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I. Introduction

This executive summary is a shortened version of the more complete report on the proceedings of the Chicago Patient Safety Workshop, held in Chicago at Northwestern Memorial Hospital (NMH) from June 19–21, 2008. The workshop was a gathering of about forty patients and family members -- many of whom had experienced preventable harm due to healthcare systems failure – and an equal number of “other stakeholders” comprised of physicians, nurses and other healthcare professionals; organizational administrators; researchers; philanthropists; government representatives; facilitators and graduate school interns. This community of change agents came together with the common goal of accelerating improvement in patient safety by developing measurable interventions that can be implemented in the Chicago region, and perhaps elsewhere.

The complete report of the Chicago Patient Safety Workshop is available at www.patientsafety.org.

II. Summary of Work Product

Action plans were developed for six selected topics:

1. Patient reporting of patient safety events;
2. Patient/family engagement in policy and process development;
3. Patient/family involvement in their own care, including driving their plan of care and their role in transitions between care settings;
4. Techniques for effective patient/physician (clinician) communication;
5. Preventing error, including setting priorities for the Chicago region; and
6. Working through error when it happens via disclosure, root cause analysis, long-term learning, and emotional support for patients, families and healthcare workers involved.

Across the six topics, two platforms for change work emerged again and again:

- First, that healthcare organizations in Chicago “open the doors” and integrate consumers into their existing safety and quality committees, processes and other infrastructure;
- Second, that healthcare organizations in Chicago engage in collaborative projects to implement change initiatives and measure progress.

In addition to action plans, twenty videotaped interviews of workshop participants were captured. They will be thematically analyzed using interpretive research methodology to illuminate the impact of medical error on the human beings involved. Papers will be submitted to peer reviewed publications on both the action planning process and the interpretive research project. Articles and stories will be disseminated via other publications as well, including those targeted to consumer audiences.

A final product of the workshop is the following Challenge to the Chicago community.

Our Challenge to Chicago

We were privileged to be engaged in developing the Chicago Patient Safety Workshop in June 2008. We were struck by the energy and commitment of everyone who attended. As patients, family members and healthcare professionals shared their stories of loss suffered as a result of medical error, they expressed a great deal of pain and anguish, along with much enthusiasm and hope.

Our hope now is that the workshop was not just a momentary acknowledgment of the human toll of medical error, but the launch of a new community of committed change agents in Chicago. Workshop participants want to make a difference. They demand and volunteer to help build a healthcare delivery system that is:

- Rigorously well-designed
- Scientifically-based
- Reliable
- Respectful
- Dignified
- Honest and trustworthy
- Open and transparent
- Collaborative
- Fair and non-discriminatory
- Caring and compassionate

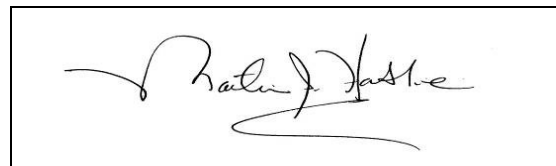
It is our wish that the proceedings published here will advance that goal as soon as possible, in the Chicago area and beyond. We seek to inspire transformation here as a model for other communities. Chicago—city of broad shoulders, the city that “makes no small plans”—and its metropolitan area can make this vision a reality.

The six work plans developed during the Chicago Patient Safety Workshop *can* be implemented, and indeed they must be. We, the Steering Committee, stand ready to work with dedicated people and organizations who want to take on this challenge.

Accomplishing this goal will require tremendous leadership from the provider and patient/family/consumer communities. We thank the representatives of the Chicago Patient Safety Forum and the Illinois Department of Public Health, in particular, for their interest in this work. Now we must act, and together move the workshop plans forward.



Cynthia Barnard
Northwestern Memorial Hospital



Martin J. Hatlie
Partnership for Patient Safety

III. Workshop Development

The workshop was jointly developed by three Chicago-based organizations: Consumers Advancing Patient Safety (CAPS), Partnership for Patient Safety (p4ps) and NMH. Our overall goal was to tap what Susan Sheridan, CAPS president and Lead of the World Health Organization (WHO) Patients for Patient Safety (PFPS) initiative, calls “the wisdom of the consumer.” The workshop was carefully designed to actively engage patients/consumers in patient safety planning work side-by-side with healthcare providers and other dedicated persons interested in accelerating ambitious patient safety improvement in the Chicago region.

Most workshop participants were from the Chicago area. But conscious that our approach of working *with* consumers—not just for them—was breaking new ground and could be adapted elsewhere, the workshop was designed to build bridges to other communities. Accordingly, participants were invited from Arizona, Colorado, Idaho, Indiana, Maine, Maryland, Massachusetts, Vermont, Washington DC, the State of Washington, Australia, Canada, Ireland and the United Kingdom.

The idea for the workshop emerged from two developing initiatives in the Chicago area. The first was leadership at NMH and the commitment of that organization to actively engage consumers in patient safety work. The second was the formation of CAPS, a Chicago-based non-profit that has been active in advancing the role of patient as partner. Already working internationally with the PFPS initiative – one of the action areas of the WHO World Alliance for Patient Safety -- CAPS was eager to get traction for such a partnership in the United States.

The workshop was also a brainchild of the 2006 NMH Board of Directors retreat. At the retreat, board members discussed the current state of patient/consumer engagement in patient safety with Martin Hatlie, president of p4ps and co-founder of CAPS. Energized by the discussion, the NMH board quickly identified improved engagement of consumers as a central goal of the hospital’s emerging Long Range Quality Plan.

Hospital executives Chuck Watts, senior vice president and chief medical officer, Julie Creamer, senior vice president for quality and planning, and Cynthia Barnard, director of quality strategies, followed up the NMH board retreat with discussions with Marty Hatlie and CAPS executive director, Mitchell Dvorak. They conceived an idea for an innovative, regionally-focused effort that would go beyond the workshops CAPS and PFPS had organized in other venues. While these efforts had been successful in developing an international network of motivated patient safety “champions” active in WHO World Alliance work, none had evolved to the point of developing practical action plans to advance actual safety of care in a local community.

Armed with this concept, the team approached two well-established supporters of patient safety. The Chicago-based Otho S. A. Sprague Memorial Institute has provided leadership and financial support for patient safety since it helped launch the Chicago Patient Safety Forum in 2001. The Agency for Healthcare Research and Quality

(AHRQ) is the nation's lead federal agency for research on health care quality, costs, outcomes, and patient safety.

Both organizations agreed to partially support this effort. The Sprague Institute had a specific interest in assuring local engagement of the entire Chicago metropolitan healthcare community, and helped to build relationships and bridges to involve providers, government, local associations, and others throughout the region. The interest of AHRQ was complementary, with strong emphasis on dissemination of results and development of a model for other communities and regions to replicate. In addition to these supports, NMH hosted the event in modern, welcoming meeting facilities and contributed in-kind services.

Planning of the actual workshop agenda and logistics started early in 2008. To ensure that all aspects of the workshop were authentically patient-centered, two dynamic leaders in consumer involvement in patient safety were approached to play leading roles. Dan Ford, vice president at the Furst Group, a healthcare search consulting firm, and Sue Sheridan agreed to participate on the workshop Steering Committee. Both Dan and Sue have experienced health system failure that led to serious injury or death of a family member, and both are respected for their advocacy and perspective on the importance of partnership among all stakeholders. Because the adverse outcome that impacted Dan Ford's family occurred in the Chicago area, all of the initial workshop developers felt it was fitting to ask Dan to serve as workshop co-chair, and we were delighted that he agreed to do so. Dan and Sue assisted in all aspects of workshop development, outreach, participant application review and facilitation during the event. Their involvement was central to the success of the program, and epitomized the constructive partnership which the workshop seeks to model and inspire.

Other organizing partners who brought international perspectives and resources included the WHO World Alliance, represented by Helen Hughes, head of the WHO office in London, UK; and the Pan American Health Organization (PAHO), represented by Alexo Esperato Martinez, both of whom served on the steering committee. As an additional benefit of the collaboration, workshop participants are now qualified to be designated as PFPS Patient Safety Champions."

In response to our commitment to the Sprague Institute to make the workshop truly a Chicago-wide initiative, planning was overseen by a Steering Committee comprised of local healthcare providers, government representatives, and consumers active in the patient safety field (Appendix B). Letters of support were supplied by the Chicago Patient Safety Forum, Illinois Hospital Association and the Metropolitan Chicago Healthcare Council. Outreach was done to all Chicago neighborhoods with the goal of reaching a diverse pool of potential applicants.

