Northwestern University Feinberg School of Medicine

Empowering Patients Through a Partnership to Improve Care

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11:30 – 12:10

NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE

Outline

- 11:30 – 11:35 System Challenges in Healthcare
- 11:35 – 11:45 Case Study Video
- 11:45 – 12:05 Case study discussion
  Small group exercise and report back
- 12:05 – 12:10 Wrap up and conclude

Systems are at the Heart of Safe and Effective Patient Care

- Medical errors are a serious problem
- The cause is bad systems
- We need to redesign our systems
- We must change the way we train our future clinicians
- We need to make safety a priority
- Simulation and team training are key

To Err is Human: Building a Safer System. 2000, Washington, D.C.: National Academy Press.

"Every System is Perfectly Designed to Get the Results it Gets"

~ Paul B. Batalden, MD

Co-Founder The Institute for Healthcare Improvement

Founding Director, Center for Leadership and Improvement,

The Dartmouth Institute for Health Policy and Clinical Practice

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Healthcare Challenges

- Lack of coordination: providers in silos, fragmented service models
- Increasing patient expectations
- Lack of active follow-up to ensure best outcomes
- Patients inadequately trained to manage their illnesses
- Large variation in outcomes for patients
- Unsustainable financial costs
- Lack of transparency of outcomes
- Discouraged, unhappy workforce

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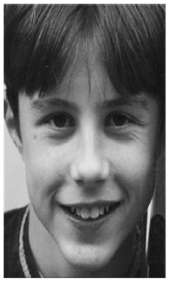
Sometimes it's easier to see the system when something bad happens

Every number has a story…



Lewis's story,
told by Helen Haskell

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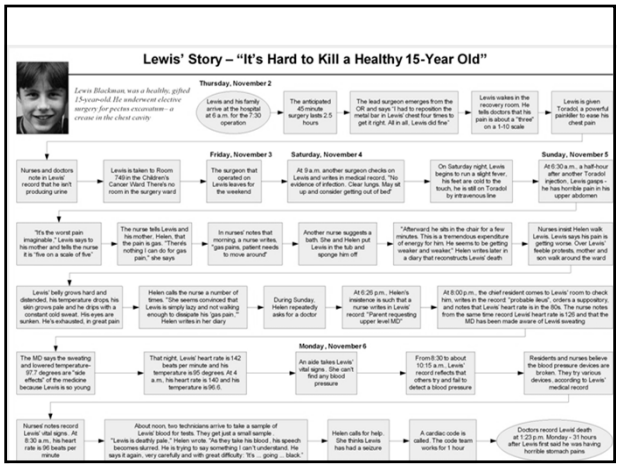
Small Group Exercise

Analyzing Patient Safety Scenarios

- Work in small groups to analyze a Lewis Blackman's story
  - Where were the system failures in the care process related to preparation, organization, environment, technology, work tasks, health care provider?
  - Where in the process of care did incidents (errors, near misses, adverse events, and harm) occur?
  - Were there opportunities in the process of care to repair physical damage? Repair relational damage? Repair emotional damage?
  - What are the key learning points and how do we learn from this incident to proactively prevent similar incidents from occurring in the future?



Report back

- Are patient stories a helpful way to learn about patient safety events?
- What else did you need to answer the questions?
- Would you be able to use something like this in your setting?
- Based on this case, what strategies you could use to engage patients and families in creating meaningful solutions to address medical harm?

The Rest of the Story

Lessons for patients, families, and healthcare professionals

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Empowering Patients and Families

- Involvement changes everything
- Collect and use stories of experience – negative and positive
- Co-Production of care can result in:
  - Improved patient engagement to lead to new care designs, plans of care, and different health care roles
  - Better results

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Tips to Include Patients

- Identify types of patients who are appropriate to involve
  - Current patient?
  - Patient based on survey results or experiences
- Arrange to formally talk with patient about interest and how their insights will be used
  - Tell me about your recent experience
  - What was best part? Worse part?
  - Suggestions for improvement

Learning from Patient Stories

- 24 case studies
  - A series of patient stories told from the perspective of the patient and/or family
  - A standard format for each case: introduction, background, case presentation, detailed case analysis, and questions
  - International perspective
  - Supplemental resource available on line
  - Published by Jones & Bartlett Learning

Wrap up and Conclude

Contact me for more information

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