will be the basis for standardized measurement ongoing beyond this year
5. A VTE interest group will be launched this Fall, with discussion of impact and ROI in acute and post-acute settings. This will include Medicare Part A & B to discuss possibilities to eliminate funding disincentives for movement.

## Notes From Group 2

### Consumer Education

#### Ways To Get The Message Out To Consumers:

- Bumper sticker (1)
- Sign on bus (1)
- Brochures (1)
- Employee-handbooks (1/2)
- Posters (1)
- PSA–radio/TV/paper/computer (2)
- Video tape (2)
- Phone messages (1)
- Pre-school and forward (3)
- Medicine as a second language (3)
- School play (2)
- Group education (1)
- Website (1)
- Billboards (1)
- Newsletter (1)
- Pharmacy (1)
- Milk carton message (3)
- Movie – Hollywood (3)
- Senior centers (2)
- Elevators (1)
- YWMC/YMCA (2)
- Daycare (2)
- Post-office/ Government Centers (3)
- Grocery Stores (1)
- Sporting events (3)
- Bathrooms (2)
- Signs used between rounds at fights (3)
- Cultural (gender, religion, ethnic, social-economic) sensitivity of providers (3)
- Create a symbol/sign to encourage dialogue

Note: 1 – 3 indicates our ranking: 1 = easy 3 = more challenging

#### Content

- Joint Commission on Accreditation for Healthcare Organizations (JCAHO)
- National Patient Safety Foundation (NPSF)
- PULSE?

#### Ways To Engage Practitioners/Providers

- Professional associations (1.5)
- Continue education organizations (3)
- Educational Organizations (college & university that train (3)
- Work sites (clinic, hospital, association, pharmacy) (1.5)
- Pharmaceutical representatives (2)
- Health plan – care coordinator (1)

- Professional boards/commissions (1)

### **Methods To Engage Practitioners/Providers**

- Programs that get or give continuing education credits
- Educational organizations – train into culture
- Brochures
- Role playing
- Story-telling
- Dedicated educator
- Patient safety fair
- Games/contest

## **Informed Consent**

### **Target Audience**

- Consumers (patients and families)
- Providers
  - Physicians
  - Nurses
  - Hospitals
  - Long-term care
  - Ambulatory care
  - EMS
- Home Care
- Community groups
- Accreditation organizations
- Health plans
- Regulatory agencies
- Legal
- Vendors – TX
- Employers

### **Methods To Communicate With Consumers**

- Written EBP – specific to issue/procedure to include risk/benefit
- Video
- Web-based
- Group
- One-on-one

### **How To Address Concerns Of Informed Consent**

- Evaluation criteria (2)
- Measures – baseline & over time (2)
  - Focus groups
  - Tests
  - Survey
- Evidence based content (1)
  - General & to specific cultural groups
  - Experience to date related to litigation/settlement
- Build better systems – value added -) take away tasks without value (3)
- Rethink traditional roles/responsibilities (3)
- Start basic – raise the bar over time on content (1)

Other comments:

- Trained providers  
“know how & what to say”
- Cost-shaving

Note: 1 – 3 ranking: 1 = easy 3 = more challenging

**PROPHYLACTIC ANTIBIOTICS**

**Parties (self-interests):**

- Surgeons/MDs
- Patient/Family
- State and Federal Governments (all payors)
- Facilities (hospitals)
- Regulatory (State)
- Manufacturers
- Staff
- Employer (RTW)
- Anaesthesia Providers
- CDC
- Home Health

**Positive Forces:**

- + no infections
- + professional satisfaction
- + LOS
- + cost overall
- + quality outcomes
- + patient satisfaction
- + no adverse drug reactions
- + informed consent
- + reinforces collaborative approach

**Negative Forces:**

- resistance to in practice
- turf wars/who's in charge
- evidence?
- organism resistance
- logistics
- informed consent
- adds up front costs

**Prophylactic antibiotics in appropriate surgical procedures.**

*Prediction:* Logistical processes within hospitals will be area of resistance.