We also acknowledge and thank the workshop participants (Appendix A), who took time from family and work to contribute their experiences, ideas and passion for making a difference in Chicago and beyond. Several workshop participants facilitated six small group work strands, and did it enthusiastically. Thanks for this work is owed to Geri

Amori, Cindy Barnard, Monica Berry, Tessa Burton, Dan Ford, Linda Kenney, Becky Martins, Michael Millenson, Gary Noskin, Bill Runciman, and Mark Williams. Their work-product was impressive and that it has a life beyond this event. We also acknowledge and thank two workshop guests: Doug Wojcieszak, spokesperson for the Sorry Works! Coalition, and David Carvalho, Deputy Director, Policy, Planning & Statistics for the Illinois Department of Public Health (IDPH). They contributed greatly to our planning efforts and coaching.

As incubators of the “brainchild” that became the Chicago Patient Safety Workshop, we take this opportunity to thank the many people described above and the many others who played a role in producing this event. It was an extremely moving experience for us to work with each and every one of them, and we are most grateful for the opportunity to have been involved in this project. We believe that the products developed there include not only the impressive and creative action plans that the teams crafted, but also the intangibles of collaboration, humor, respect, teamwork and trust. These are results that transform lives and make healthcare quality improvement truly possible.

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IV. Workshop Overview

Assumptions and context

The Chicago Patient Safety Workshop was based on the proposition that users of healthcare -- patients, consumers, clients, residents -- are an underutilized resource in patient safety work. The workshop built on emerging initiatives and tools that engage consumers as partners. The goal was to capture and apply their ideas and perspective to informing six patient safety issues that seemed ripe for intervention in the Chicago community. CAPS work in conjunction with the WHO World Alliance for Patient Safety indicates that these same issues are emergent in many communities across the globe.

The planners saw the workshop as a research development event, the findings of which will be widely disseminated. We sought to go as far as possible within the workshop in developing implementable plans. We hoped that the workshop would generate enough enthusiasm and sense of community to stimulate a number of post workshop activities as well, including:

- Further refinement of action plans, if needed;
- Development of at least two articles published in peer reviewed journals;
- Further dissemination of workshop plans and messages to consumer audiences via the Internet and other media;
- The development of a sustainable, patient-centric approach to patient safety work in greater Chicago, perhaps under the auspices of the Chicago Patient Safety Forum, or as an independent effort;
- Pilot projects or other research activities in Chicago as outlined in the action plans; and
- Cross-fertilizing linkages with patient safety advocates in other communities, including the WHO Patients for Patient Safety Initiative.

Objectives and Subjectives

The central objective of the workshop was to inform six selected topics, which, to be optimally advanced, depend on consumer engagement with healthcare providers and policymakers: The topics are:

1. Reporting medical errors and/or near misses;
2. Patient and family engagement in healthcare organization policymaking and operation via participation in safety, quality or policy-making activities at the organizational level;
3. Active patient and family engagement in ensuring the safety of their own care or that of their loved ones;
4. Effectively responding when error occurs, and engaging patients in organizational learning from such events;
5. Prioritizing error prevention initiatives in Chicago; and

-
6. Working through error when it happens via disclosure, root cause analyses, long-term learning, and emotional support for patients, family members and healthcare workers involved.

In addition to targeted objectives, the success of the workshop was dependent on subjective factors such as trust, a sense of goodwill and common purpose. Strategies to achieve these “subjectives” included:

- Requiring participants to fill out an application which probes readiness for change;
- Short pre-workshop paired interviews between consumer participants and provider participants, during which some common ground is almost always identified;
- Development of rules of engagement emphasizing mutual respect;
- Building a consumers-only session into the front end of the agenda to provide an opportunity to tell personal stories, express anger or frustration, identify and address feelings of inadequacy due to lack of expertise, and coach participants on what to expect as the workshop proceeds; and
- Opening presentations by inspiring leaders from both the consumer side of our community (Dan Ford, Susan Sheridan) and the provider side (Chuck Watts)

Rules of Engagement

The following ground rules were presented when consumers first arrived. They were approved as presented, and no modifications were made:

- Listen when others are talking because everyone here is an expert in their own care, in their own experience, in what they bring to the table.
- It’s okay to disagree. We’re not here to reach consensus. It’s okay to disagree, but let’s presume when we do that the person who has a different point of view is acting in good faith.
- Do not be afraid to challenge, but do it respectfully. ; Think about how you want people to treat you; think about how you would want to be challenged.
- Participate to your fullest ability.
- Keep your agreements.
- Keep confidences if asked to do so. If you do have a concern about being quoted, just tell us and we will work around it.

Methodology

The workshop adapted a group process methodology known as Appreciative Inquiry (AI), designed to tap participants’ personal and professional successes in addressing challenges and creating inspired, positive change. The AI methodology is rooted in social constructionism—the theory that human beings co-create what is thought to be “reality” through language, thoughts, images and beliefs about what is. Change is

energized, therefore, by the discovery of new thoughts, beliefs and language that shift current mental models about what is (“patients who experience medical error are angry, potential litigants”) to what could be (“patients who experience harm are a unique resource to continuous learning systems”). AI searches for and builds on the best in people, their organizations and the relevant world around them, thereby fostering collaboration and energy that can be transformative.

AI was developed and pioneered at the Cleveland Clinic in 1980 by David Cooperrider, PhD, and his associates as a new paradigm with the potential to replace the conventional problem-solving approaches that focus on analyzing deficits in order to make corrections. A central challenge to problem-based approaches is strong resistance to the guilt, shame or disorientation that may attend the experience of concentrating on deficits. Appreciative Inquiry shifts this focus to a desired future or outcome, based on strengths and passions that are apparent or have been experienced in the past and present. AI does not ignore problems, but recognizes and repositions them as a desire for something else, then works to identify and enhance that “something else.”

This positive change strategy is particularly well suited to challenges that require the formation of new and optimistic relationships. This can be challenging in the patient safety context, given the traumatic impact of medical error and negative feelings harbored by both consumers and healthcare professionals who have experienced system failure. This challenge is met by capturing stories that foster images of success, even if they arise from failure. Past tragedies are respected and losses are acknowledged and appreciated, but the focus is on what these painful experiences have produced that is positive and future oriented. What was discovered during the experience? Where was innovation demonstrated? Who worked together and how did that happen? What was remedied?

AI methodology presumes that stories can be transformative in two ways. First, they have the potential to create a relatedness of experience that is then shaped by conversation among meeting participants into a path to future change as a community. Second, reflecting on the stories of others or responding to others’ questions about one’s own story can lead to internal reframing of what happened—a shift of perspective that helps individuals move forward in a process of healing or overcoming their own resistance to change. In other words, the AI process inspires change at both the group level and for the individuals participating in the group. The process enables consumers, providers and policymakers to generate fresh perceptions of one another, thereby allowing for the revitalization of the social bond and a heightened collective will to act. In its broadest focus, it involves systematic recovery of what gives “life” to a living system when it is most alive, most effective, and most constructively capable.

On Day 2, Starman was relocated to the larger meeting room where new workshop participants were arriving. In the opening session of Day 2, Starman proved useful as a visual aid in conveying to the combined group how deeply motivated consumers were to partner and get to work.

Summary of Proceedings

A brief description of the workshop follows for those who wish to read it for context.

Pre-Work

Each person attending the workshop had “homework” to do. As mentioned earlier, participants were sorted into pre-assigned pairs and given three interview questions. They were encouraged to connect by phone and get acquainted so that they could introduce each other on the morning of Day 2.

Day 1 Evening: Patients/Family/Consumers Only

Registration activities were followed by a welcome and orientation, buffet dinner, and a brief introduction to the themes and concepts of patient safety and systems. The evening provided time for all those present to introduce themselves and discuss their reasons for participating. Dan Ford facilitated and Marty Hatlie built a graphic portrait of the collective experience of the workshop participants using the “Starman” graphic facilitation tool described above.

The evening was candid, emotional, humorous, grieving, and occasionally contentious. A notable contribution made by workshop participants of African ancestry was their raising the theme of racial discrimination in healthcare and its impact on the safety of minority patients. This prompted discussion of the overlap perceived by some between safety issues and discrimination on the basis of race, HIV status, and other factors. Participants also engaged in some debate about the relative importance of systems accountability versus personal accountability in making health care safer. Some participants were rather quiet, others very engaged.

