CMS Quality Conference 2023

Building Resilient Communities:

Having an Equitable Foundation for Quality Healthcare

Who Can Save Patient Safety?

- Welcome and Introductions
- Session Objectives
- Reprioritizing Patient Safety – a Call to Action
  - Transparency
  - Patient & Family Engagement
  - Oversight & Accountability
- Q&A

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Session Objectives

In this session, participants will:

- Understand how patient safety activists are reenergizing the national Patient Safety agenda,
- Identify opportunities at hand to improve patient safety now focusing on Transparency, Patient and Family Engagement, and Accountability and Oversight,

Introductions

Michelle Schreiber, MD, CMS Deputy Director of Center for Clinical Standards and Quality (CCSQ) and Director of the Quality Measurement and Value-based Incentives Group (QMVIG)

Carole Hemmelgarn, MS, MS, Founding Member, Patients for Patient Safety US

Col Steven Coffee, USAF, MA, MA , Founding Member, Patients for Patient Safety US

Martin Hatlie, JD , Founding Member, Patients for Patient Safety US

Patients for Patient Safety US

Patients for Patient Safety – Founding Members

Margo Burrows
Milwaukee, Wisconsin

Steve Burrows
Milwaukee, Wisconsin

Lt. Col. Steven L. Coffee
Woodbridge, Virginia

Alicia Cole
Los Angeles, California

Martin J. Hatlie
Chicago, Illinois

Carole Hemmelgarn
Denver, Colorado

Soojin Jun
Chicago, Illinois

Armando Nahum
Atlanta, Georgia

Sue Sheridan
Boise, Idaho

Beth Daley Ullem
Newport Beach, California

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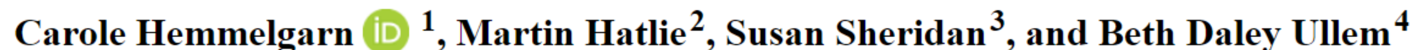
Editorial

Who killed patient safety?



[1] MedStar Institute Quality and Safety, Washington, DC, USA Email: c.l.hemmelgarn@hotmail.com
[2] MedStar Institute Quality and Safety, Washington, DC, USA
[3] Independent Scholar, Boise, USA
[4] Independent Scholar, San Juan Capistrano, USA

The medical community's commitment to patient safety has withered to over the past 10–15 years after the original call to action in 2000 with the release of the IOM report, To Err is Human.[1] The tragedy of this decline in action around safety lies in the lives of the families like ours, who have lost loved ones, been harmed, and often permanently injured by medical error. What was once a motivating call to action, safety in hospitals and oversight by our government has been deprioritized, defunded, and devalued leaving patients like us to wonder: What happened to Patient Safety?

PFPS US Strategic Alliances

Government Agencies, Health Care Facilities, Safety and Quality Organizations, Civic Organizations, Industry and others

Centers for Medicare & Medicaid Services	Presidents Council of Advisors on Science and Technology	Centers for Disease Control and Prevention	Inspector General – Health and Human Services	World Health Organization	MedStar Institute for Quality and Safety
Office of the Secretary of HHS	Agency for Healthcare Research and Quality	National Quality Forum	Pittsburgh Regional Health Initiative	John D. Stoeckle Center for Primary Care Innovation	IHI-Lucian Leape Institute
National Association for Healthcare Quality	Ariadne Labs	Society to Improve Diagnosis in Medicine	Collaborative for Accountability and Improvement	American Academy of Pediatrics	Leapfrog Group
Open Notes	Connecticut Center for Patient Safety	CommonSpirit Health	Patient Safety Movement Foundation	Institute for Safe Medicine Practices & ECRI	PFCC Partners
The New Agreements	H2PI	Safe Care Campaign	Parents of Infants and Children with Kernicterus	Yes and Leadership	Anthony Bates Foundation
Project Patient Care	Dòcola	European Network for Safer Healthcare			

* Colors:

Signed Official Partner

Engaged as collaborator

PFPS US Patient Safety Champions

Our Idea Generation Process

IDENTIFY

Areas of work and oversight of partners and their unique levers to accelerate and provide safe care in all settings

