Northwest Communication and Resolution Program Leader Retreat

Achieving Benefits, Avoiding Pitfalls

September 27-28, 2017

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

WELCOME: DAY 1

Thomas Gallagher

Peter Dunbar

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

WHAT IS A CRP?
WHY DOES IT MATTER?

Timothy McDonald MD JD
Director, Center for Open and Honest Communication
MedStar Institute for Quality and Safety

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT
FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Reflection

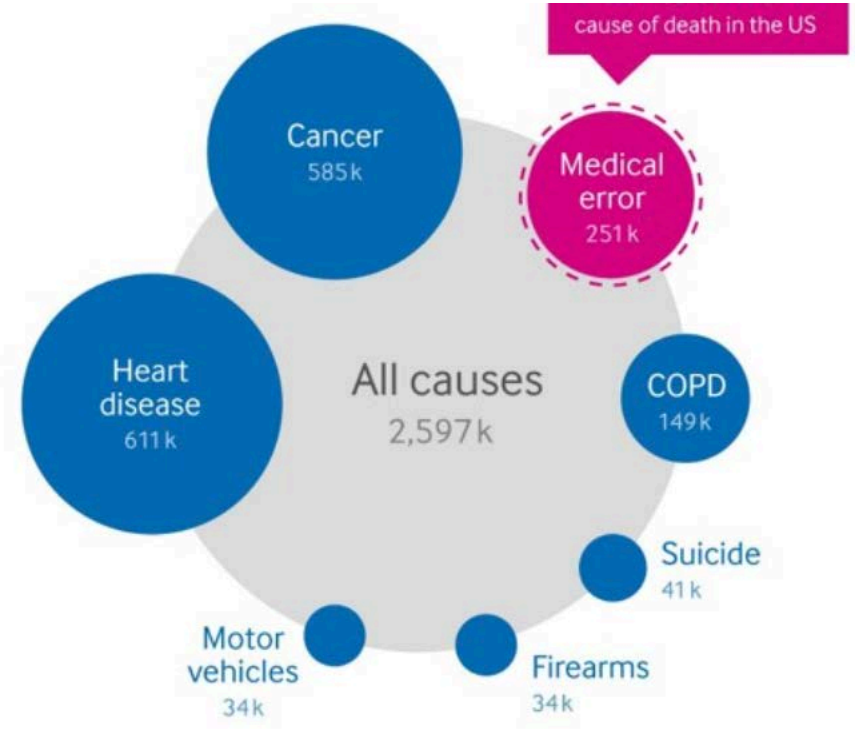
A lack of transparency results in distrust and a deep sense of insecurity. Honesty and transparency make you vulnerable. Be honest and transparent anyway. Trust, honesty, humility, transparency and accountability are the building blocks of a positive reputation.

Mother Teresa

The Problem

Makary and Daniel *BMJ 2016; 352:i2139*

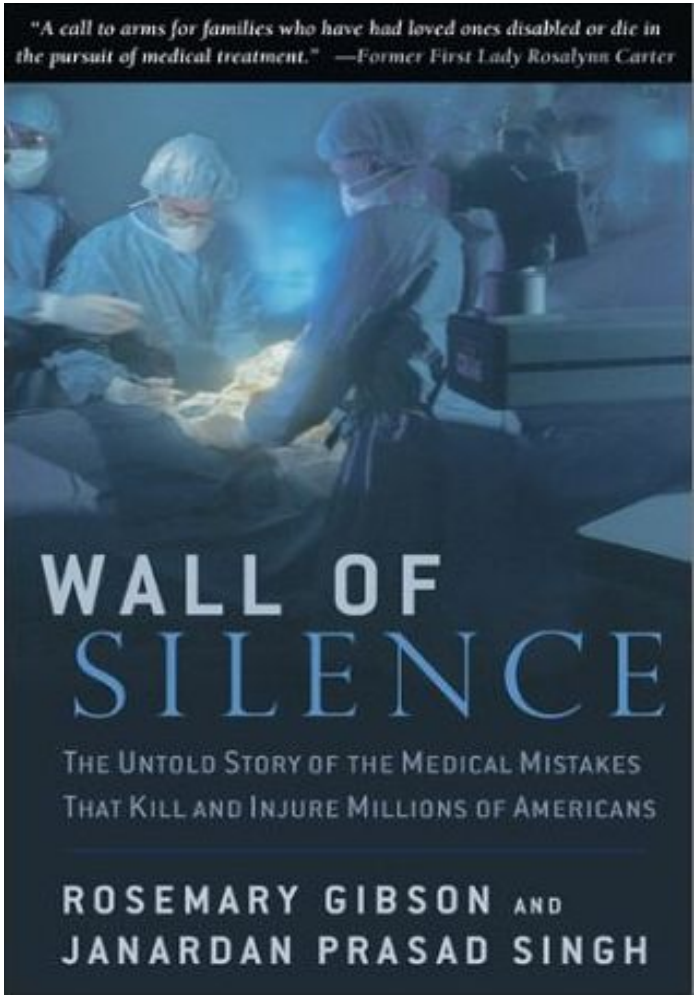
Researchers: Medical errors now third leading cause of death in United States



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Making Matters Worse

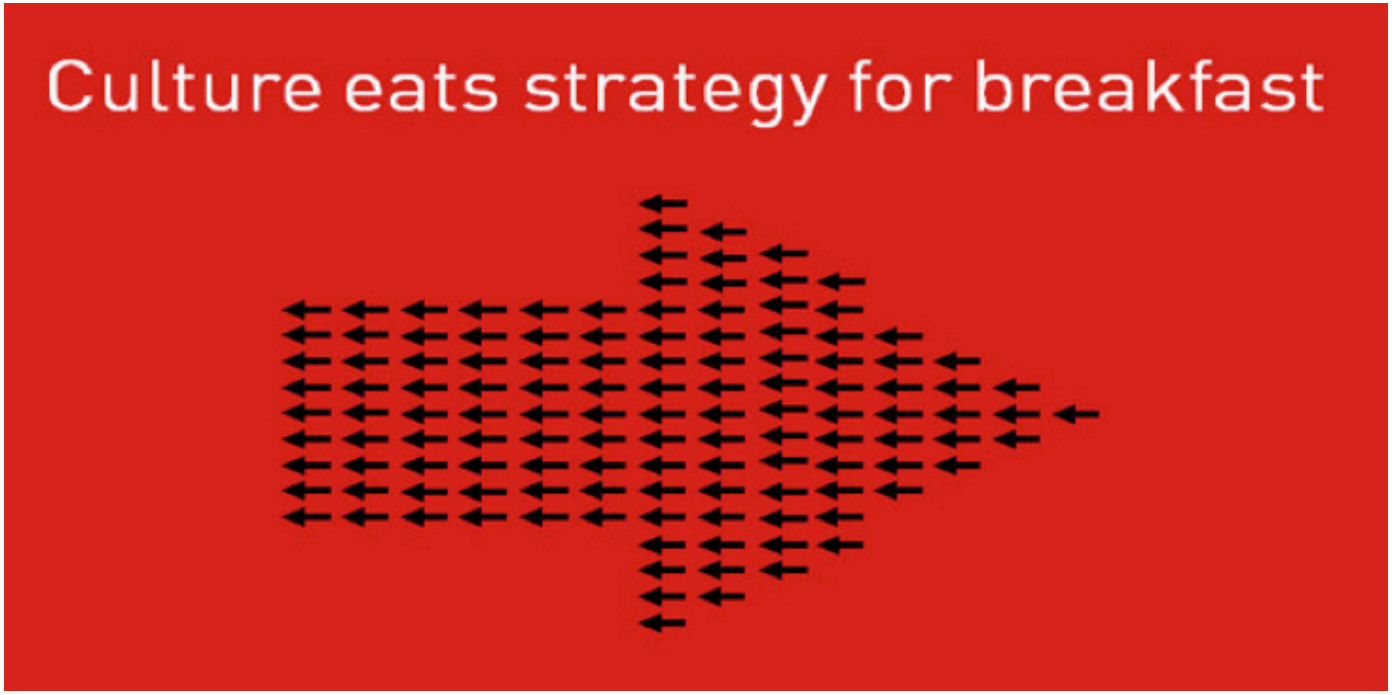


Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

A Case To Illustrate The Wall of Silence

- 39 year old COO of sister hospitals presents for pre-operative testing
- CBC shows WBC of 1,000
- Not acted upon
- Undergoes surgery
- Post op CBC shows WBC <500
- Not acted upon
- Patient dies 6 weeks later with leakemia
- We “delay deny and defend” for 4 years
- Settle for millions
- Learned little and suffer immensely



Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

The Unkind Acts Cascade:
Collateral Damage of The Wall of Silence

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

There is a Better Way to Communicate and Break Down the Wall

- Following the death of the COO at our sister hospital
- The development of a comprehensive approach to the prevention and response to patient harm
  - We will provide effective communication rapidly following all serious harm events
  - We will apologize and fairly and rapidly resolve all cases of inappropriate care
  - We will learn from our mistakes
  - We will support patient, families and care givers throughout

Thanks to Rick Boothman

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

- Barriers
- Benefits

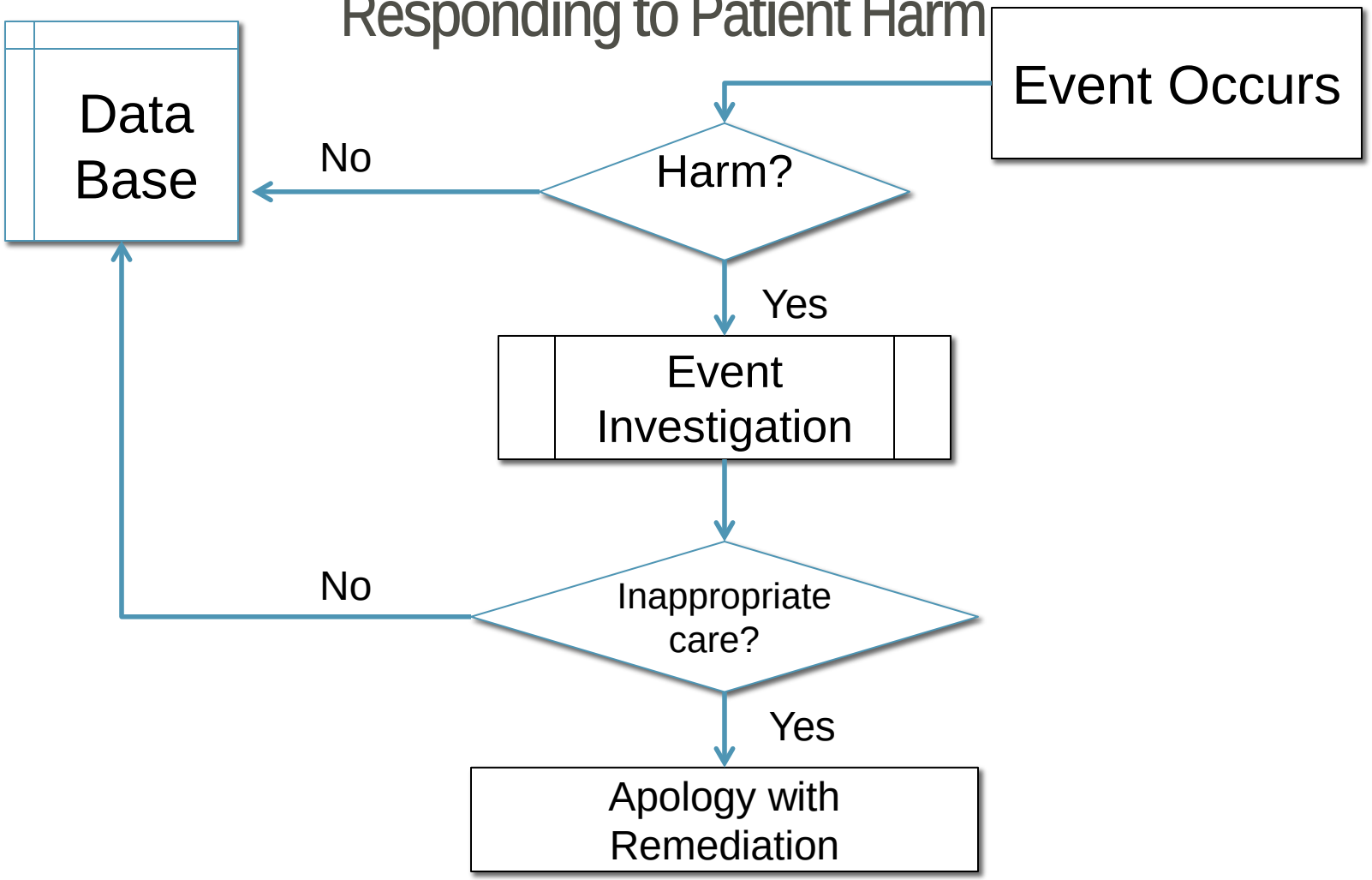
What About Being Open and Honest?

-
  - Lack of skill
  - Loss of job
  - Reputation
  - “Shame and blame”
  - More claims
  - More money
  - Psychologically hard
  - Fear of lawyers
  - Non-standard process
-
  - Communication Training
  - Adopt “Just Culture”
  - Value of Transparency
  - Change to “Fair and Accountable”
  - Less claims
  - Less money
  - Psychological support 24/7
  - Lawyers only when necessary
  - Standardize it

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

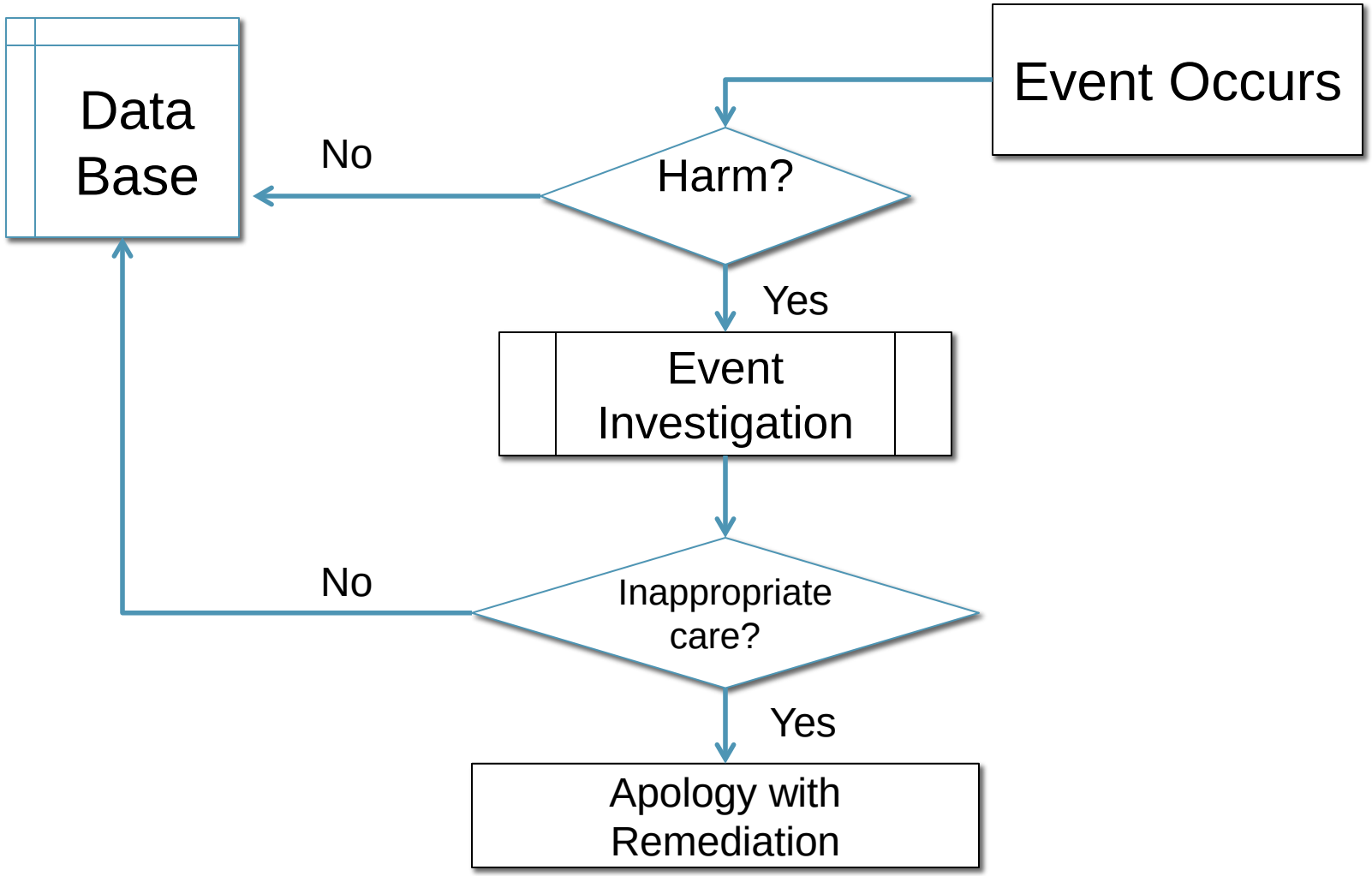
The Original "Seven Pillars" Approach to Responding to Patient Harm



