

How Patient- and Family-Centered Hospital Communications Reduce Medical Errors

May 20, 2024

Moderator & Panelists



Moderator
Cristie Travis
National Alliance Advisor



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& Safety



Christopher Landrigan, MD
PCORI-Funded Investigator,
Harvard Medical School

Webinar Background



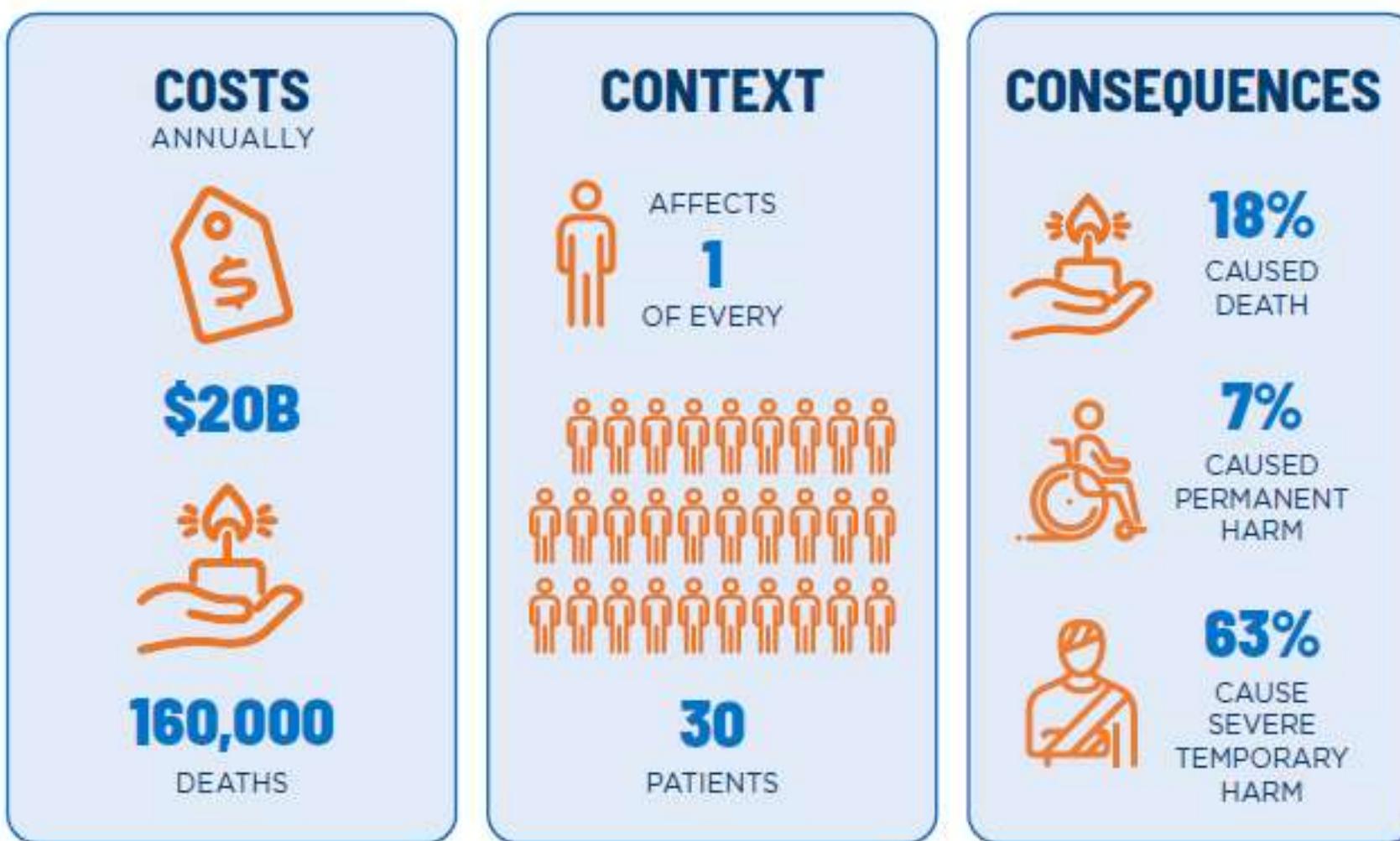
The National Alliance is disseminating relevant PCORI Research to coalitions and employer purchasers across the country that will have a measurable impact on patient-centered experiences and can serve as a model for future and continual dissemination.

The materials educate employers on the value of using stronger evidence-based approach in their health care planning



PCORI helps people make informed healthcare decisions, and improves healthcare delivery and outcomes, by producing and promoting high-integrity, evidence-based information that comes from research guided by patients, caregivers, and the broader healthcare community.

