TRANSFORMING HEALTH CARE

A Compendium of Reports from the National Patient Safety Foundation’s Lucian Leape Institute

A guide for health care leaders in assessing where their organizations stand in the journey to safer care and what steps they can take to make greater progress

The National Patient Safety Foundation’s Lucian Leape Institute
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INTRODUCTION

Call to Action

*We urge health care leaders to use the recommendations presented here to assess where their organizations stand in the journey to safer care and what steps they can take to make greater progress.*

The National Patient Safety Foundation created the Lucian Leape Institute in 2007 to provide vision and a strategic roadmap for the field. Named for internationally known patient safety leader Dr. Lucian Leape, who served as the Institute’s initial chairman and continues to serve as a member, the Institute is charged with identifying new approaches to improving patient safety at the systems level.

In their initial paper (Leape et al. Transforming healthcare: a safety imperative. *Qual Saf Health Care* 2009;18:424-428), the Institute members outlined

*Five concepts fundamental to making sustainable improvements to the safety of our health system: Transparency, Care integration, Patient/consumer engagement, Restoration of joy and meaning in work, and Medical education reform.*

Subsequently, the Institute members began their work exploring the concepts in depth and reporting on findings and recommendations. This compendium brings together the executive summaries, recommendations, and action checklists from five reports published between 2010 and 2015.

The series of reports has revealed how much the issues overlap and intersect. It is difficult to imagine robust patient and family engagement without greater transparency, for example. Likewise, greater patient and family engagement is essential if we are to work together to improve care integration.
What has become particularly clear is the fact that strong leadership and a culture of safety are essential for lasting improvement in patient safety. But changing culture takes time, and not all leaders know where or how to begin. This compendium should be referenced to inform discussions, set work priorities, and make what may sometimes be difficult decisions.

The move from fee-for-service to value-based payment models is forcing CEOs—and board members—to become much more engaged in quality and safety issues than they have been traditionally. Leaders, directors, and others who hold the power to improve patient and workforce safety need to ask the right questions and demand results.

It is important to note that we have made progress in patient safety. System flaws are now much more widely recognized as causes of medical error than they were 20 years ago. Research about human factors, adverse events, and sources of errors has proliferated, with a number of journals now focused specifically on quality and safety. Indeed, the field is now recognized as a unique medical discipline, with more than 1,200 people worldwide holding professional certification in patient safety.

But changing the status quo requires more than research, science, and the development of protocols. It requires leadership commitment, vision, and the will to make the right choices. We hope those who use this compendium will agree that we cannot be diverted from our focus on safety—for our patients and for those who care for them.
EXECUTIVE SUMMARY

During the course of health care’s patient safety and quality movements, the impact of transparency—the free, uninhibited flow of information that is open to the scrutiny of others—has been far more positive than many had anticipated, and the harms of transparency have been far fewer than many had feared. Yet important obstacles to transparency remain, ranging from concerns that individuals and organizations will be treated unfairly after being transparent, to more practical matters related to identifying appropriate measures on which to be transparent and creating an infrastructure for reporting and disseminating the lessons learned from others’ data.

To address the issue of transparency in the context of patient safety, the National Patient Safety Foundation’s Lucian Leape Institute held two roundtable discussions involving a wide variety of stakeholders representing myriad perspectives. In the discussions and in this report, the choice was made to focus on four domains of transparency:

- Transparency between clinicians and patients (illustrated by disclosure after medical errors)
- Transparency among clinicians themselves (illustrated by peer review and other mechanisms to share information within health care delivery organizations)
- Transparency of health care organizations with one another (illustrated by regional or national collaboratives)
• Transparency of both clinicians and organizations with the public (illustrated by public reporting of quality and safety data)

One key insight was the degree to which these four domains are interrelated. For example, creating environments in which clinicians are open and honest with each other about their errors within organizations (which can lead to important system changes to prevent future errors) can be thwarted if these clinicians believe they will be treated unfairly should the same errors be publicly disclosed. These tensions cannot be wished away; instead, they must be forthrightly addressed by institutional and policy leaders.

In this report, the NPSF Lucian Leape Institute comes down strongly on the side of transparency in all four domains. The consensus of the roundtable discussants and the Institute is that the evidence supports the premise that greater transparency throughout the system is not only ethically correct but will lead to improved outcomes, fewer errors, more satisfied patients, and lower costs. The mechanisms for these improvements are several and include the ability of transparency to support accountability, stimulate improvements in quality and safety, promote trust and ethical behavior, and facilitate patient choice.

In the report, more than three dozen specific recommendations are offered to individual clinicians, leaders of health care delivery organizations (e.g., CEOs, board members), and policymakers.

If transparency were a medication, it would be a blockbuster, with billions of dollars in sales and accolades the world over. While it is crucial to be mindful of the obstacles to transparency and the tensions—and the fact that many stakeholders benefit from our current largely nontransparent system—our review convinces us that a health care system that embraces transparency across the four domains will be one that produces safer care, better outcomes, and more trust among all of the involved parties. Notwithstanding the potential rewards, making this happen will depend on powerful, courageous leadership and an underlying culture of safety.