*Statewide Optimal Goal:* 95% of all appropriate pre-operative patients would receive appropriate antibiotics within 30 minutes of surgery.

- Measures:*
1. Establish that all hospitals participate  
~ educational approach
  2. Create uniform data collection tool after scanning for other similar efforts
  3. Baseline
  4. Improvement Plan/Measurement
  5. Ongoing Measurement
  6. Disseminate + Communicate
  7. Clearinghouse
  8. Partners  
~ Qualis Health

~	WSA	~	WSAHQ	~	AWHP
		~	Malpractice/Risk Mgmt	~	CMS
		~	WSHA	~	Hospital
		~	WSMA	~	MD
			(Interspecialty	~	Pharmacy
			Council)	~	Nursing
		~	WSPA	~	PHARMA
~	WSNA				

**Informing/educating consumers as to their roles as a participant/partner in ensuring their safety in care process.**

- hospitals
- consumers
- providers
- staff
- payors
- plans
- public health
- schools
- media
- employers
- professional associations
- regulators
- community Rx
- vendors

**Positives**

- + fewer errors
- + decreased costs resulting from errors
- + satisfaction for patients, providers, etc.
- + communication
- + health
- + new roles
- + knowledgeable consumer
- + litigation

- new roles
- up front costs
- more work
- fewer patients
- no \$ reimbursement for education
- unpredictable results
- diversity of patients drives complexity
- litigation
- patient complaints
- consumer demand for drugs, procedures, data (threatening that patients know stuff that used to be MD domain)

**Negatives:**

*Proposed Strategy:* Educate Consumers with common themes/messages  
 Poly Pharmacy  
 Speak Up

Sandwich Resources  
Informed Consent/Advanced Directive



**Goal:** Educate the general public of things they can and should do to participate securing safe health services.

**1<sup>st</sup> Year Baseline:** Statewide Coordination & Tool Preparation / Local Operational

1. secure numbers to send out card + paper bag (Premera +WSMA)
2. measure results of intervention (survey)
3. on-going improvement
  - ~ consider additional means of dissemination (media, senior newsletters, health plans, consumers, library)

support

~ consider I.T.

~ Apple Commission

~ phone books

~ cereal boxes (card)

~ milk cartons

~ newspapers

~ post office

4. poly pharmacy (> 50, add others by second year)

**By 2<sup>nd</sup> Year:** have had an assessment of poly pharmacy

1. 70% of over-50 population will
2. strategy for uninsured

**Partners:**

AARP + Plans (partnership)

Association for Health Educators

Pharmacy Schools

Senior Centers

Media

CMS

Public/Health/Local Access Coalition

Smart Rx Program

Service Organizations

Assisted Living

Rx Chains

Home Health

## Group 4 Notes

END GOAL: Improve Patient Safety

KEY STRATEGY: Improve the capture of errors and events, in order to identify trends and patterns, and target improvement efforts

OUR RECOMMENDATION TO ADVANCE THIS STRATEGY:

- Support collaborative activities which involve multiple organizations, have a focus on common data collection and assessment, and have an emphasis on expanding skills to strategies for addressing safety and quality issues. Examples include IHI-style Collaboratives, the existing WHF users' group for the Maryland Hospital Indicators.

- Identify neutral 3<sup>rd</sup>-party settings to facilitate information sharing and convene working groups in an atmosphere of safety. Examples include MHI users' group, and the proposed state-wide "coalition"  
Key actors: hospitals can pursue opportunities and forums for collaborative work and for sharing results of work they have already done. WHF will look for new participants to invite to MHI user's group, and new ways to publicize the work that comes out of such groups, to reach new audiences.

Purchasor reps could ask providers to sit down and talk with them about safety programs, plans, etc.

Purchasors could share new info/perspectives with others in their interest group, to advance the general understanding of patient safety work.