Facts about *preventable* hospital errors in the US



Source: National Institutes of Health

CHRISTOPHER P. LANDRIGAN, MD, MPH

PCORI-Funded Investigator,

Chief, Division of General Pediatrics,
Boston Children's Hospital

Director, Sleep and Patient Safety
Program, Brigham and Women's Hospital

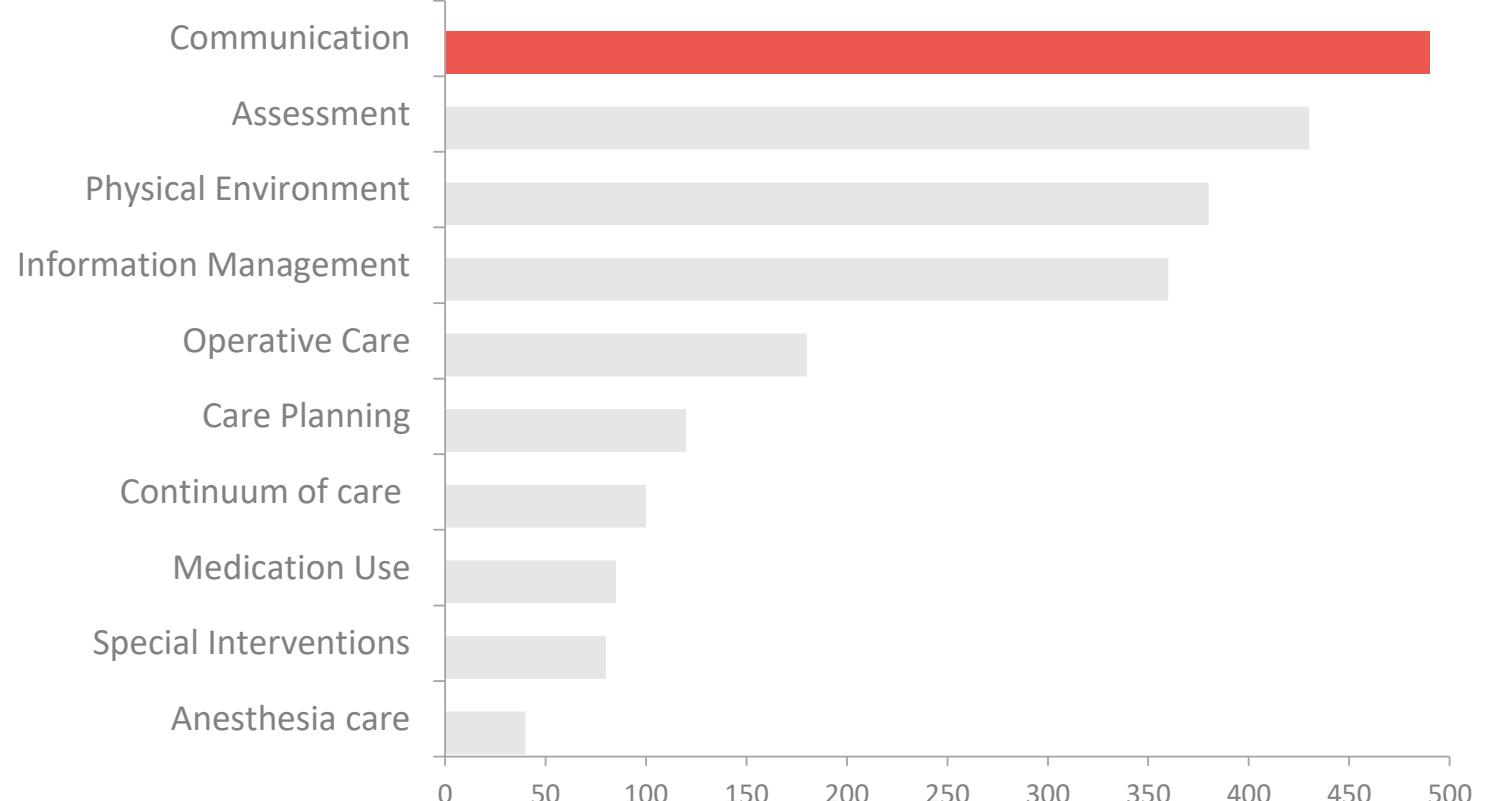
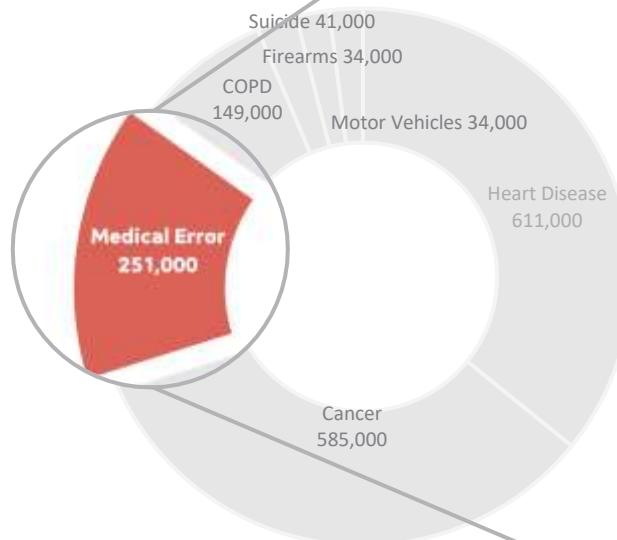
William Berenberg Professor of Pediatrics
and Professor of Medicine, Harvard
Medical School



Medical errors are the third leading cause of death in the U.S.

The leading cause of medical errors is **communication failures**.

Causes of Death, U.S.



I-PASS Institute Handoff Bundle

Structure / Universal Language



Illness Severity

Stable, "Watcher," Unstable



Patient Summary

Summary statement; events leading up to admission; hospital course; ongoing assessment; plan



Action List

To do list; timeline and ownership



Situation Awareness & Contingency Planning

Know what's going on; plan for what might happen



Synthesis by Receiver

Receiver summarizes what was heard; asks questions; restates key action/to do items

Comprehensive Change Management Bundle

I-PASS Campaign



I-PASS Structure

Champion Development



Training Curriculum

Real-time Observations & Feedback



Verbal Handoff Process Changes

I-PASS Written Handoff Document



Simulation Exercises



I-PASS Evidence



The NEW ENGLAND
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Journal of
Hospital Medicine

crico

Protecting Providers.
Promoting Safety.



Single center pilot study at Boston Children's Hospital found significant **reduction in medical errors** after handoff bundle implementation. (JAMA 2013)



9-center federally funded study found **30% reduction in injuries from medical errors** after I-PASS implementation. (NEJM 2014)



Maximum benefits achieved with robust change management: **47% reduction in handoff-related harms** in AHRQ-funded 32-center I-PASS study in nursing, internal medicine, surgery, and across other clinical areas (JHM 2022)