**SUMMARY OF RECOMMENDATIONS**

**Actions for All Stakeholders**

1. Ensure disclosure of all financial and nonfinancial conflicts of interest.
2. Provide patients with reliable information in a form that is useful to them.
3. Present data from the perspective and needs of patients and families.
4. Create organizational cultures that support transparency at all levels.
5. Share lessons learned and adopt best practices from peer organizations.
6. Expect all parties to have core competencies regarding accurate communication with patients, families, other clinicians and organizations, and the public.
**Actions for Organizational Leadership: Leaders and Boards of Health Organizations**

7. Prioritize transparency, safety, and continuous learning and improvement.
8. Frequently and actively review comprehensive safety performance data.
9. Be transparent about the membership of the board.
10. Link hiring, firing, promotion, and compensation of leaders to results in cultural transformation and transparency.

**Actions Related to Measurement**

_Agency for Healthcare Research and Quality (AHRQ) and National Quality Forum (NQF)_

11. Develop and improve data sources and mechanisms for collection of safety data.
12. Develop standards and training materials for core competencies for organizations on how best to present measures to patients and the public.
13. Develop an all-payer database and robust medical device registries.

_Accreditation Bodies_

14. Work with the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Health Resources and Services Administration (HRSA) to develop measures of care that matter to patients and clinicians across all settings.

_Centers for Medicare and Medicaid Services (CMS)_

15. Require as a condition of participation in Medicare or Medicaid that all performance data be made public.

_All Parties_

16. Ensure that data sources are accessible to patients and the public, including claims data, patient registry data, clinical data, and patient-reported outcomes.

**Actions to Improve Transparency Between Clinicians and Patients: CEOs, Other Leaders, Clinicians**

_Before Care_

17. Provide every patient with a full description of all of the alternatives for tests and treatments, as well as the pros and cons for each.
18. Inform patients of each clinician’s experience, outcomes, and disciplinary history.
19. Inform patients of the role that trainees play in their care.
20. Disclose all conflicts of interest.
21. Provide patients with relevant, neutral, third-party information (e.g., patient videos, checklists) and expand the availability of such resources.

_During Care_

22. Provide patients with full information about all planned tests and treatments in a form they can understand.
23. Include patients in interprofessional and change-of-shift bedside rounds.
24. Provide patients and family members with access to their medical records.

**After Care**
25. Promptly provide patients and families with full information about any harm resulting from treatment, followed by apology and fair resolution.
26. Provide organized support for patients involved in an incident.
27. Provide organized support for clinicians involved in an incident.
28. Involve patients in any root cause analysis, to the degree they wish to be involved.
29. Include patients and families in the event reporting process.
30. Involve patients in organizational operations and governance.

**Actions to Improve Transparency Among Clinicians: CEOs and Other Leaders**
31. Create a safe, supportive culture for caregivers to be transparent and accountable to each other.
32. Create multidisciplinary processes and forums for reporting, analyzing, sharing, and using safety data for improvement.
33. Create processes to address threats to accountability: disruptive behavior, substandard performance, violation of safe practices, and inadequate oversight of colleagues’ performance.

**Actions to Improve Transparency Among Organizations**

**CEOs, Other Leaders, Boards**
34. Establish mechanisms to adopt best safety practices from other organizations.
35. Participate in collaboratives with other organizations to accelerate improvement.

**Federal and state agencies, payers, including the Centers for Medicare and Medicaid Services (CMS), and liability insurers**
36. Provide the resources for state and regional collaboratives.

**Actions to Improve Transparency to the Public**

**Regulators and Payers**
37. Ensure that all health care entities have core competencies to accurately and understandably communicate to the public about their performance.
38. Ensure that health care organizations publicly display the measures they use for monitoring quality and safety (e.g., dashboards, organizational report cards).

**Health System Leaders and Clinicians**
39. Make it a high priority to voluntarily report performance to reliable, transparent entities that make the data usable by their patients (e.g., state and regional collaboratives, national initiatives and websites).
Advancing Transparency in Health Care

The National Patient Safety Foundation’s Lucian Leape Institute roundtable on transparency in health care, in their report *Shining a Light: Safer Health Care Through Transparency* (NPSF LLI 2015), define transparency as:

The free, uninhibited flow of information that is open to the scrutiny of others

The report identifies and focuses on four domains of transparency:

- Transparency between clinicians and patients
- Transparency among clinicians
- Transparency of health care organizations with one another
- Transparency of both clinicians and organizations with the public

This checklist is based on the report, which is available for download at www.npsf.org.

5 Things Health Care Leaders and Board Members Should Be Doing Today

- **1.** Do all you can to create a safe and supportive culture for everyone in your organization by role modeling, developing systems for accountability and transparency, and linking incentives for your leaders to their success in creating a culture of safety and openness.

- **2.** Include patient and family representatives on your organization’s boards and all committees and programs that impact quality improvement and safety.

- **3.** Create processes to address threats to accountability: disruptive behavior, poor performance, violation of safe practices, and poor oversight of colleagues’ performance.

- **4.** Ensure that your organization consistently applies principles and programs related to patient and family engagement, shared decision making, disclosure and apology, and peer support.