What will be better if these groups take these actions?

- partnerships between facilities will be enhanced
- best practices will be more widely disseminated
- the community will have a better understanding of patient safety, and of how to identify and choose safe care
- with an emphasis on voluntary collaborations, the risk of reporting errors is decreased
- with an emphasis on practices with strong evidential support, activities will likely coalesce around key topics, setting a de facto agenda for patient safety
- this is likely to lead to consensus-driven agreement on common measures and definitions, and sharing of data
- QA/peer review protections will be maintained
- patient safety will be advanced

## HOW DID WE GET HERE?

### Identifying Stakeholders and Interests:

<p><u>Providers:</u>          Improve their systems          Confidentiality of pooled data          Manage problems w/ specific staff          More information = choose safer practices          Competitive – want to be better than my colleague/other depts/other facilities</p>	<p><u>“Consumers”</u>          Employers – choose safe care; protect viability of my business          Patients – choose safe care          Community – protect the viability of businesses in our area</p>
<p><u>Payors:</u>          Differentiate between purchasing options based on data          Extend contracts with safe providers          Direct customers to safe care</p>	<p><u>Regulators:</u>          Protect the public          Share learnings with other institutions</p>
<p><u>Media:</u>          Sell papers, garner ratings, put up headlines          Protect the public</p>	<p><u>Trial Lawyers:</u>          Get \$\$ for self and clients          Make a big reputation</p>

### Common Desires/Agreement:

- Accurate, reliable, timely data
- Decisions driven by these data ( could be purchasing decisions, improvement priorities, etc)
- Prevent incidences/errors
- Avoid litigation
- Improve the quality of care
- Developing capacity to collect/report data is costly (e.g. CPOE, electr. medical record ...)

### Potential Areas of Disagreement:

- What data are collected?
- Reported to the state-wide pool?
- When, how and with whom information is to be shared
- “Appropriate” use of data by others?
- What is an error
- Who bears the cost for care if it arises as a result of an error?

### What drives disagreement?

- I’m afraid the data may be used against me/my institution
- I’m concerned that secrets are being kept
- The data are complicated and hard to understand. Will everyone understand them / use them in a common way?

## WHAT ACTIONS WOULD WE PROPOSE TO ADVANCE OUR KEY STRATEGY? (Brainstormed list)

- Define errors
- Learn from industries that are more open
- Pay everyone to provide data
- Advertise error rates
- Invite external reviews from others
- Provide a technology solution for collecting and monitoring the data
- 3<sup>rd</sup> party mediation of complaints
- Create a state-wide program to monitor errors
- Electronic capture of clinical data
- Electronic system to flag near misses
- Employee training – honestly state errors, why, how, what is gained
- Demonstrate to reporters that reporting leads to improved care
- Have a plan for responding to trends
- Provide a common state-wide database
- Grace periods for reparative actions
- Tort reform (Limit tort awards to actual damages, no punitive damages, no-fault compensation, state-managed pooled fund for damages ...)
- Agree to report equally
- Data-sharing across organizations
- Internal focus groups
- Patient-empowered approach
- Rewards & recognition for safety ideas
- Share information with other providers
- Monitor the effects of new technology for data collection/reporting, to detect/prevent new sources of error

The work group chose top priorities based on their personal assessments of feasibility, degree of agreement among interests, time frame, resources, whether the action would “make a difference”. A consensus emerged that these items should be the top priorities:

1. Identify and employ methods, tools and processes from other industries that have successfully improved safety
2. Advance the implementation of electronic medical records
3. Train employees on the reasons, value, impact and methods of error reporting
4. Advance the creation of a state-wide pool of error/event data, collected and held by a non-regulatory body (e.g. WA Health Foundation, Fdn for Health Care Quality)
5. Provide a “buffer” for poor performance by allowing a grace period before public reporting, to assess the situation and implement improvements

Initial discussion of an action plan focused on creating a state-wide data pool. As the discussion advanced, it became clear that there was not agreement that this was the right first strategy for all to support and recommend. Work group members discussed objections and what would address their objections. The following table includes highlights of that discussion.