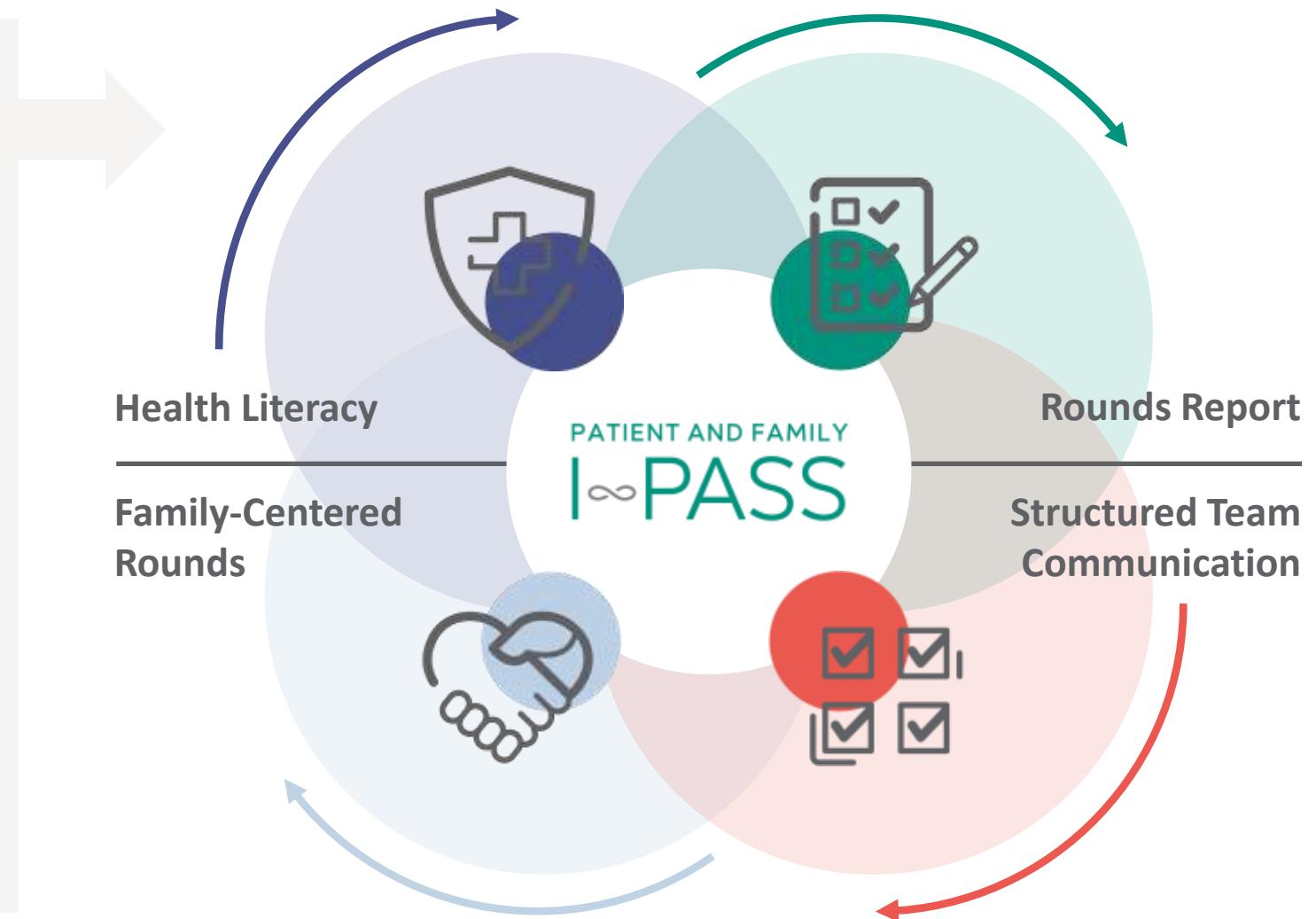


CRICO-funded study of ~500 randomly selected cases: found **49% of all malpractice claims involve miscommunications**. 40% of miscommunications involved a failed handoff, most potentially averted using I-PASS

Adapting I-PASS for Patient & Family Centered Rounds

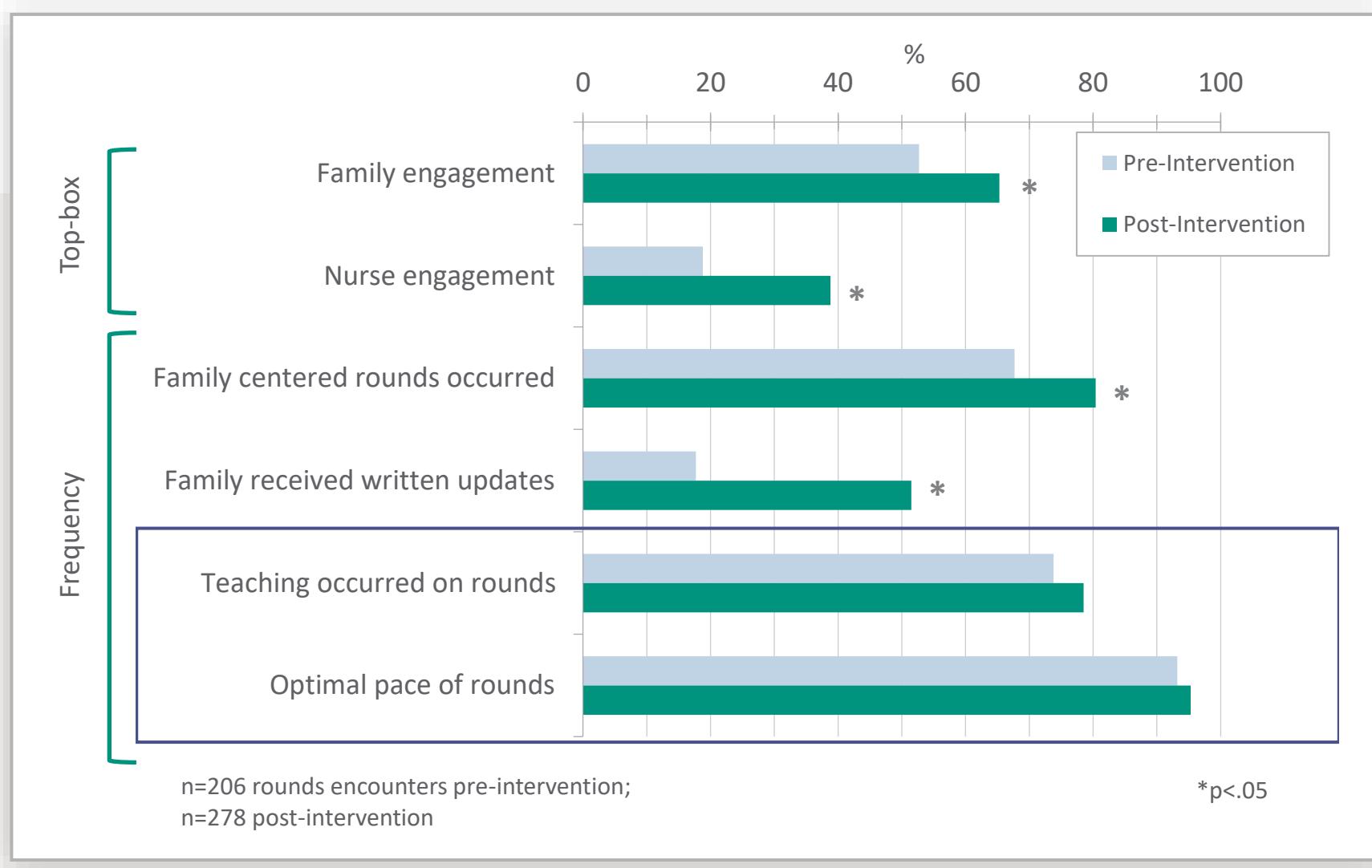
Patient and Family I-PASS Study

- Funded by a grant from PCORI
- Aim: To determine if improving communication and integrating patients/families into all aspects of decision-making during hospitalization will
 - Improve patient safety
 - Improve patient and family experience



