

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 26, 2005**

Category: Implementing Safety Systems in HCOs

Code 15 (Collaboration) – Interorganizational Collaboration: The submitted testimony recommends: Encouragement of programs and/or initiatives where organizations make a commitment to work together in a collaborative manner (e.g., shared goals and commitments) to solve complex patient safety challenges.

Recommendation #D5: All organizations and practitioners concerned with the delivery of health care services and consumers are encouraged to work collaboratively in order to generate innovative solutions to patient safety challenges and to expedite the translation of these solutions into practice to improve patient safety in Michigan.

Recommendation #D5a:¹ An appropriate state-level structure that encourages collaborative interactions and concerted action around patient safety should be established for the purpose of providing organizations and practitioners concerned with the delivery of health care services plus patients, families of patients and other consumers a “place” to work together to:

- Increase everyone’s awareness of patient safety as an important health care concern
- Develop and prioritize Michigan-specific patient safety goals
- Share expertise and best practices around patient safety strategies
- Develop creative strategies to improve patient safety in Michigan, and
- Report progress in improving patient safety.^{2 3 4 5 6 7 8 9 10 11}
Examples of areas needing creative solutions: reporting of adverse events and near misses, inclusion of rural health care practitioners and facilities in patient safety initiatives¹², shortage of nurses for staffing hospitals¹³, implementation of electronic health records¹⁴ or other information technology solutions.

Recommendation #D5b:¹⁵ All organizations and practitioners concerned with the delivery of health care services including the State of Michigan should expedite the translation of patient safety relevant evidence into practice through supporting and participating in collaborative learning opportunities.^{16 17 18 19 20}

Rationale: The unique advantage of using a collaborative approach to address a complex (and non-competitive) issue such as patient safety is the power to combine the perspectives, resources, and skills of groups of people and organizations – to create synergy and to overcome the problem of small numbers. Breaking through “business as usual” approaches to innovate is the

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key to getting the most from working together. A successful collaborative relationship around patient safety will:

- Generate creative, comprehensive, practical, and transformative thinking
- Strengthen action by bringing together both partners with similar strengths and technologies and partners with different strengths and technologies to allow a multi-faceted comprehensive approach to a complex problem
- Provide a mechanism for reaching out and engaging the greater community in a way that can strengthen even further the thinking and increase the resources, skills, and support available to work on the problem of concern²¹ and
- Generate sufficient data through pooling information from multiple entities to allow identification of the processes that impact the outcomes of care.

Evidence and/or information on comparable initiatives being carried out in other states:

Patient Safety related Collaborative Learning in Michigan

A wealth of patient safety-related collaborative learning projects are underway in Michigan with many Michigan organizations taking lead roles and themselves partnering with national experts and funding agencies to develop and implement the initiatives.²²

The indication that many collaborative learning projects are in progress in Michigan raises interest in discussing whether it would be useful to patient safety improvement efforts in the state to have a state-level understanding of who all are participating in these collaborative learning opportunities, how much the guidelines from the various collaborative initiatives and programs have permeated throughout the state, and what kind of data collection/evaluation is occurring to assess the long-term effects and sustainability of these initiatives and programs. Where is the next “push” needed? Do practitioners and systems need to know more about what should be done or more about how to do it and sustain it? Is there a need to focus more intensely on changing state-level climate/culture around patient safety?

Collaborative Learning in Other States:

Minnesota: The Institute for Clinical Systems Improvement, a collaborative of 50 medical groups and hospital systems (including 55 hospitals and 7400 physicians) was formed in 1993 to establish structure for concerted action around evidence-based health care throughout the state. It has collaboratively developed guidelines and trains and coaches members in system improvement - “The most difficult passage on the road to evidence-based health care is achievement of systems thinking in our organizations.”²³

Wisconsin: Between 8/01 and 7/02, the Wisconsin Patient Safety Coalition fielded a CMS approved and Wisconsin Patient Safety Institute endorsed medication safety practices project. The effort included a clearinghouse, guest