Day 2 Morning

The second day brought together all of the healthcare participants along with the returning patients/consumers. Following registration and a leadership welcome from Chuck Watts, Sue Sheridan and Dan Ford, the partners who had met each other in the “pre-work” interviews offered introductions of each other. This took significant time, but was energizing for just about everyone. Marty Hatlie reviewed the themes of the previous evening, using Starman as a prop.

The latter portion of the morning included didactic and informational presentations on contemporary thinking about patient safety systems, and the work of the World Health Organization in international perspectives on improving safety. The complete agenda

and summaries of context-setting presentations made by Chuck Watts, Susan Sheridan and Dan Ford are included in the full meeting report available at the CAPS website (www.patientsafety.org.)

The morning concluded with a challenge to the workshop participants to pool their collective energy and experience to develop practical, useful action plans in the six problem areas in healthcare patient safety identified under the “objectives” segment, listed above.

Day 2 Afternoon: Investigating the Questions

Each participant selected one of the six topics as “home” focus. Cards were prepared so that an approximately equal number of consumers and healthcare participants joined each topic. In the first hour following lunch, participants and topic-facilitators considered brief white papers intended to convey what is already known on the topic, and to outline the questions that would be addressed. Among the materials considered were research and survey data, best practices, authoritative sources, and short presentation literature.

The groups brainstormed to define the outcome with the help of the following statement: *In order to improve patient safety in Chicago, when this workshop is over we will have accomplished this: _____*”

Day 2 Afternoon: “Fishbowl” Discussion with Invited Guests

Part of the goal of the workshop was to ensure that participants stayed focused on the regional agenda and goals and avoided a parochial focus on a specific provider or a specific community. Guests spoke briefly and then opened the discussion on regional concerns. Our guests were David Carvalho, Illinois Department of Public Health, Doug Wojcieszak of the Illinois-based Sorry Works! Coalition, and Cindy Barnard and Carrie Nelson, both of whom have leadership roles in re-energizing the Chicago Patient Safety Forum.

Day 2 Afternoon: World Café: Brainstorming Action Plans, Part One

The teams of participants moved from their “home” topics to three other topics in succession. In each setting, the facilitators explained what the topic was, and described the work that the “home” and rotating teams had completed so far to define goals and actions to advance the topic. This exercise was designed to engage participants as creative partners, perhaps prompting them reexamine their own thoughts and belief structures. A further goal was to build shared ownership of all topics while advancing mutual respect as the teams continued to get to know each other.

Day 3 Morning: World Café: Brainstorming Action Plans, Conclusion

The small teams continued to circulate through the last two topics, adding their voices to the goals and action plans, which were constructed and continuously improved.

By the end of this segment, all participants had “touched” all six topics—either as a home topic or one that they visited. This process was meant to develop agreement about the future direction of the Chicago area patient safety community.

Day 3 Morning: Action Plan Integration

Each rotating team returned to their “home” topic, where facilitators briefed them on the amendments, revisions and contributions to goal statements and action planning that had accumulated during the rotations over the past twenty-four hours.

The owner-teams were reminded of their assignment: Create an action plan that can be implemented in the Chicago region,

- Finalize the action plan:
 - Using the input of all rotations, crisply state the goal or accomplishment you have targeted; and
 - In five to seven steps, outline the action plan to achieve this goal.
- Identify a timeline;
- Define who needs to be involved;
- Define short- and long-term benchmarks for progress; and
- Evaluate: How will we know we are successful? Can it be measured?

Day 3 Noon: Presentations, Debriefing, Next Steps

Before and during lunch, the groups presented the results of their labors. The graphic plans were colorful, detailed and vivid, and the accompanying narratives even more so. They were all captured for the future goal of publishing and disseminating results.

This session ended with an opportunity for every participant to share thoughts about what they had experienced and their personal commitments for the future.

Day 3 2:30 p.m.: Workshop Adjourns

V. Topics and Workshop Action Plans

The Chicago Patient Safety Workshop articulated the ambition to engage consumers and other healthcare stakeholders in practical action planning for improvement on selected topics that are priorities in the Chicago region. It built on work done previously by CAPS and the WHO PFPS initiative, using the same AI-influenced methodology to reconfigure “who talks to who about what” and build invigorated communities across the globe that are dedicated to achieving patient safety goals. However, these earlier events focused more on articulating mission and goals and achieving the pledge of partnership between consumers, providers and policymakers. In Chicago, we sought to

push the frontier forward by producing plans that could be implemented in the Chicago region.

To recap, the selected topics were:

1. Patient reporting of patient safety events;
2. Patient/family engagement in policy and process development;
3. Patient/family involvement in their own care, including driving their plan of care and their role in transitions between care settings;
4. Techniques for effective patient/physician (clinician) communication;
5. Preventing error, including setting priorities for the Chicago region; and
6. Working through error when it happens via disclosure, root cause analysis, long-term learning, and emotional support for patients, families and healthcare workers involved.

The action plan elements were:

- A. A clearly articulated goal statement: ***In order to improve patient safety in Chicago, when this workshop is over we will have accomplished this:*** _____;
- B. ***In 5 to 7 steps, outline the actions needed*** to achieve this goal;
- C. Discuss ***who needs to be involved*** at each step and ***why each step is important***; and
- D. Determine ***short- and long-term benchmarks*** for progress, by completing the statement: ***Success looks like*** _____.

It should be noted that we approached this work as a research project as well as an action planning exercise, the research being the capture of consumer and provider experiences that informed the action plans. Each of the six groups had facilitators and was given a briefing about what the research showed “we know or don’t know” on the specified topics. Graduate student interns were assigned to take notes and develop summaries of the small group discussions. In addition, all small group discussions were captured on audiotape and transcribed.

Table 1
Action Plans Side-by-Side

Selected Topic	Action Plan Goals
1. Patient Reporting of Patient Safety Events	<p>Goal: <i>Establish in Chicago a mechanism for consumers to report medical errors that has these key attributes:</i></p> <ul style="list-style-type: none"> • <i>Available in all healthcare settings, not just hospitals</i> • <i>The reports can be analyzed and mapped to patient safety reporting/learning systems maintained in Chicago that providers report to;</i> • <i>There is feedback to consumers who report about how their report is analyzed and used.</i> <p><i>A subset of data analyzed thematically should be publicly reported.</i></p>
2. Engaging Patients/Families in Quality Improvement & Patient Safety Policy Development	<p>Goal : <i>Establish in Chicago the perspective that these key outcomes are important:</i></p> <ul style="list-style-type: none"> • <i>Patients should be “at the table” for in all settings where patient safety and quality policies are developed:</i> <ul style="list-style-type: none"> ○ <i>In healthcare organizations, for example: patient safety committees, complaint committees, adverse event review committees, infection control committees, clinical program leadership, quality and safety committees;</i> ○ <i>In the Chicago region, for example: patient/family advisory panels for the region, Chicago Patient Safety Forum, government, other policy groups.</i> • <i>The region needs a model tool kit, that addresses roles of consumers and a recruitment process for engaging them;</i> • <i>We need to drive fear out of our work, and prepare to manage conflict;</i> <p><i>It's important that we evaluate what we have learned, via a survey of perceptions, measures of each project's success and the spread of good ideas.</i></p>
3. Patient and Family Involvement in their Own Care	<p>Goal: <i>To ensure complete and accurate medical info for every patient in Chicago, through shared goals and responsibility of the care team and patients across the continuum of care, where patients are:</i></p> <ul style="list-style-type: none"> • <i>Valued;</i> • <i>Listened to AND understood;</i> • <i>An integral and equal part of the team;</i> • <i>Allowed access to advocates (interns, relatives); and</i> <p><i>Communicated with especially about medications and procedures</i></p>
4. Techniques for Effective Patient/Clinician Communication	<p>Goal: <i>Develop a team oriented, patient-centric, reciprocal communications model that is transparent, truthful, respectful, reliable, systemic and accountable (aka Optimal Tools and Strategies for Patient Clinician Communications)</i></p>
5. Preventing Error through Patient/Provider Partnership	<p>Goal 1: <i>Ensure complete and accurate medical information for every patient in Chicago (3-5 years);</i></p> <p>Goal 2: <i>Provide information for patients to improve safety (6-12 months);</i></p> <p>Goal 3: <i>Curriculum for education for Chicago area on the principles and practices for safety (2-4 years);</i></p> <p>Goal 4: <i>Determine healthcare processes for which standardization would be appropriate (1.5 years+)</i></p> <p>Goal 5: <i>Create a mechanism for involving the patients in error prevention – refer to other groups (Patient Involvement in Policy, Patient Involvement in Own Care, Communication Practices)</i></p>
6. Disclosure, Root Cause Analysis, Learning & Emotional Support	<p>Goal: <i>To establish a meaningful best practice for response after error throughout Metropolitan Chicago for responding to an adverse event, using evidence-based research.</i></p>

Topic 1 Action Plan: Patient Reporting of Patient Safety Events

Goal statement:

Establish in Chicago a mechanism for consumers to report medical errors that has these key attributes:

- Available in all healthcare settings, not just hospitals;
- The reports can be analyzed and mapped to the patient safety reporting/learning systems maintained in Chicago that providers report to;
- There is feedback to consumers who report about how their report is analyzed and used; and
- A subset of data analyzed thematically should be publicly reported.

