

A New CAPS



Last June the CAPS Board honored me by asking me to be the Executive Director of your CAPS organization. I've been working with CAPS in Patient and Family Engagement consulting and developing Education events for six years. My advocacy was a response to my now adult child's lifelong chronic complex medical needs.

Professionally, my background is in broadcasting and marketing. I've worked with some of the best radio stations in America and have taught communications and marketing. But, as I navigated the healthcare system with Skyler, I saw the need for healthcare to create better connections with patients and families. I have worked to build

collaborative relationships between providers and patients/families at many levels.

I feel strongly that CAPS should represent the patients and persons who are consumers of Health Care and a part of the CAPS Community. Many of us have experienced first-hand the impact of lapses in patient safety. We want to collaborate to improve healthcare. We want to make healthcare more responsive to patients and caregivers.

Strides CAPS has made since June include:

- CAPS website – patientsafety.org – has been revamped and will be updated more often. We will have an official re-launch of the site in the next few days. Please check with us soon and let us know what you think of the new website!
- A Consumer Advocates Panel for Safety – the CAPS CAPS – has been formed to advise CAPS and offer input into healthcare education efforts
- CAPS wants to support your co-creation/collaboration efforts. Let us know how we may support you!

-Lisa Morrise

MedStar Patient Safety Lecture

"Giving patients more of a voice in healthcare is hugely important."

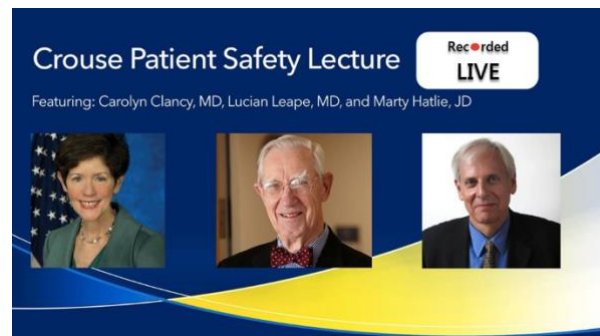
-Marty Hatlie

Marty Hatlie, CAPS founder and board member, participated on a panel at the MedStar Crouse Patient Safety Lecture on October 2, 2019. Hatlie joined patient safety legends Dr. Lucian Leape, professor emeritus of the Harvard School of Public Health, and Dr. Carolyn Clancy, Deputy Undersecretary for Discovery, Education and Affiliate Networks in the Veterans Health Administration, to discuss patient safety.

Dr. Leape is known as the grandfather of patient safety. His article, Error in Medicine, which appeared in the Journal of the American Medicine Association in 1994, was the first to bring attention to the high numbers of medical error deaths and the first to suggest systems theory as a solution. Dr. Clancy headed the Agency

for Healthcare Research & Quality for ten years as it worked to quantify and develop solutions for the problem. Marty Hatlie was instrumental in the formation of the National Patient Safety Foundation and was its first executive director. This distinguished panel addressed what has improved and what still needs to be done in the 25 years since Leape's article kicked off the modern patient safety movement.

Leape noted that, "It's not bad people, it's bad systems." Hatlie urged more systems adopt Just Culture and the CANDOR system of respectful and equitable response to adverse events. He noted that, "Giving patients more of a voice in healthcare is hugely important." Hatlie also noted, "Let's have our boards more reflect the consumers of care."



Dr. Clancy suggested getting boards out of the board room and out on rounds. She said doing so would energize the board. Clancy pointed out that healthcare is a team sport. Patients and caregivers should be on the team!

Use this link to download and listen to the full lecture:

bit.ly/2Oo6eL0

CAPS at Work

CAPS provided Patient and Family Engagement technical support to the Hospital Engagement Networks (2012-2015) and Hospital Improvement Innovation Network (2015-2020) programs and the Transforming Clinical Practice Initiative (2015-2019). These programs were efforts made by the Center for Medicare and Medicaid Innovation (the Innovation Center).

The HEN, HIIN and TCPI programs focused on improving Patient Safety, with Patient and Family Engagement (PFE) as an integral part of the work. Over 150 patients, for example, participated on weekly educational webinars in the HEN and HIIN programs. Patients participated in in-person events and were members of Affinity Groups. Affinity Groups are special interest groups that work on specific issues.