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speakers, monthly phone calls, the formation of groups focused on self-selected medication safety practices, coaches for the groups, monthly statistical progress reports that tracked process outcomes/quality indicators and a final learning congress/celebration. At the end of the project, progress on the desired outcomes ranged from 60-100%.²⁴

Georgia: The Partnership for Health and Accountability is a comprehensive, voluntary patient safety program developed by the Georgia Hospital Association in association with State regulatory agencies and health care professional groups. Its purpose is to translate research or care innovation into broader clinical practice through the active processes of dissemination and implementation. Examples of programs in each of these areas can be found in Table 1 reproduced in the Endnote section. Two outcomes noted: 88% of hospitals reported data for CQIP in 2003-04 and the mean error rate for targeted medication errors decreased 35.8%.²⁵

Colorado: The mission of the Colorado Patient Safety Coalition is to foster development of a statewide culture of patient safety in Colorado. This is accomplished by: e.g., promoting collaborative efforts and programs among facilities and health professionals.²⁶

Maryland: One of the foci of the Maryland Patient Safety Center is collaboration and education. It facilitates education activities and collaborative workshops for providers to share information, best practices, lessons learned and implement system changes. The Maryland Patient Safety Collaborative Workspace is a place where health care providers work together to study the causes of unsafe practices and put practical improvements in place to prevent errors. Collaborative Patient Safety Teams will receive coaching, tools, and measurement strategies to both improve care and track progress (CUSP, Comprehensive Unit-based Safety Program) and then work through interventions shown to impact quality and safety of care and ultimately reduce mortality in Maryland hospitals.²⁷

Missouri: The 2004 report to the Governor calls for a new private Missouri Center for Patient Safety to act as a leadership vehicle for patient safety improvements and be a resource for healthcare organizations, professionals, and consumers. It should:

- Provide leadership for improvements in patient safety.
- Develop and promote minimum patient safety standards for healthcare organizations and professionals.
- Establish a “consumer coalition” to make the patient a more active, better-informed member of the treatment team.
- Act as a research institute for the collection, analysis, and sharing of patient safety data.
- Promote the use of best practices in all healthcare settings.

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- Assist healthcare organizations in developing counseling resources and support groups for patients and facilities affected by adverse events and outcomes.
- Develop and promote undergraduate, graduate, and continuing education curricula on patient safety through an “education coalition.”
- Assist outpatient settings, such as smaller physician practices, in developing patient safety models that adapt to their size.
- Develop and implement award/recognition programs for outstanding patient safety achievements.
- Adopt a common terminology and data sets for patient safety in Missouri.
- Act as the state patient safety organization if federal legislation passes.²⁸

General Information on State Patient Safety Coalitions:

Common goals include:

- Sharing information and resources through collaboration;
- Leadership development;
- Creation of a “non-punitive” culture to encourage incident reporting;
- Education and advocacy to inform professionals, policy makers, and the public about error prevention strategies; and
- Avoiding duplication of efforts among the many organizations concerned with patient safety.

To promote best practices and clinical excellence, coalitions create and distribute a variety of tools to promote best practices and clinical excellence. These include:

- Identifying, evaluating, and promoting patient safety best practices;
- Promoting creation of a culture of safety to encourage learning from adverse events and near misses;
- Creating and/or disseminating self-assessment tools for medication errors, leadership practices, or safety culture and encouraging member organizations to use the tools and, in some cases, collecting and reporting results of these initiatives;
- Implementing statewide programs to assess and reduce specific types of adverse events, for example, surgical wound infections;
- Promoting adoption of clinical practice guidelines; and
- Developing or sponsoring important patient safety research projects.

Coalitions are important forums for stakeholders to share new ideas about error prevention, especially as relationships mature and members feel more comfortable with each other. They offer all parties the chance to test ideas, to learn if there are unanticipated or harmful consequences of actions or policies they are considering, an important benefit, given the lack of well-tested error management models in health care.²⁹

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Rural health care delivery challenges:

Challenges facing health care providers in rural areas are summarized in the following table. The IoM report *Quality through collaboration: The future of rural health* presents a number of recommendations for federal agencies to assist rural communities in addressing their unique challenges but it is not clear if or how quickly these recommendations will be acted on. In particular, the financial constraints of rural health systems may make it hard for them to participate in innovative efforts intended to stimulate fundamental re-design of the health care delivery system. Creative solutions may be necessary to assist these providers to fully participate in patient safety improvement initiatives.

