Meaningful Patient and Family Partnerships: Evidence and Leadership

6th International Conference on Patient- and Family-Centered Care
Westin Bayshore Hotel, Vancouver, BC

August 7, 2014
Our Mission
Accelerating healthcare improvement and transformation for Canadians

Our Goals
• Healthcare Efficiency
• Patient- & Family-Centred Care
• Coordinated Healthcare
Patient and Family Engagement at CFHI

From 2010 to 2013, CFHI supported 17 organizations, through our pan-Canadian Patient Engagement Project (PEP) initiative, demonstrating the improvements that come when management, providers and patients work together.

Better patient experience and outcomes, as well as safer and more productive work environments were just some of the benefits.
Improving patient experience and incorporating patient input into the design of healthcare services have emerged as critical priorities for many healthcare systems but progress has been limited. Greater engagement of patients and families in organizational roles and care teams has helped a number of healthcare organizations to improve quality, safety and patient experience. Insights from exemplar organizations suggest broader opportunities to improve health system performance. This brief provides a context and summary of research findings on case studies of patient engagement for health system improvement across organizations in four countries.

Emerging evidence does suggest that patient and family engagement translates into patient and organizational improvements (primarily in the areas of safety and effectiveness) but the mechanisms that

Background

Patient-centered care was identified as one of the six core goals for United States healthcare in the seminal Institute of Medicine report, Crossing the Quality Chasm,\(^1\)}
Meaningful Patient and Family Partnerships: Evidence and Leadership

• **Sue Sheridan**, MBA, MIM, *Director of Patient Engagement; Patient-Centered Outcomes Research Institute (PCORI)*, Washington, DC

• **Ross Baker**, PhD, *Professor, Institute of Health Policy, Management, and Evaluation; Director, Master of Science Program in Quality Improvement and Patient Safety; University of Toronto*, Toronto, Ontario

• **Leslee Thompson**, *Chair of CFHI’s Board; President and CEO, Kingston General Hospital; Professor, Faculty of Health Sciences, Queen’s University*, Kingston, Ontario
PICK:
A Model of Meaningful Patient and Family Partnerships in Healthcare Improvement

Sue Sheridan MIM, MBA
Director of Patient Engagement - PCORI

cfhi-fcass.ca
Cal Sheridan suffered kernicterus after he was born in 1995
Testimony at the First National Summit on Medical Error and Patient Safety

Written Statement

Panel 1: Consumers and Purchasers

Testimony by Susan E. Sheridan, Consumer, Boise, ID

The first National Summit on Medical Errors and Patient Safety Research was held on September 11, 2000, in Washington, DC. Sponsored by the Quality Interagency Coordination Task Force (QuiC), the Summit’s goal was to review the information needs of individuals involved in reducing medical errors and improving patient safety. More importantly, the summit set a coordinated and usable research agenda for the future to answer these identified needs.

Individuals were selected by the Agency for Healthcare Research and Quality (AHRQ) to testify at the summit as members of the witness panels. Each submitted written statements for the record before the event, documenting key issues that they confront with regard to patient safety as well as questions to be researched. Other applicants were invited to submit written statements.
Porous safety net allows lethal medical mistakes

Care has failed to keep up with technological advances

By Robert Davis and Julie Appleby
USA TODAY

An overworked nurse infuses the wrong type of blood into a patient. An inexperienced pharmacist puts the wrong drug in a child's medicine bottle. A less experienced surgeon forgets a heart procedure that is performed more frequently and flawlessly down the street.

All the patients die, victims of medical errors.

Up to 500,000 deaths a year — perhaps the nation's most pressing health care problem — have health officials scrambling to find clues.

They are spurred by an Institute of Medicine report last November that named errors made by doctors, nurses and hospital workers the U.S.'s eighth-leading killer.

What they have discovered are glaring problems in the health care system, many of which are expected to be at the heart of a new initiative report in the next few months.

- For many modern drugs and treatments for doctors to keep in mind as they rush from patient to patient.
- Nurses taking on more work as pharmacists and other hospital departments close ranks or reduce their staffs to save money.