WHAT I WANT TO GET	WHAT I'M WILLING TO GIVE TO GET IT
<p>Hospital: protection in the marketplace</p> <p>Buffer zone to fix problems ID'd in reporting</p> <p>Focus on those things strongly proven to improve safety (e.g. 14 recommendations)</p> <p>Assurance that data-sharing won't accidentally create a disincentive to report, negatively impact the culture of reporting</p> <p>Representation from all participants in discussions about safety initiatives – including patients</p>	<p>Anonymous reporting</p> <p>Deep descriptions of how we address safety, our systematic plans, internal structures and methods, etc.</p> <p>Participate in voluntary IHI-style Collaboratives</p>
<p>Purchasers: assurance that organizations I do business with aggressively and systematically attend to patient safety</p>	<p>"We'll back off" from some strategies</p> <p>We'll go to bat for you with others</p> <p>We'll help educate consumers and business on what robust patient safety systems look like</p> <p>Buffer zone to fix problems</p>

In the course of this discussion the theme of voluntary collaborative activities emerged, and work group members began throwing out existing avenues for this kind of collaboration that they were familiar with. The final recommendation took shape from this exchange, with good consensus among work group members.

## Group 5

This Workgroup focused on providing useful information on safety and quality issues for providers and patients.

Its objectives were to:

I. Develop a patient safety coalition to

II. Assist and healthcare organizations to develop information into useful messages to:

- pursue the three leapfrog recommendations initially
- pursue other patient safety initiatives subsequently

III. Develop good and common measures of performance changes and outcomes due to the implementation of patient safety initiatives

These three objectives are detailed below.

### I. Develop a patient safety coalition

A. Forming a coalition is the necessary first step in making an advance.

B. This is a process, rather than a content, step, because the patient safety interests among organizations and sectors are not yet aligned. It is necessary to stop the divisiveness within the industry and a sense, by different sectors, of "being done to" in patient safety. It is also necessary because Washington state may be a special case with regard to the statistics on patient safety matters, not directly reflective of national statistics. The purpose is to create aligned and knowledgeable constituencies and to reduce the individual risk of participating individuals and organizations for their participation in advancing patient safety recommendations.

C. The guiding principles of this coalition include having the same goal and focusing on the goal. The purpose is to have one coalition, not several, pursuing patient safety advances. One coalition requires having one agenda, one set of messages, one set of projects, and one set of measures. The convening body should be neutral among the several sectors of the healthcare industry and have sufficient time available to make progress.

D. The participants in a coalition are or should be driven by the patient safety agenda. Participants may be drawn from hospital administrators, physicians, nurses, pharmacists, members and patients, member groups, consumer associations, professional and institutional associations, sponsoring organizations, plan executives, purchasers, employers, risk managers/insurers,

Qualis, FHCQ, and similar foundations. Once the focus and plan have been developed, the coalition may need measurement specialists, financial analysts, marketing and other consultants, and communication specialists. Other participants may be required as additional evidence-based recommendations begin to be pursued.

E. Participants/partners need to find that their interests are served by the coalition in a gain-gain approach. This requires a continuous process to identify the critical self-interests of participants and acknowledging them. The approach should be proactive, taking the moral high ground on patient safety rather than being driven by negative media. The approach should also include building physician/patient trust and buy-in. The approach should begin with the IOM and other significant reports on patient safety to encourage rapid consensus. The purpose of the coalition should not be to sell the idea of patient safety but to provide the specific information about issues, advances, and the necessary system adjustments required to make progress.