Rural Health Care Provider Challenges³⁰

<i>Financial stability for health delivery systems:</i>
<ul style="list-style-type: none"> ▪ Small scale and low hospital operating margins impact ability to afford innovations ▪ Continued concerns about equity of Medicare payments to physicians; lowered payments from Medicaid have heavily impacted providers
<i>Data</i>
<ul style="list-style-type: none"> ▪ Rural-specific comparative data needed on some aspects of the care process (e.g., ER care, stabilization, and transfer services for AMI) ▪ Redesign of payment program may leave rural communities behind depending on the applicability of standardized performance measures & performance-based payment approaches to rural providers
<i>Customized tools to fit local needs</i>
<ul style="list-style-type: none"> ▪ How to adapt quality improvement knowledge and tools (e.g., evidence-based reports, practice guidelines, standardized performance measure sets) when clinical care may need to be viewed within the broader context of population health and community-wide collaborative structures in order to support an integrated approach to decision-making ▪ Need for flexibility in developing QI programs so as to have the greatest impact in the rural context, e.g., regional base may make more sense than individual provider base
<i>Information and communication technology</i>
<ul style="list-style-type: none"> ▪ Little or no access to Internet (let alone high-speed connections) and populations with minimal ICT experience ▪ Surcharges and administrative fees levied by LATA networks can make data exchange prohibitively expensive ▪ Most rural systems are in critical need of financial and technical assistance to establish electronic health records and secure platforms for health data exchange ▪ Health professionals and consumers need access to online information sources and technical assistance with online applications such as distance monitoring. Health professionals need distance education programs.

Evidence shows that rural health care providers affirm the importance of patient safety and want access to tools and resources to help achieve the goal of improving it.^{31 32} They are also very concerned about issues related to reporting and disclosing errors since decisions related to this can have particularly far-

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reaching consequences in rural settings where people's lives can intersect every day.

Pros:

- Collaboration offers the power to combine the perspectives, resources, and skills of groups of people and organizations and create a whole that is greater than the sum of its parts. (If I can bring water and you can bring an onion, we can make a thin broth. If others bring carrots, potatoes, parsley and maybe a chicken(!), we will have a tasty soup.)
- Successful collaboration generates creative, comprehensive, practical, and transformative thinking.
- The participants in a collaborative can shore each other up when the going gets rough.

Barriers:

- Time and other commitments
- Competitiveness and lack of trust
- A dislike of spending time on process versus cutting straight to tasks directly related to the outcome desired
- Fear or distrust of change

Additional Comment/Concerns:

Collaborative approaches require resources and nurturing. Getting the most out of collaborating may mean learning to work with competitors in a non-competitive way. Organizations need to see what they will gain from working collaboratively. When participation is voluntary and the goals of participants' own institutions compete with participation on an external collaborative, it is likely that the collaborative will lose and be unable to consistently sustain its work over time.³³

Implementation Steps:

- Decide that collaboration will be a strategy in your toolbox for fixing Michigan's patient safety crisis.
- Come to agreement on the type and location of state-level structure to serve as the "place" for all concerned with patient safety to gather to work together.
- Identify specific goals to be accomplished and a timeline for progress checks.
- Determine what resources will be needed to support this "place" and make arrangements for them.
- Make a commitment to assist small and/or rural health care providers to participate in patient safety initiatives and projects.

Cost: TBD

Implementation Target Date: TBD

Grade: TBD

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¹ Compiled from 8 of 17 recommendations (from 8 informants) coded 15 (Collaboration), 1 testimony concern, and 1 published document.