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

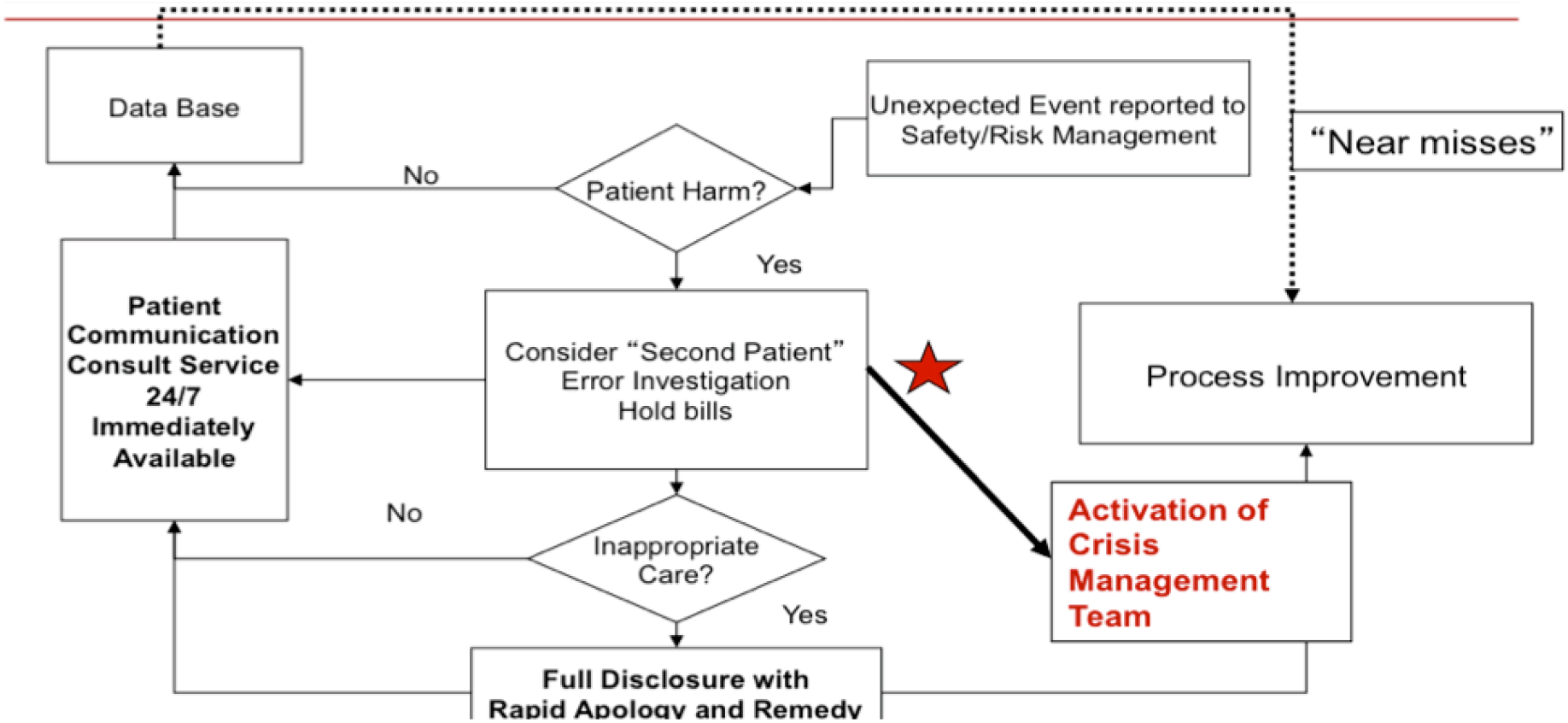
What's Wrong With This Picture?



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

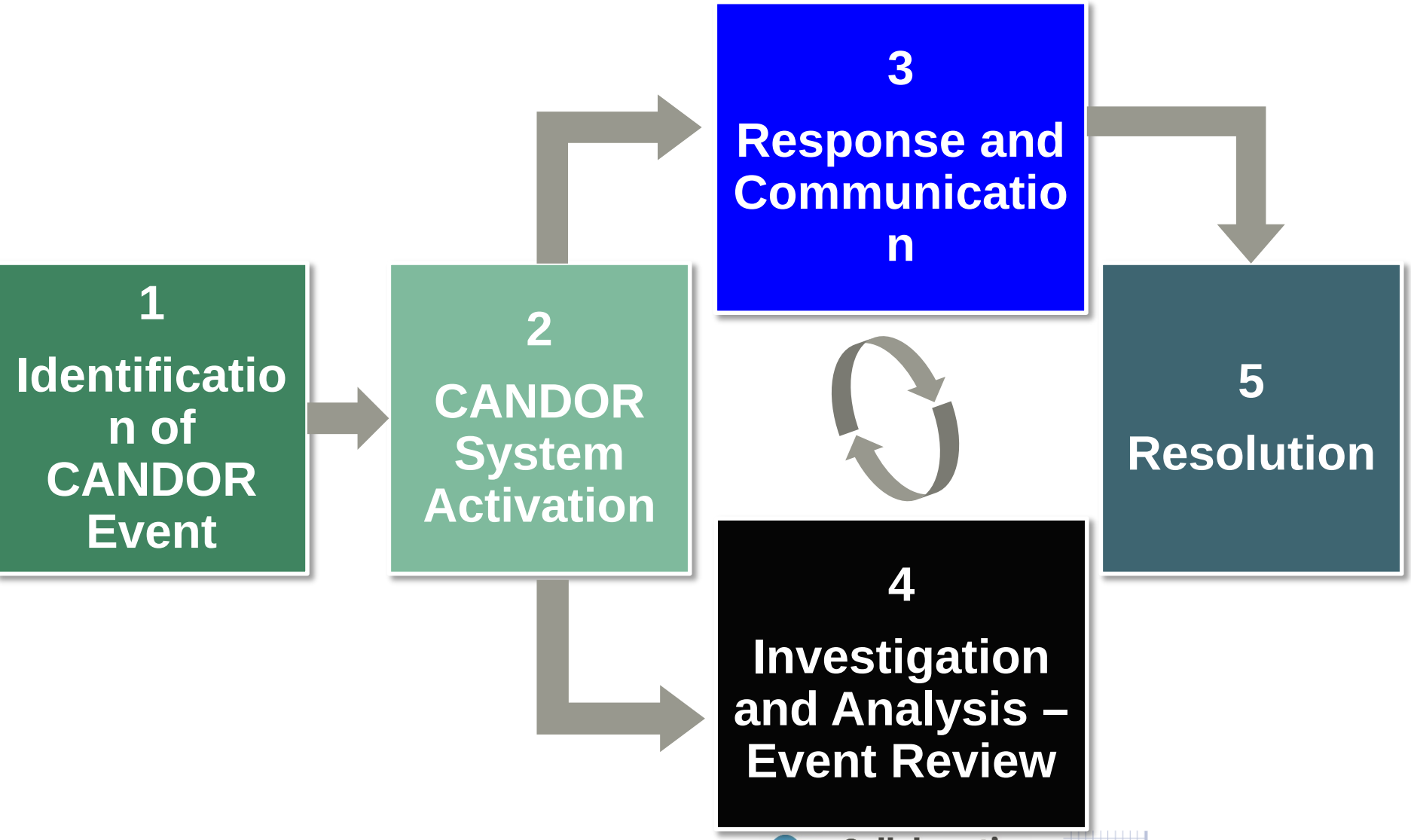
After patient, family, and clinician input – the Seven Pillars/CANDOR Approach