Actions steps:

1. Design a reporting system accessible by patients, families and other consumers in Chicago that has the key attributes outlined above.
2. Establish a reporting mechanism that is Web-based and that includes an “800” number with a trained workforce (nurses, for example) that will accept reports by telephone in English and Spanish.
3. Use a classification system as the back end that allows consumer reports to be analyzed in the same way provider reports to PSOs (Patient Safety Organizations) are analyzed, so comparisons can be made.
4. Use the data reported for learning purposes, for example, to analyze risks and thematic factors in health system failures; complaints seeking accountability should be triaged elsewhere (for example, state agencies or Joint Commission).
5. When themes are identified, corrective strategies are implemented.
6. Data are continually monitored to see if corrective strategies are making a difference in place.

Who needs to be involved?

- Healthcare organizations, although hospital-only reporting may be too circumscribed. National or regional reporting systems should be considered.
- Patients and families who will report.
- Patient and family educators.
- Trained report receivers, such as nurses, who can triage learning reports from patient satisfaction reports or complaints that need to be handled by state agencies, the Joint Commission or others.
- Report analysts who are trained in using classification systems, such as the quality improvement staff of healthcare organizations.
- Joint Commission and Illinois State agencies.
- Lawyers, to address questions of what is protected from discovery.

Measures (what will success look like?)

- Healthcare settings have processes in place to make sure patients know about the reporting system and are invited and encouraged to use it.
- Consumer reporters can see what has been done about the report they made. (It may work something like this: After a report is made it gets sent to the place of care, and it becomes the responsibility of the healthcare facility to report back to the patient via email what has been done, or to send a form email that states “we have received your complaint and added it to our data, and we are working toward a resolution of the problem.”)
- Majority view: The mechanism is used to improve healthcare outcomes, not for comparisons. (Minority view: Reports should be used for accountability as well.)
- Reports and their analyses are used by researchers and providers to study and cost effectiveness.
- Corrective strategies are recommended for implementation throughout Chicago.
- Implementation of corrective strategies is monitored over time.
- Over time, consumers are surveyed to determine if they know what the reporting system is for, and what it is *not* for.

Topic 2 Action Plan: Engaging Patients/Families in Quality Improvement & Patient Safety Policy Development

Goals Statement:

Establish in Chicago the perspective that these key outcomes are important:

- Patients should be “at the table” in all settings where patient safety and quality policies are developed:
 - In healthcare organizations, for example: patient safety committees, complaint committees, adverse event review committees, infection control committees, clinical program leadership, quality and safety committees;
 - In the Chicago region, for example: patient/family advisory panels for the region, Chicago Patient Safety Forum, government, other policy groups.
- The region needs a model tool kit that addresses the roles of consumers and includes a recruitment process for engaging them;
- We need to drive fear out of our work and prepare to manage conflict; and
- It’s important that we evaluate what we have learned via a survey of perceptions, measures of each project’s success and the spread of good ideas.

Action steps:

1. Learn how to select/prepare patients and staff to be effective as partners

-
2. Locate and recruit patients/families
 - Outreach through existing groups (e.g., MRSA, advocacy, patients, clinicians, advertisements, etc.)
 - Patients who have been harmed
 - Patients who have had excellent experiences
 - Screening
 3. Develop formal orientation, training, support
 - Target: 2+ patients per committee (not just one)
 4. Identify role models
 - IRB, IFCC, Australia
 - UK resources and research
 5. Identify settings/committees/progressive process
 - Diversity
 - Include non-hospital settings
 6. Collaboratively define the process of involving patients—the “job description”—broad involvement
 7. Prepare the healthcare teams
 - Prepare to manage conflict
 - Address expectations
 - Accountability—the committee has to come to some form of closure
 - Accountability—for follow up and action
 8. Work to drive out fear
 9. Share results, for example with: WHO, CPSF, Northwestern Memorial Hospital Web site and other Web sites, through publications, by holding a conference in the Chicago area.

Who needs to be involved?

- Consumers Advancing Patient Safety
- Chicago Patient Safety Forum
- The Joint Commission
- “Real” Patients & Families
 - Harmed patients
 - Patients/families who have had good experiences
 - Those with special expertise in systems, etc.
- Providers

Measures (what will success look like?)

-
- Within a year at least five hospitals in Chicago will have meaningful involvement on committees, including:
 - Patient safety committees
 - Infection control committees
 - Quality committees
 - Patient/family advisory committees
 - There will be a tool kit for other organizations to start similar patient involvement programs
 - Measurable evidence of meaningful improvement, including better safety outcomes after implementation of patient engagement strategies.
 - Measures that identify barriers to engagement, for example, via stories and monitoring of continuous improvement.
 - Measures of actual patient/consumer involvement, for example:
 - Actually have representatives on relevant committees
 - Orientation/training, expenses, time
 - Principles of engagement—partnership
 - Measure the engagement by asking them!
 - Pre-/post-involvement measures?
 - Evaluate the “spread” of good ideas

Topic 3 Action Plan: Patient/Family Involvement in Their Own Care, Driving the Plan of Care and Transitions in Care

Goals Statement:

The goal is to ensure complete and accurate medical information for every patient in Chicago, through shared goals and responsibility of the care team and patients across the continuum of care, where patients are:

- Valued;
- Listened to AND understood;
- An integral and equal part of the team;
- Allowed access to advocates (interns, relatives); and
- Communicated with especially about medications and procedures.

Action steps:

1. Establish a patient-centered personal health record.
2. Provide information to patients to improve safety, with the information developed to meet their needs and tested before and after implementation.

-
3. Develop a best practices demonstration project among Chicago providers:
 - a. Find the best practices;
 - b. Implement the best practices;
 - c. Create focus groups to guide implementation; and
 - d. Work together to support multidisciplinary adoption in all levels of care.
 4. Develop an educational curriculum for practitioners (MD, PharmD, RN).
 5. Standardize core healthcare practices and involve patients in planning and implementing standardization.

Who needs to be involved?

An identified team needs to be formed, possibly with an executive sponsor to ensure delivery and follow through.

Measures (what will success look like?)

- The patient is respected as a partner and a teacher.
- Care team and patient share responsibility for goals and the continuum of care.
- Patients are invited to use care partners/advocates.
- Clinicians and patient use teach-back techniques.
- Evaluation: patient/staff satisfaction, better outcomes, decreased harm and complications, fewer errors.
- Treatment outcomes are measured continuously after implementation.

Topic 4 Action Plan: Techniques for Effective Patient Clinician Communication

Goal Statement:

Develop a team oriented, patient-centric, reciprocal communications model that is transparent, truthful, respectful, reliable, systemic and accountable (aka *Optimal Tools and Strategies for Patient Clinician Communications*)

Action steps:

Our Key Strategies to achieve the goal are:

1. Build on what current knowledge exists - don't reinvent the wheel; but make sure the view is balanced, and really reflects the patients' needs;
2. Clarify what the optimal patient experience looks like in each clinical setting from a patient's perspective – the doctor's office, the outpatient clinic, the inpatient experience, and on discharge -- adapt the tool to each setting;
3. Define the tools -- common rules of communication engagement between patient and caregivers that are likely to be effective for the patient – the do's and don'ts --

based on courtesy, respect, mutual listening and using simple, non clinical language; create an understanding of those communication styles that are *not* productive among clinicians.