- **5.** Ensure that your organization publicly displays safety and quality measures in a meaningful and clear way and participates in programs to improve safety and quality.
5 Things Health Professionals Could Do Tomorrow

☐ 1. Engage patients and families in their care by including them in care planning, asking about their preferences and what matters to them, sharing decision making, and explaining and using patient portals.

☐ 2. Show openness by sharing any potential conflicts of interest in all conversations. Be honest and apologize when an error occurs.

☐ 3. Ensure that you provide patients full access to information about their care, including use of electronic patient portals.

☐ 4. Always introduce yourself to patients and family members. Be sure they understand your job, including your status as a trainee, and your role in their care. If your role in their care changes, let them know.

☐ 5. Use your safety reporting system in the event of a near miss, error, or harm.

5 Things Patients and Families Could Do Tomorrow

☐ 1. Know your rights as a patient, including what to do if you or a loved one has a problem with care.

☐ 2. Ask for and read information on your care and condition:
   • Let your health care providers know about personal preferences related to your care.
   • Be honest about your health and health history.
   • Be sure you understand the pros and cons of all tests and treatments, including their risks and benefits.
   • Think about whether you want to get a second opinion.

☐ 3. If you do not understand what your doctor says or the information you get, ask questions. Write down your questions so you remember to ask your doctor or nurse, and write down the answers.

☐ 4. Make a list of all of the medicines you take and give it to each of your health care providers (doctors, nurses, pharmacists, and others). Understand the reason you are taking each of your medications.

☐ 5. Ask about your doctor’s and health care facility’s experience and results with care situations that are like yours. Know that there are tools available for you to review the safety and quality performance of your health care organization and physicians.
SAFETY IS PERSONAL
Partnering with Patients and Families for the Safest Care

The National Patient Safety Foundation’s Lucian Leape Institute
Report of the Roundtable on Consumer Engagement in Patient Safety
2014

Health care leaders and policy makers, as well as clinicians, need to partner with patients at all levels of health care.

EXECUTIVE SUMMARY

Receiving safe care is definitely a personal experience. The harm to patients resulting from medical errors at the most vulnerable moments of their lives is a profoundly intimate experience for everyone involved. Clinicians and staff are also deeply affected when they are involved in an adverse event and frequently suffer shame, guilt, fear, and long-lasting depression.

But ensuring safety can also be shared and rewarding. The insights and perspectives of both those who experience care at its best and those who experience it at its worst can help health care leaders, clinicians, and staff at every level make the improvements needed to create a safer and more patient-centered system.

Engaging patients and families in improving health care safety means creating effective partnerships between those who provide care and those who receive it—at every level, including individual clinical encounters, safety committees, executive suites, boardrooms, research teams, and national policy-setting bodies. Increasing engagement through effective partnerships can yield many benefits, both in the form of improved health and outcomes for individuals and in safer and more productive work environments for health care professionals.

Patients, families, and their advocates increasingly understand the wisdom of this partnership. Too often, standing in the way is the health care system itself—whether by intention
or not—because of its fragmentation, paternalistic professional culture, abundance of poor process design, and lack of experience on the part of health care leaders and clinicians with practical methods of engaging patients in the safety enterprise.

While patients and families can play a critical role in preventing medical errors and reducing harm, the responsibility for safe care lies primarily with the leaders of health care organizations and the clinicians and staff who deliver care. Many of the barriers to engagement faced by patients and families—such as lack of access to their health records, intimidation, fear of retribution, and lack of easy-to-understand tools and checklists for enhancing safe care—can only be overcome if leaders and clinicians support patients and families to become more confident and effective in their interactions with health care providers. Many of the tools necessary to do this already exist, but the system must also provide the education and training needed by professionals and patients alike to become more effective partners.

**Recommendations**

The Roundtable on Consumer Engagement in Patient Safety convened by the National Patient Safety Foundation’s Lucian Leape Institute offers the following recommendations for health care leaders, clinicians, patients, families, and policy makers aimed at advancing the patient safety mission through partnerships with patients and families:

**Leaders of health care systems**

- Establish patient and family engagement as a core value for the organization.
- Involve patients and families as equal partners in the design and improvement of care across the organization and/or practice.
- Educate and train all clinicians and staff to be effective partners with patients and families.
- Partner with patient advocacy groups and other community resources to increase public awareness and engagement.

**Health care clinicians and staff**

- Provide information and tools that support patients and families to engage effectively in their own care.
- Engage patients as equal partners in safety improvement and care design activities.
- Provide clear information, apologies, and support to patients and families when things go wrong.
Health care policy makers

- Involve patients in all policy-making committees and programs.
- Develop, implement, and report safety metrics that foster transparency, accountability, and improvement.
- Require that patients be involved in setting and implementing the research agenda.

Patients, families, and the public

- Ask questions about the risks and benefits of recommendations until you understand the answers.
- Don’t go alone to the hospital or to doctor visits.
- Always know why and how you take your medications, and their names.
- Be very sure you understand the plan of action for your care.
- Say back to clinicians in your own words what you think they have told you.
- Arrange to get any recommended lab tests done before a visit.
- Determine who is in charge of your care.

