STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
JUNE 8, 2005

Category A: Leadership and Knowledge

Code: Consumer Protection/Advocacy (30): Submitted testimony recommends the inclusion of advocates for consumer/patient preferences and values in patient safety issue discussions aimed at general improvement of patient safety in a system or geographic area (e.g., specific hospital, region, or state).

Recommendation A1:
In keeping with the goal of safe, patient-centered care, finding concrete ways for the consumer/patient voice to become a legitimate and ongoing part of the structure and process of care delivery needs to be at the heart of patient safety efforts at the state level and within health care delivery organizations.[1]

> **Recommendation A1a:**
> State-level bodies and organizations involved in developing policies or designing systems, facilities and programs in patient safety should include consumers/patients as part of its composition.[2 3 4]
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> **Recommendation A1b:**
> By all means available, the state should encourage the development of consumer/patient advisory councils for hospitals, long-term care facilities, and at the community level to work within institutions and communities on patient safety issues and topics, from developing educational materials to providing input on facility design and re-engineering care processes. [5 6]
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> **Recommendation A1c:**
> Non-profit hospital boards should have appointments from consumers as well as community and employee organizations, to reflect the communities they serve and ensure they serve the public interest.[7]
>
> **Recommendation A1d:**
> The state should encourage a range of pathways to resolve disputes and address grievances when medical errors occur, that seek just and equitable redress for aggrieved parties. [8 9]

Rationale:
As one (hospital) respondent very succinctly put it,"…patients should be first and foremost in patient safety efforts in Michigan."[10] Recommendations we saw two weeks ago were aimed primarily at change in the provider/patient relationship. In complement, this set of recommendations moves up to the organizational level and aims to embed the practice of involving patients and their families in the design of care systems, processes and programs, at whatever level design and decision-making about the operation of organizations takes place. One part also

advocates for realignment of the injury compensation system in keeping with the principles of patient-centered care. In all, these recommendations respond to a number of concerns expressed in the testimonies and echoed in the literature:

- An unrecognized and often marginalized role for patients and families in decisions about care in general and patient safety in particular[11 12 13]
- Patients assumed to be (and treated as) passive and victims of errors, rather than active partners "capable of understanding and contributing to risk management, quality improvement and communication activities."[14 15]
- Anger and disappointment at the lack of support--and especially the lack of accountability--by caregivers and hospital administrators when medical errors occur[16 17]
- Frustration at the lack of alternate pathways for conflict resolution, other than litigation, when errors do occur, and bewilderment (and frustration) at the variability in compensation.[18]

Information on comparable initiatives being carried out in other states: There is no lack of support for the concept of patient- and family-centered care and its importance in implementing agendas in patient safety, whether the source is national level organizations such as the Institute of Medicine, the Joint Commission, the National Quality Forum, the National Patient Safety Foundation, or the Institute for Family Centered Care; state level patient safety centers, commissions, and consumer health care coalitions; or the patient safety literature. There is also an increasing (or perhaps a renewed) call for this goal to be translated into action by integrating patients and families into the structure and operation of health care delivery organizations as members of boards and planning committees, for example, or as teaching staff in educational programs on navigating hospital systems and improving communication between providers and patients.

Many health care organizations—hospitals in particular—have already addressed some of the issues identified here. Beverly Johnson of the Institute for Family-Centered Care, based in Maryland, presented a good number of examples at the Michigan Health and Safety Coalition 2004 Annual Meeting.[19] Among the organizations highlighted during her talk was the *Dana Farber Cancer Institute* in Boston, where patients and families:

- Serve on adult and pediatric Patient and Family Advisory Councils
- Educate oncology fellows and surgical residents
- Serve on the clinical quality committee, the patient/family education committee, and design planning committees
- Serve as patient representatives for clinical centers
- Interview candidates for clinical leadership positions
- Participate in "glitch rounds."
- Produce the *Side by Side* newsletter.

And at the Medical College of Georgia in Augusta:

- Patient- and family-centered care has been integrated into their strategic and master planning
- Patients and families serve on the patient safety committee and are involved in HIPAA planning
- Service excellence behavioral standards and patient/family centered care behavioral standards have been developed
- Patient advisors are used for specific programs wherever possible.