- a. Develop or adopt an existing clinician/patient communication intro/framework (using a tool like SBAR, SEGUE) to shape the dialogue between patient and physician and to address the issue of communication; all of care team members need to work together to address this issue;
 - b. Develop or adopt an existing clinician/patient glossary so that language becomes less of an obstacle and everyone is on the same page;
 - c. Develop/adopt an existing medication FAQ so that there is a standard way to approach the issue of existing medications, and to ensure there is a process to capture these at the point of care.
 - d. Develop or adopt an existing “trigger phase” to allow patients to challenge in a non confrontational manner – the patient needs to feel comfortable enough to do this and the physician needs not to take this personally;
 - e. Consider using visual multimedia (dvd’s, web, print) to reinforce these messages effectively – using effective adult learning practices to bring them to life;
 - f. Identify opportunities/contexts in each clinical setting to utilize a patient advocate – when and where does it belong, how does this role get staffed, voluntary vs. caregiver role, who does it, how is it paid for;
4. Pilot the model in multiple Chicago inpatient and outpatient settings using these *Optimal Tools and Strategies For Communications Between Patients and Caregivers* for validation, re-alignment and impact on patient and caregiver satisfaction;
 5. Measurement is key – primarily in pre and post patient satisfaction studies, likelihood to recommend, etc.

Who needs to be involved?

- Focused groups of clinicians and patients
- Marketing professionals
- Patient advocates

Measures (What will success look like?)

- Tools are developed and distributed to clinicians and patients
- Patients show up with advocates more frequently
- Inpatient pilot study: model is being used, and patient feedback is positive (measured by exit interviews or surveys)
- Patients are asking questions about their medication (measured by interviews with staff or surveys of patients)
- Trigger phase use is measured by staff interviews or patient surveys
- Tools are well used in Chicago and adopted by communities beyond Chicago
- Pre and post benchmark study of patient behavior when they use advocates

Topic 5 Action Plan: Preventing Error through Patient/Provider Partnership

Goal Statements:

This working group developed goals, each with an action plan, and incorporated a 5th developed by other small groups. (See Table on following page for summary.)

1. Ensure complete, accessible and accurate medical information for every patient in Chicago
2. Provide information for patients to improve safety
3. Implement standardized curriculum / education for Chicago area health care providers on principles and practices for safety
4. Determine healthcare processes for which standardization would be appropriate and begin to implement them
5. Create a mechanism for involving patients in error prevention (adopted from groups 2 (Patient Engagement in Policy), 3 (Patient Involvement in their own care) and 4 (Effective communication practices))

Who needs to be involved?

- Physicians
- Nurses
- Pharmacists
- Insurers
- Companies
- Patients
- Families
- Organizations involved in curriculum development, including American Association of Medical Colleges (AAMC), American Association of Colleges of Pharmacy (AACCP), nursing schools

Action Steps and Measures (What will success look like?)

These Action Steps and Measures numerically track the goals and action steps above:

1. Ensure complete, accessible and accurate medical information for every patient in Chicago (3-5 years).

Action steps:

- 1.1 Determine what information ought to be included
 - 1.1.1 Measure (short term): Multidisciplinary committee is developed
 - 1.1.2 Measure (long term): Repository for patients is fully operational
- 1.2 Determine the sponsor for this type of product (web-based or?)
 - 1.2.1 Measure (short term): Identify a potential sponsor
 - 1.2.2 Measure (long term): Secure a deal

-
- 1.3 Implementation (books on wheels, partner with local companies, libraries, etc.)
 - 1.3.1 Measure (short term): Roll out the program where feasible through companies and patient groups
 - 1.3.2 Measure (long term): 30% of population reached in 5 years

 2. Provide information for patients to improve safety.
Action steps:
 - 2.1 Define what information is to be provided
 - 2.1.1 Measure (short term): Organize the committee
 - 2.1.2 Measure (long term): Have the definitions established
 - 2.2 Delivery of information (DVDs, videos, PSAs)
 - 2.2.1 Measure (short term): Delivery of information vehicles
 - 2.2.2 Measure (long term): Actual implementation

 3. Develop curriculum from education for Chicago area on principles and practices for safety
Action steps:
 - 3.1 Develop a committee
 - 3.1.1 Measure (short term): Develop a committee
 - 3.1.2 Measure (long term): Charge a group to develop the curriculum
 - 3.2 Develop the curriculum
 - 3.2.1 Measure (short term): Develop the curriculum
 - 3.2.2 Measure (long term): Implement the curriculum in schools

 4. Determine healthcare processes for which standardization would be appropriate.
Action steps:
 - 4.1 Develop a forum
 - 4.1.1 Measure (short term): Develop the forum
 - 4.1.2 Measure (long term): Establish criteria
 - 4.2 Set definitions and benchmarks
 - 4.2.1 Measure (short term): Set up first set of definitions and benchmarks
 - 4.2.2 Measure (long term): Doing this continuously

 5. [Goal 5 referred to other groups – no action steps or measures specified here.]

Topic 6 Action Plan: Disclosure, Root Cause Analysis, Learning and Emotional Support

Goal statement:

The goal is to establish a meaningful best practice for response after error throughout Metropolitan Chicago for responding to an adverse event, using evidence-based research.

Action steps:

1. Standardize the process.
2. Drive implementation of the process by getting buy-in from all key stakeholders.
3. Regulate the process through a central “go to” group established with resources to aid implementation.
4. Provide training to clinicians on disclosure and support with coaching.
5. Establish cadre of counselors available to patients, family members and providers who are grieving.
6. Develop a tool kit that stays free of jargon and buzzwords.
7. Pilot the program before extensive rollout.
8. Define an end point for implementation and use evaluation measures to assess short and long term success; suggested: 80% of hospitals in Chicago in 5 years have process in place.

Who needs to be involved?

A governing board comprised of representatives from the following organizations and stakeholder groups (among others):

- Consumers Advancing Patient Safety
- Chicago Patient Safety Forum
- Illinois Hospital Association\
- Metropolitan Chicago Health Council
- Midwest Business Group on Health
- Hospital workers unions
- Illinois Trial Lawyers Association
- Medical societies
- Medical and Law school deans
- Illinois Department of Public Health
- CHARMS

Measures (What will success look like?)

- Key allies are engaged, including Chicago Patient Safety Foundation, Illinois Hospital Association, Metropolitan Chicago Health Council
- Number of organizational participants is a measure, including Illinois Trial Lawyers Association, hospital worker’s unions, medical societies, CMS, deans of

medical & law schools, CHARMS, Midwest Business Group on Health, Department of Public Health, among others

- Reports from various types of hospitals -- academic medical centers & other communities
- Fully established and operational governing board
- Best practices for the Chicago community are identified
- A package of tools is developed and endorsed
- Publication of an article & presentation at an international patient safety meeting
- Tool kits are developed, continually monitored & adapted as the practices change.
- Patient surveys
- Hospital standards are in place, including perhaps a significant penalty (up to \$50,000?) if an event is not disclosed and/or a report to the National Practitioner Data Bank. (But there should also be a “just culture” or these penalties will not be seen to be fair. Just culture means reckless disregard for the consequences of an action.)
- Nursing or social work can help with evaluation through interviews.

VI. Conclusion

The Chicago Patient Safety Workshop was a memorable event for those who planned and participated in it. Evaluations were strong (see Appendix D), and many of those who contributed state that they are eager to do more. An active network is taking shape as participants periodically contact both facilitators and each other. Thanks to funding support that allowed invitations to participants from other states and countries, cross-fertilization with other communities is occurring as well. CAPS is now planning similar workshops in Arizona, Colorado and Maryland, each generated by the initiative of Chicago Workshop participant who resides in those locales. Many Workshop participants have joined CAPS or registered with the WHO World Alliance for Patient Safety as patient safety “champions,” thus adding to the cause-related networks these organizations foster globally.

The greatest potential of the Chicago Patient Safety Workshop to advance change should lie in the six action plans generated, each of which are tailored to perceived needs in Chicago. The authors of this report are personally committed to do all reasonable things within our power to carry this agenda forward in the greater Chicago metropolitan area. Indeed, at least one action planning group clearly articulated an intention to hold the Workshop conveners accountable for not letting the work of this intensive event stay only on paper. Clearly expectations were raised during the Workshop that implementation would follow planning.