For the HIIN program, the CAPS team worked to support the Patient and Family Engagement Contractor, American Institutes of Research or AIR. AIR worked both with the HIINetworks and their hospitals to implement five PFE Metrics. With technical support and regular education efforts, the uptake on the Metrics improved significantly year on year. Major conclusions were:

- 1.** Patients and families lend new insights into how to achieve quality and safety goals.
- 2.** Including patient and families in quality improvement efforts leads to greater levels of improvement.
- 3.** Emerging evidence that utilizing clinical (encounter) PFE strategies, including preadmission planning (PFE Metric 1) and bedside rounding (PFE Metric 2) leads to improved outcomes.
- 4.** Health equity is an important component of understanding how to achieve quality and safety goals.
- 5.** When a Hospital or practice decides to implement PFE, they will experience greater success if they have access to multiple forms of technical assistance, including one on one coaching.

The Five PFE Metrics

Point of Care

- Metric 1: Preadmission Planning Checklist
- Metric 2: Shift Change Huddles OR Bedside Reporting

Policy & Procedure

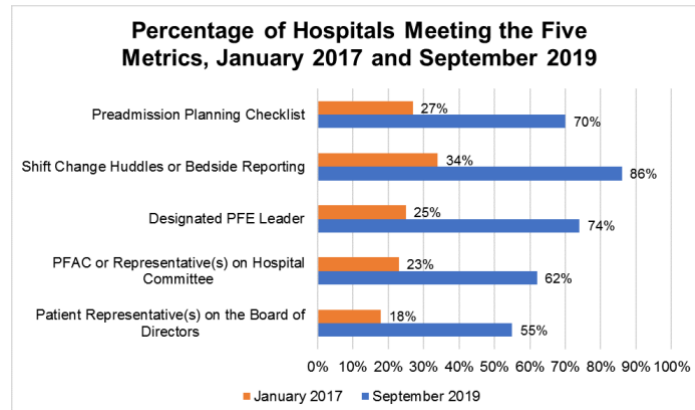
- Metric 3: Designated PFE Leader
- Metric 4: PFAC OR Representatives on Hospital Committee

Governance

- Metric 5: Patient Representative on Board of Directors

One benefit of including patients and families as colleagues in quality improvement work can be the richly rewarding camaraderie and sense of purpose their presence engenders. One challenge is when these important team members succumb to their health issues. In the last few years of the HEN and HIIN programs, Kim Blanton, Ensia Yaisrael and Bob Malizzo passed away. Their energy will be missed, but their passion motivates continued improvement efforts.

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Please See Me

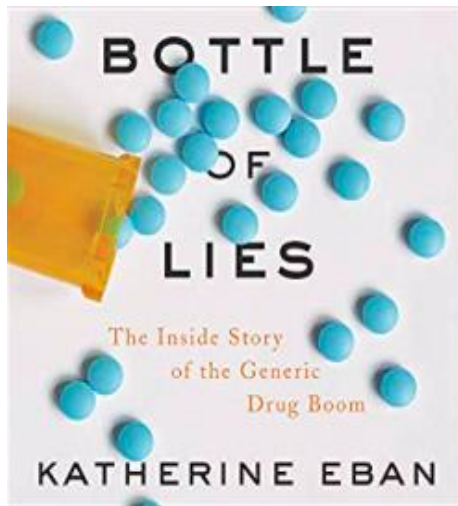
Did you know:

Please See Me is an online literary journal that features health- and healthcare-related stories in the form of fiction, creative nonfiction, poetry, and digital media, including photography, podcasts, and short films. At the heart of the publication is the cultivation of meaningful patient-provider partnerships in the spirit of wellness. To that end, Please See Me publishes work written by patients, family members, creatives, caregivers, and providers.

The Second issue is now available! Congratulations to CAPS board Member Tracy Grzyk who produces Please See Me:

<https://pleeseeeme.com/>





CAPS Book Club

I read Bottle of Lies – The Inside Story of the Generic Drug Boom by Katherine Eban. It traces the frightening lack of effective oversight and integrity in the Generic Medicine supply chain. My family has likely been impacted by poor quality generics. This reads as a true to life thriller. I was impressed that patient advocacy has played a role in starting to resolve some of the generic medicine issues. But not all! Much remains to be done, especially for patients that live outside of the United States. If you are taking a generic medicine and it is not as effective as the name brand, talk to your provider. -Lisa Morrise

Please tell us if you know of a book for the CAPS Book Club.

Webinar Planned:

Dr. Ron Wyatt - Erica Steed
Healthcare Equity and You
October 30, 2019 – Noon Central Time

Registration Link to come soon.

Do you have information for CAPS
Newsletter?

Please send us information about what you are doing to Advance Patient Safety.
Send it to capspatientsafety@gmail.com

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