



To: Translating Research Into Practice Breakout Group
March 3, 2003 Breakout Session #3

Making the Health Care Systems Safer Participants

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RE: Summary of Breakout Session

Dear Colleagues:

Thank you for participating in the Translating Research into Practice Breakout Session. Based on what we learned and discussed on March 4, our breakout session should be thought of Integrating Research with Practice... We had a great discussion with lots of ideas and recommendations. I suspect we could have gone for hours.

Special thanks to our panel members for stimulating our discussion:

- Sanjay Saint, MD, MPH
 - Director, Patient Safety Enhancement Program
 - University of Michigan and Ann Arbor VAMC
- Frances Stewart, MD
 - Program Director, Patient Advocacy and Medical Ethics
 - Department of Defense
- Heidi Norman
 - Patient Safety Program Director
 - Pittsburgh Regional Healthcare Initiative
- Nancy Donaldson, DNSc, RN, FAAN
 - Director, Center for Research and Innovation in Patient Care
 - UCSF School of Nursing

We started out with a large agenda. We only scratched the surface. I look forward to future discussions with all of you – as together we pursue a healthcare environment continually freer from unsafe care.

Thanks for making the moderator job so easy and for sharing the patient safety vision!

Translating Research into Practice

Breakout Session 3

Agency for Healthcare Research and Quality
"Making the Health Care System Safer"
March 3, 2003 Arlington VA

Background

We are all here today because of our commitment to improving the care our patients receive. We are all passionate about patient safety and patient safety research. As we search for strategies to reduce the risks our patients are exposed to, we must be cognizant of the need to translate our research findings into practice. In our hospitals, ambulatory settings, nursing facilities, and home care. We collectively spend billions recovering from errors and some errors have no possible recovery. Our ability to narrow the quality chasm and achieve the expectations set forth by the Institute of Medicine, our government, and our patients depends very much on our translating research into practice. This session will focus on challenges and solutions faced by researchers and delivery systems as they attempt to broadly implement their patient safety research findings.

The Setting

The Patient Safety Research Coordinating Center identifies 138 patient safety research activities funded by the Agency for Healthcare Research and Quality. Almost all of these projects have the potential for findings that can improve care at the delivery level. Many of the projects seek the answers to questions that have the potential for an immediate impact on care at the delivery level. Common themes include:

- Understanding and changing an organization's culture
- Using information technology to reduce medical errors (e.g., PDAs, decision support tools, computerized order entry)
- Use of technology to reduce medication administration errors
- Learning from errors reported through common reporting systems
- Applying human factors engineering lessons to clinical care
- Strategies to detect and intercept medical errors
- Staffing mix, levels, and working conditions in the inpatient setting
- Improving communication among caregivers
- Increasing competency through novel interventions (e.g., simulation)
- Building patient – provider partnerships
- Disclosing errors to patients and families

The Questions and Discussion of Successful Strategies

1. How do we overcome a culture resistant to systems approaches to error reduction?
2. When does patient safety research become performance improvement? In delivery settings, how do we face the challenges of crossing between internal performance improvement activities and patient safety research? When must hospital IRBs be involved in studies?
3. When research suggests a long term benefit (and return on investment), what strategies should be considered for implementing short term changes in a cash strapped organization? (i.e., how do we cope with the comment that this is just another unfunded mandate)
4. How should AHRQ and organizations committed to improving patient safety facilitate healthcare organizations in implementing best practices to reduce errors? What successes have we seen so far? (e.g., JCAHO National Patient Safety Goals)

Some Thoughts About Implementation Success

1. Evidence opens the door. There is value in studies with sufficient scientific rigor.
2. Make sure you have local champions.
3. Once you have success, selling a safe practice the next time will be easier.
4. Competing interests is a challenge – How does an organization prioritize among them?
5. To implement a possible safety effort, call it a pilot at first. That gives people the freedom to back out. If it works, then people won't let go.
6. For initial programs, evidence is often insufficient. Many want to see that it works (i.e., test an intervention or service out) before they will adopt even with compelling evidence.
7. The paradigm is different between changes and adoptions of products than for changing and adopting new processes.
 - Product changes can be adopted if the product is clearly better, doesn't disrupt the environment, or adds to existing protocols.
 - Process changes require an acceptance that a process is better, that old practices are obsolete, and the desire to reach beyond the loss associated with abandoning a familiar strategy.
8. Some of what we discussed is not evidence based medicine, but rather evidence based management.

Challenges: Financial challenges.

- Evidence based medicine and evidence based management must meet – there must be synergy between clinical and administrative leaders for change to yield success.
- What do we do when evidence shows something is safe yet it will not save money? How does one argue the value business case rather than the financial business case?
- Often the benefits of adopting a patient safety practice accrue to a different part of the organization than those being asked to adopt the practice. Safety requires a holistic approach to patient care, abandoning or reaching beyond the recognized silos.

Challenges: Leadership

- Leadership provides the vision and guidance to drive cultural changes. You cannot order people to feel differently – they need to be motivated to change their approaches.
- Leadership can be a bottleneck – a weak or misguided leader can squelch an environment of change. But if leaders cannot make it happen in an organization, nobody can.
- Leadership needs to recognize that while leaders provide the vision and direction, it's the front line staff and care givers that actually make things happen.
- Leadership is more than being a CEO, for example.
- Our military system provides evidence that even the biggest systems can change, albeit not overnight.

Challenges: The approach

- The epidemiologic approach – embrace the null
 - Don't assume any particular practice or intervention will work until it's tested.
 - If we really know the answers, change would be easy.
 - Many of the practices we think (or believe) work, may not. Often practice has been adopted in the absence of clear evidence (e.g., extended course of antibiotics for surgical patients)
- The human factors approach
 - For rare events, it is impossible to use the epidemiologic approach
 - Questions and issues need to be stratified based on particular situations
- The patient safety agenda depends on a combination of the epidemiologic and human factors approaches.
- Don't underestimate the power of anecdotes over system studies for initiating or driving changes.

Spotlight on Pittsburgh Regional Healthcare Initiative

- Focused on implementation of evidence generated by research
- The initiative is at forty hospitals in Western Pennsylvania
- The business case – for value
 - Comes down to the change in culture and who has the ability to change the culture
 - The Initiative did not approach the CEOs with a financial business case, they used a values based model.
- CEOs of the various systems, although in many ways competitors, come together around the issue of patient safety.
 - The central notion is that it all starts with the patient – a patient centered approach to value.
 - The vision needs to exist to look beyond the silos and the financial business case.
 - Key CEOs looked at the evidence and concluded “that’s it, no more”
 - The Region agreed to eliminate seven unsafe abbreviations
 - One CEO, followed by others, adopted the philosophy that if there was a list of practices that were unsafe, they should all be eliminated. Adopted the “no more, starting tomorrow” approach.