MASSACHUSETTS ROADMAP TO HEALTH CARE SAFETY
Task Force: Support for Patients, Families, Clinicians and Staff
Final overview July 2023

Purpose

The Support for Patients, Families, Clinicians and Staff Task Force was charged with developing practical recommendations, tools and policy proposals that:

- Recognize the value of and facilitate the engagement of patients, families, clinicians and staff in ongoing patient and workplace safety improvement work; and
- Offer support to ensure individuals' well-being when safety lapses cause harm.

The task force held its discussions with the guidance that recommendations should have potential for high impact, rely on best practices when possible, and be applicable or adaptable to health care organizations of all types and sizes. Recommendations should also serve to boost the agency and safety of people from communities that experience inequities in health care and safety outcomes.

Background

Patients and families who experience medical error or other traumatic health care events often suffer long-lasting physical, emotional and financial harms. Many lose trust in their providers or try to avoid getting needed care.[1,2]

VISION

Massachusetts is home to a health care system where patients and families are supported in communicating effectively about their care including any concerns they might have about safety, and that patients and families receive ongoing, culturally competent support and compassion in the aftermath of adverse or traumatic events. In addition, health care provider organizations offer support to clinicians and staff in the aftermath of adverse or traumatic events, to promote healing, and work to mitigate clinician and staff stress, moral injury and burnout.

Health care professionals can experience traumatic events such as preventable patient harm and workplace violence that lead to or exacerbate burnout. Epidemic levels of burnout, characterized by high emotional exhaustion, cynicism, and a low sense of personal accomplishment from work, have been reported by health care professionals who encounter overwhelming demands exacerbated by insufficient resources and broken or inefficient processes.[3] Patients and families are in turn impacted by clinician and staff burnout, which not only reduces satisfaction and confidence in the care experience but increases the risk of medical error.[4,5]

Patients and family members who witness errors or other risks to safety are frequently reluctant to speak up.[6] Research shows that patients and families are reliable observers of where, how or when safety system breakdowns can and do lead to harm events.[7] Yet few organizations have the resolve, infrastructure, and relationship with their patient population to actively elicit their concerns and help in making safety improvements.

In the aftermath of adverse events or unexpected outcomes, transparent, structured, culturally competent communication and support can improve the well-being of patients, families and members of the care team alike.[8,9] Massachusetts is home to leading experts and programs on peer support, and communication and resolution. The Commonwealth also has several ongoing initiatives aimed at preventing and addressing the problem of burnout among health care professionals. These are an excellent start, but more work needs to be done to enable wider implementation.

Challenges

The task force acknowledged the complexity of ensuring patients, families, clinicians and staff are true partners in safety improvement work and feel supported when something goes wrong in care. The task force also recognized that many individual health care organizations, advocacy groups, and researchers have collaborated on efforts to support patients, families, clinicians and staff within the health care system. Much of this existing work informed the task force's discussions.

It has been difficult to embed appropriate and effective supports into the day-to-day operations of health care provider organizations. Among the barriers identified by the task force were:

- Low awareness of the incidence of health care harm, including among the public, policymakers, health care leaders, and frontline clinicians and staff;
- A health care culture that emphasizes the roles of individuals, rather than systems, to prevent or cope with instances of health care harm, symptoms of burnout, and other emotional stressors related to delivering or receiving care;
- Implementation science lags knowledge about how to do this work, making it seem like "one more thing to do" rather than an integral part of workflows;
- Reluctance, particularly of medical professionals but also patients, to acknowledge the need for or seek help;
- Asymmetry in knowledge and power between patients and providers, among providers, and among provider organizations;
- Low awareness of ways in which patients and families experience the health care system, especially during stressful encounters and health care harm events;
- Reducing administrative burdens on frontline clinicians and staff feels beyond the control of individual provider organizations;
- Initiatives to improve support are often seen as "competing" rather than complementing other organizational priorities;
- Patient concerns are heard as "complaints" rather than seen as opportunities to improve; and
- Reimbursement systems discourage time needed for effective, supportive conversations between patients and care teams.