² Recommendation – Testimony 807-B (professional organization) “Having said that, we would like to provide some practical evidence that our efforts are successful and hope as a result, that the Commission ensure a continued role for ICP input when designing future, safer healthcare systems in Michigan. [W365-367] This is clear demonstration of the activities that are ongoing in Michigan and APIC-GD and MSIC are interested using these and others as examples to assist the Commission with its goals of collating safety initiatives and developing recommendations to share with providers, purchasers, and the citizens of Michigan. We plan to build on this collaboration and approach in future educational events and would welcome opportunities to formally participate in Michigan Health & Safety Coalition educational events as well. [W422-427] We believe we can assist the commission as the issue develops in the near future. [W481-482] APIC-GD along with MSIC, by utilizing its’ extensive network of members in almost every setting along the continuum of care is pleased to offer the Commission its support and expertise for the following improvement interventions. [W505-506] The items above are only a few of the ways APIC-GD, MSIC and all Michigan ICPs, can assist the Commission with its assigned responsibilities.” [W531-532]

³ Recommendation – Testimony 808-B (professional organization) “There must be collaboration with healthcare professionals to develop strategies and raise awareness.” [O 203-205]

⁴ Recommendation – Testimony 810-O (professional organization) “Michigan hospitals accept responsibility for improving care and safety and are aggressively forging new methods of bringing the best evidence-based care to all Michigan citizens. We know, however, that the journey has only begun. [O133-137] On behalf of the 144 acute care hospitals in Michigan, I invite you to hold us accountable and work with us to make healthcare safer.” [O158-160]

⁵ Recommendation – Testimony 811-O (professional organization) “We hope this Commission will ultimately help develop additional educational programs to assist our members to be better equipped to protect the safety of our patients. [O40-43] We also welcome the opportunity to work with you in developing these programs and presenting these programs. [O44-46] Our association stands willing to collaborate with other organizations to address patient safety.” [O55-56]

⁶ Recommendation – Testimony 822-B (professional organization) “... collectively they (MICAH hospitals) are providing a significant volume of patient care to their share of Michigan communities. In addition, most of the facilities serve as a hub of rural healthcare activity that forms the nucleus for noncompetitive networking with a variety of providers in their local communities. The roots of integrated healthcare and continuum of care development have already begun and are essential in any discussion concerning rural healthcare performance improvement.

Coordination of EMS and first responder activities and support of the development and recruitment of primary care providers round out this significant and diverse set of responsibilities for the rural CEO and Governing Board. For these reasons it is believed that the Commission will be well served to include MICAH and other similar groups in the process of defining methods to improve patient safety. [W 36-47]

As plans develop to look at the vast array of continuum providers it is believed that the Michigan Center for Rural Health and MICAH can be excellent partners in your efforts. [W 122-123] Any effort to improve the performance of overall healthcare systems and impact safe and quality care must include critical access hospitals. [O 36-38] In closing, I would like to say that the quality network supports the efforts to provide safer care throughout Michigan. We share your commitment to serve and look forward to working with you to identify plans to achieve improved patient safety and reducing medical errors.” [O 80-85]

⁷ Recommendation – Testimony 828-W (professional organization) “Regulation and legislation must support collaborative approaches among hospitals, physicians, hospital employees, and health plans to stimulate and improve patient safety and must be non-punitive.” [W 96-98]

⁸ Recommendation – Testimony 405-O (consumer) “Today I’m going to briefly review the mission and goals that were developed in that workshop. I offer them really to you as recommendations for you to think about and consider as you move forward in your patient safety work in Michigan.

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[O56-60]

To begin with, our mission is for a healthcare system that is safe, compassionate and just. How will we achieve that mission? We have six goals. [O164-167]

The second goal is to create consumer-led advisory councils, preferably at the community level, to really be sort of a standing focus group for healthcare providers in the community to go to consumers for their input on everything from patient education materials to facility design to any of the other issues you've heard today." [O178-185]

⁹ Recommendation – Testimony 606-W (insurer) “At Health Alliance Plan (HAP), we believe that a true partnership among insurers, providers and purchasers will make it possible to improve patient safety. [W80-82]