Many of these recommendations are not new, nor are they the province of any particular interest group or organization; rather, they draw from the growing evidence about the power of engagement, and seek to build on what we know can work to reduce adverse events.

Driven by a sense of urgency, the NPSF Lucian Leape Institute hopes this report serves as a call to action for leaders of health care organizations, health care professionals, patients and their families, and the public. This should not be seen simply as a new initiative or program; it is rather an effort to inspire a strategic alignment across the communities of health care consumers and advocates, policy makers, researchers, and health care leaders and clinicians to commit to increasing patient engagement in order to reduce harm.

We need to mobilize. We are all in this together. Let’s get this work done now.
Engaging Patients and Families in the Safest Care

Priority Actions for Health Care Leaders, Clinicians, and Policy Makers

LEADERS OF HEALTH CARE SYSTEMS

1. Establish patient and family engagement as a core value for the organization.
   - Create written behavioral values and standards for all clinical and non-clinical staff that speak to: treating the patient and family member with dignity and respect, information sharing, participation in care, and collaboration in improving care.
   - Make unlimited visitation policies the standard for all inpatient units, ICUs, and emergency departments.
   - Give patients and their proxies full access to their clinical records and personal health information through patient portals, written materials, and options such as OpenNotes® and the U.S. Department of Health and Human Services Blue Button®.

2. Involve patients and families as equal partners in all organizational activities.
   - Establish patient and family advisory councils for all major clinical services and large ambulatory practices.
   - Incorporate patient and family advisors into governance board roles, quality and safety committees, and other relevant safety- and research-oriented committees and teams.
   - Have patients and family members routinely review all patient-oriented written materials and educational brochures for content, relevance, and clarity.

3. Educate and train all personnel to be effective partners.
   - Place high priority on creating a learning culture that emphasizes patient safety, models professionalism, enhances collaborative behavior, encourages transparency, and values the individual learner.
   - Establish patient/family faculty programs to educate clinicians, staff, and health professional students about the experience of illness and perceptions of safe care.
   - Incorporate into all programs training in communication skills that focuses on patient and family partnerships, shared decision making, and disclosure and apology.
   - Launch a broad effort to emphasize and promote the development and use of interpersonal skills, leadership, teamwork, and collaboration among faculty and staff.

4. Partner with patient advocacy groups and other community resources.
   - Participate in the design and implementation of programs that involve the broader community—churches, schools, community organizations, public health entities—to help inform adults and young adults about how to get the care they need, how to use patient safety checklists, and how to choose the right health care system and health care professional.
   - Partner with patient advocacy groups to develop community education campaigns to inform people that it is important to understand the purpose of medications, to always question unusual or unexpected tests or medications, and that it is okay to speak up with questions and concerns about anything that happens in the course of receiving care.
HEALTH CARE CLINICIANS AND STAFF

1. Support patients and families to engage effectively in their own care.
   - Routinely involve patients in informed decision making about all diagnostic tests and treatment options, including medications.
   - Use strategies such as Ask Me 3® and teach-back to overcome health literacy barriers and to ensure that patients truly do understand their condition, what they need to do next, and why it is important to do so.

2. Engage patients as partners in safety and care design.
   - Invite patients and family members to partner with clinical and administrative staff in quality improvement activities.
   - Involve patients and family members as full partners in the design and redesign of clinical workflows and care delivery.

3. Support patients and families when things go wrong.
   - Create healing environments that include a physical setting and an organizational culture that support patients and families through the stresses imposed by illness, hospitalization, medical visits, healing, and bereavement.

HEALTH CARE POLICY MAKERS

1. Involve patients in all policy-making committees and programs.
   - Include patients and family members in safety-related policy-setting groups and committees at all governmental levels and within relevant bodies (e.g., accreditation, certification) in the private sector.
   - Train patients and families through initiatives such as the National Breast Cancer Coalition’s Project LEAD® to prepare them to fully participate in these activities and to advocate on behalf of other patients.

2. Develop and implement safety metrics.
   - Implement and improve CAHPS (Consumer Assessment of Healthcare Providers and Systems) scores. This measure of patient experience now encompasses the continuum of care and includes many dimensions of the care experience related to improving safety, such as communication, responsiveness of staff to patient concerns, coordination of care, hand hygiene, and shared decision making.
   - Implement and improve SOPS (Hospital and Medical Office Surveys of Patient Safety Culture) scores, which measure important attributes of organization culture contributing to patient safety. In many cases, it correlates closely with CAHPS measures.
   - Participate in state and federal medical error reporting including measures such as falls, readmission rates, infections, adverse drug events, employee injury rates, and worker’s compensation payments.
   - Create new measures of patient safety related to diagnostic error, medication reconciliation, care inconsistent with patient preferences, and other key safety issues.