GENERATE

Ideas for and with our partners to create specific accountability to improve existing levers and incentives

INNOVATE

New bolder approaches to safety improvement incentives and oversight on a broad scale where the right solutions do not exist

ISSUE

LEVER

IMPROVEMENT IDEAS

Transparency

Accountability and Oversight

Patient and Family Engagement

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Transparency

PFPS US Strategic Priorities

Transparency

AIM: To understand the magnitude of harm, maximize learning and to respect and empower patients

Priorities:

1. Require and enforce transparency in reporting of harm
2. Improve the quality and integration of data to better understand harm
3. Establish Communication and Resolution Programs (CRPs) as the standard of care
4. Ensure patient access to medical records
5. Expand spectrum of patient safety events that must be collected and publicly reported

Call to Action (with appropriate incentives and penalties):

- Improve enforcement of existing requirements for reporting of harm events to Federal, State and Accreditor reporting systems
- Advocate for a transparency bundle as a Condition of Participation that includes:
  - Communication and Resolution Plans, i.e., open and honest communication after harm (such as the AHRQ CANDOR program)
  - Elimination of confidentially clauses that gag patients
- Expand public reporting of patient safety events beyond the HACs
- Enforce compliance of 21st Century Cures Act
- Reform the PSO program to require contributing to the National Patient Safety Database

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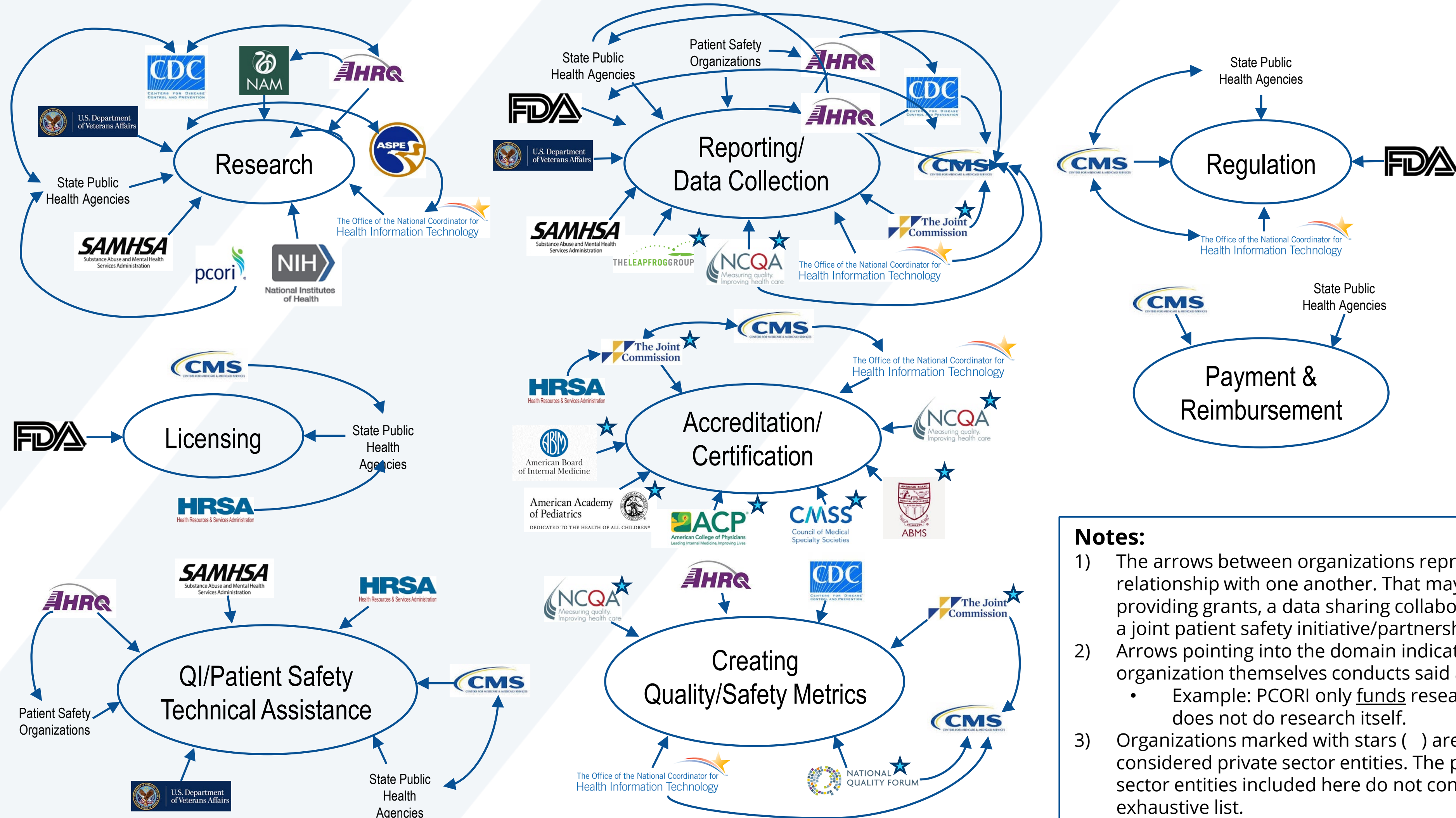
The Existing Patient Safety Ecosystem in the U.S. –- Many players, No Team, No Coach



