

Prototype Consumer Reporting Systems for Patient Safety Events

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Prototype Consumer Patient Safety Reporting System

In an effort to realize the untapped potential of health care consumers to provide local providers with their important perspective regarding adverse events they have experienced, the AHRQ has funded the development of a Prototype Consumer Reporting System for Patient Safety Events (CRSPS)





Consumer's Role

AHRQ recognizes that the unique perspective of health care consumers could reveal important information that is not reported through current mechanisms. Patient reports could complement and enhance reports from providers and thus produce a more complete and accurate understanding of the prevalence and characteristics of medical adverse events.



Lack of Opportunity for Patients to Report on their Experience with Care

- Nearly all patient safety event reporting systems are designed for use by health care providers, not consumers.
- Current patient safety event reporting systems do not accommodate the desire of patients and their families or caregivers to provide input on their experiences with care.





If We Were to Build Such A Systems, What Would They Look Like?

- What type of information would consumers provide regarding patient safety events?
- What are the different options for consumer reporting systems? How would these systems differ at the local, state, regional, national, or international level?
- What type of infrastructure is needed to enable effective, actionable consumer reporting of patient safety events? What is the most effective operational approach?
- How would consumer reporting systems be linked to quality and/or patient safety improvement efforts?
- How could consumer reporting systems maximize the willingness and ability of consumers to report patient safety event information?



Two Part Process

Establish Design Criteria
Developed under contract with RTI
Build and test a prototype reporting system
Being developed under contract with RAND







We relied on a multi-disciplinary panel (patient safety experts, healthcare leaders, and patient advocates), building on existing event reporting models, and input from national healthcare leaders and consumers who experienced adverse events.

An iterative consensus-building process, including:

- Environment Scan and Literature Review
- Technical Expert Panel (Multidisciplinary)
- 25 Stakeholder Interviews (Multidisciplinary)
- 10 Consumer Focus Groups (Two Rounds)





IDEALS Concept & Key Project Activities







Purpose:

- Learning system to improve patient safety and to develop interventions to prevent future harm.
- Type of Information:
 - All types of patient safety events, ranging from near-miss and no-harm events to adverse events.
 - Factual account of the patient safety event combined with the consumer's perspective.





Ease of Use:

- Multiple reporting modalities (in-person, internet, email, phone, fax, etc.).
- Structured and unstructured reporting (quantitative and qualitative data collection methods).
- Allow family members, caregivers, and others who witness an event to report on behalf of the patient.
- Facilitate use by diverse populations.

Confidentiality of information (whistleblower protections)



Level of Operations:

 Ranging from Local Community to State, Regional, National, and International

Linkages:

Ensure timely information sharing, improve data analyses, share results, and use actionable information to improve patient safety.

Analytic Functionality:

Root cause analyses on selected patient safety events, and a selected patient safety events.



Feedback to Consumers' Reports:

- Provide meaningful and timely feedback to consumers (beyond acknowledgement and receipt of report).
- Evaluation of feedback: Was response satisfactory?
- Follow-Up Action on Consumers' Reports:
 - Share information with healthcare institutions.
 - Recommend actions to improve patient safety.
 - Evaluation of response.





Involving Patients:

- Public awareness campaigns to let patients know that reports on their experience with care are valued, and that consumers' reports will be used to improve patient safety.
- Provide patients with tools to report on their experience with patient safety events.
- Maximize the ease of use of reporting tools.





Consumer Reporting Systems for Patient Safety Events: Design Concept







Part Two: Prototype System

- is being conducted by RAND Corporation, with Brigham and Women's Hospital, Dana Farber Cancer Institute, and ECRI Institute This research has the following goals:
- To develop and design a prototype system to collect information about patient safety events.
- To develop and test web and telephone modes of a prototype questionnaire.
- To develop and test protocols for a follow-up survey of health care providers.







- designed for hospitals, systems, group practices, and others to collect information from patients about adverse events that resulted or nearly resulted in harm or injury.
- to test this prototype for its ability to record data from consumers about patient safety events that are defined as an "incident" or "near miss" by the AHRQ Common Formats.





OMB Approval Required

Federal Register on September 11, 2012, and allowed 60 days for public comment.





- New System for Patients to Report Medical Mistakes by ROBERT PEAR Published: New York times September 22, 2012
- Generated great deal of interest and public comment
- Comments from Congress





AHRQ received 45 substantive comments and 64 personal stories from members of the public. To address these comments, substantial revisions were made to the data collection tools and supporting documentation.







Demonstrating system Summer 2013

- Operation of Pilot Test Fall of 2013 pending OMB approval
- Testing on a regional basis

Examine reports by providers and consumers





Questions

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