F. There are significant barriers to patient safety advances that the coalition must be aware of. For example, on the initiative dealing with the use of intensivists in intensive care units, there are tangible costs to hospitals and purchasers, limitations on the supply is of providers, perceived challenges to primary care providers, cultural reluctance, telemedicine, scheduling and other infrastructure problems, physician distrust, and physician independence and their own agenda for survival.

G. The proposed timeline for forming a coalition was short -- 3 months. The following tasks were suggested:

- Produce a report as soon as possible of the conference
- Quarterly meetings starting September 2002
- Developing the required paperwork for a sound organization
- Relying on existing startup dollars to begin
- Quickly recruiting more funding sponsors
- Recruitment of chief executive officers and other significant players
- Developing an effective communication system through newsletters and other means
- Forming an initial steering committee

H. Participants at this table agreed to make the following immediate individual commitments to patient safety:

Payer -- develop a process in my organization to communicate with other hospitals on the patient safety issues.

Hospital -- share our best practices on patient safety, by convening discussions with other hospitals.

Payer -- adopt a surcharge on services to develop the needed metrics about patient safety; write a plan that is COAP-like on patient safety

Hospital -- talk to my leadership team and physicians to get buy-in, develop and rely on peer pressure

Payer -- report to my headquarters and seek buy-in from them

Risk manager -- discuss these issues with other risk managers, reinforcing the communications issues on patient safety

Hospital -- talk to my hospital Quality Improvement Council and Chief Executive Officer to get buy-in

Professional association -- bring this issue to the practice committees who will take it to their host facilities; take the AHRQ and non-AHRQ recommendations to the safety committees; take these issues to the professional conventions and also make them a union issue; assist in developing messages reported out in newsletters and similar media.

I. Finally, the workgroup looked at what they hoped would have happened within two years time:

- The three initial recommendations will have "traction", the mean on these practices will have risen and the variability across sites and practitioners will have decreased.
- There will be an inter-institutional shakeout and market differentiation among hospitals on these practices and patient safety in general.
- There will be more acceptance of this issue and how to talk about it in the industry.
- Leadership among physicians in Washington will have developed on patient safety.
- Patients and patient safety will become primary concerns within the industry.
- Hospitals will adopt a proactive culture on patient safety.
- There will be clear financial commitments to patient safety.



- Healthcare in Washington will have a patient safety model similar to the aviation industry's model in safety.
- Surveys will show that the public expresses much greater trust on these issues.
- Surveys will show that providers are more comfortable with sharing information on patient safety.

And, in three years time, there will be a common set of measures and baseline information to examine and show improvement in patient outcomes and practice variability.

Ila. Assist healthcare organizations (e.g., plans, payers, providers, hospitals, carriers) to develop and translate information (data, evidence) into useful messages regarding:

- intensive care unit utilization and staffing
- medication safety
- high-volume specialty referrals

Extensive initiatives regarding these three advances have already begun and could be built upon, followed by pursuit of other recommendations such as the 11 appearing in the AHRQ report.

The group felt that overcoming communications errors among providers within institutions and between providers and consumers would provide a quick win, through immediate startup, small-scale initiatives, and reasonable investments committed to known returns.

Members of the group suggested a variety of communications issues that required attention including patients knowing what their medications were; the correct surgical site identification; informed consent and advance directives; informed decision-making by patients regarding providers and hospitals; communications training for providers in working with patients; data collection and data protection about provider and hospital performance; getting evidence-based information to consumers before they become inpatients and still have "teachable moments"; easing the learning curve for patients; determining what information consumers need and can actually understand and use; getting quality improvement information to providers; communicating more effectively with patients about prevention and self-care; publishing better comparative information on providers and hospitals to patients, members, and consumers at large; resolving the issue of too many clinicians providing separate information to the same patient; communication via telephone and computer; transportability of patient information across the Internet and on individual patient cards containing computer chips; improved communications between payers and providers; the role of informatics in decision-making; communication as the basis of collaboration; finding ways to filter excessive information into useful information; making performance measures transparent; understanding the multiple information bases on which consumers make decisions; determining what information regarding patient safety advances should be communicated to members/consumers and in a non-threatening way; providing patients with information about how to protect themselves at/before admission to the hospital; finding an advocate in the hospital; and so on.