Communication Process Scores

Khan et al, BMJ 2018

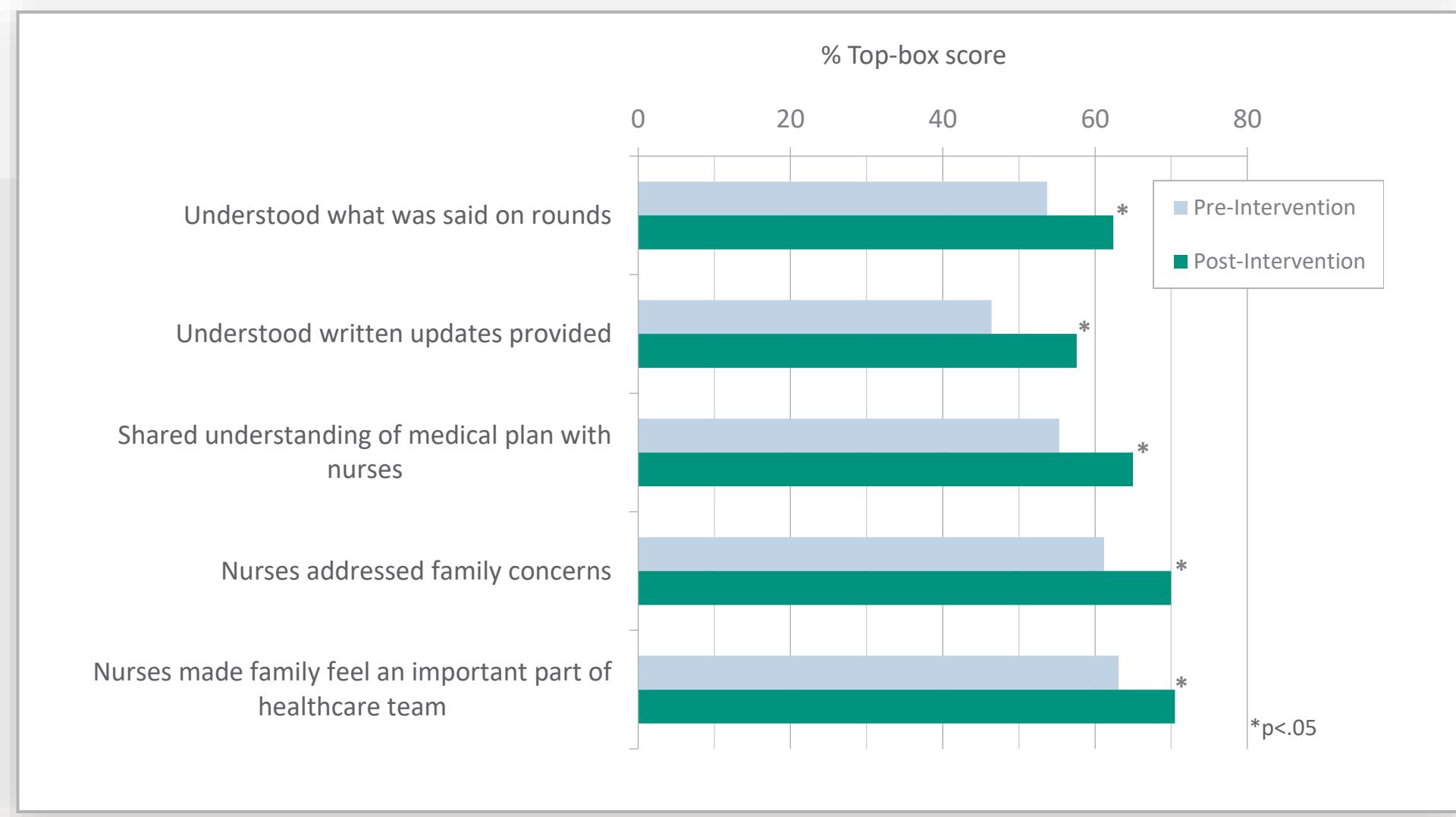


Medical Error Rates

Khan et al, BMJ 2018

Per 1000 patient-days	Pre	Post	P-value
Medical errors	41.2	35.8	0.21
Harmful errors/ Preventable AEs	20.7	12.9	0.01
Nonharmful errors/ Near misses	20.0	22.0	0.50