3. Engage patients in setting and implementing the research agenda.
   - Engage patients and family members as partners to identify effective safe practices, create checklists and practice bundles, and test these innovations.
   - Build patient and family input into defining key research questions and into strengthening the evaluations of relationships between patient experience and patient safety across the continuum of care. Suggested research topics for advancing the role of patients and families in ensuring safe care include:
     - Clinical studies that seek to understand the nature and extent of medical errors and the clinical effectiveness of interventions that can prevent or mitigate the extent of harm
     - Research on tools for optimizing the integration of patient preferences into clinical decision making
     - Studies that seek to examine and enhance patient adherence to recommended therapies
     - Research on how to improve communication between patients and their caregivers in ways that enhance the safety and effectiveness of care
     - Research on how to evaluate and support the critical contributions of family caregivers
EXECUTIVE SUMMARY

The health care workforce is composed of well-intentioned, well-prepared people in a variety of roles and clinical disciplines who do their best every day to ensure that patients are well cared for. It is from this mission of caring for people in times of their greatest vulnerability and need that health care workers find meaning in their work, as well as their experience of joy.

Yet many health care workers suffer harm—emotional and physical—in the course of providing care. Many are subjected to being bullied, harassed, demeaned, ignored, and in the most extreme cases, physically assaulted. They are also physically injured by working in conditions of known and preventable environmental risk. In addition, production and cost pressures have reduced complex, intimate, caregiving relationships into a series of demanding tasks performed under severe time constraints. Under these conditions, it is difficult for caregivers to find purpose and joy in their work, or to meet the challenge of making health care safe for patients they serve.

Vulnerable Workplaces

The basic precondition of a safe workplace is protection of the physical and psychological safety of the workforce. Both are conspicuously absent or considered optional in many care-delivery organizations. The prevalence of physical harm experienced by the health care workforce—physical, psychological, and emotional—is a precondition to patient safety.
workforce is striking, much higher than in other industries. Up to a third of nurses experience back or musculoskeletal injuries in a year, and many have unprotected contact with blood-borne pathogens.

Psychological harm is also common. In many health care organizations, staff are not treated with respect—or, worse yet, they are routinely treated with disrespect. Emotional abuse, bullying, and even threats of physical assault and learning by humiliation are all often accepted as “normal” conditions of the health care workplace, creating a culture of fear and intimidation that saps joy and meaning from work.

The absence of cultural norms that create the preconditions of psychological and physical safety obscures meaning of work and drains motivation. The costs of burnout, litigation, lost work hours, employee turnover, and the inability to attract newcomers to caring professions are wasteful and add to the burden of illness. Disrespectful treatment of workers increases the risk of patient injury.

What Can Be Done?

An environment of mutual respect is critical if the workforce is to find joy and meaning in work. In modern health care, teamwork is essential for safe practice, and teamwork is impossible in the absence of mutual respect.

Former CEO of Alcoa Paul O’Neill advises that, to find joy and meaning in their daily work, each person in the workforce must be able to answer affirmatively to three questions each day:

1. Am I treated with dignity and respect by everyone?
2. Do I have what I need so I can make a contribution that gives meaning to my life?
3. Am I recognized and thanked for what I do?

Developing Effective Organizations

To create a safe and supportive work environment, health care organizations must become effective, high-reliability organizations, characterized by continuous learning, improvement, teamwork, and transparency. Effective organizations care for their employees and continuously meet preconditions not subject to annual priority and budget setting. The most fundamental precondition is workforce safety, physical and psychological. The workforce needs to know that their safety is an enduring and non-negotiable priority for the governing board, CEO, and organization.

Knowing that their well-being is a priority enables the workforce to be meaningfully engaged in their work, to be more satisfied, less likely to experience burnout, and to deliver more effective and safer care.
Achieving this vision requires leadership. The governing board, CEO, and organizational leaders create the cultural norms and conditions that produce workforce safety, meaning, and joy. Effective leaders shape safety culture through management practices that demonstrate a priority to safety and compassionately engage the workforce to speak about and report errors, mistakes, and hazards that threaten safety—their own or their patients’. Joy and meaning will be created when the workforce feels valued, safe from harm, and part of the solutions for change.

Recommendations

Strategy 1: Develop and embody shared core values of mutual respect and civility; transparency and truth telling; safety of all workers and patients; and alignment and accountability from the boardroom through the front lines.

Strategy 2: Adopt the explicit aim to eliminate harm to the workforce and to patients.

Strategy 3: Commit to creating a high-reliability organization (HRO) and demonstrate the discipline to achieve highly reliable performance. This will require creating a learning and improvement system and adopting evidence-based management skills for reliability.

Strategy 4: Create a learning and improvement system.

Strategy 5: Establish data capture, database, and performance metrics for accountability and improvement.

Strategy 6: Recognize and celebrate the work and accomplishments of the workforce, regularly and with high visibility.

Strategy 7: Support industry-wide research to design and conduct studies that will explore issues and conditions in health care that are harming our workforce and our patients.
Getting Started on Workforce Safety

*Actions to advance joy and meaning in your health care organization’s workforce*

1. Establish a goal of zero harm (physical and psychological) for your workforce.
   - Foster and maintain a culture that provides the same high level of dignity and respect to every member of the workforce (with consistent consequences for non-compliers).
   - Explicitly make connections between respect, workforce safety, and patient safety by identifying workforce safety as a precondition to respect and harm-free care.
   - Measure, analyze, and report respect and culture using existing staff surveys or culture surveys.
     For example, each person in the workforce must be able to answer affirmatively to the three questions put forth by Paul O’Neill, former Chairman and Chief Executive Officer of Alcoa, if joy, meaning, and patient safety are to be realized:
     - Am I treated with dignity and respect by everyone, every day, in each encounter, without regard to race, ethnicity, nationality, gender, religious belief, sexual orientation, title, pay grade, or number of degrees?
     - Do I have what I need—education, training, tools, financial support, encouragement—so that I can make a contribution to this organization that gives meaning to my life?
     - Am I recognized and thanked for what I do?
   - Ensure that physical harm is reported to the highest levels of organizational leadership.