The nation's hospitals are facing a growing number of complaints about the quality of care, even as the number of deaths from heart disease and cancer continues to decline.

- A shift toward performing more surgeries in less-regulated facilities outside hospitals and clinics, putting patients at greater risk.
- In perhaps the most unnerving development, a slowdown by the medical community to embrace technology that could help doctors avoid errors. Not only does the situation create more risk for patients, but it has slowed progress.

The federal government has tried to improve care through incentives.

In Washington, D.C., the United States today, can be pretty awful, says Andrew Weintraub, a prominent physician who is overseeing the development of a computer system to help Kaiser Permanente practice safer medicine.

Improvements must be made, he says. "There is a moral imperative about it."

He and others are following the technology in Washington, D.C., where physicians use a $300,000 computer system that scans codes on patient records and matches errors on patient records and medications. If a doctor is about to make a mistake,
Original PICK moms
What effect does breastfeeding have on jaundice?

Most breastfed babies do not have a problem with jaundice that requires interruption of breastfeeding. However, if your baby develops jaundice that lasts a week or more, your pediatrician may ask you to temporarily stop breastfeeding for a day or two. If you must temporarily stop breastfeeding, talk to your pediatrician about pumping your breasts so you can keep producing breast milk and can restart nursing easily.

If your baby has jaundice, do not be alarmed. Remember that jaundice in a healthy newborn is not serious and usually clears up easily. If your baby has a very serious case of jaundice and other medical problems, your pediatrician will talk to you about other treatments.

http://www.aap.org/family/jaundice.htm
Parents of Infants and Children with Kernicterus

PICK

Parents of Infants and Children with Kernicterus was founded in late 2000 by a group of parents whose children suffer from kernicterus. A non-profit organization, PICK promotes awareness, prevention, and treatment of kernicterus. The organization’s success is due to a unique operational model that emphasizes active partnerships with healthcare institutions and agencies as a means of achieving change.

What is Kernicterus?

Kernicterus is a preventable neurological disorder caused by neonatal jaundice that can result in permanent loss of hearing, auditory processing problems (e.g., poor speech and voice discrimination), and delays in the development of motor skills. Newborn jaundice affects 60–70% of newborns in the United States each year and is the number one reason for hospital readmission within the first month of life. The condition can often be prevented by treating jaundice promptly and by changes such as reducing jaundice management guidelines, shortened hospital stays, and reduced infant exposure to jaundice. In general, kernicterus is caused by jaundice in infants and children with kernicterus. The long-term effects of excessive jaundice on the newborn brain can range from subtle (e.g., hearing loss, children who were or are at risk for hearing loss) to severe (e.g., hearing loss, children who were or are at risk for hearing loss) and sometimes completely preventable.

Kernicterus is completely preventable.
PICK Partnerships in Action
(The JC, CDC, and NQF)

Sentinel Event ALERT

Eosinophilic}
Partnerships in Action – AWHONN
(Association of Women’s Health, Obstetrics and Neonatal Nursing)

Universal Screening for Hyperbilirubinemia

AWHONN supports universal screening to identify elevated bilirubin levels in newborns to facilitate the prevention of acute bilirubin encephalopathy and kernicterus. Kernicterus is a chronic and irreversible bilirubin encephalopathy, and it is a preventable disorder. Screening should be done through a combination of assessing and monitoring visual inspection alone. Nurses who care for newborns should change their practice and report bilirubin levels in terms of a newborn’s age in hours, not days, so that the infant can be more readily assessed for risk of development of kernicterus. AWHONN supports the development of additional new methodologies to accurately assess bilirubin levels in the newborn.

Health care providers should work as a team to ensure that all infants are screened for risk of elevated bilirubin levels. Hyperventilation should be administered prior to discharge from the hospital. Hospitals should adopt facility-wide policies and procedures that ensure the standardized care for all newborns in order to prevent acute bilirubin encephalopathy and kernicterus. In addition, facilities and health care providers should promote and support breastfeeding, as a natural breastfeeding helps to decrease elevated bilirubin levels. AWHONN encourages facilities to aggressively test mechanisms to educate all clinical staff that visual inspection is a robust and the sole means of determining elevated bilirubin levels. Upon infant discharge, all facilities should receive specific instructions to use their private health care provider when the infant is 24–120 hours of age. If the risk screen is positive for an elevated bilirubin level, facilities should also be prompted to ask the provider about additional bilirubin screening.