Ilb. Assist healthcare organizations to communicate with and educate patients on patient safety issues.

The group briefly discussed using existing training models of provider communications that were already evidence-based, such as those at Miles and Kaiser. These, they suggested, provided demonstrable advances through training in frequently asked questions, practice sessions, peer review, and role modeling.

### III. Assist healthcare organizations in the development of good and common measures of performance change and outcomes in patient safety.

The group endorsed the need for standardized performance reporting in ways useful to the industry and consumers, specific to procedures, medications, and so on; reporting would be tailored to the needs of specific audiences. For example, on certain procedures, information should be universally disseminated at the individual provider level.

## Group 6

The group sprang to action by sharing ideas on what high level broad issue and what specific issue would be best to work on. Several ideas were offered. Two broad over-arching concerns were the need for patient involvement in their own care and physician compliance with non-controversial evidence-based guidelines. Both involved different sorts of communications and actions in response to it. For patients, this included the need to promote self-management and self-empowerment, supporting “smart” consumer action. We noted that providers’ reaction to this might be varied and stressed that we did not mean that care should be consumer driven.

By physician compliance with guidelines, we noted that this could have a large and positive impact on practice. It would mean replacing or changing practice patterns, and we agreed that it is key to get the information to providers and then to assist them in using it and assess how it is used.

The two specific issues came from the “List of 14” and were the ICU Intensivist initiative from the Leapfrog Group and Informed Consent.

After some discussion we agreed that we should focus on the two specific issues, and by doing so, we could address the broader patient and physician communication in that context.

### **INFORMED CONSENT The range or scope of this is a general concern; what exactly do we mean by this term?**

#### **Self Interests**

Hospitals	It is a requirement already for certain things (e.g., admission, surgery)
	It provides legal protection
Patients	Basic “right to know”
	Fosters empowerment by providing information
Physicians	Part of the patient education they do
	Could be a distraction or disruption in their work
Plans	A benefit for patients
	Promotes the use of evidence in the process of informing patients
Regulatory	Challenge of standardizing this

Enlarged interests (where we agree)

Positives – It’s a good idea that patients be involved in their own care

Concerns

It’s unclear what the definition of “informed consent” is

The message and the method must be very explicit.

There are a variety of regulatory approaches that could be used  
 There are operational resource issues involved  
 This area involves many cultural challenges – both for different population groups and for the profession of medicine

Summary statement (what we want to see, the “enlightened interest”)

For all encounters, the patient understands and acknowledges the content of the encounter, including any applicable treatment options, knows what evidence exists for the options, feels safe and is respected regarding their belief system. The provider is responsive to the patient’s informed wishes.

Measures of success: patients acknowledge that informed consent happens.

Some action needed: (beginning to align our interests)

- Check with Patient Bill of Rights to see what language related to this is included
- Look at what health plans are doing or requiring of their provider networks
- Identify groups or partners to share this initiative
- Facilitate a Walk in the Woods for providers and plan enrollees
- Frame the best approach that emerges from this activity, including leadership for it

**An Action Plan for Aligned Work on Informed Consent**

**The goal would be to CHAMPION this objective**

The identity of the conference group (Coalition?, etc) is firm	within one month
Identify partners (providers & consumers)	2 months
Discuss/develop ownership [“Walk in the Woods”?]	Fall, 2002
Survey question or tool or method to measure success	Fall, 2002
Potential check or monitor activity	On-going

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**INTENSIVISTs IN ICUs**

A general discussion showed that concern is that this objective is framed too rigidly by the Leapfrog Group (requiring constant presence of a certified intensivist for the duration of a daytime 8 hour shift with no allowance that the person assigned can do anything else). We agree a goal could be a statement of some minimum standards for specialized care in an ICU. Entities that would have a special interest in this would be The Leapfrog Group, the national group of Intensivist physicians, practitioners in general, and small hospitals. In addition, purchasers, plans and state-wide groups such as the Hospital Association (WSHA) and medical association (WSMA) would be interested. There are implications of this for graduate medical education and productivity impact on other providers.