2. Create a learning system in which every member of your workforce learns, understands, and demonstrates respect and safe behaviors with a commitment to 100% compliance.
   - Include training for respectful and safe behavior in the orientation and performance evaluation processes for every member of the workforce.
   - Establish unit-based champions for every department, and recognize individuals and teams for problem identification and continuous improvement.
   - Conduct site visits to places of excellence as part of the education process.

3. Create a real-time, transparent, timely measurement system to measure physical and psychological harm.
   - Define, track, and analyze metrics of physical and psychological harm.
   - Expand the scope of psychological harm to include bullying, harassment, and other non-team-promoting behaviors.
   - Within 24 hours after a physical injury to any member of the workforce, post the relevant information to an internal website or real-time dashboard (with access for every employee and Board of Directors).
   - Create a reliable process for timely reporting by the workforce of disrespectful and non-team-promoting behavior.

4. Create a multidisciplinary, reliable process for responding to physical and psychological harm involving all relevant departments and disciplines (Patient Safety, Risk Management, Quality, Occupational Health, Employee Assistance, Human Resources, Clinical Leadership, and others).
   - Reference Joint Commission or other standards that define a process for reporting and responding to non-team-promoting behavior.
   - Ensure accountability and immediate counseling for non-team-promoting behavior.
   - Provide post-event workforce support programs that address immediate and long-term needs.
   - Establish an interdisciplinary committee structure to review events from a systems perspective.
   - Perform an event analysis of every incident of harm, within 24 hours if possible.
   - Create a reliable threat assessment system to address workplace violence as part of disaster and contingency planning.

What is a safe workplace?
A workplace free from risks of both physical and psychological harm.

What is psychological harm?
Fear, intimidation, diminished individual and collective pride and morale, and lack of support, joy, and meaning, at the individual level and/or within a culture, that are the result of disrespectful and non-team-promoting behavior, including but not limited to: bullying, ignoring, isolating, yelling, intimidation, put-downs, non-verbal expressions of judgment, and humor at another’s expense.
As the complexity of delivering health care solutions increases, thoughtful design and planning of the care process must keep pace.

OVERVIEW

Lack of care coordination and integration was identified as a major contributor to the frequency of avoidable errors in patient care in the Institute of Medicine (IOM) report To Err Is Human (1999). Care integration was presented as the cornerstone for achieving high quality in the subsequent IOM report Crossing the Quality Chasm (2001). The Agency for Healthcare Research and Quality (AHRQ) has included care integration and patient safety in its scope of work since early in this decade. Federal government administration arguments for the Patient Protection and Affordable Care Act of 2010 included numerous references to this issue.

Modern care delivery is extraordinarily complex. To protect the patient and avoid errors requires a planned, coordinated, and fully integrated approach to care. In addition to the complexity inherent in modern treatment for patients with difficult and often multiple conditions, complexity is found throughout the care experience: in the number of physicians involved, the number of professionals and support personnel required, the multiple venues where care is provided, and the diverse requirements and expectations of patients. As a consequence, the risks of harm also rise unless careful attention is given to the way care is organized and delivered, that is, to the system of care delivery itself. The system must be designed to protect the patient while ensuring that he or she receives the full benefits of the remarkable advances that have occurred over the past century.
And here we arrive at care integration, the planned, thoughtful design of the care process for the benefit and protection of the patient. Unfortunately, physicians and leaders of delivery systems (with notable exceptions such as those at the Mayo Clinic, the Geisinger Health System, and Kaiser Permanente) have been unwilling or unable to embrace greater care integration. As described in *Crossing the Quality Chasm*, most patient care is fragmented and uncoordinated. Where integration has occurred, it is most often structural: assembling piece parts under a single governance umbrella while leaving the underlying care delivery processes largely untouched.

The care delivery system is struggling to escape the straitjacket of physician autonomy and economic independence, a payment system that reinforces fragmentation and independent decision making, and a regulatory framework that places legal responsibility on the individual professional without corresponding accountability of the team or the system within which that professional works. The medical education system reinforces these expectations and does little to prepare new physicians for the team-based, interdependent work that is required to achieve high-quality and safe care.

**ACCELERATING CARE INTEGRATION**

We present six areas that address critical issues in improving care integration. We do not mean to suggest that they represent a comprehensive prescription for achieving widespread reform. Rather, they are initiatives that could—especially in combination—begin to accelerate care integration.