Guiding principles

The Consortium encouraged task force members to keep the following principles in mind as they developed their proposals, recommendations and toolkits. The guiding principles below build on two decades of history and experience on health care safety improvement — what tends to work and what stymies success. Task force recommendations should strive to:
- Move the health care system toward a mindset of zero tolerance for defects that can result in physical or emotional harm to patients, families and staff
- Support approaches to continuous, proactive safety improvement that break down silos and enable all stakeholders — including provider organization staff at all levels, patients, payers, and policymakers and regulators — to carry out their respective roles
- Promote a "just culture" by adopting a fair and consistent approach to safety improvement that fosters psychological safety and holds leadership accountable for breakdowns and shortfalls
- Advance health equity through the elimination of disparities in safety and quality outcomes on the basis of race, ethnicity, language, age, disability, income and more

- Encourage an approach to health care and safety that maximizes the benefits of co-production, recognizing that patients and families provide expertise essential to person-centered care.
- Reduce low-value administrative burdens
- Remove all forms of waste from work, making it easier to do the right thing.

Discussion points

The task force through its discussions developed the following discussion points and recommendations for the Consortium to consider as it finalized the *Roadmap to Safety.*

Improving support for patients and families

A. Partnership with patients and family members as contributors to the safety of their own care

1. Health care provider organizations can develop and execute strategies that provide patients with safety information that is specific to their organization's processes and practices. Essential information includes:

   - How to access their medical records, visit notes, and follow-up care information;
   - Where/to whom to direct concerns about quality and safety; and
   - Opportunities to participate in safety and quality improvement efforts.

2. All patient-facing clinicians and staff can assist in this work with skills that help them better communicate with patients and families about working together to reduce the risk of harm in their care.
   - To be effective, training on patient and family communication should be offered at multiple points in time and include appropriate levels of information for all patient-facing clinicians and staff. A complete program of training should consider that clinicians and staff will not be able to absorb and retain all the information at once.
   - All patient-facing clinicians and staff should be versed in best practices for engaging patients and families as partners in the safety of their own care during interactions over treatments, procedures, medications, routine appointments, and other clinical encounters. Each health care organization can review key basic skills for this engagement during onboarding of new personnel and require periodic trainings to reinforce these skills.

B. Partnerships with patients and family members as contributors to safety improvement work within and across provider organizations

1. A key priority is to actively engage and enable diverse patient populations to contribute to health care organization's safety and quality improvement initiatives.
2. All hospitals and all accountable care organizations serving MassHealth members have an available mechanism, the Patient and Family Advisory Council (PFAC), by law. Effective approaches include:

- Conceptualize the PFAC as a "steering committee" for patient engagement on safety and quality (e.g., by including PFAC members on committees and other activities aimed at improving quality and safety)
- Diversify the membership of PFACs to be reflective of patient/ACO member population. Strategies for recruiting a more diverse population could include:
  a. Deploying culturally competent patient navigators, social workers, community health workers or other staff to do community outreach and recruitment
  b. Offering resources (stipends, childcare, transport, interpreter services) that facilitate participation
3. All provider organizations can solicit and leverage patient input about safety and quality concerns through their Continuous Improvement System, patient relations, clinical staff, and other available mechanisms.

C. Disclosure and remedy of harm events to the patient and family in a timely, transparent and compassionate manner

1. Clinicians need information, skills, and support to:
   - Understand and apply the "disclosure and apology law," MGL c. 233 §79L, which requires providers to "fully inform" a patient who suffers unanticipated outcomes with significant medical complications as the result of a medical error. The law also bars provider expressions of apology and remorse from being used as evidence of negligence in most instances.
   - Disclose adverse events and apologize when appropriate.
   - Seek help for themselves/colleagues impacted by an adverse or traumatic event.
2. Clinicians and staff need access to just-in-time coaching on disclosure and apology to inform conversations with patients and families in the aftermath of adverse events.
3. Communication, apology and resolution programs (CRPs) are a proven alternative to costly medical malpractice litigation in many instances of medical harm. To make this approach more widely available to patients in Massachusetts:
   - Larger, more complex organizations can establish organization-based CRPs.
   - Medical malpractice carriers can establish CRPs for members who are not employed at larger organizations.
   - The Betsy Lehman Center can facilitate CRP and disclosure coaching services in instances of patient harm that occurs across multiple provider organizations.

D. Ready access to a network of peer supporters to meet their unique emotional needs in the aftermath of adverse or other unexpected outcomes in their care

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A CALL FOR DELIBERATE INCLUSION

Care should be taken to include patients and families who are known to be most vulnerable to preventable harm due to race, ethnicity, language, disability, sexual orientation, gender or gender identity, age, or other conditions that make them more likely to encounter implicit bias (e.g., obesity, behavioral health, substance use disorder).

This is relevant for all activities involving patients and families from safety education efforts to communication in the aftermath of harm.