## Self-Interests

Hospitals	Cost of implementation Quality makes sense Potential domain issue – professional, perhaps labor
Patients	perception of high quality Possible misunderstanding of where this applies, where it is appropriate
Physicians	Clinically desirable Bad operationally (as stated by Leapfrog Group)
Plans	Variation of provider & facility capacity & resources Has to be cost-effective Has to have evidence to garner support
Purchasers	Quality care is good Concerns for the cost – potential to affect premium
Regulatory	What priority would be given to this Would there be a credentials issue

## Enlarged interests (what we agree on)

### Positives

- It's a good idea
- It is evidence based

### Concerns

- The Leapfrog initiative is too rigid
- Cost
- There is a shortage of intensivists
- Has potential for disruption of culture & patterns of care
- Potential for misunderstanding by the public, both positive (good quality) and negative (appropriateness, market impact)

## Summary statement (what we want to see, enlightened interest)

Every patient admitted to an ICU is evaluated and decisions for care are made by someone with intensivist skills. An intensivist will be available on short notice for the duration of the patient's stay should they be needed.

## Measures of Success:

- The proven outcome is that status and outcomes improve and morbidity & mortality in ICUs decline
- 100% of WA hospitals with ICUs meet this standard
- Injury and avoidable errors in all ICUs decline
- Costs of ICU stays decline

## Action Plan (aligned interest) for Leapfrog Intensivist Initiative

- Get identity for this group (as first item for 'informed consent' issue) one month

Hone our language and develop a strong rationale for it months	3 to 6
Let other interest groups know our intentions 2003	by Jan
Speak to the Puget Sound Advisory Group related to Leapfrog initiative Call Arnie Milstein to explore Leapfrog position	
Take a "Walk in the Woods" with opposing parties 2003	Feb

## Patient Safety Conference

### Group 7

#### **Recommendation #1: Prophylactic antibiotic use and surgical site infection.**

Major strategies: use the CDC guidelines for definition of what a nosocomial surgical site infection is (so that everyone is talking about the same thing), and use best practices and processes to optimize prophylactic antibiotic use and decrease infections.

One-year goals:

- (1) Every hospital in the state uses the CDC guideline
  - Evaluate current use of the guideline (not every hospital uses it)
  - If not using, determine why
  - Establish policies and procedures for using the standards
  - Report who has adopted use of the standard
  
- (2) Develop best practices and processes
  - Work with hospital stakeholders
  - Use consensus process to adopt/endorse best practice standards for antibiotic use
  - Implement use of processes to implement the recommendations
    - Each hospital develops its own processes
    - Develop a formal collaborative process statewide

Two-year goal:

Peer (hospital) reporting of infection rates?

Three-year goal:

Consider public reporting of infection rates?

Also expand to additional settings (e.g., outpatient surgery) as research is available to support antibiotic use.



**Recommendation #2: Use of Computerized Physician Order Entry (CPOE) systems.**

We had significant discussion about the multitude of barriers to acquisition and maintenance, and initially focused on strategies to obtain funding as a major barrier. We then agreed that the respective self-interests of the major players, primarily the hospitals and LeapFrog, had to be explored before funding searches could go forward. Although the long-term goal is to increase funding available for acquisition, implementation, and maintenance, we identified the following six-months goals:

Goals: Gain a shared understanding among stakeholders of the challenges and opportunities associated with CPOE; develop a plan for funding.

Primary strategy: Convene the key stakeholders for a “walk in the woods” about CPOE – LeapFrog, employers, hospitals, consumers, state pharmacy, small business, and labor