1. **Shared Understanding**

First, we need mechanisms for establishing a shared understanding among public and private stakeholders, from the White House and the Centers for Medicare & Medicaid Services (CMS) to the media and consumer advocacy groups, regarding the link between care integration and patient safety. Such mechanisms might include joint working groups or public forums, any opportunity that would allow open dialogue about consumer needs and experience and strategies for addressing them. Best practices for improving care integration, including tools that enable consumers to serve as their own advocates for safer care, should be cataloged and promulgated. Tools intended for consumers must be designed in partnership with patients and families to ensure that they are realistic with respect to actions or responsibilities patients and families are comfortable performing.

The shared understanding among stakeholders should also be communicated publicly to raise awareness of the importance of care integration to the public’s well-being and that of their
families and loved ones. Patients and consumers need guidance regarding how to work with their providers to obtain integrated care solutions even when the care itself has not moved to the levels of formal integration described in this report.

2. Patient Engagement

Patients, their families, and representatives from their communities can play key roles in accelerating movement toward clinical integration, notwithstanding the current general lack of shared understanding about the link between integration and patient safety.

Their impact can occur at three levels. First, when patients and family members are active participants in process improvement activities and care redesign efforts, they can identify gaps in integration and offer solutions that are effective—and often more practical and cost effective than those that clinicians design. When patients and families tell their own stories to members of a clinical care system, the organizational culture begins to reflect patient-centeredness.

The next level is organizational accountability. When patients and their families—and sometimes, depending on the issue, representatives of the community—participate in reviews of the performance of the organization, their viewpoints shape expectations for patient-centered, integrated performance. This can help the institution achieve a balanced view of what qualifies as excellent performance along the dimensions of clinical integration.

The final opportunity for patient engagement is in care process design itself. Treating patients as members of the care team will require that they be adequately supported in this role. Integration cannot be outsourced to patients and family members, but rather must be met with internal resources, infrastructure, leadership, and intentionality to bring about needed change.

3. Measures

We need measurements that gauge care integration and the clinical and economic performance that results from it and that reflect the diversity of patient preferences and needs in U.S. society. Moreover, a clearinghouse of measures that reflect the diversity of integration requirements for distinct patient populations would be beneficial, particularly if coupled with an advocacy effort to incorporate these measures into public reporting systems that are widely available and advertised across the U.S. population. Measures should be continually refined and improved based on experience in use. Organizations like CMS and the Joint Commission should encourage the measurement of care integration in their accreditation requirements as soon as a validated tool becomes available. One step in this direction will be the addition in 2013 of the Care Transition Measure to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) standard survey required by CMS.
4. Evaluation

Robust assessment of delivery system effectiveness could prove critical. A hopeful sign is the inclusion of health care systems, such as those for coordination of care for patients with multiple chronic conditions, among the recommended national priorities of the new Patient-Centered Outcomes Research Institute (PCORI). Significant investment in such clinical effectiveness research could facilitate the cataloging and promulgating of best practices for integrating care. This could be a significant improvement opportunity because all PCORI funding requires that patients and families be included in the design and implementation of the research. Funding for this “applied” care delivery research, on the order of at least 20–25% of the total federal investment in medical research and development, is the level at which real progress might be achieved.

5. Education and Training

We need a curriculum for hospital and health system boards of directors and system executives that focuses on the specific issue of patient safety and the broader issue of care integration. Similarly, undergraduate and graduate health professional education would benefit from curricula in care integration that focus on team-based problem solving rather than autonomous decision making. Training adequate numbers of hospital and health system leaders and health professionals (i.e., doctors, nurses, and the array of practitioners that comprise health care teams) will require partnerships with those who can fund and deliver these curricula to the target audiences.

6. National Spread

Research should define the capacity required to provide the organizational and operational expertise to support care integration throughout the country and explore means to build this capacity. This includes but is not limited to the development of the requisite technology infrastructure and standards for its interoperability.
UNMET NEEDS

Teaching Physicians to Provide Safe Patient Care

Lucian Leape Institute
Report of the Roundtable on Reforming Medical Education
2010

*Medical education institutions need to ensure that student physicians are properly trained to become part of the patient safety solution.*

**EXECUTIVE SUMMARY**

Health care delivery continues to be unsafe despite major patient safety improvement efforts over the past decade. The Roundtable concluded that substantive improvements in patient safety will be difficult to achieve without major medical education reform at the medical school and residency training program levels. Medical schools must not only assure that future physicians have the requisite knowledge, skills, behaviors, and attitudes to practice competently, but also are prepared to play active roles in identifying and resolving patient safety problems. These competencies should become fully developed during the residency training period.

Medical schools today focus principally on providing students with the knowledge and skills they need for the technical practice of medicine, but often pay inadequate attention to the shaping of student skills, attitudes, and behaviors that will permit them to function safely and as architects of patient safety improvement in the future. Specifically, medical schools are not doing an adequate job of facilitating student understanding of basic knowledge and the development of skills required for the provision of safe patient care, to wit: systems thinking, problem analysis, application of human factors science, communication skills, patient-centered care, teaming concepts and skills, and dealing with feelings of doubt, fear, and uncertainty with respect to medical errors.

In addition, medical students all too often suffer demeaning experiences at the hands of faculty and residents, a phenomenon that appears to reflect serious shortcomings in the medical
school and teaching hospital cultures. Behaviors like these that are disruptive to professional relationships have adverse effects upon students, residents, nurses, colleagues, and even patients. Students frequently tend to emulate these behaviors as they become residents and practicing clinicians, which perpetuates work environments and cultures that are antithetical to the delivery of safe, patient-centered care.