Notes:

1) The arrows between organizations represent a relationship with one another. That may include providing grants, a data sharing collaboration, or a joint patient safety initiative/partnership.
2) Arrows pointing into the domain indicate that the organization themselves conducts said activity
   - Example: PCORI only funds research and does not do research itself.
3) Organizations marked with stars ( ) are considered private sector entities. The private sector entities included here do not constitute an exhaustive list.

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JEWISH HEALTHCARE FOUNDATION

PITTSBURGH REGIONAL HEALTH INITIATIVE

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PFPS US Strategic Priorities (1)

Accountability and Oversight

Aim: Enforce patient safety and equity standards to measurably reduce inequities and harm events

Priorities:

1. Re-assert patient safety as a priority
2. Close the health equity safety gap
3. Establish a leader or entity at Federal level in charge of patient safety
4. Enforce patient safety standards, CoPs and reporting

Call to Action:

- Establish an office or entity in charge of patient safety accountable for coordinating budget, measurement, and public reporting across all Federal Agencies
- Establish an independent agency modeled after the National Transportation Safety Board (NTSB) for patient safety that collects and analyzes data, investigates harms, identifies risks and expedites proactive implementation of solutions
- Reallocate resources to invest in patient safety
- Establish structural metrics that tie organizational leadership and executive/physician compensation to patient safety outcomes
- Strengthen OIG oversight and effectiveness

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Patient and Family Engagement

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PFPS US Strategic Priorities (2)

Patient and Family Engagement

AIM: Patient safety improvement efforts are co-developed with diverse patients and families

Priorities:

1. Establish policies, structures, funding criteria, strategies, and budgets that require and support diverse PFE
2. Redesign mechanisms that effectively engage and learn from patients/families
3. Require co-development (design, measurement and oversight) of safety of clinical practices and prevention of diagnostic errors
4. Engage, orient, and train diverse patients and family members to form a skilled community of diverse patient and family partners

Call to Action:

- Establish PFE Infrastructure in healthcare organizations and oversight bodies. By infrastructure we mean:
  - Structures for PFE (FACA, PFE Advisory Boards, PFACs)
  - Explicit policies that require, support and evaluate diverse PFE
  - PFE Metrics and payment incentives for healthcare organizations
  - Funding support for PFE capacity building among diverse patients
- The engagement and learning mechanisms we propose include:
  - A place or system that captures patient and family reports of harm
  - Redesign of CAHPS/HCAHPS to integrate questions related to experiences in safety
- Inclusion of patients and families as co-creators of structural, process and outcome measures around the safety of clinical practices, such as diagnostic errors, infection, and mother/newborn safety

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