1. The Betsy Lehman Center offers a statewide network of trained peer supporters to work with patients and family members who request support in the aftermath of adverse or other unexpected outcomes in their care. More effort is needed to raise awareness about this resource.
2. The network can be improved by becoming more reflective of and responsive to patients and families who are known to be most vulnerable to preventable harm due to race, ethnicity, language, disability sexual orientation, gender, gender identity, age, or other conditions that make them more likely to encounter implicit bias (e.g., obesity, behavioral health, substance use disorder).

E. Collaboration among stakeholders to develop and deliver ongoing safety education for the general public that emphasizes:
- How to be alert to safety risks;
- How to speak up to frontline clinicians or staff in the moment (including standard language);
- How to leverage provider notes to identify omissions or inaccuracies in their own medical records; and
- How to report safety concerns to organizational leadership.

Improving support for the health care workforce

A. Mechanisms that acknowledge and address the physical and emotional needs of clinicians and staff stemming from the day-to-day stresses of their roles

While the Continuous Improvement Task Force put forward strategies to engage the workforce in improvement efforts and decrease workplace stresses, most organizations need a more structured approach to reducing stress, moral injury and burnout among health care practitioners and staff.

Provider organizations need capacities to:

- Elicit and solve for "pain points" that add undue stresses to roles or individual staff;
- Facilitate access to internal or external resources for clinicians and staff that teach techniques for stress management and resilience and help them cope with acute levels of stress that impede their ability to do their jobs safely. These resources should be responsive to the needs of a diverse health care workforce;
- Prevent violence in the workplace, in partnership with clinicians and staff;
- In teaching programs, facilitate access to internal or external resources that meet both the criteria above and the unique needs of residents and other trainees; and
- Use measurement tools to assess the effectiveness of organizations' support efforts.

Clinicians and staff need consistent, supportive messages about the importance of personal well-being to the safety of the care they provide to others, starting early, and continuing throughout their health care careers.
- Consistent messaging can come from:
  - Medical educators and trainers, with particular emphasis on having clinical supervisors consistently signal the value of well-being.
  - Provider organizations:
    - During onboarding or orientation to a new role, leveraging existing Employee Assistance Program or other internal/external resources; and

- - - During routine internal meetings with organization leadership or direct supervisors reinforcing messages.
    - Medical malpractice insurance carriers.
  - Effective messaging strategies include:
    - Describe the bi-directional relationship between clinician well-being and care quality and safety;
    - Leverage detailed evidence that it is common for clinicians to feel overwhelmed from time to time and to seek help when appropriate; and
    - Emphasize the importance of well-being and facilitate appropriate treatment for all mental and physical health conditions within the organization.

B. Ready access to a network of peer supporters to meet their unique emotional needs in the aftermath of adverse or other traumatic events in patient care

Peer support, which connects affected health care personnel with peers who have similarly experienced a difficult event in patient care, has been shown to be a highly effective mechanism for helping clinicians and staff recover.

- Larger, more complex health care provider organizations can offer a peer support program available to clinicians and staff that is:
  - Integrated with other clinician and staff well-being offerings;
  - Designed to overcome barriers to access such as stigma, time constraints and low awareness; and
  - Designed to meet the needs of its diverse workforce.
- State agencies and industry groups can collaborate to develop, promote and sustain a statewide peer support network for clinicians and staff who work at organizations that are not equipped to build organization-based peer support programs or prefer to seek support services outside of their primary place of employment.

Building leadership commitment to patient, family, clinician, and staff support

To supplement the work of the Leadership and Governance Task Force, this task force urges that curriculum for leaders of Massachusetts health care provider organizations builds leaders' capacity and skills to:

A. Support and engage patients and families in the safety of their own care, when things go wrong with their care, and in the organization's work to improve safety for all patients
- Curriculum and training for leaders of all health care organizations will benefit from the inclusion of the following essential knowledge about patient and family support and engagement:
  - The principles of 'patient-centered care,' specifically as it relates to fully supporting participation of patients and families to minimize safety risks in their own care;
  - The value of patient and family observations about risks, and how to routinely elicit such input to improve safety at the organizational level;
  - The role of provider organizations in offering or facilitating access to support for patients and families following adverse events, unexpected outcomes, or other trauma during their care;

- o How racism and implicit bias create barriers to engaging and supporting patients of color and members of other marginalized groups;
  - o The business case for investing in patient-centered care and supports, and for making time for clinicians and staff to receive training on and to deliver such care and supports; and
  - o Massachusetts law regarding disclosure and apology of errors in care to patients and families (MGL c. 233 §79L).
- For leaders of more complex provider organizations, the following additional items are part of essential knowledge on this topic:
  - o Why and how to include patients and families in governance structures, quality and safety committees, and quality/safety improvement activities; and
  - o Best practices for disclosing medical errors to patients and families, including obligations for communicating about Serious Reportable Events (SREs) per MGL 105 CMR §§ 130.332,140.308 when applicable (hospitals and ambulatory surgery centers).