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Communication AND Optimal Resolution



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

The Paradigm Shift

Reporting	• from delayed • to immediate
Communication	• from delay, deny and defend • to immediate and ongoing
Event Review	• from shame, blame, and train • to human factors process redesign
Care for the Caregiver	• from suffering in isolation • to immediate support
Resolution	• from having to “fight for it” • to early offer

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Cascade of CANDOR "Kindness"

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

- Psychological Science published online 6 May 2013

How Positive Emotions Build Physical Health: Perceived Positive Social Connections Account for the Upward Spiral Between Positive Emotions and Vagal Tone

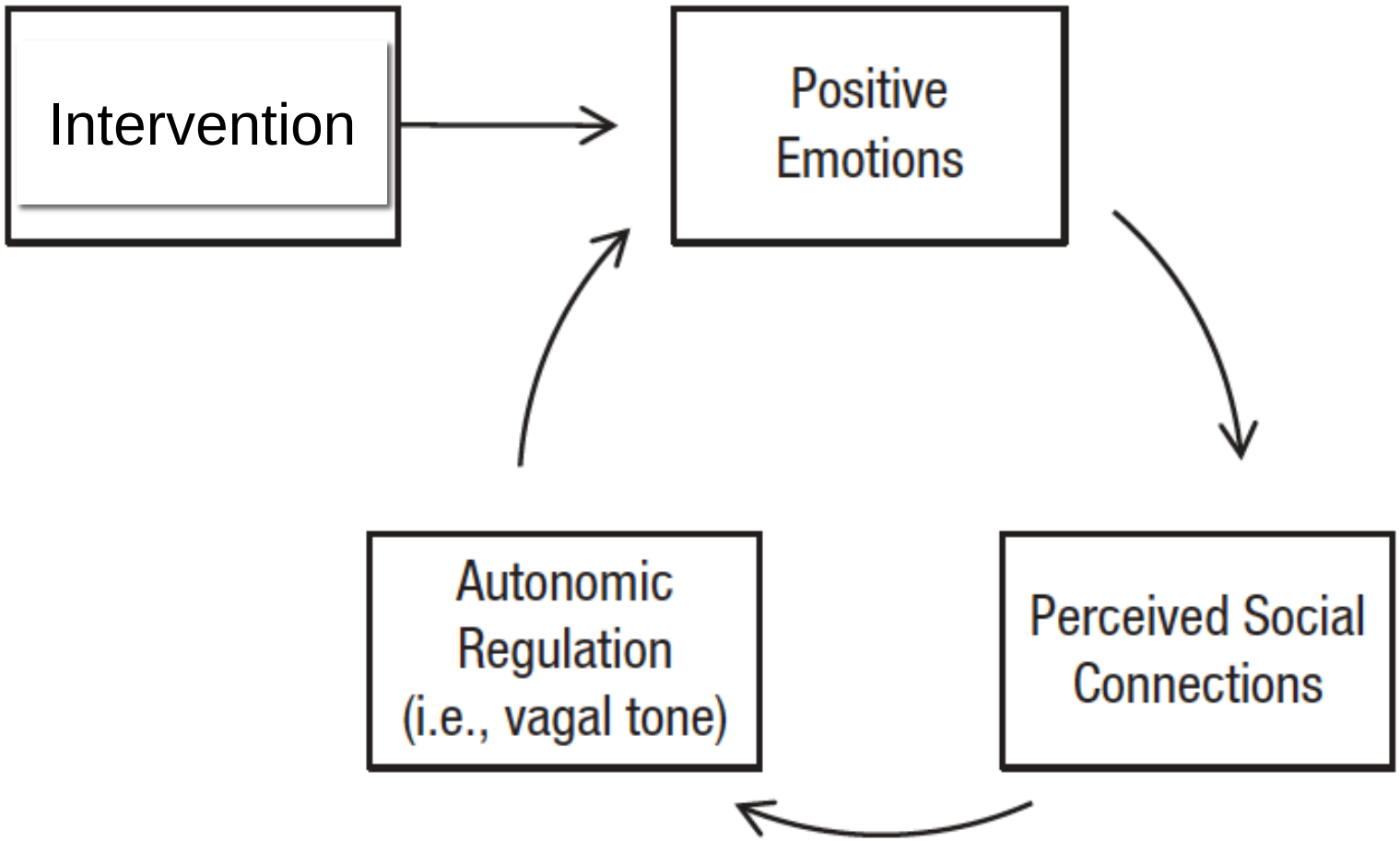
Bethany E. Kok[1], Kimberly A. Coffey[1], Michael A. Cohn[2], Lahnna I. Catalino[1], Tanya Vacharkulksemsuk[1], Sara B. Algoe[1], Mary Brantley[3], and Barbara L. Fredrickson[1]

[1]Department of Psychology, University of North Carolina at Chapel Hill; [2]Osher Center for Integrative Medicine, University of California, San Francisco; and [3]Duke Integrative Medicine, Duke Center for Living Campus, Duke University

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Reciprocal Kindness Loop



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Cascade of Kindness

Physiological Impact

- Increased oxytocin
- Lowered blood pressure
- Increased serotonin
- Improved immune response*
- Stronger impact than exercising 4 x per week
- Decreased pain and anxiety
- Decreased mortality rate

Cascade of Kindness

Positive Mood on the Day of Influenza Vaccination Predicts Vaccine Effectiveness: A Prospective Observational Cohort Study.

Ayling et al

Brain Behav Immun. 2017 Sep 15. pii: S0889-1591(17)30423-3. doi: 10.1016/j.bbi.2017.09.008. [Epub ahead of print]

What About The Other Data

Data

- Event reporting increased [resident physicians]
- “Strong” process improvements increased
- Claims decreased
- Liability costs decreased
- Balance in self-insurance fund increased
- Annual amount to fund decreased
- Time to resolution continued to decrease
- Decrease in practice of defensive medicine

- **As physicians, we often prefer to: Diagnose and Treat** at times when our patients need us to
- **Listen and Learn**
- **As physicians, our reflex is often to distance ourselves and lean away** when our patients need us to
- **Come closer and lean in**
- **As physicians, we have lost our empathy and experienced unprecedented burnout** at a time when our patients need us to
- **Find our compassion and enhance our resilience**
- **As physicians we have been advised to delay, deny and defend** at a time when our patients rightfully need us to
- **Promptly confirm, reconcile and be kind**

- The CRP approach offers the paradigm shift to **meet the needs of our patients and ourselves;**
- It provides an opportunity to **listen and learn with trust and compassion.**
- An opportunity to **heal and move forward with resilience and confidence in a way that brings joy and meaning back to the workplace**
- Everyone in this room **is capable of catalyzing this necessary paradigm shift…**

- CANDOR benefits your conscience
- And you cardiovascular system
- CANDOR keeps patient/families from getting burned
- And prevents physicians from burning out
- CANDOR is good
- And good for you and your patients

Questions

THE C-SUITE/BOARD PERSPECTIVE

Timothy Dellit, MD (Associate Dean for Clinical Affairs, University of Washington and Associate Medical Director, Harborview Medical Center)

Gary Kaplan, MD, FACP, FACMPE, FACPE (Chairman and CEO, Virginia Mason Health System)

Stu Freed, MD, (CMO, Confluence Health)

Dave Knoepfler, MD, MBA, FACP, FHM (CMO, Overlake Medical Center)

Joanne Roberts, MD, MPH (Chief Clinical Officer, Western Washington at Providence St. Joseph Health)

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

A Defining Moment

SPECIAL 2005 PATIENT SAFETY GOAL ISSUE

CenterPIECES

Virginia Mason's Weekly Staff Newsletter

November 28, 2005

Mrs. Mary McClinton died in our care last year due to an error we made. Her life and untimely death were an inspiration to us to do everything possible to eliminate avoidable death and injury at Virginia Mason.

