"Participating in Patient TIPS is especially meaningful… it makes me feel hopeful."
- A Patient Advisor

With enthusiasm, the Patient and Family Engagement Program of Beth Israel Deaconess Medical Center would like to nominate Sigall Bell, MD, David Browning, MSW, and Pamela Varrin, PhD, for the 2012 MITSS Hope Award. The three educators have developed and implemented the "Patient Teachers in Patient Safety" (Patient TIPS) program, which closely aligns with the MITSS mission through its effective partnering between patients/family members and providers to improve safety, and through the respect shown for all parties affected by adverse medical events.

Patient TIPS includes patients and family members as teachers and active co-learners in interdisciplinary workshops on medical error disclosure and prevention. Each workshop brings together participants including patients and family members, medical students, residents, faculty physicians, nurses, nurse managers, and social workers in a "one room schoolhouse" that dissolves traditional barriers, models team communication, and engages participants in an action plan to observe, reflect upon, and improve collaboration with patients and family members in their own practice. Using live medical error disclosure enactments, the project's goals include improving communication with patients and family members when things go wrong, enhancing relationships among interprofessional team members to improve patient safety outcomes, and testing new approaches to collaborative learning with healthcare professionals that incorporate the wisdom of patient-teachers in a variety of ways.

The curriculum, funded by the Schwartz Center, is a collaborative effort among IPEP, BCH, and BIDMC, reaching several Harvard teaching hospitals and aiming to develop a nationally disseminatable model. The program builds upon IPEP's established track record in developing innovative learning interventions addressing difficult conversations in health care.

Patients and family members involved in the experience have found it to be stimulating, hopeful, and eye-opening. One patient-teacher said, "It's been empowering to participate in Patient TIPS….As a patient, I can be on equal footing with medical professionals who are also grappling with medical errors." Another commented, "I see how much health care providers worry about error and how hard it is to talk about it." A third remarked, "I had never heard medical people acknowledge feelings before."

When asked about the experience of learning with patients, a nurse responded, "[I learned about] the collective wisdom of 'us,' and the 'us' includes patients." A physician assistant said the program provides a "perspective that we don't usually get. I don't really know what patients are really feeling. "Clinicians listed future practice changes including: "Ask patients how we could have done a better job taking care of them," "Engage an interdisciplinary team to find solutions," "Invite patients and families to share ideas and suggestions," and "Engage patients in patient safety committees."

The assessment plan for Patient TIPS, like the rest of the project, has placed patient-teachers in the position of helping to define what success should look like. The assessment is implemented using a pre-post design with parallel surveys for patients/family and clinicians, using both quantitative and qualitative metrics. These data are organized in a database and monitored for trends, with comprehensive analysis planned after completion of the grant period. Patient-teachers are invited to write about their experience during each phase of their participation, so that their observations can be documented along the way. The assessment aims to discover whether including patients and families in clinician training on medical error disclosure and patient safety adds value as an educational model, and whether the experience affects attitudes about collaboration among patients, families and clinicians.

Skill development and changes in safety, teamwork, and disclosure culture are also measured based on validated scales. Clinicians are assessed for their confidence and readiness to communicate with patients and families after adverse events, and for their comfort collaborating with patients and family to promote safety. All participants are asked to describe specific lessons learned from interprofessional colleagues, to reflect upon the relational dimensions of patient safety, and to make a specific practice commitment to improve collaboration between clinicians and patients/families. Preliminary data are quite promising: Participants universally express support for the program and for the value of including patients, family members, and clinicians from different disciplines in this kind of educational effort.

The workshops have already stimulated institutional improvements. For example, participants from Cambridge Health Alliance (CHA) used their experience to expand the scope and focus of their own Patient and Family Advisory Council, and will be sending CHA patient-teachers to join BIDMC patient-teachers in future Patient TIPS workshops. In addition, the Patient TIPS program will become part of IPEP's course offerings for additional hospitals and health care centers, and the patient-teacher model will be extended to other IPEP workshops, including a recently submitted national proposal to include parents in NICU communication training. Finally, in collaboration with patient-teachers, the educators plan to outline a "how-to" document so their approach can be replicated in other healthcare settings.

The program benefits from a strong leadership team: Dr. Bell, Co-Director of Patient Safety and Quality Initiatives at the Institute for Professionalism and Ethical Practice (IPEP), Boston Children's Hospital (BCH), and a physician in the Division of Infectious Diseases at Beth Israel Deaconess Medical Center (BIDMC); Mr. Browning, Senior Scholar and Co-Director of Patient Safety and Quality Initiatives at IPEP, and a clinical social worker at Massachusetts General Hospital cancer center; and Dr. Varrin, Coordinator of Family Support Services at the Cotting School in Lexington, MA, who brings to the project the dual perspective of clinical psychologist and the mother of a child with complex and chronic healthcare needs.

Every step of the way, Dr. Bell, Mr. Browning, and Dr. Varrin have engaged patients and family members in providing feedback that has shaped the program. Their commitment

to creating strong partnerships with patients and family members, particularly as it relates to improving patient safety and promoting error disclosure, is based in the firm belief that the knowledge and insights of the recipients of care need to be more robustly integrated into medical settings in order for critical challenges in patient safety to be addressed.