Nurses play an integral role in the implementation of universal screening for elevated bilirubin levels in the newborn. Best practice includes documentation through the use of an institutional triage algorithm and risk assessment and communication to the primary care provider and family. Nurses are also the health care providers who provide discharge instructions to the family. Nurses must assess the family’s level of understanding and discharge instructions that are not recommended or should actually cause the bilirubin levels to rise, such as the administration of supplemental water.


Background

Acutel bilirubin encephalopathy may include the following neurologic symptoms:

- Excessive pyramidal movement disorders
- Gaze abnormalities
- Lethargy

2013, AWHONN. All rights reserved. - 310-1850 S. LaSalle St. • Chicago, IL 60616 • 1-800-621-8694 • awhonn.org - www.awhonn.org
Partnerships in Action – NANN
(National Association of Neonatal Nursing)

Draft Position Statement for NANN Membership Review

The following position statement, “Prevention of Kernicterus in Newborns”, is presented below in draft form. NANN members are encouraged to review and comment on the draft position statement. All suggestions will be reviewed by the NANN Board and, as deemed appropriate, incorporated into the document before the final release.

Before June 4, 2003, please send your comments to NANN by:

- e-mail: education@nann.org
- fax: 388/477-6266
- mail: NANN, 4700 W. Lake Avenue, Glenview, IL 60025 (Attention: Brandon Dybala)

Position Statement
Prevention of Kernicterus in Newborns

The National Association of Neonatal Nurses (NANN) believes neonatal nurses must be proactive in the assessment and management of hyperbilirubinemia in the newborn. NANN also believes parents should be educated about the risks of untreated hyperbilirubinemia and the need for close follow-up of their infant(s) after discharge. NANN further believes...
Partnerships in Action – HCA 
(Hospital Corporation of America)

INVESTOR CONTACT: 
Mark Redgrough 
615-344-2688

MEDIA CONTACT: 
Jeff Prescott 
615-344-5700

FOR IMMEDIATE RELEASE

Hospital Corporation of America’s Screening of Newborns Preventing Brain Damage Caused by Severe Jaundice

Nashville, Tenn., June 28, 2005 – Data released today by Hospital Corporation of America (NYSE: HCA) shows that a simple, $1 test is preventing irreparable brain damage in newborns.

The test detects severe jaundice, which is easy and inexpensive to treat, but if left undetected can lead to kernicterus, a condition that leaves babies brain damaged and often physically impaired. Experts estimate that as many as 60 percent of all newborns are affected by some level of jaundice.

HCA, which has 169 hospitals, performs the test on babies born in its 124 obstetrics units before they are discharged. More than 225,000 babies are born each year in HCA’s hospitals.

“The medical community continues to underestimate the severity and incidence of kernicterus,” said Dr. Yael Blumen, a clinical professor of neurology at the Stanford University School of Medicine who has conducted extensive research on the prevention of kernicterus. “We have seen an increase in this disorder since hospitals stop the mothers and babies shortened in the early 1980s. Visually assessing newborns is not enough. All babies should be screened for severe jaundice before they go home, in order to prevent kernicterus.”

A study conducted by Dr. Blumen using data from HCA hospitals from May 1 through December 31, 2004 – before HCA began screening babies – documented a monthly average of 1.2 cases of babies with jaundice severe enough to put them at high risk for kernicterus. There were 131,990 babies born during that period. From February 1 of this year, when HCA began screening babies born in its hospitals through May 31, there have been no new cases. During that time, 72,870 babies were born in HCA hospitals.

“The results of the 2004 study clearly show a much higher incidence rate than the medical community previously thought,” Blumen said. “HCA’s efforts this year demonstrate that screening newborns is preventing kernicterus.”