Topic 1: Patient Reporting of Medical Error: This group generated thoughtful discussion on potential mechanisms for patient reporting, barriers to motivating patients to report and privacy concerns, among many other issues. The value of patient reports

as a contributor to learning from failure was central to discussion, but the use of reports as input or triggers to oversight of providers was also favored by some. The Topic 1 planners recommended the development of community-wide reporting system outside of any one organization's walls, yet acknowledges that provider reporting is the issue on the bubble, pending expected finalization of the federal Patient Safety Organization (PSO) regulations later in 2008 and implementation of several new reporting requirements in Illinois, including new infection and "never event" reporting laws.

However, the reporting issues which surfaced during the discussion beg for a smaller scale research/pilot program as a first step toward regional implementation in Chicago. One option is to design such a pilot to function within a single Chicago hospital or among a collaborative of hospitals. Such an approach would be highly synergistic with Topic 2 and Topic 6 goals.

Topic 2: Engaging Patients/Families in QI and Patient Safety: This working group generated many ideas about the structures (committees, advisory groups, other nodes) in healthcare organizations that exist now or should be put in place for engaging patients. There was extensive discussion about the kind of support needed for patients who do volunteer for various roles, the interpersonal dynamics that need to be anticipated, whether conflict management strategies would be needed, and how to develop toolkits that meet these needs. Looking at Topic 2 planning in context with the other groups, once healthcare organization safety/quality related committees open up to greater consumer participation, they become platforms for advancing several of the action plans developed at the Workshop, including:

- Patient reporting pilot projects within Chicago hospitals (Topic 1),
- Toolkit development to promote effective communication among providers (Topic 4),
- Research and piloting of a personal health record (Topic 3),
- Development of standardized best practices addressing clearly preventable risks (Topics 3, 5),
- Patient and provider education about managing risk (Topics 3, 5), and
- Implementation of best practices for disclosure, accident investigation, emotional and psychological support, etc. when harm occurs. (Topic 6).

Topic 3: Patient and Family Involvement in their Own Care: This action plan is the most extensively interlinked with others. Examination of notes and transcripts underscores that issues which started to be developed in other topic groups were discussed at length here and in at least one instance "assigned" to this group. And several planned activities that first surfaced here were picked up and further developed elsewhere. In addition to the synergies noted in the last paragraph, these connections are notable:

- Development and implementation of standardized approach for preventing failures that is predictable – the same goal emerged in the Topic 5 plan and virtually the same implementation strategy (collaborative project among Chicago

hospitals to define and pilot regional best practice) was designed by the Topics 5 and 6 groups.

Topic 4: Effective Patient/Clinician Communication: A primary focus of the Topic 4 plan is developing tools to support and advance communication among providers, patients and families. Needed tools include a glossary of terms, patient education, deployment of a “trigger phrase” that signals a safety concern, and development of a patient advocate resource. Any or all of the identified tools and strategies could be built on the hospital-based patient engagement platform that is a focus of Group 2. They also are interventions that could be implemented and tested in the kind of Chicagoland community-based collaborative outlined by the Topics 5 and 6 groups or the already existing patient safety collaborative process of the Illinois Hospital Association.

Topic 5: Preventing Error through Patient/Provider Partnership: The Topic 5 plan ambitiously develops four separate goals, as well as articulating a 5th that they “assigned” to the Topics 2, 3 and 4 groups. A decided emphasis in this Topic Group was closing the gap between what we know and what we do through better implementation of best practices and more systemic education of both providers and consumers about managing risk. The four goals kept in Topic 5 also clearly link to other groups and appear ready to be built in regional collaboratives.

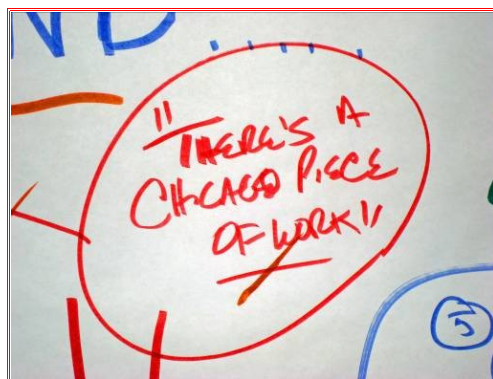
Topic 6: Disclosure, Root Cause Analysis, Learning & Emotional Support: The process of openly and honestly disclosing error to patients and appropriately responding already has a substantial footprint in Chicago. The University of Illinois (UIC) at Chicago was an innovator, establishing a program that has been continually refined for almost nine years. Other Chicago-based organizations have implemented similar approaches. Representatives of UIC and others who have been working with disclosure brought a sense to this group that an ambitious community goal – a Chicago best practice implemented in 80% of regional hospitals in 5 years – was more akin to planning a trip to Bhutan than a trip to the Moon. The journey would be difficult and require careful preparation, but it was possible to do now.

Whereas planning in other groups had a pioneer sensibility, as if new paths forward were being carved through mostly uncharted frontiers, Topic 6 group activity resembled a road crew assembled to convert a minor road into a major thoroughfare. Much time was spent assessing the players, budgets and politics of healthcare in Chicago, and their session ended with a clearly articulated intent to hold CAPS, CPSF and the Illinois Hospital Association accountable for moving their plan forward, starting immediately.

Moving Forward: The linkages just reviewed started to emerge as each Topic group presented their action plans in the final Workshop module. As our intensive three day planning event drew to a close, Australian participant Professor Bill Runciman asked for the floor to express the concern that ingrained attitudes and ideas in healthcare had slowed transformation for too long. He called the adherence to old views and practices “mindlines,” and voiced his optimism in seeing some old attitudes challenged during the course of this remarkable Chicago event. British participant Helen Hughes,

representing the World Health Organization, encouraged one and all to become more actively involved in the WHO World Alliance for Patient Safety as now fully qualified patient safety “champions.” Terry Powell -- a Chicago resident, frequent patient and gospel singer – performed a song that touched many, calling to mind a “perfect world” we can aspire to create. And Carrie Nelson, a physician and Chair of the Chicago Patient Safety Forum, asked our new community of planners and champions to stay involved and continue to work towards healthcare transformation in Chicago.

We adjourned with hope and a pledge of partnership.



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Appendices

- Appendix A: Workshop Participants**
- Appendix B: Workshop Steering Committee**
- Appendix C: Topic 1 Action Plan (Patient reporting of Patient Safety Events)**
- Appendix D: Topic 2 Action Plan (Engaging Patients/Families in Quality Improvement & Patient Safety Policy Development)**
- Appendix E: Topic 3 Action Plan (Patient/Family Involvement in Their Own Care, Driving the Plan of Care and Transitions in Care)**
- Appendix F: Topic 4 Action Plan (Techniques for Effective Patient/Clinician Communication)**
- Appendix G: Topic 5 Action Plan (Preventing Error Through Patient/Provider Partnership)**
- Appendix H: Topic 6 Action Plan (Disclosure, Root Cause Analysis, Learning and Emotional Support)**
- Appendix I: Workshop Evaluations**

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Appendix C

Topic 1: Patient Reporting of Patient Safety Events

Action Plan

Goal: *Establish in Chicago a mechanism for consumers to report medical errors that has these key attributes:*

- *Available in all healthcare settings, not just hospitals;*
- *The reports can be analyzed and mapped to patient safety reporting/learning systems maintained in Chicago that providers report to;*
- *There is feedback to consumers who report about how their report is analyzed and used; and*
- *A subset of data analyzed thematically should be publicly reported.*

Action Step	Who does it	Why important	Short-term success	Long-term success
<p>1.0 Design a reporting system accessible by patients, families and other consumers in Chicago that has the key attributes above.</p> <p>1.1 Develop an Oversight Committee in Chicago and a Working Group.</p> <p>1.2 Work with the Oversight Committee and Working Group to develop the design.</p>	<p>Chicago patient safety leaders, patient and families should be recruited to Oversight Committee.</p> <p>Working Group should include patient safety leaders, consumers, market researchers, project design & development experts, etc.</p> <p>Joint Commission and Illinois State agencies.</p> <p>Lawyers.</p>	<p>Leaders important to get buy-in and develop financial support.</p> <p>Technical experts to ensure feasibility of design.</p> <p>Lawyers important to address medico-legal concerns.</p> <p>Joint Commission and State agencies important to establish triage links.</p>	<p>Oversight Group is established; working group is established; planning process is designed and implemented.</p>	<p>Design is developed.</p>