¹⁰ Recommendation – Testimony 103-O (hospital) “Similarly, so that each institution doesn't have to reinvent the wheel, I think it's important to develop a means where institutions can share their solutions, share best practices. ... And anything that can be done through statewide efforts to encourage the sharing of those practices I think would be very helpful.” [O 94-97, 101-103]

¹¹ Concern – Testimony 606-W (insurer) In fact, [a true partnership among insurers, providers and purchasers] is the only realistic way to move forward; in many instances, smaller hospitals and health facilities could not afford to implement the high-cost solutions discussed in these proceedings on their own. [W82-84]

[Rationale re: health plans] [...to ensure access to cost-effective, high-quality health care....] Our methods of paying for care must reward delivery of the right care at the right time in the right place. [W90-91]

[Rationale re: patients] For instance, consumers who understand the value of generic drugs can help control pharmaceutical costs, and patients who understand that antibiotics don't cure colds are less likely to pressure doctors to prescribe them. [W101-104]

[Rationale re: purchasers] Quality-based competition among health plans results in improved patient care, greater efficiency and better value for the health care dollar. [W107-109]

¹² Committee on the Future of Rural Health Care, Board on Health Care Services (2005). *Quality through collaboration: The future of rural health care*. Washington, D. C.: National Academies Press. Retrieved 5.23.05 from <http://www.nap.edu/catalog/11140.html>

¹³ Recommendation – Testimony 105-B (hospital) “I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan. [W 16-19; O 24-29]

And lastly, nurse staffing and nursing vacancy [“rates” added in oral]. We need to create partnerships between hospitals, colleges and universities to increase the numbers of young women and men entering the nursing profession. This will require increased funding for schools and scholarships. [O 251-258; W 140-142] Having an appropriate number of new registered nurses graduating from nursing programs is critical to providing a safe environment for patients.” [O 205-208; W 110-112]

Recommendations [from Executive Summary]: “Partnerships must be promoted between hospitals and schools of nursing to increase the number of young women and men choosing nursing as a profession.” [W 182, 188-189]

¹⁴ Recommendation – Testimony 904-B (Other) “MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include.” [W 61-62; O 19-20] “The implementation of electronic health records” [W 65; O 21]

“A key area where patient safety can be improved and produce positive results involves the adoption of interoperable electronic health records (EHR).” [W 180-181]

“A key area where partnering can produce results involves the adoption of electronic health records. One day in the not too distant future physicians will be able to share patient records across the information highway.” [O 39-41]

“In April of this year, President Bush called for widespread adoption of electronic health records within 10 years.” [W 189-190; O 46-47]

¹⁵ Compiled from 5 of 17 recommendations coded 15 (Collaboration) plus one recommendation coded 10.24 (Resources/ResEval) from 5 informants.

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5/24/05; updated 9.26.05 & 9.29.05

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¹⁶ Recommendation – Testimony 212-W (provider) “The state could provide financial incentives to organizations who design “safe” facilities and who implement meaningful patient safety programs and support “evidence-based” collaboratives. [W259-261]

¹⁷ Recommendation – Testimony 204-B (provider) “Fund patient safety/risk reduction demonstration projects involving small to medium size practices or a collaborative of small to medium size practices.” [W134-135]

¹⁸ Recommendation – Testimony 110-W (hospital) “Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Provide a learning environment and coordinated project techniques similar to the MHA Keystone ICU project (uses collaboration and support) [W 100-101]) for advancement of additional operational implementations. [W 126-128] Continued efforts to help healthcare organizations to engage with each other will lessen the steep learning curve and the ability to build on each other’s experiences.” [W 94-96]

¹⁹ Recommendation – Testimony 904-B (Other) “MPRO firmly believes there are several quality improvement initiatives that can improve patient safety statewide. Recommendations include: [written: “Stakeholder”] collaborations to create systematic change [W 61-64; O 19-21] Collaboration is Key to Creating Systematic Change” [bolded in original] [W 71]

²⁰ Recommendation – Testimony 104-O (hospital) “I’d like to provide a summary of the nine initiatives which have assisted and supported our patient safety journey and hopefully this can be processed in other hospitals, these recommendations. [O9-13] We need to join and learn with others. Lots of organizations have a lot of good information. [O156-157]

²¹ Lasker, R. D., Weiss, E. S., & Miller, R. (2001). Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *The Milbank Quarterly*, 79, 179-205.