About this issue of CenterPIECES

This issue of CenterPIECES offers an overview of the work being done at Virginia Mason to make care safer and to recognize those who are doing that work. Many staff members are named in these pages, and our recognition also extends to the many staff members who are not personally named but whose efforts have been important to our patient safety goal.

Look for further recognition and updates on our 2005 patient safety goal – and information about our 2006 goal – in another special publication early next year. If you have any questions or comments about this issue of CenterPIECES, please contact Pat Schrepf at ext. 36090.

Our 2005 Patient Safety Goal
Ensure the Safety of our Patients:
Eliminate Avoidable Death and Injury

Above All, Do No Harm

— Hippocratic oath

When patients come to us for care, they expect that we will not harm them. A year ago, Mrs. Mary McClinton came to us with that expectation. We failed her. She died in our care due to an error we made.

We cannot undo that mistake, but we can, and have, promised her family, our patients, and ourselves that we will relentlessly work to eliminate avoidable death and injury at Virginia Mason. Anytime we feel that that job is too difficult or not possible, the example of this brave woman's life puts us back on track.

The first step in fulfilling our promise is to be thoroughly honest with ourselves about how we are doing. Frankly, we are in the early stages of becoming the organization we want to be – one that delivers safe care 100 percent of the time. But we are moving in the right direction and there is real progress – thanks to you.

We are recognizing all of our patient safety work teams in this special issue of CenterPIECES for their hard work in advancing our patient safety goals.

Gary S. Kaplan, MD, Chairman and CEO
J. Michael Rona, President

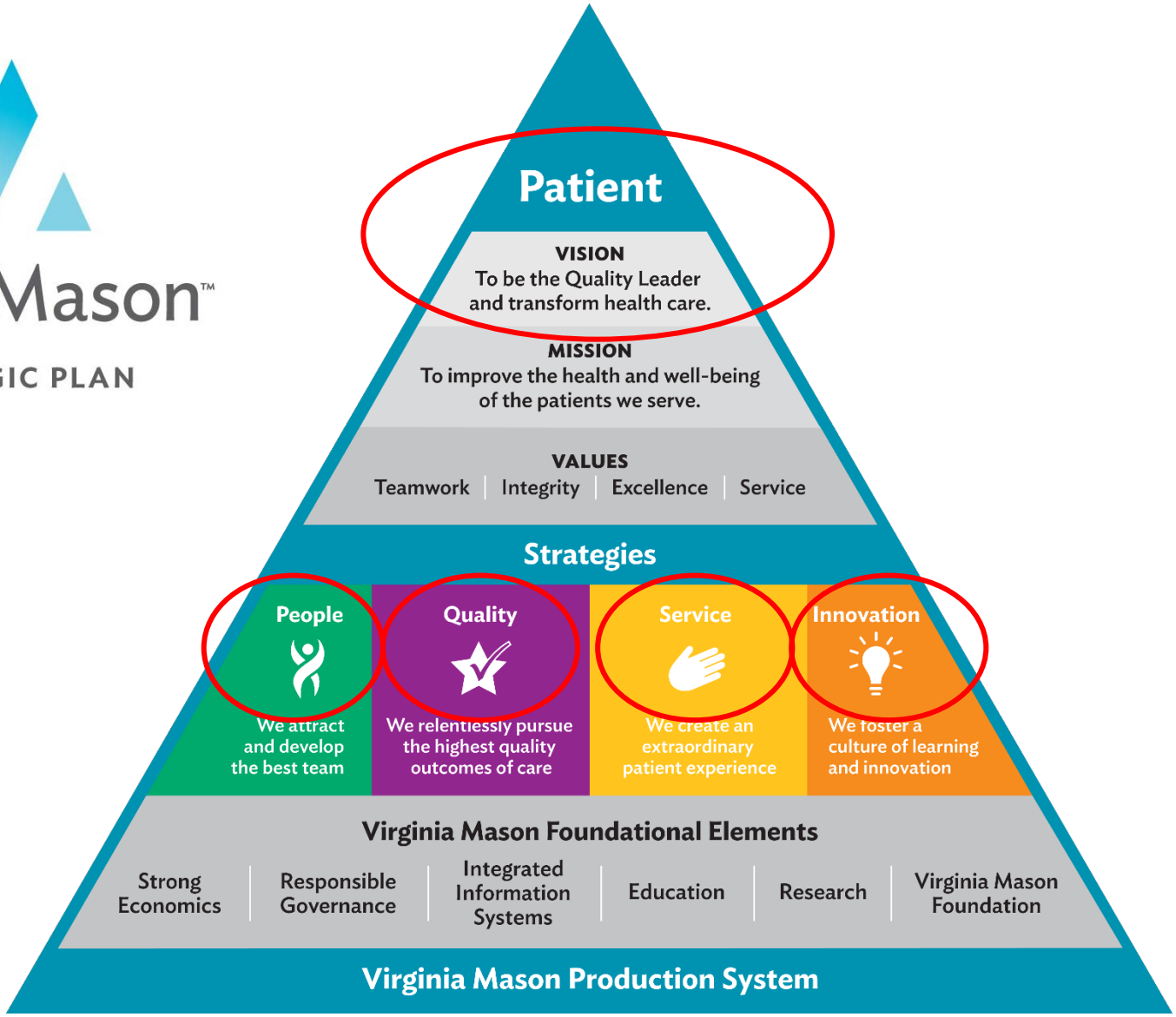
See back cover for an important announcement

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Virginia Mason™

OUR STRATEGIC PLAN



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

BREAK

10:00-10:10 AM

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

DESIGNING SAFETY

August de los Reyes

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT
FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