The LLI Expert Roundtable on Medical Education Reform makes the recommendations set forth below.

**Setting the Right Organization Context**

Health care has undergone a major sea change over the past two decades. As these changes and the complexities of health care have escalated, patient safety problems have become increasingly evident, and medical education and training institutions have found themselves struggling to keep up with the need to assure that student physicians are properly equipped with the skills, attitudes, knowledge, and behaviors (i.e., patient safety competencies) that will make them capable of becoming part of the patient safety solution. This need constitutes a major challenge to medical schools and teaching hospitals, and particularly their leaders and faculty, to develop their own competencies to guide their charges in learning to manage a new “disease state.”

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**Recommendation 1.** Medical school and teaching hospital leaders should place the highest priority on creating learning cultures that emphasize patient safety, model professionalism, enhance collaborative behavior, encourage transparency, and value the individual learner.

**Recommendation 2.** Medical school deans and teaching hospital CEOs should launch a broad effort to emphasize and promote the development and display of interpersonal skills, leadership, teamwork, and collaboration among faculty and staff.

**Recommendation 3.** As part of continuing education and ongoing performance improvement, medical school deans and teaching hospital CEOs should provide incentives and make available necessary resources to support the enhancement of faculty capabilities for teaching students how to diagnose patient safety problems, improve patient care processes, and deliver safe care.

**Recommendation 4.** The selection process for admission to medical school should place greater emphasis on selecting for attributes that reflect the concepts of professionalism and an orientation to patient safety.
Strategies for Teaching Patient Safety

Medical schools have done an excellent job of providing students with the knowledge and related skills they will need for the technical practice of medicine. However, the new and still evolving care environment requires more than this with respect to patient safety. The elemental nature of patient safety education has profound implications for future curricular design. The teaching of patient safety needs to begin on Day 1 of medical school and be extended throughout the four-year medical school experience and beyond by becoming embedded in all teaching activities. It is equally important to understand that patient safety education is much more than the absorption of concepts and knowledge and requires particular attention to the acquisition of desired skills, attitudes, and behaviors. This is because the long-term intent is that these skills, attitudes, and behaviors become an integral of the physician’s professional way of life.

Recommendation 5. Medical schools should conceptualize and treat patient safety as a science that encompasses knowledge of error causation and mitigation, human factors concepts, safety improvement science, systems theory and analysis, system design and re-design, teaming, and error disclosure and apology.

Recommendation 6. The medical school experience should emphasize the shaping of desired skills, attitudes and behaviors in medical students that include, but are not limited to, the Institute of Medicine and Accreditation Council for Graduate Medical Education (ACGME)/American Board of Medical Specialties (ABMS) core competencies—such as professionalism, interpersonal skills and communication, provision of patient-centered care, and working in interdisciplinary teams.

Recommendation 7. Medical schools, teaching hospitals, and residency training programs should ensure a coherent, continuing, and flexible educational experience that spans the four years of undergraduate medical education, residency and fellowship training, and life-long continuing education.

Leveraging Change

There is today apparent growing interest among medical school faculty and students in understanding and teaching patient safety. Many of the current efforts involve limited courses, but some schools are pursuing much more aggressive and elaborate patient safety education and training initiatives. However, the progress is uneven at best and still non-existent in some schools, while the urgency to train physicians to become patient safety problem-solvers and leaders is great. This requires attention to formulating strategies that are likely to leverage
acceleration of the desired changes set forth in this paper. Among the potential strategies, modernization of the Liaison Committee on Medical Education (LCME) and ACGME standards appears to offer the greatest opportunity to create universal substantive positive change. In addition, public monitoring of school efforts in making these changes is another potentially strong lever. Other opportunities exist as well.

Recommendation 8. The LCME should modify its accreditation standards to articulate expectations for the creation of learning cultures having the characteristics described in Recommendation 1 above; to establish patient safety education—having the characteristics described herein—as a curricular requirement; and to define specific terminal competencies for graduating medical students.

Recommendation 9. The ACGME should expand its Common Program Requirements to articulate expectations for the creation of learning cultures having the characteristics described in Recommendation 1; to emphasize the importance of patient safety-related behavioral traits in residency program faculty; and to set forth expected basic faculty patient safety competencies.

Recommendation 10. The LCME and the ACGME should direct particular attention to the adequacy of the patient safety-related preparation of graduating medical students for entry into residency training.

Recommendation 11. A survey of medical schools should be developed to evaluate school educational priorities for patient safety, the creation of school and teaching hospital cultures that support patient safety, and school effectiveness in shaping desired student skills, attitudes, and behaviors.

Recommendation 12. Financial, academic, and other incentives should be utilized to leverage desired changes in medical schools and teaching hospitals that will improve medical education and make it more relevant to the real world of patient care.

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UNMET NEEDS: Teaching Physicians to Provide Safe Patient Care. Report of the NPSF Lucian Leape Institute Roundtable on Reforming Medical Education

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Roundtable on Consumer Engagement in Patient Safety: Standard Register Healthcare
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