²² These include the MHA Keystone Center for Patient Safety and Quality (in particular its current ICU project), the many BCBSM and BCN quality improvement (particularly in the area of information systems) and hospital and physician incentive programs as well as the recent BCBSM Foundation funded project to encourage the sharing of safety-enhancing practices among hospitalists at facilities across SE Michigan, MAHP’s Integrating Evidence-based Medicine into Office Practice Systems, MPRO’s many education efforts with Michigan professional organizations, health care service providers, and community health coalitions (for example, the Guidelines Applied in Practice (GAP) Project, the Nation Pneumonia Project, the health literacy training project, the partnering with the Michigan Podiatric Medical Association to develop a diabetic foot assessment training for primary care physicians’ offices), the partnering of MICAH and M-PRO to develop transfer metrics appropriate for small and low volume hospital quality improvement efforts, as well as the participation of various facilities in IHI collaborative learning programs, e.g., Quantum Leaps in Medication Safety & Improving ICU Care plus the current 100K Lives Campaign, the Munson Medical Center / Northwestern Michigan College partnering to increase the number of nurses available in their local area (further discussed under the staffing recommendation area), and of course the efforts of the Michigan Health and Safety Coalition itself which include the guidelines for eight areas of hospital care and the Web-based intensive care unit toolkit.

Experience-based evidence is offered for the success of a number of these initiatives and programs, e.g., Testimony 811-O (professional organization): “This [the primary care provider diabetic foot assessment program] was a very successful project that resulted in greater diabetic foot screenings and we hope fewer lower extremity amputations in the future” (O47-56).

Testimony 110-W (hospital): “The MHA [Keystone ICU] process should be investigated closely and used as a benchmark for other focused techniques. Its methods prove the ability to change patient outcomes and cultural improvement via collaboration and support versus simply public accountability that causes the hospitals to “spin” as they attempt to respond to their environment.” [W 99-102]

Testimony 212-W (provider): “... national initiatives, such as IHI’s learning collaboratives Quantum Leaps in Medication Safety and Improving ICU Care and the CMS-CDC-sponsored Surgical Infection Prevention Collaborative. Such collaboratives have proven to be successful because they promote the sharing of information; promote learning from other “innovative” organizations, and foster the “spread” of evidence-based best practices throughout the organization.” [W242-249]

Testimony 904-B (Other) offers more systematic evidence for two

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projects: 1) "Leaders of the GAP Project estimate that if these [evidence-based guidelines for diagnosis and management of AMI] were implemented nation-wide, the mortality rate of acute heart attack could drop by as much as 25 percent; this translates into tens of thousands of lives saved." [W80-82; O35-37] and 2) "The effect of the efforts of many of our health and community agency partners including the Michigan Department of Community Health and Dr. Kimberly Dawn Wisdom our State Surgeon General, MPRO has realized more than a 55% reduction in our disparity rates among African-American Medicare beneficiaries within the health topic of diabetes. [Bolted in original] This reduction is phenomenal and has been recognized by CMS as the greatest reduction in the nation." [W 374-381]

²³ Mosser, G. (2004, October 18). How to grow evidence-based health care in a whole state. Presentation at the Wisconsin Quality and Safety Forum, Eau Claire, WI.

²⁴ Gold, J. A., Walker, S., Williams, N., Streicher, E., Kosseff, A., Schuch, R. (2002). A local project to affect the adoption of practices aimed at improving the safety of medication use in Wisconsin hospitals. Unpublished manuscript.