INTRODUCTION

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

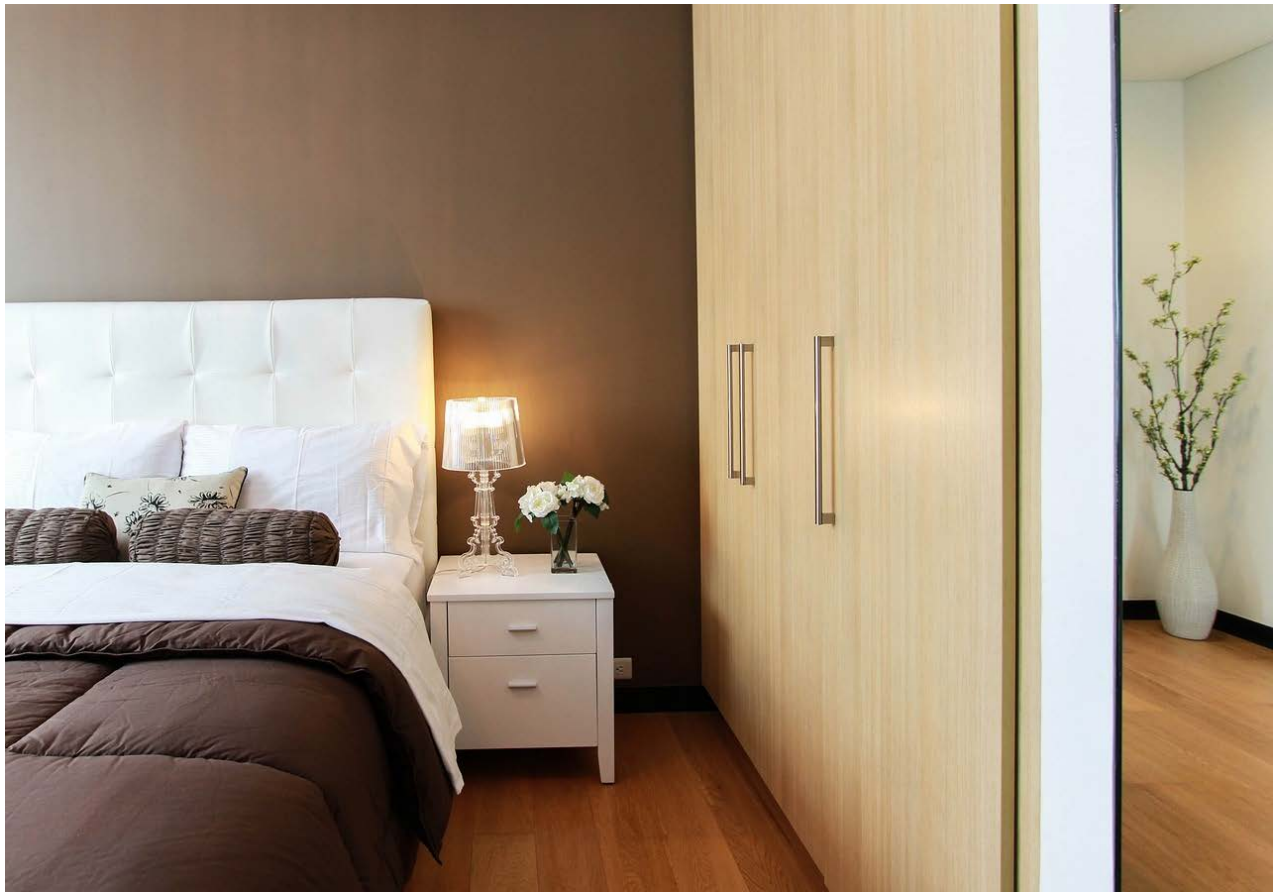
Quick Bio

- Projects I've worked on: Philips Sonicare, MSN Messenger, Windows, Surface, Samsung TVs
- Xbox
- Pinterest
- Part-time academic
- Harvard Design and Business
- Oxford Fellowship

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

The accident



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Current Situation

- Head of Design and Research at Pinterest
- 200M users
- Male admirers to female admirers
- Looking at what happened through a design lens

LIFE AS A DESIGNER

Before the accident

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

THINK UNIVERSAL.
ACT PERSONAL.

A GOOD IDEA STARTS WITH A LOT OF IDEAS

The case for multi-disciplinary design.

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

LIFE AS A DESIGNER

After the accident

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Three Ideas

- Accessibility
- Inclusive Design
- Patient Safety

INCLUSIVE DESIGN

Universal Design

Inclusive Design

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

DISABILITY REDEFINED

Medical → Societal

Mismatch

Disability = Designed

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

INCLUSION LEADS TO INNOVATION

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

More than curb cuts and door openers

- Telephone
- Keyboard
- Email protocols
- Database
- Bendable straw
- Electric toothbrush
- OXO Good Grips
- Closed Captioning

Love stories.

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

Think universal. *Act personal.*

Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

02.17.16 | THE BIG IDEA

Microsoft's Radical Bet On A New Type Of Design Thinking

By studying underserved communities, the tech giant hopes to improve the user experience for everyone.

Design, unbound: Xbox's **August de los Reyes** came to a new understanding of design after thinking about disability.

BY CLIFF KUANG LONG READ

On one otherwise unremarkable day in May 2013, August de los Reyes fell out of bed and hurt his back. Forty-two years old at the time, he was just six months into his dream job at Microsoft: running design for Xbox and

RELATED STORIES

GRAPHICS

Google Has A New Favorite Phrase–Here's

PASSION PROJECT

Passion Project

- Approach
  - System thinking
  - For example: Silicon Valley
  - What causes success or failure
- Plan
  - Planning: Research, Business, Technology
  - Multi-disciplinary workshop: from philosophers to architects to MDs
  - Brainstorm solutions
  - Create personal solution and scale
- Hypothesis

Hypothesis

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Passion Project

- 1 in 6M error rate
- Higher purpose
- No over-reliance on technology
- Integrated performance chain (concentrate on entire system)
- Acute visibility
- Keep it simple. Very simple.

CONCLUSION

When I was in the Neuro ICU

- *I want to make sure this does not happen to anyone else.*
- Family, friends, and literally all my neighbors
- Versed in medical history
- Assertive and articulate
- Has great health insurance and resources

- Could it happen to someone with lesser means, information, or resources?
- Could it happen to you?

THANK YOU!


Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

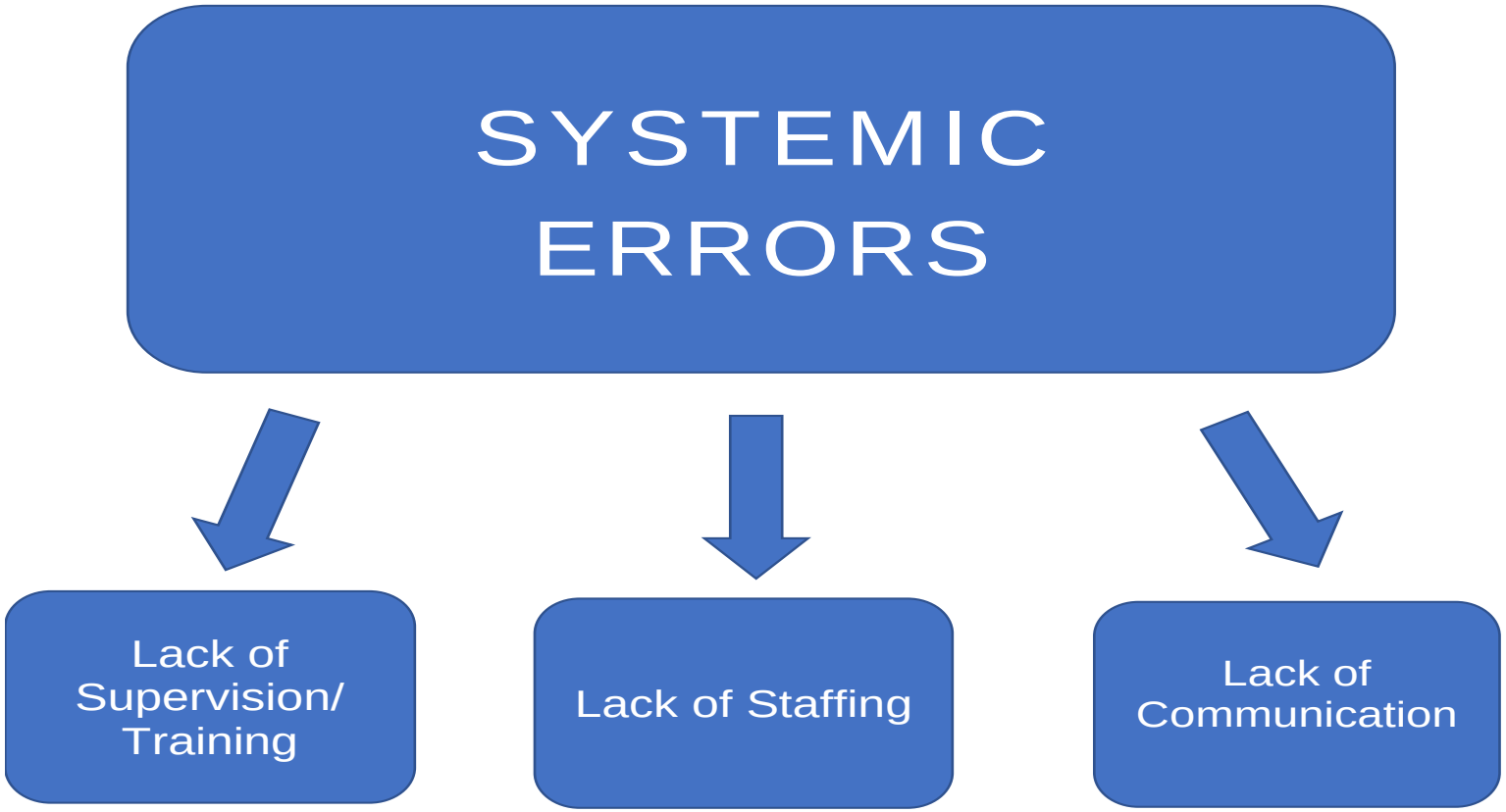

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

ATTORNEY PERSPECTIVE

Joel Cunningham

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

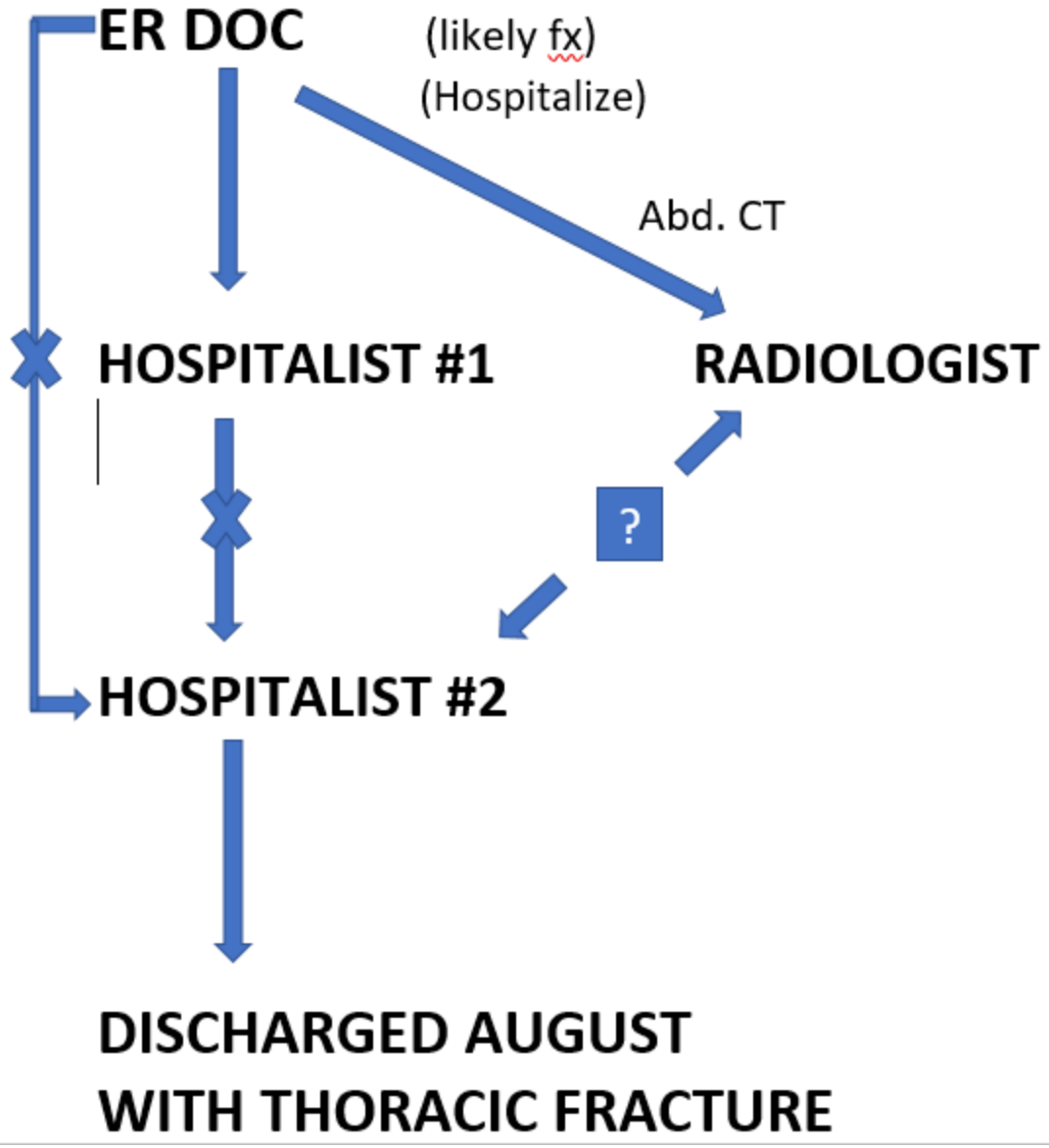

SYSTEMIC ERRORS
Lack of Supervision/ Training
Lack of Staffing
Lack of Communication

de los Reyes

1. Told them he had bamboo spine. AS.

2. Told them he fell and hurt his back and thought he might have a fracture.

3. Told them he wanted to be sure he had no fracture before discharge.


ER DOC
(likely fx)
(Hospitalize)
Abd. CT
HOSPITALIST #1
RADIOLOGIST
?
HOSPITALIST #2
DISCHARGED AUGUST
WITH THORACIC FRACTURE

Focus Studies

1. Doctors don't talk to each other anymore

2. He likely had A+ insurance (Microsoft)

3. He knew his disease and clearly described it to his doctors

4. If it could happen to a guy like that, it could happen to me

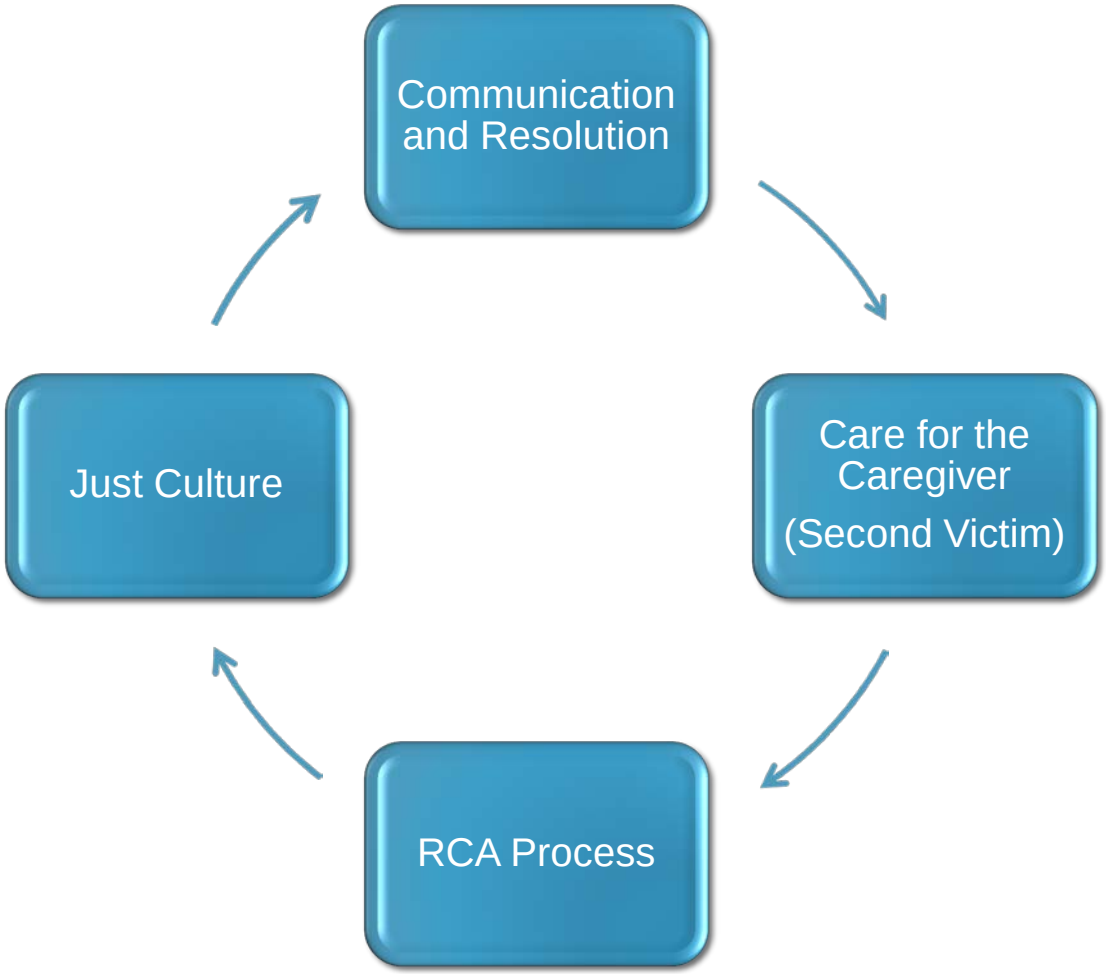
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