“As a mother of a child with this horrifying disorder, I know firsthand the devastating effects it can cause,” said Sue Sherrill, spokesperson for the advocacy, educational and support group P.I.C.K., Parents of Infants and Children with Kernicterus and co-founder of Committee Advancing Patient Safety. “If any of our children were given this simple, inexpensive test shortly after he was born, today he would be a healthy boy. Every baby must be screened. I strongly encourage all hospitals to follow HCA’s example.”

P.I.C.K.
From Bench to Bedside: Preventing Bilirubin-Induced Brain Injury (BIBI) in the Newborn and Kernicterus in the 21st Century

On July 21-22, 2003, a conference was held to discuss knowledge gaps and propose methods to rectify kernicterus and neonatal hyperbilirubinemia. The scientific background for this meeting was as follows: in spite of extensive research and knowledge about metabolism of bilirubin in the newborn period, the incidence of BIBI has increased over the past decade. BIBI is occurring at higher rates in otherwise healthy newborn infants, born at near-term or term. The conference focused on critical areas of research that need to be considered to further explore biological and social factors that might lead to BIBI. The workshop was designed around three themes: a) evaluating the neurobiology of BIBI, including exploration of the molecular and cellular basis for breakdown of blood-brain barrier function for bilirubin and factors modulating regional susceptibility or resistance of neurons to damage from bilirubin, etc.; b) evaluating various system-related causes that have led to the mini-epidemic of BIBI and kernicterus so that appropriate strategies can be developed; and c) evaluating the value and limitations of the existing and evolving methods for rapid diagnosis of hyperbilirubinemia and its effective treatment, including phototherapy. Dr. Tonse Raju developed and organized the workshop.

Conference Agenda and Participant List
PICK Research Partnerships in Action – MCHB
Maternal Child Health Bureau

About MCHB

Programs
Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children

Funding Opportunities
Second Meeting

Data

Resources & Publications
September 22 & 23, 2004

Links

The Secretary’s Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children was convened for its second meeting at 9:00 A.M. on September 22, 2004, and was adjourned at 3:00 P.M. on September 23, 2004 at the Jurys Hotel, Washington, D.C.

In accordance with the provisions of Public Law 92-463, the meeting was open to the public from 1 P.M. to 2:00 P.M., September 23, 2004.
“Prevent This” - PICK Education Video
Hospitals urged to test for rare disorder among newborns

By Robert Davis and Julie Appleby
USA TODAY

New guidelines to be released today will require hospitals to test or monitor every newborn for a rare condition that leads to brain damage.

The condition, kernicterus (kern-iKTER-us), stems from severe cases of jaundice. It is easy to cure if caught early but left untreated it can be fatal.

The Joint Commission on Accreditation of Healthcare Organizations, known as JCAHO, monitors and accredits hospitals. It is expected to issue a nationwide safety alert calling for health care workers to test newborns for kernicterus.

The medical news story has not been seen before.

It is not uncommon for newborns to suffer jaundice, yellowing of the skin. But sometimes the discoloration can be a sign of a more serious problem. In this case, it is kernicterus.

A baby who is jaundiced for too long can develop kernicterus, a condition in which a buildup of bilirubin -- a yellow bile pigment -- in the blood tissue or brain.

JCAHO’s new guidelines call for all hospitals to devise similar procedures.

One registry reports 90 cases of kernicterus in newborns in the last seven years. In 80 percent of those cases, newborns had to be treated in the hospital and suffered permanent brain damage.

A mother who had a newborn with kernicterus, who is now 2 years old and living a healthy life, says she was not aware of the condition until she saw the story.

Doctors say kernicterus can be prevented if detected early.

New federal health agencies and the American Academy of Pediatrics are debating how worried parents should be about these rare cases. Sue Sheridan, the mother of a boy whose jaundice went untreated until it was too late, has won federal support for her campaign to alert parents about the problem.

Doctors say kernicterus is a preventable disorder, but are worried about how to handle the issue.

The debate reflects growing tension over how to make sure that all children are seen for a routine physical check-up.

Pediatricians say they are already overwhelmed with tests and messages to deliver to new mothers. Ms. Sheridan argues that preventable disorders, even if rare, deserve high priority.