Aspects of Family Experience that Improved

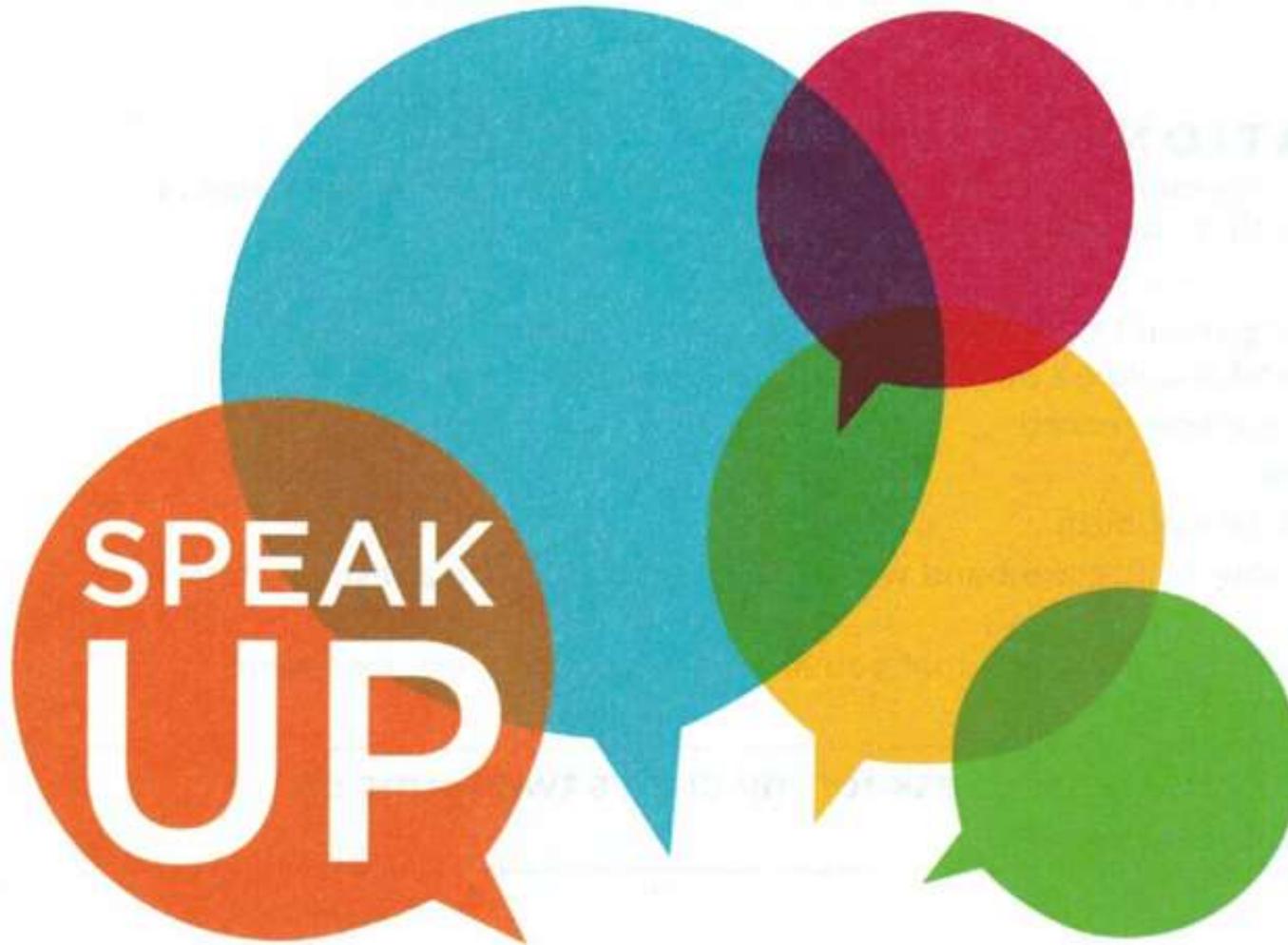


CAROLE HEMMELGRAN

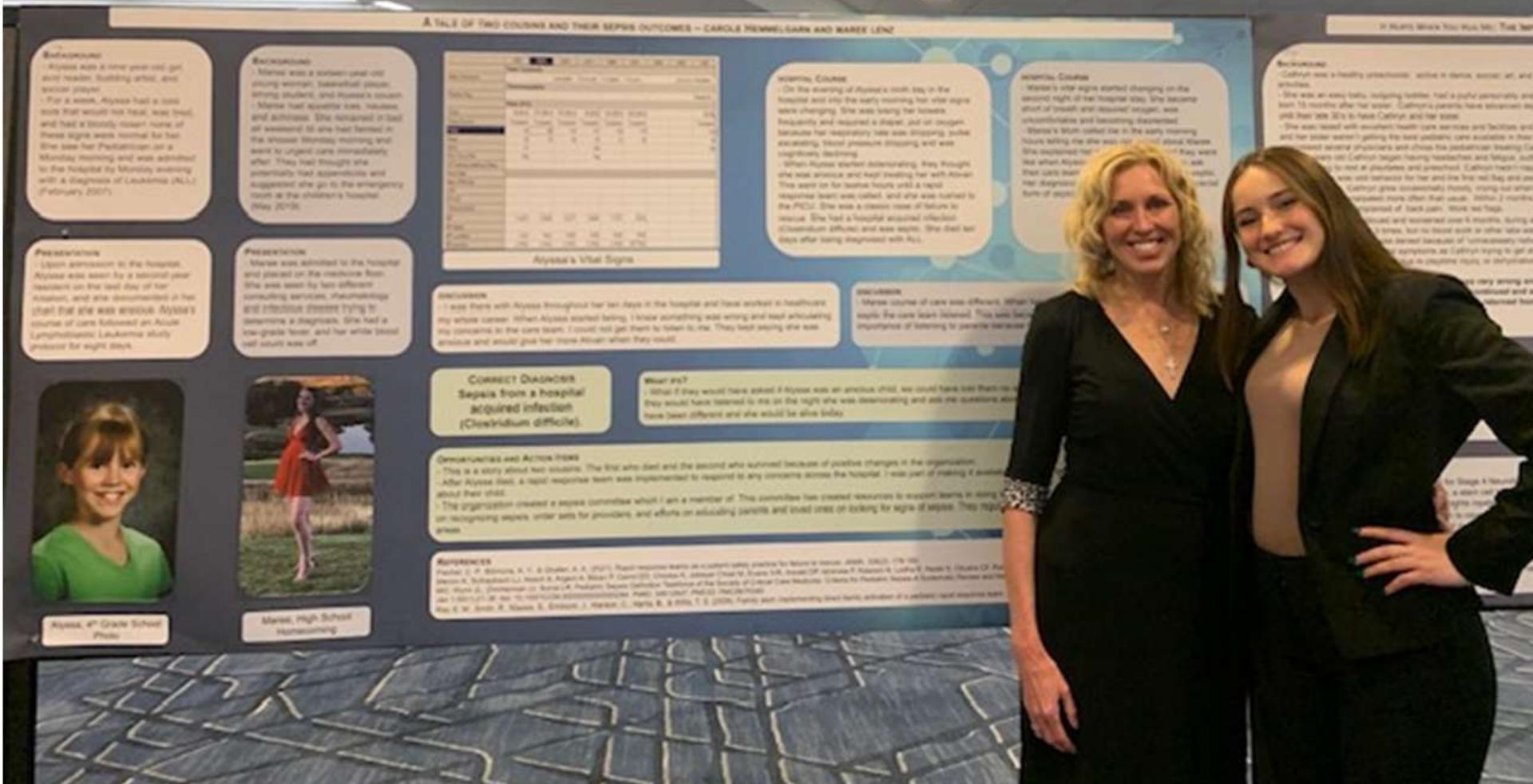
Georgetown University, MedStar Institute
for Quality & Safety







Children's Hospital
Colorado



MISSY DANFORTH

The Leapfrog Group



About The Leapfrog Group

- National not-for-profit organization, founded by employers and purchasers, and headquartered in Washington, DC
- On a mission to trigger giant leaps forward in the safety, quality, and affordability of health care by using transparency to drive informed decision-making and promote high-value care
- The data we collect and the ratings we publish are used by national and regional health plans, employers and purchasing groups, transparency vendors, researchers, policy makers, healthcare consumers, and many others





LEAPFROG HOSPITAL SURVEY



EXPLORES QUALITY AND SAFETY

The Survey is annual, includes broad range of patient safety, quality, and resource use measures, and is applicable to all hospitals.