<p>2.0 Establish a reporting mechanism that is Web-based but that includes an "800" number with a trained workforce (nurses, for example) that accepts reports by telephone in English and Spanish.</p> <p>2.1 Pilot the reporting system in Chicago.</p> <p>2.2 Refine after pilot and implement across the region.</p>	<p>Sponsor of the reporting system.</p> <p>Trained report receivers, such as nurses.</p> <p>Joint Commission; State agencies.</p> <p>Patient and family educators.</p>	<p>Sponsor important to underwrite reporting system.</p> <p>Trained report receivers important to sort learning reports from patient satisfaction reports or complaints that need to be handled by state agencies, Joint Commission or others.</p> <p>Pilot phase important to test and refine the process.</p>	<p>Develop strategic plan and business plan.</p> <p>Secure funding.</p> <p>Reports are received. After a report is made the place of care is notified and they must report back to the patient via email either what has been done, or send a form email that states we have received your complaint and have added it to our data, and we are working toward a resolution.</p>	<p>Consumers submit reports.</p> <p>Healthcare settings have processes in place to make sure patients know about the reporting system and are invited & encouraged to use it.</p>
Action Step	Who does it	Why important	Short-term success	Long-term success
<p>3.0 Use a classification system as the back end that allows consumer reports to be analyzed in the same way provider reports to PSOs are analyzed, so comparisons can be made.</p>	<p>Analysts who are trained in using classification systems, such as quality improvement staff of healthcare organizations.</p>		<p>Reports and their analyses are provided to healthcare providers & researchers; summary reports widely disseminated to public.</p>	<p>Reports and their analyses are used by researchers and providers to analyze risk, cost of errors.</p>
<p>4.0 Use the data reported for learning purposes, for example, to analyze risks and thematic factors in health system failures; complaints seeking accountability should be triaged elsewhere (for example, state agencies or The Joint Commission).</p>	<p>Risk managers, QI and patient safety officers.</p> <p>Local healthcare provider safety officers.</p> <p>Consumers.</p> <p>Chicago Patient Safety community.</p> <p>Other communities.</p>	<p>Majority view: The mechanism is used to improve healthcare outcomes, <i>not</i> for comparison.</p> <p>Minority view: Reports should be used for accountability as well.</p>	<p>Corrective strategies are recommended for implementation throughout Chicago.</p>	<p>Consumer reporters can see what has been done about the report they made.</p>
<p>5.0 When themes are identified, corrective strategies are implemented.</p>	<p>All local healthcare providers, including hospitals, clinics, extended care facilities, etc.</p>		<p>Corrective strategies are implemented.</p>	<p>Corrective strategies are evaluated to determine impact on reducing error and harm.</p>

<p>6.0 Data are continually monitored to see if corrective strategies are making a difference in place.</p>	<p>Reporting system operators.</p> <p>Oversight authorities.</p> <p>Public health experts.</p>			<p>Trends in number of reports submitted annually.</p> <p>Over time, consumers are surveyed to determine if they know what the reporting system is for, and what it is <i>not</i> for.</p>
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Appendix D
Topic 2: Engaging Patients/Families in Quality Improvement & Patient Safety Policy Development
Action Plan

<p>Goal: <i>Establish in Chicago the perspective that these key outcomes are important:</i></p> <ul style="list-style-type: none"> • <i>Patients should be “at the table” in all settings where patient safety and quality policies are developed:</i> <ul style="list-style-type: none"> ▪ <i>In healthcare organizations, for example: patient safety committees, complaint committees, adverse event review committees, infection control committees, clinical program leadership, quality and safety committees;</i> ▪ <i>In the Chicago region, for example: patient/family advisory panels for the region, Chicago Patient Safety Forum, government, other policy groups.</i> • <i>The region needs a model tool kit, that addresses the roles of consumers and includes a recruitment process for engaging them;</i> • <i>We need to drive fear out of our work and prepare to manage conflict;</i> • <i>It’s important that we evaluate what we have learned via a survey of perceptions, measures of each project’s success and the spread of good ideas.</i> 				
Action Step	Who does it	Why important	Short-term success	Long-term success

Identify role models: patients/families who understand advocacy and partnership.	<p>Consumers Advancing Patient Safety.</p> <p>Chicago Patient Safety Forum.</p> <p>The Joint Commission.</p>	<p>Change culture.</p> <p>Reduce "fear" of health care system regarding patient input as an attack .</p>	<p>With in a year at least 5 hospitals in Chicago will have meaningful involvement on committees, including :</p> <p>Patient safety committees, infection control committees, quality committees.</p> <p>Create toolkit for other organizations to start similar pati</p>	<p>Patients and healthcare staff survey.</p> <p>Perceived benefit.</p> <p>Measure each idea as implemented</p> <p>Evaluate "spread" of ideas and how participants get involved more broadly .</p>
Advocate for consumer and patient organizations to be part of the decision making wherever policies and process improvements are made regarding patient safety in Illinois.				
Develop recruitment process to identify and select patients.				
<p>Consider a community resource council of patients/families that might make members available for any hospital or provider effort,</p> <p>– or –</p> <p>Some hospitals/providers that might have the resources to develop their own council of patients/families.</p>				
Collaboratively define the process of involving patients—develop a model "job description"—encourage broad involvement.				
Prepare to manage conflict. Reduce fear!!				
Develop approach to evaluation.				

Appendix E
Topic 3: Patient/Family Involvement in Their Own Care, Driving the Plan of Care and Transitions in Care
Action Plan

<p>Goal: <i>To ensure complete and accurate medical info for every patient in Chicago, through shared goals and responsibility of the care team and patients across the continuum of care, where patients are:</i></p> <ul style="list-style-type: none"> • <i>Valued;</i> • <i>Listened to AND understood;</i> • <i>An integral and equal part of the team;</i> • <i>Allowed access to advocates (interns, relatives); and</i> • <i>Communicated with especially about medications and procedures</i> 				
Action Step	Who does it	Why its important	Short term success	Long term success
1.0 Establish a patient-centered personal health record. [<i>Maps in part to Group 5, Goal 1</i>]	An identified team-possibly with an executive sponsor to ensure delivery and follow through.			Treatment outcomes are measured continuously after implementation and outcomes improve.
2.0 Provide information to improve safety to patients that meets their needs and is tested before & after implementation. [<i>Maps to Group 5, Goal 2 and to Group 4</i>]	Patient educators, Providers, public health authorities, industry		Clinicians and patient use teach-back techniques	Care team and patient share responsibility for shared goals across the continuum of care.
3.0 Develop a demonstration project of best practices among Chicago healthcare providers. 3.1 Find the best practices. 3.2 Implement the best practices 3.3 Create focus groups to guide implementation 3.4 Work together to support multidisciplinary adoption in all levels of care. [<i>Maps to Group 5, Goal 4</i>]	An identified team-possibly with an executive sponsor to ensure delivery and follow through		Patients are invited to use care partners/advocates	Care team and patient share responsibility for shared goals, continuum of care. Evaluation: of patient/staff satisfaction, better outcomes, decreased complications, fewer errors.
4.0 Develop an educational curriculum for practitioners (MD, PharmD, RN). [<i>Maps to Group 5, Goal 3</i>]	.			The patient is respected as a partner and a teacher.
5.0 Standardize core health care practices and involve patients in planning and implementing standardization. [<i>Maps to Group 5, Goal 4</i>]	.			Patient/staff satisfaction, better outcomes, fewer errors, decreased complications

Appendix F

Topic 4: Techniques for Effective Patient/Clinician Communication

Action Plan

Goal: <i>Develop a team oriented, patient-centric, reciprocal communications model that is transparent, truthful, respectful, reliable, systemic and accountable (aka Optimal Tools and Strategies for Patient Clinician Communications)</i>					
Action Step	Who does it	Why important	When	Short term success	Long term success
Develop or adopt an existing clinician/patient communication intro.	Focused group of clinicians and patients	Need a good template for effective communication	ASAP	Tools are developed and distributed to clinicians and patients.	Inpatient pilot: model/tool is being used and patient feedback is positive. This can be measured with exit interviews or surveys.
Develop or adopt an existing clinician/patient glossary.		A common language between patients and clinicians is needed.	ASAP		Inpatient pilot: patients are asking questions about their medication. This can be tested by interviews with staff, or surveys distributed to patients.
Develop or adopt an existing medication FAQ.		Patients need assistance in asking the right questions of their providers.	ASAP		
Develop or adopt an existing "trigger phrase".		Nurses and patients need a non-threatening phrase that gives them permission to challenge/ address	ASAP		Inpatient pilot: measured by interviews or surveys to see if people are using the phrase when necessary.