Jaundice can signal risk of a rare but irreversible neurological disorder called kernicterus. Once fairly common, kernicterus virtually disappeared in the U.S. by the 1970s, only to stage a comeback over the past decade. One specialist estimates there are 75 to 100 cases a year in the U.S.

For more information on kernicterus, visit the American Academy of Pediatrics website at www.aap.org/jaundice.
International Outreach

PAHO, UK, WHO
June 7, 2007

Region Launches Newborn Jaundice Screening Program in Calgary

The Calgary Health Region is launching a newborn jaundice screening program that will reduce the need for blood tests by up to 90% and will ensure all babies are accurately tested for jaundice.

Calgary babies will be tested for jaundice with a device called a Transcutaneous Jaundice Meter (TJM). To measure the level of jaundice, the TJM is briefly placed on the baby’s forehead. The procedure is quick, accurate and painless. The meter is very reliable in identifying which babies have developed significant jaundice and need a blood test to determine the level of bilirubin. If the test shows high levels of bilirubin the baby receives treatment under special lights (phototherapy) to help reduce the level.

Newborn infants will have TJM measurements done while in the hospital nursery. After hospital discharge, Postpartum Community Services public health nurses will also assess the baby with the TJM during regular home visits or clinic contacts and will draw a blood test if necessary.

Previously, jaundice tests involved an initial visual check for a yellowish skin tone and a follow-up blood test to determine the amount of bilirubin that was present. The TJM is a more accurate way of measuring all skin tones.
Have We Made a Difference?

The Effect of Instituting a Prehospital-Discharge Newborn Bilirubin Screening Program in an 18-Hospital Health System

Larry D. Eggert, Steven E. Wiesmeyer, June Wilson and Robert D. Christensen

Pediatrics 2006;117;855-862
DOI: 10.1542/ped.2005-1338

This information is current as of June 7, 2006

The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://www.pediatrics.org/cgi/content/full/117/5/e855

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1924. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2006 by the American Academy of Pediatrics.
Have We Made a Difference?
Have We Made a Difference?
Have We Made a Difference?
National Parent Education Campaign
HHS

Did you know that jaundice can sometimes lead to brain damage in newborns.

Before you leave the hospital ask your doctor or nurse about a jaundice bilirubin test. All babies can get jaundice in the first few days of life. So ask your doctor or nurse around a jaundice bilirubin test is the only way to know. For sure if your baby has jaundice that cause to be treated. If your baby is in the sun at home is not a safe way to treat jaundice. Just as important, make sure to get your baby a doctor’s check-up when he is three or four days old. For more information, call 1-888-CDC-INFO or visit www.cdc.gov.
Research as the Foundation for Improving Outcomes

- Patient and Family Centered Research
- Policy
- Evidence Based Care
- Improved Outcomes
Past Recipients of the VSA Playwright Discovery Awards

Cal Sheridan

*Cal Sheridan: Not Suffering*

Cal Sheridan, 18, recently graduated from Boise High School in Boise, Idaho. For Cal, the stage is his life. Whether writing or acting, he loves being a part of the theatrical experience. He has written two plays: Chestnuts Roasting and Cal Sheridan: Not Suffering. His theater experience also includes working on stage crew as well as numerous acting credits. When not participating in theater, he enjoys writing scripts for cartoons and songs on Garageband. Cal studies under Dwayne Blackaller, a professional playwright at the Boise Contemporary Theatre.
“Make no little plans; they have no magic to stir men’s blood”

Daniel H. Burnam, Director of Works
World’s Columbian Exposition, 1893
Patient Engagement, Leadership and Quality of Care

G. Ross Baker, Ph.D.
Institute of Health Policy, Management and Evaluation
University of Toronto
August 7, 2014
Healthcare’s Perfect Storm

• Growing prevalence of chronic disease
• New technology improves outcomes but increases costs
• Rising patient and public expectations
• Professional autonomy still trumps system change
• An aging and unhappy workforce
• Limited integration across services and organizations
• Little appetite for increased taxation – or higher premiums
The 21st Century Challenges