HOSPITALS SUBMIT A SURVEY

Hospitals **voluntarily** submit data via an Online Survey Tool.



PROGRESS TOWARDS MEETING NATIONAL STANDARDS IS REPORTED

Expert panels establish national standards for performance on each measures, and progress is publicly reported.

Hospital Survey Results – ratings.leapfroggroup.org

LEAPFROG RATINGS

About • FAQs THE LEAPFROG GROUP

Search Leapfrog's Hospital and Surgery Center Ratings

Search by:

- Facility Name
- Location
- Same-Day Procedure
- Maternity Care
- Guided Search

Facility name: Start typing the name of the facility here.

Search

The highest-performing hospitals on the Leapfrog Hospital Survey are recognized annually with the prestigious Leapfrog Top Hospital award.

View List

TOP HOSPITAL 2023

The highest-performing surgery centers on the Leapfrog ASC Survey are recognized annually with the prestigious Leapfrog Top ASC award.

View List

TOP AMBULATORY SURGERY CENTER 2023

Valley Children's Hospital

9300 Valley Children's Place
Madera, California 93636
Survey Submission Date: August 11, 2023
Facility info, location, and more

Show all

Patient-Centered Care

Measure name	Leapfrog's Standard	Hospital's Progress
Billing Ethics	Hospitals should provide patients with complete billing information and access to a representative that can quickly resolve billing issues. In addition, hospitals should not sue patients over late or unpaid bills.	 ACHIEVED THE STANDARD

This hospital provides a detailed bill within 30 days of receiving insurance payments: Yes
This hospital provides access to a representative who can quickly investigate billing errors and establish payment plans: Yes
This hospital sues patients: No

Informed Consent

Hospitals should ensure that all patients are fully aware of risks and alternatives prior to tests, treatments, and procedures.	 ACHIEVED THE STANDARD
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All staff involved in the informed consent process achieve the appropriate training: Yes
Doctors explain expected difficulties and recovery time and allow patients to ask questions: Yes
Doctors involved in the test, treatment, or procedure are listed on the consent form, and patients are notified if the doctor will be absent and if trainees will be involved: Yes
Consent forms are written at a fifth grade reading level: Yes
Staff ask patients about their preferred language for decision-making and make a trained medical interpreter available if appropriate: Yes
Doctors use the "teach back method" to ensure patients understand what will be performed and what are the risks: Yes

Responding to Never Events

Hospitals should have a never events policy that includes all nine (9) actions that should occur following a "never event," which includes apologizing to the patient and not charging for costs associated with the never event.	 ACHIEVED THE STANDARD
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Current Survey Standards focused on Communication with Patients and Family Caregivers



Informed Consent: Assesses whether hospitals have a robust informed consent process in place that includes training for staff, a process to ensure clinicians explain risks and patients can ask questions, forms written at a 6th grade reading level, ample access to trained medical interpreters, and the use of the “teach back method” with patients to ensure that patients/legal guardians understand what will be done, why it will be done, and what are the primary risks.

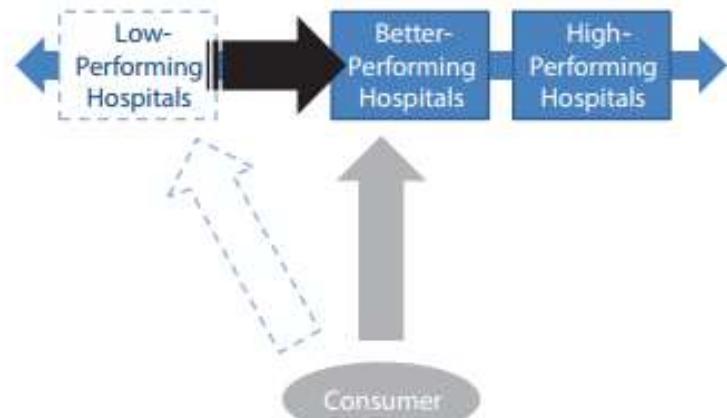


Patient Reporting of Concerns: Assesses whether hospitals have a protocol to follow-up on patient-reported concerns about their care that includes notifying all patients how to report concerns, having a hospital representative follow-up within 30 days of making the report, and logging all patient reports in an incident reporting system.

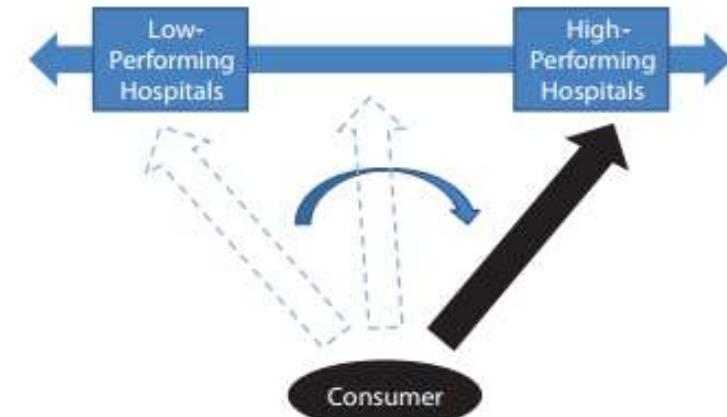
Employers/Purchaser Initiatives

-  Educate their employees on choosing a place to receive care
-  Leverage purchasing power to structure value-based payment arrangements
-  Design benefits to steer employees to the most high-quality facilities
-  Encourage transparency and accountability in hospitals in their community

Strategy 1: Shift Hospital Performance



Strategy 2: Shift Consumer Choice



Source: Altarum Institute

Purchasing Groups and Business Coalitions

Purchasing Groups and Business Coalitions use Survey Results to engage their employer members around patient safety and quality and to inform value-based strategies.