Utilize multimedia (web, print, dvd's) to ensure Messages are understood.	Marketing resource to assist in development of tools	People are visual learners and we need to use different media to reach them effectively today	After written content is developed, materials produced	Tools should be developed in various formats for wider dissemination	Tools are well used, and adopted by others outside of the Chicago area.
Encourage patients to use advocates (friends, family, etc) in any clinical setting.	Clinicians reinforce this, and tools reflect this strategy, encouraging the patient to bring someone along	People are often unable to listen well or understand everything said to them during their visit/stay; need someone who is specifically devoted to their interests, their plan of care, and who 'listens' on their behalf.	Needs to be part of the 'team framework' tool	Patients show up with advocates more frequently.	Pre and post benchmark study that examines behavior in this area, before and after implementation of the tools

Appendix G

Topic 5: Preventing Error through Patient/Provider Partnership

Action Plan

Action Step	Who Does It	Why Important	When do it	Short term success	Long term success
Goal 1: <i>Ensure complete and accurate medical information for every patient in Chicago (3-5 years)</i>					
1.1. What information ought to be included	Develop a multi-disciplinary steering group (doctors, nurses, pharmacists, insurers, companies)	To prevent intrusions on privacy, ensure correct information	1/2-year project	Getting the committee together and establishing it	Fully operational repository for patients
1.2 Determine the sponsor for this type of product (web-based or what, funding)	Steering committee	Sustainability would require some resources (government resources)	6-12 months after first action item	Identifying a potential sponsor	Securing a deal
1.3. Implementation (books on wheels, partner with local companies, public libraries)	Chicago metropolitan area patients. (Tie this in to childhood vaccination?)	To effectively communicate health info across all settings. People in the Chicago area do not all have access to computers.	1-2 years after development of the product	Rolling out programs where we can initiate efforts and enrollment. We ought to include both patients and companies and groups that can help.	At least 30% of the population within 5 years
Goal 2: <i>Provide information for patients to improve safety (6-12 months)</i>					
2.1. Define what information is to be provided	Steering committee (patients, clinicians, stakeholders)	To be able to determine the information appropriate to be provided	3-6 months	Organize the committee	Have the definitions established
2.2. Delivery of information (DVDs, videos, PSAs)	Steering committee	To make sure that all people with different learning backgrounds are included	3-6 months	Delivery of information vehicles defined	Actual implementation
Goal 3: <i>Curriculum for education for Chicago area on the principles and practices for safety (2-4 years)</i>					
3.1. Develop a committee	Commission of organizations for curricular development (medical (AAMC), pharmacy (AAPE), nursing schools)	To have a foundation for patient safety and have early awareness	6-12 months	Develop a committee	Committee charging a group to develop a curriculum
3.2. Develop the curriculum	Committee charged by the commission	To develop consistency in the curriculum within schools and continuity across the schools	1-3 years	Develop the curriculum	Implementation at the schools

Goal 4: Determine healthcare processes for which standardization would be appropriate (1.5 years+)					
4.1 Develop a forum	Forum would be comprised of all appropriate stakeholders (all disciplines)	To increase patient safety, efficiency of care by care standardization – best practices	6-12 months	Develop the forum	Get criteria put together
4.2 To set definitions and benchmarks	Forum	To increase patient safety, efficiency of care by care standardization – best practices	Initial rollout -1 year, ongoing thereafter	Setting up the first set of definitions and benchmarks	Doing this continuously
Goal 5: Create a mechanism for involving the patients in error prevention – refer to other groups (Patient Involvement in Policy, Patient Involvement in Own Care, Communication Practices)					

Appendix H
Topic 6: Disclosure, Root Cause Analysis, Learning
and Emotional Support
Action Plan

Goal: <i>To establish a meaningful best practice for response after error throughout Metropolitan Chicago for responding to an adverse event, using evidence-based research.</i>						
Map to the Goal →						
What	Process Driver ID	Stakeholder Buy-in/ Process Owner ID	Collaborative/Best Practices	Tool Kits/ Resources	Pilot Roll-out	Perpetuation & Evaluation
Who	CAPS	Governing Board (reps from various legal, hospital, patient & gov't groups)	Hospitals (which ones?) – Involve Becky Steward to run the collaborative	Collaborative faculty	Collaborative learning meeting	Governing Board – Major Stakeholders
Why important	Combination of “idea leaders” & those with connection to stake-holders	To identify the barriers and break down silos in a cooperative way	Most proven way to effectively accomplish the goals	Required to roll out and share info	To evaluate & validate the implemented tools & process	Continue momentum of the process – remain viable
When	ST - 7/08, LT – 1/09	ST – 4/09, LT – 01/13	ST – 9/09, LT – 4/11	ST – 09/09, LT – 3/10	ST – 9/11, LT – 2/13	Ongoing
Where	CAPS – Chicago					
Short Term Success	Engagement of other key allies, including CPSF, IHA, MCHC by 9/15/08	Stakeholders can & will participate in the process: ITLA, hospital workers’ union, medical societies, CMS, deans of med & law schools, CHARMS, Midwest business group for health, Dept of Public Health – 4/09	Planning committee has met	Tools to be developed, identified & assigned	Report out of various types of hospitals – academic med centers & other teaching communities	Responsibility maintained for the process
Long Term Success	Fully established & operational governing board that is funded	Implement, perpetuate & evaluate the goal	Finish the work, best practices are identified	A full change package developed & endorsed	Publication & presentation at an international patient safety meeting	Tool kits continually monitored & adapted as the practices change

Appendix I Workshop Evaluations

Workshop on Consumer Engagement in Patient Safety June 19-21 2008: Evaluation Form

As this is the first workshop of its kind, you have been participating in building something new and exciting. We hope that this workshop can become a model for others, allowing more patients, consumers and health care professionals to have the opportunity to work collaboratively in improving patient safety. Your feedback about what worked well and areas that could be improved is very important to the future of workshops like this one. Please give us your honest feedback to give us the full benefit of your thoughts and feelings.

SURVEYS RETURNED: 42

1.	Strongly Disagree		Strongly Agree			Average Score
2. Friday morning session successfully introduced us all to basic concepts in patient safety and systems improvement	1	2	3	4	5	3.83
3. Topics we worked on were important for improvement of patient safety in Chicago	1	2	3	4	5	4.38
4. As a group of both consumers and healthcare participants, we developed ideas which we could not have done without this collaboration	1	2	3	4	5	4.37
5. I believe that the ideas we produced can be practically implemented	1	2	3	4	5	3.98
6. I believe that the ideas we produced, if implemented, will make a difference and will improve patient safety	1	2	3	4	5	4.45
7. I formed some new relationships in this workshop which I would like to continue	1	2	3	4	5	4.29
8. It was useful to have outside experts participate in the "fishbowl" session on Friday	1	2	3	4	5	4.12
9. The topic overviews prepared for the six themes were useful	1	2	3	4	5	4.24
10The workshop met my expectations	1	2	3	4	5	4.36
11My personal participation in this workshop made a difference in the outcome	1	2	3	4	5	4.02
12Comfort of the facility	1	2	3	4	5	4.29
13Quality of food	1	2	3	4	5	4.29

What single most important change would you make to this workshop?

Please comment specifically on as many of these questions as you like (additional pages are welcome!):

Your recommendations for future workshops:

	Too Long	Appropriate	Too Short
The time spent with the whole group was:	7	29	5
The time allocated for small group work was:	1	19	19
	Too much	Appropriate	Too Little
The level of activity and workload prior to the workshop was:	2	33	6
The level of activity and workload during the workshop was:	2	31	4

- How will you use the energy/passion/aspirations/vision articulated during the course of the Workshop in your work and your life?
- Please add any other thoughts or comments regarding this workshop
- May we quote your evaluation form for any publicity or press/media materials? Yes
No

Are you.... 21__Consumer/Patient Participant 20__Healthcare Participant

Optional: Name: _____