The Institute for Family-Centered Care[20] has a rich set of resources and much experience to help health care delivery organizations adopt the approach of patient- and family-centered care. The Institute recently partnered with the American Hospital Association to produce *Strategies for Leadership: Advancing the Practice of Patient- and Family-Centered Care,* A *Resource Guide for Hospital Senior Leaders, Medical Staff and Governing Boards*, which was distributed to AHA member hospitals. The document outlines the principles of patient- and family-centered care and offers resources, references and self-assessment inventories for hospitals to use.

With respect to the issue of injury compensation and conflict resolution, one respondent suggested creating a hospital/medical grievance commission, patterned after the Attorneys Grievance Commission.[21] Other avenues were proposed by JCAHO in a recent white paper on strategies to improve the medical liability system.[22] One of three major recommendations was creation of “an injury compensation system that is patient-centered and serves the common good”[23]. The discussion acknowledged the inadequacies of the current tort system in serving the best interests of both injured patients and physicians. The goal of restructuring “should be to reduce litigation by decreasing patient injury, by encouraging open communication and disclosure among patients and providers, and by assuring prompt and fair compensation when safety systems fail”.[24] Five sub-recommendations to work toward this goal called for:

a. Demonstration projects of alternatives to the medical liability system. Proposals included alternative compensation mechanisms, such as early settlement offers; dispute resolution through ‘no-fault’ administrative systems or health courts; and shifting liability from individuals to organizations;
b. Continued development of mediation and early-offer initiatives. Two demonstration projects underway indicate that this alternative can successfully limit litigation: one project in Pennsylvania is using mediated dispute resolution and a similar program in Colorado encourages physicians to communicate with patients when errors occur and apologize to them.
c. Prohibiting confidential settlements that prevent learning from events leading to litigation;

d. Redesign/replacement of the National Practitioner Data Bank – due to incomplete and underreported information; and
e. Advocating for court-appointed, independent expert witnesses to mitigate bias in expert witness testimony.

Support at the national level for peer protection as well as medical liability reform is an important part of the foundation for any similar effort at the state level.

Pros:

- Increased transparency to the community of health care delivery organizations and their clinicians
- Better health outcomes, greater patient and family satisfaction with their health care
- Better access to information tailored to the needs of patients and families
- Availability of tools and strategies - many steps can be taken that do not entail high costs, only the willingness and resolve to carry through on implementation

Barriers:

- Success relies on support from leadership in adopting philosophy and implementing tools at all levels of organizational
- Change in injury compensation requires legislative action as well as change in culture and behaviors – progress will be difficult and slow

Additional comment/concerns: Adopting an approach of patient-centered care at the organizational and community levels clearly needs to be part of and supported by the guiding principles underlying care delivery for all health care facilities. As such, the recommendations here will likely dovetail those under the heading of guiding principles and leadership. In Round Two, links between these two sets of recommendations, as well as recommendations related to consumer education and patient inclusion will need to be made.

Implementation steps: TBD

Cost: TBD

Implementation Target Date: TBD

Grade:

Endnotes

[1] Compiled from seven recommendations in six testimonies (1 hospital; 4 consumers; 1 insurer)
[2] Testimony 102B
[3] Testimony 403O
[4] Testimony 608W
[5] Testimony 403B
[6] Testimony 405O
[7] Testimony 410O
[8] Testimony 401O
[9] Testimony 405O
[10] Testimony 102B:O124-129; W120-121.
[11] Testimony 403O
[12] Testimony 405O
[13] Amori G, Spath PL (2004). "Strategies for bringing patients into the patient safety process." Presented at the WHA Quality and Safety Forum, October 19.
[14] Testimony 403W
[15] Spath PL (2003). "Can you hear me now?" *Hospitals and Health Networks*, 77(12), December.
[16] Testimony 401O
[17] Testimony 403W
[18] Testimony 401O
[19] Johnson B (2004). "Developing and sustaining patient and family involvement in safety." Presented at the 2004 Michigan Health and Safety Coalition Conference, *Improving patient safety through innovation and action*. Dearborn, MI: April 14-15.
[20] See www.familycenteredcare.org .
[21] Testimony 401O:41-43
[22] Joint Commission on Accreditation of Healthcare Organizations (2005). *Health care at the crossroads: Strategies for improving the medical liability system and preventing patient injury*. *Executive Summary*. Washington, DC: JCAHO. Retrieved 4.18.05 from http://www.jcaho.org/about+us/public+pollicy+initiatives/medical_liability.pdf .
[23] JCAHO, op.cit., p.11.
[24] JCAHO, op.cit., p.12.