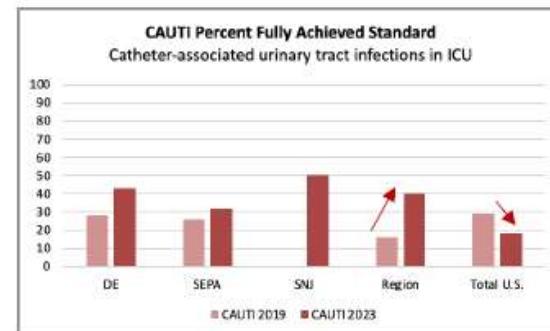
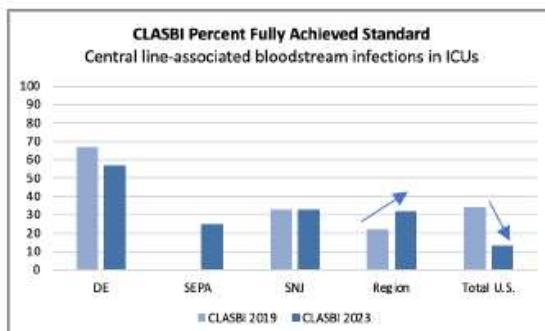
GPBCH LEAPFROG BRIEF 2019 vs 2023 Hospital Survey Findings

Healthcare-Associated Infections

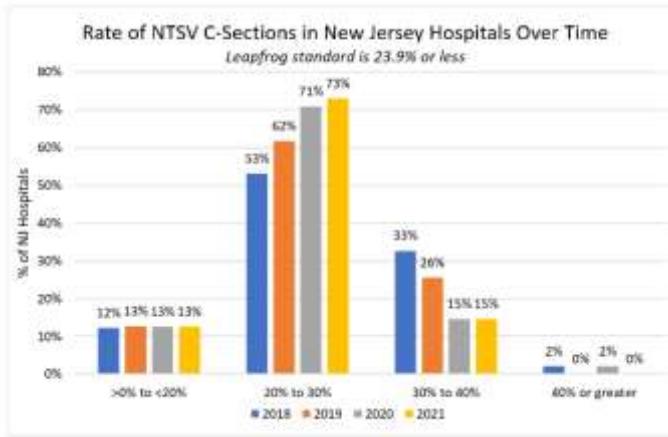
*Hospitals in Greater Philadelphia Region improved on fully meeting some Leapfrog standards during pandemic
More improvement still needed*

Healthcare-Associated Infections (HAIs) are common and complicating, yet largely preventable for hospitalized patients. Each day approximately 25 patients in U.S. hospitals contracts an HAI. These infections can delay recovery, increase expense of a hospital stay, and even result in death. Of approximately two million American patients who acquire an HAI annually, an estimated 90,000 will die. Studies have shown that selected HAIs can be reduced by as much as 70% with the help of the proper patient-safety interventions. The direct cost of HAIs to hospitals is estimated at between \$28 billion and \$45 billion. These costs are passed along to insurers and employers, as well as to patients in the form of higher out-of-pocket costs. ([Leapfrog Group Castlight HAI Report](#))

This Brief shares Leapfrog Hospital Survey findings for HAIs for hospitals in Delaware (DE), Southeastern Pennsylvania (SEPA) and Southern New Jersey (SNJ), comparing 2019 and 2023, pre- and post- pandemic. The results below show the aggregate of hospitals that reported on these measures each year and fully meet the Leapfrog Standard. Excluded are Unable to Calculate for Survey participants and hospitals that Declined to Respond to Survey. See page 2 for individual 2023 hospital results in the region.



Health Plan Collaboration for Network Quality Improvement



CASE STUDY:
HOW ONE HEALTH
PLAN HARNESSED THE
POWER OF THE
LEAPFROG VALUE-
BASED PURCHASING
PROGRAM TO IMPROVE
MATERNITY OUTCOMES
IN NEW JERSEY

Q & A



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Resources

NEW Infographic released on “Reducing Medical Errors in the Hospital”

It includes:

- PCOR/CER research study
- Medical error fast facts
- The role of employers
- Recommendations for employers
- Additional resource links

Reducing Medical Errors in the Hospital

The Role of Employers in Promoting Patient- and Family-Centered Communications to Improve Safety



THE CHALLENGE: Even with significant efforts to improve safe medical errors in hospitals that harm patients still occur at alarming rates and result in considerable financial and human costs, including patients and families in conversations during rounds when possible shows great promise in reducing errors. National Alliance coalition members often serve as a bridge between employment and health systems, helping employers play a key role in driving costs down and safety and patient satisfaction up, starting with these four steps. Details about implementing the steps are found on site two.

- 1 Reduce hospitalizations by improving access to care and coverage levels for preventive care, paying particular attention to social drivers of health.
- 2 Communicate in health plans and other networks using them to establish accountability for integrating clear and effective end-to-end communication protocols across healthcare teams (i.e., diagnosis, treatment, discharge, transition to home).
- 3 Choose that employee education materials and health plan and hospital partners' communication materials are aligned to literacy and health literacy challenges, including communication materials and materials for common limitations.
- 4 Set expectations for providers to articulate how hospital education and hospital safety committees for employees to take part in planning and implement hospital strategic.

Health literacy An integral part of patient safety



PCORI® Research Study

A research team wanted to see if improving communication would help reduce hospital errors and patient safety. The team created a program to help doctors and nurses communicate with families during rounds. The program took place in hospital pediatric units.

- The program included:**
- A way to measure doctors and nurses included families on daily rounds
 - A way to involve medical staff talked about everything important on daily rounds



Reducing Medical Errors in the Hospital

The Role of Employers In Promoting Patient- and Family-Centered Communications to Improve Safety

Details for employers/purchasers, following the recommendations on site 1:

- 1 **Reduce Hospitalizations**
 - Improve access to and coverage levels for comprehensive preventive care and care for chronic conditions.
 - Hold virtual or in-person employer/family health fairs or promote community health events. Encourage families to participate in successful health events.
 - Find creative, cost-wise ways to invite healthcare providers and their employees to events, such as holiday luncheons or lunch-and-learn initiatives. Have translators on hand to meet the needs of specific employee communities.
 - Understand the social determinants/ drivers of health in your organization, working to mitigate their impact.
 - Promote the use of urgent care clinics and telehealth to avoid unnecessary hospital emergency department visits.
 - Work with your health plan to establish accommodations for integrating clear and effective end-to-end communication protocols across healthcare teams (i.e., diagnosis, treatment, discharge, transition to home).
- 2 **Establish Communication Protocols**
 - Ask your position, and health plans and other vendors to build relationships with patient-family centered communications expectations. Fact check to see that expectations are reasonable, reimbursable and enforceable.
 - Ask your health plan benefit partners how they are supporting training for medical professionals that addresses challenges associated with complex patient-family conversations.
 - Advocate for a cultural shift within healthcare organizations that promotes a culture of transparency and honesty.
- 3 **Educate Employees and their Families**
 - Strengthen shared responsibility partnerships with employees and their families.
 - If possible, include spouses, children, and visitors in patient conversations, especially in children's hospitals.
 - Offer access to cost and quality comparison tools such as [Leapfrog Hospital Safety Grade](#).
 - Invest in a culture of communications so employees know how to prevent and reduce hospital errors.
 - Develop reimbursement mechanisms that provide incentives for providers to engage in patient-family discussions.
 - Integrate health system reporting of medical errors or adverse events in your network evaluation to establish/inforce accountability.
- 4 **Partner with Health Plans, Vendors and Primary Care Groups on Continuous Education**
 - Ensure systems are in place for collaborative communications to protect patients from preventable harm, including [Informed Consent](#).
 - Address individualized needs through patient and consumer support programs to prevent avoidable hospitalizations and hospital errors.
 - Prioritize continuity of care in hospital and outpatient settings.
 - Develop reimbursement mechanisms that provide incentives for providers to engage in patient-family discussions.
 - AHA Checklists to improve Patient Safety (for providers)
 - AHRQ I'M SAFE Checklist and QuestionBuilding App (for patients)

The National Alliance gratefully acknowledges funding through a Patient-Centered Outcomes Research Institute® (PCORI) Eugene Washington PCORI Engagement Award (EADI-26862).