²⁵ Rask, K. J., Naylor, D., & Schuessler, L. (2005). Voluntary hospital coalitions to promote patient safety. *Advances in patient safety (Vol 3, p. 493-505)*. Retrieved 5.22.05 from <http://www.ahrq.gov/downloads/pub/advances/vol3/Rask.pdf>

Table 1. Examples of PHA programs that facilitate and support practice change

Dissemination	Implementation
Targeting, tailoring, increasing awareness, changing attitudes, increasing knowledge	Enabling or facilitating change in practice, local change agents, address barriers, local perspectives
<ul style="list-style-type: none"> ▪ Informs hospitals of prevention strategies, high-risk situations, and new guidelines via <ul style="list-style-type: none"> - Safety alerts - E-newsletters - Other publications 	<ul style="list-style-type: none"> ▪ Actively involves influential local providers and administrators on committees and as leaders
<ul style="list-style-type: none"> ▪ Organizes teleconferences/conferences/presentations on timely topics of interest 	<ul style="list-style-type: none"> ▪ Brings together peers from across the State's medical community
<ul style="list-style-type: none"> ▪ Conducts orientations to new initiatives or tools 	<ul style="list-style-type: none"> ▪ Facilitates change via local self-assessment and monitoring components through <ul style="list-style-type: none"> - Clinical studies - Safe medication use improvement plans (targeted medication error rate - mean decreased 35.8%) - Safety issue action plans(e.g., pressure ulcers, patient falls, deep vein thrombosis) - Patient safety award programs
<ul style="list-style-type: none"> ▪ Facilitates the sharing of data, best practices, and issues among hospitals 	<ul style="list-style-type: none"> ▪ Provides administrative structure for improvement activities and reduces the burden on individual hospitals
<ul style="list-style-type: none"> ▪ Provides via the Internet centralized, easy access to <ul style="list-style-type: none"> - Evidence-based practices - Tools such as bulletin board kits 	<ul style="list-style-type: none"> ▪ PHA field representatives provide onsite technical support for improvement processes

²⁶ Colorado Patient Safety Coalition: Retrieved 4.11.05 from <http://www.coloradopatientsafety.org/>

²⁷ The Maryland Patient Safety Center: Retrieved 4.11.05 from <http://www.marylandpatientsafety.org/>

²⁸ Missouri Patient Safety Report. Retrieved 4.13.05 from <http://insurance.mo.gov/aboutMDI/issues/patsafety/PatientSafety.pdf>

²⁹ NASHP (National Academy for State Health Policy), Public-private collaboration. Retrieved 3.28.05 from http://12.109.133.213/Files/gnl_44_patient_safety_coalitions_for_the_web.pdf

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³⁰ Committee on the Future of Rural Health Care, Board on Health Care Services. (2005) *Quality through collaboration: The future of rural health care*. Washington, D. C.: National Academies Press. Retrieved 5.23.05 from <http://www.nap.edu/books/0309094399/html/>

³¹ Strategies – Testimony 822-B (professional organization): “As the Commission develops plans to address patient safety issues, MICAH is offering their current expertise and experience to provide advice on inclusion of CAH facilities in the effort. We want to assist in evaluating performance measures, use of centralized collection systems, reporting processes, and development of a partnership program similar to the MPRO project. “ [W 107-111]”
“The other opportunity is to work with the MICAH to reach out to the local networking functions currently in place throughout the CAH rural community. “[W 113-114] [Essentially the same in the oral testimony]: “As the Commission develops plans to address patient safety issues, MICAH is offering to assist and help provide advice on how to include small rural hospitals in this effort. This opportunity also allows the Commission to reach out to the local networking functions which currently take place in the small rural communities. Critical access hospital facilities represents critical points of primary care and have formed relationships with their local primary care physicians, clinics, and health departments.” [O 68-79]

³² Cook, A. F., Hoas, H., & Guttmanova, K. (2005). From here to there: Lessons from an integrative patient safety project in rural health care settings. *Advances in patient safety (Vol 1)*. Retrieved 5.22.05 from <http://www.ahrq.gov/downloads/pub/advances/vol1/Cook.pdf>

³³ Alexander, J. A., Weiner, B. J., Metzger, M. E., Shortell, S. M., Bazzoli, G. J, Hasnain-Wynia, R., et al. (2003). Sustainability of collaborative capacity in community health partnerships [Supplement]. *Medical Care Research and Review*, 60(4), 130S-160S.