• How do we improve the quality of healthcare while restraining increases in costs?
• Can we engage care providers to use current resources more effectively?
• Does patient engagement for improving care at an individual, microsystem and organizational level provide important leverage for improving quality of care?
Current Status

• Patient and family-centered care is seen as a core element of healthcare quality
• New initiatives in Canada, the US and England see patient experiences as a key success metric
• But, while organizations are continuing to embrace PFCC, many organizations are still in early stages and the pace of patient engagement lacks urgency
Patient Engagement Project Research

• Five Components
  – Detailed analysis of CFHI Patient Engagement Project (PEP) team experiences
  – Literature synthesis on patient engagement
  – Paper examining use of Web 2.0 for patient engagement
  – Interviews with experts in various settings
  – Case studies in different jurisdictions
Case Studies

• England
  – Northumbria Healthcare Trust
  – Respiratory Services at Whittington Hospital and Whittington Health NHS Trust

• United States
  – Georgia Regents Health System (GR Health)
  – Cincinnati Children’s Hospital Medical Center

• Canada
  – McGill University Health Centre
  – Glenrose Rehabilitation Hospital

• France
  – L’hôpital Sainte Anne
  – Institut Gustave Roussy
  – La Croix Rouge Française
Key Issues for Case Studies

• What have these organizations learned about engaging patients?
  – Strategies for engaging patients
  – The impact of patient engagement on service delivery and patient experiences
  – What factors contribute to and constrain the effectiveness of patient engagement efforts

• Are there differences across systems in patient engagement strategies? Do system policy and programs influence patient engagement efforts?
Patient engagement is more than patient-centered care, it is the involvement of patients in the design of care, including participation in improvement projects.

Bate and Robert, 2006
Carman, et al.,
Health Affairs
2013
Factors Linked to High Performing Patient and Family-Centered Care

• Visionary leadership
• Dedicated champions
• Partnerships with patients and families
• Focus on the workforce
• Effective communication at every level
• Performance measuring and monitoring

Shaller and Darby, 2009
Patient Engagement

Enlisting and Preparing Patients

Asserting patient experience and patient-centered care as key values and goals

Communicating patient experiences to staff

Ensuring leadership support and strategic focus

Engaging staff to involve patients

Supporting teams and removing barriers to engaging patients and improving quality
Enlisting and Orienting Patients

• Georgia Regents Health System has 200 patient and family advisors who work through the organization
  – Decisions in the organization must integrate patient and family views

• Northumbria Healthcare Trust works with user groups outside the hospital to get insights on patients views of their services
  – Design of stroke services within and outside the hospital
Integrating Patient Engagement Efforts with Organizational Work

• Orienting patients and staff and facilitating their joint work helps to create a more genuine partnership
  
  • How can we encourage meaningful dialogue between patients and staff?
  • What are effective ways to move from individual experiences to broader assessments of current processes and systems?
  • How do we link the information from patients gained from their participation in councils and teams with other data from surveys and feedback?
Real Time Patient Experience Data

• Northumbria Healthcare Trust sends patients a short question on their hospital experience
• A four member improvement team collects, analyzes and reports the patient feedback to service managers
  – Currently 30 of 50 patient units receive real time feedback
  – All quality improvement initiatives incorporate a patient experience component
  – The Director of Patient Experience has a small budget to support immediate changes based on survey results
How Patients are Engaged Influences Staff Views

• The value that staff assign to patient engagement will depend on the extent to which patient engagement improves care and work environments

• Many of the most effective patient engagement strategies link patients into improvement initiatives
  – McGill University Health Centre integration of patients into Transforming Care at the Bedside
  – Cincinnati Children’s Center for Innovation in Chronic Disease Care and other initiatives
  – Saskatoon Health Region integration of patients into Rapid Process Improvement Workshops
  – UK projects on Experience Based Co-Design
Patient Engagement and QI

• Integrating patients into quality and system redesign efforts links patient engagement more clearly to quality and patient safety outcomes. If so, what is the best way to link patients into these teams?
  • How should improvement work be linked to other areas of patient engagement, including Patient and Family Councils?
Scale and Spread