B. Understand that an essential element of providing high quality, safe care is support for clinicians and staff both in the management of day-to-day stresses inherent in delivering health care services and in the aftermath of difficult events in patient care

- Curriculum and training for leaders of all health care organizations will benefit from the following essential knowledge about clinician and staff support and engagement:
  - o The safety consequences of a work environment that is not respectful of all personnel;
  - o The value of fostering engagement, including through regular, direct interactions with frontline personnel;
  - o The correlation between a positive patient safety culture and the solicitation of and prompt responses to reports of safety events or concerns;
  - o The need to offer, invest in and promote an integrated set of resources that advance individual well-being, both for its intrinsic value as well as its role in preventing staff turnover;
  - o The immediate and long-lasting emotional impacts that result from medical errors, adverse events and other difficult outcomes in patient care; and
  - o The demonstrated effectiveness of peer support as one tool to address the emotional impacts from difficult events in patient care.

Tools and resources

The task force identified tools and resources that can be used or adapted by provider organizations. Below is a *sample* inventory of tools and resources. Nearly all are being used by organizations in Massachusetts.

	Resources	*Organizations*
Leadership curriculum development	PROMISES project	Massachusetts Medical Society
	Clinician well-being and Resilience	National Academy of Medicine
	Caring for the Caregiver	MA Health & Hospital Association
	Multiple resources	Lucian Leape Institute
	Multiple resources	Institute for Patient and Family Centered Care

	Implicit bias training	Multiple sources
Public awareness about safety		
	Stop the Line campaign	US Veterans Services
	PAUSE model	Ariadne Labs
	Speak Up About Your Care	The Joint Commission
	Multiple resources	PULSE Center for Patient Safety Education and Advocacy
	When Doctors Don't Listen	Leana Wen
Patient and family interactions	PFACs: Resources for the Field	American Hospital Association
	PFAC models (non-MA health systems)	Kaiser Permanente; Johns Hopkins; University of Rochester
	Peer support models	Betsy Lehman Center for Patient Safety
	Communication, Apology and Resolution	AHRQ, Betsy Lehman Center for Patient Safety
Clinicians and staff	Multiple resources	Schwartz Center for Compassionate Care
	Survey tools	Mayo Clinic (well-being); Maslach (burnout); Oldenburg (burnout)
	Wellness coaching for physician trainees	MA General Hospital
	Multiple resources	MA Medical Society
	Multiple resources	Wellness Council of America
	Virtual behavioral health tools	BetterHelp, TalkSpace, Lara, Ginger, ModernHealth
	Multiple resources	Institute for Healthcare Improvement
	Health care worker well-being	National Academy of Medicine
	MindBodyStrong	College of Nursing, Ohio State University
	Multiple resources	Dr. Lorna Breen Heroes' Foundation

Summary

Massachusetts is home to leading innovators when it comes to strengthening the role of patients and families in their health care, as well as fostering the well-being of clinicians and staff. It was the first state to enact a law calling on all hospitals to establish Patient and Family Advisory Councils. It also, more than a dozen years ago, took the lead in forming an alliance of hospitals working together to put communication, apology and resolution theory into practice in their settings. More recently, the Massachusetts Health & Hospital Association collaborated with the Massachusetts Medical Society to better understand and address the stressors driving scores of trained clinicians and staff to leave their

roles or professions. The Betsy Lehman Center for Patient Safety has led efforts to make peer support more widely available to patients, families, clinicians and staff affected by harm and other traumatic events in patient care.

Task force members urge Massachusetts to build on those efforts so that programs, supports, and resources are available across the state in health care settings large and small. They call on health care provider organizations and their leaders to involve patients and families in safety improvement work, train clinicians and staff to communicate more openly about safety and safety lapses with their patients, and prioritize the well-being of their workforce. In addition, there is a role for the state to play in facilitating the knowledge, tools, and incentives to build and sustain the capacity of organizations and practices to respond appropriately when safety lapses result in harm.

The benefits of treating patients, family members, clinician and staff as partners in safety efforts extend beyond the walls of any one facility or institution. This approach solidifies consumers' satisfaction with their health care, contributes to the state's collective ability to better serve populations known to be most vulnerable to harm, and bolsters commitment to careers in health care.

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Endnotes

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