DID YOU KNOW?

Primary care doctors would need a 27-hour workday to follow current medical guidelines. That's why it's important to ask health plans and other vendor partners to identify and address time constraints and prioritize safety initiatives.

Source: National Institutes of Health, 2023, The New York Times

RESOURCES

- PCORI Study: Does a Patient- and Family-Centered Hospital Communications Program Reduce Hospital Errors?
- The Leapfrog Group Informed Consent Fact Sheet and Hospital Safety Grades
- Interventions to Prevent Potentially Avoidable Hospitalizations
- Approach to Improving Patient Safety: Communication
- AHA Checklists to Improve Patient Safety (for providers)
- AHRQ I'M SAFE Checklist and QuestionBuilding App (for patients)

4/18/24

Thank You

We would appreciate your feedback!



Developed to Scale the I-PASS Methodology



The NEW ENGLAND
JOURNAL of MEDICINE



HARVARD
BUSINESS SCHOOL



HARVARD
MEDICAL SCHOOL



2008

2016

Digital Solutions Developed to Support Large Scale Hospital Implementations

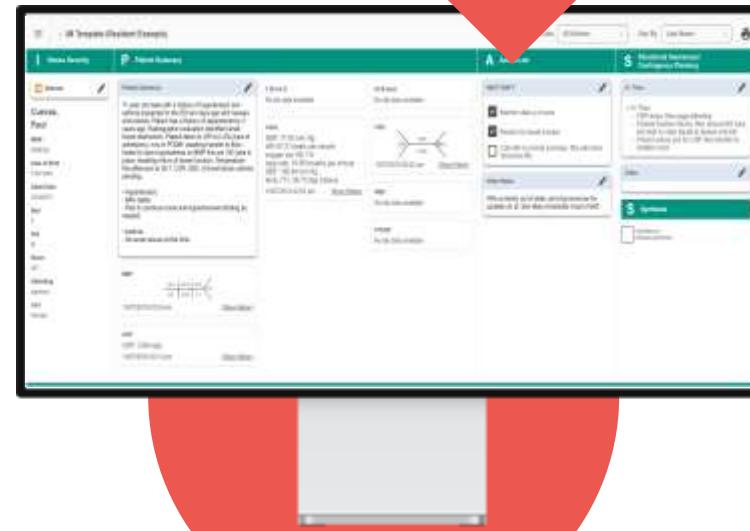
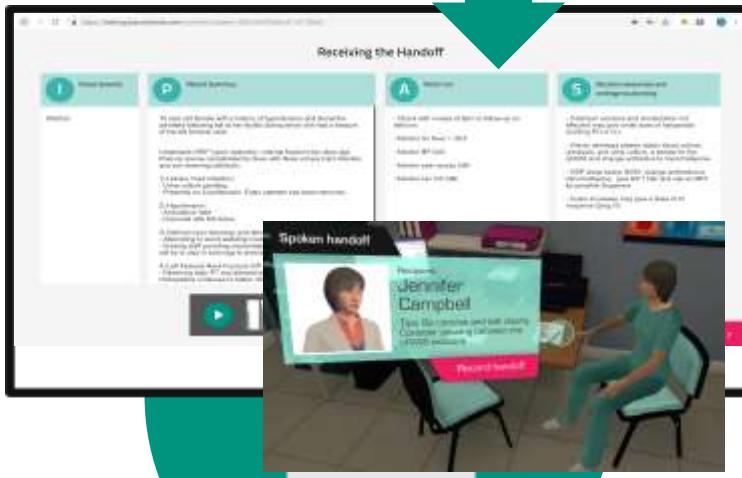
LEARNING



WRITTEN TOOL

MEASUREMENT

<p>Rounds Report</p> <p>“Who are who and what other team members come in a group in the community? Who are the people you can call if you need help? What do you do if you are lost? What do you do if you are scared? What do you do if you are angry? What do you do if you are sad? What do you do if you are alone and make a plan for the day for yourself?”</p> <p>Date: _____ Location: _____ Comments: See how important part of the team you are for your child! This team will help you know what will happen today and tomorrow. You can also ask questions about what will be learned and any questions you have to let in the day or tomorrow on events.</p> <p>I Did you just come to the hospital? P What was the last time you ate? A What should be done today before we can get back to our room? S Are you sick? Are you tired? Are you too hot? Are you too cold?</p> <p>Questions on Google to search the web for child abuse resources: Please feel free to use these links as a resource for research resources.</p> <p>Additional notes and information: Please feel free to enter notes in this section for the next session.</p>	 <p>Family & Community Family & Community Community & Emergency</p> <p>Medical Medical Healthcare Healthcare</p> <p>Child Abuse Child Abuse Child Abuse Child Abuse</p> <p>Other Other Other Other</p> <p>Child Abuse Child Abuse Child Abuse Child Abuse</p> <p>Other Other Other Other</p>
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Workflow & Throughput Highlights

ED to Inpatient Callbacks



Brigham & Woman's Hospital

80%

Fewer Clarifying Callbacks

Reduced Sign Out Time



St. Jude's Cancer Research Hospital

18 mins

reduction in length of NICU sign-out per patient

Nursing Overtime Reduction



KAPI'OLANI
PALI MOMI
STRAUB
WILCOX

Hawaii Pacific Health

70%

reduction in Nursing Overtime

Decrease in Interruptions



Boston
Children's
Hospital

Boston Children's Hospital

40%

reduction of interruptions



St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

St. Christopher Hospital for Children's

92%

reduction in interruptions

The Evolution of I-PASS...A 15-Year Journey