- Many organizations have bright spots, but no larger strategy for patient engagement
- Most organizations begin with pilot projects and microsystem initiatives that depend on local champions
  - What is the best way to spread these efforts? How do we support broad scale engagement?
  - Effective patient and family engagement requires integration, not parallel structures and processes so it becomes an integral element of current structures
Leadership Connects Local Efforts

• Leaders help to shape strategy, execution and continuity
  – Leaders develop and resource key structures and positions
  – Leaders communicate the values and impact – connecting engagement to other goals
  – Leadership needs to be distributed across the organization not resident only at the top
  – Leaders role model the integration of patient and family engagement through their behaviours and its integration into their daily work
Key Findings

• Many organizations have discovered that involving patients and families in quality improvement, patient safety and service redesign initiatives accelerates both patient engagement and the work of improvement teams.

• Patient engagement in improvement efforts may improve outcomes

• Effective patient centered care and patient engagement require changes in values and relationships, but these, in turn, depend on creating structures, roles and policies that support these values and relationships.

• Successful patient engagement initiatives have staff that both managed local work effectively and communicated its importance, relevance, and contributions to leadership.

• Leadership for patient engagement and to develop patient and family centered care is critical to its success
Conclusions

• Patient engagement is an important strategy for creating more effective health services

• Learning from the experiences of leading organizations provides an understanding of the strategies and approaches that contribute to more effective engagement, better patient experiences and improved health services

• Patient engagement offers a critical strategy that addresses key health system priorities
KGH 2009

Government supervisor
Big, growing deficit
High sick time
Low morale
High infection rates
Dirty
Bad relations with partners
Community trust broken
What to do?
Engage ..... 3000 people
It was hard to hear
Our strategy

We are a community of people dedicated to transforming the patient & family experience

www.kgh.on.ca
1. Transform the patient experience through a relentless focus on quality, safety and service

We will:

- Engage patients in all aspects of our quality, safety and service improvement initiatives
- Eliminate all preventable harm to patients
- Eliminate all preventable delays in the patient journey to, within and from KGH
Our stake in the ground

“ANY decision where there is a material impact on the experience of patients, a patient will be at the table”
Our Journey
Open conversations
From the bedside...
To the boardroom
New eyes = New ideas
Our Reset

“I have called you here today because we are not living up to the expectations we have set for ourselves, or for those who count on us for care..... Something is terribly wrong at KGH.... We have the worst infection rates in the province, worst hand hygiene compliance rates and last week.... a patient I will call Brian, died of C-Diff.... A preventable death”

CEO KGH
Oct 2010
34% to 95% HH
Accountability
Results

Enhanced community Engagement + Reputation
✓ 55 Patient Advisors & all levels committees
✓ Improved reputation, brand, pride
✓ Eliminated financial deficit

Improved Outcomes:
✓ Reduced infection rates
✓ Increased hand hygiene compliance
✓ Improved patient satisfaction

Increased Clinical Efficiency:
✓ Reduced length of-stay
✓ Reduced waiting times, better turnarounds

Enhanced Employee Engagement:
✓ Reduced sick time
✓ Improved workplace safety
What’s in a change?
Everyone says they are FOR the patient
Truth and Trust
Patient Centered Leadership

- Share
- See
- Include
- Listen
What does that number really mean?
Have I shared a story today?
Have I included a patient?
Flip the interview: Patients first
What have I learned from a patient today?
Helping others learn
Patient Centered Leadership
Winning Conditions

1. Strategy
2. Leadership support
3. Culture of continuous improvement
4. Champions & change agents (and colleagues as coaches)
Connecting the dots
Winning Conditions cont.

5. Patients – a gift of time and themselves
6. Authenticity – keep it visible & visceral
7. Infrastructure
8. Hold the gains & keep on learning!
Patient advisers a prescription for health-care power shift

KELLY GRANT HEALTH REPORTER

When candidates for a phlebotomist’s job came to Kingston General Hospital for interviews recently, they faced a hiring panel comprised of three people: A human resources official, a manager from the lab and immuno-