THE HOSPITAL PERSPECTIVE

Paula Bradlee, RN, CHRM

Director, Risk Management and Patient Safety


Communication and Resolution
Care for the Caregiver (Second Victim)
RCA Process
Just Culture

Specific Steps Taken

- Multiple internal reviews
- Post settlement, met with August to share and involve him in the process as we identify steps to be taken
- Meeting with Plaintiff Attorney for additional learning's
- Revamped and implemented Spine protocols
- Involved and educated ED and Hospitalist Groups about hand off process
- Initiated new process for Radiologists to access patient epic information
- Education throughout organization via On Our Watch, Communication and Resolution and RCA's

Overlake Learnings

- Don’t wait for mistakes to happen
- Know you will make mistakes
- Proactive preparation
- Communication, communication, communication
  - Transitions of care
  - Before, during and after an event
- Don’t be afraid to correct system issues right away
- Support everyone involved immediately and ongoing
- Develop a review process for transfers out of the facility
- Importance of a Just Culture
  - Speaking Up
- Share your stories- “Overlake On Our Watch”

TRANSFORMING MEDICAL LIABILITY IN MASSACHUSETTS

Northwest Communication and Resolution Program

September 27, 2017

MACRMI

Massachusetts Alliance for Communication and Resolution following Medical Injury

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Massachusetts Alliance for Communication and Resolution following Medical Injury

MITSS
Medically Induced Trauma Support Services

CRICO RMF
Protecting providers. Promoting safety.

COVERYS

MBA

Massachusetts Medical Society
Every physician matters, each patient counts.

Beth Israel Deaconess Medical Center

Baystate Health

MACRMI
Massachusetts Alliance for Communication and Resolution following Medical Injury

MHA Massachusetts Hospital Association
The leading voice for hospitals.

Board of Registration in Medicine

Massachusetts Coalition for the Prevention of Medical Errors

Atrius Health

STURDY MEMORIAL HOSPITAL

PARTNERS HEALTHCARE

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

"**CARe**" (Communication, Apology, and Resolution) is MACRMI's preferred way to reference the process.

What's Wrong with the Status Quo a/k/a Deny and Defend?

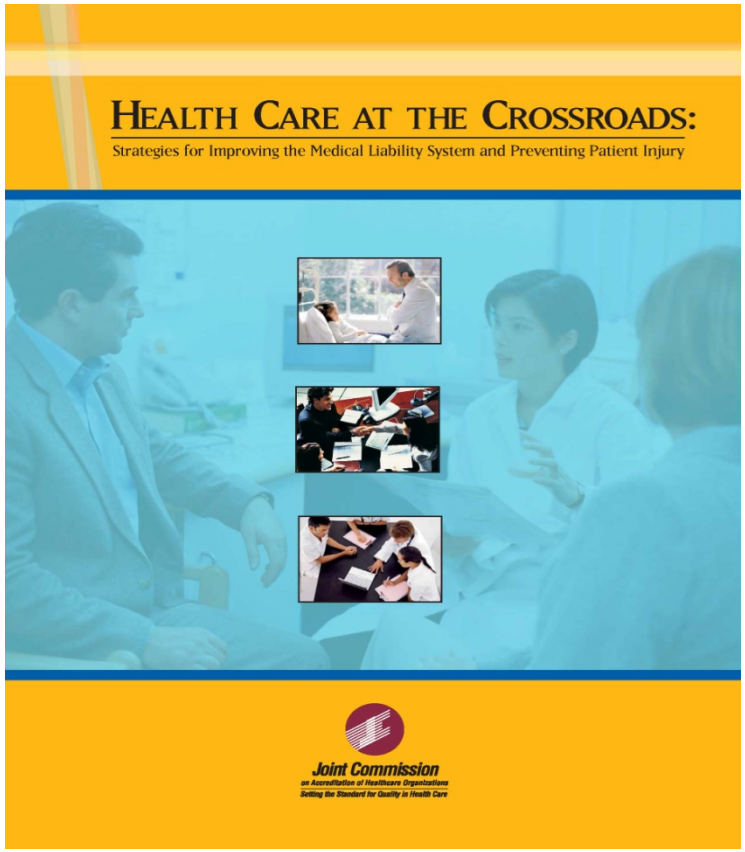
- **Patients** - unfair, slow, inequitable, inefficient, isolating and no apology
- **Physicians** - expensive, stressful, impacts health, modify practice and motivates defensive medicine
- **Healthcare system** - compromises patient safety, workforce and access to care and drives defensive medicine, healthcare costs and number of underinsured

Medical Liability Reform

- Tort system
  - Dysfunctional by any measure and limited ability to change
  - Reform can attenuate liability premiums
  - Minimal impact on defensive medicine

- A different system
  - A fundamental transformation
  - Fair, efficient, reliable, just and accountable
  - Supports patient safety improvement
  - Stops driving defensive medicine

DA&O Components

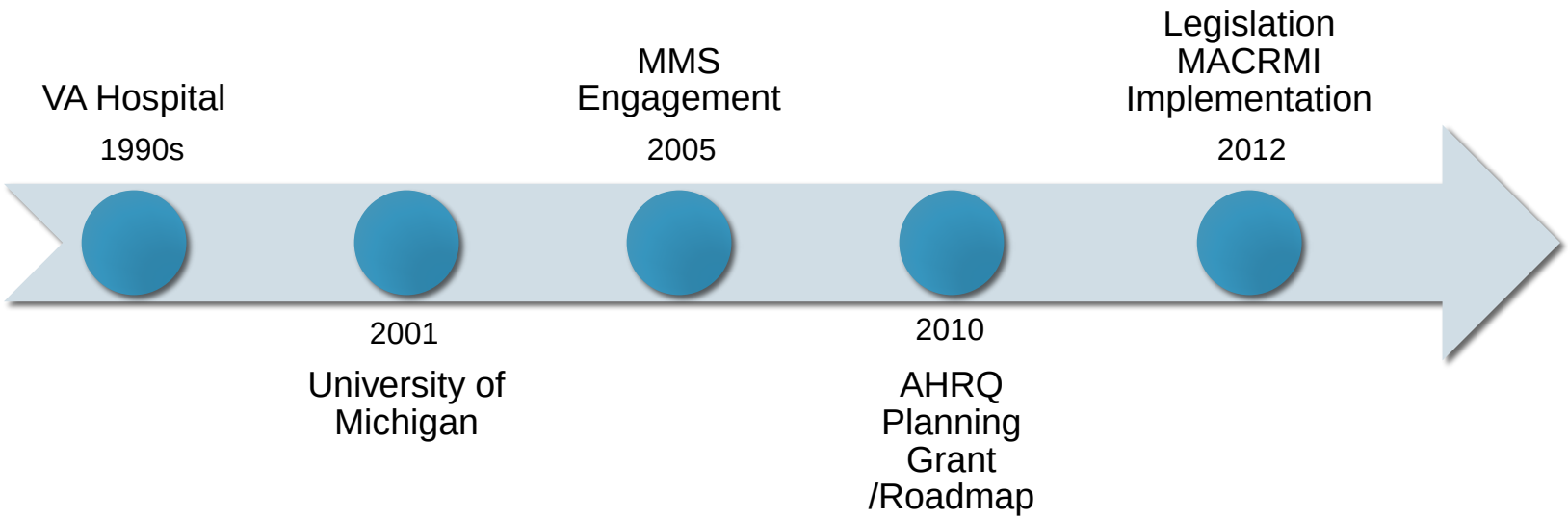


- Baseline “just culture” of safety
  - Root cause analysis and safety improvement
- Full disclosure
- Apology for avoidable injury
- Timely fair compensation
- Alternative dispute resolution
- Tort is the last resort

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

DA&O / CARe History through 2012



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Evidence: University of Michigan

- Started in 2001 (262 claims and > 300 open cases)
- By 2007, only 73 new claims and < 80 open cases
- Average case resolution time down from 20 months to 8 months
- Transaction expenses reduced $48k to < $20k/case
- Stopped buying reinsurance
- Reduced reserves $72M to <$20M, funding patient safety initiatives
- Court cases reduced more than 90% (1-2/yr)
- Provide unlimited coverage with lower premiums
- Incident reporting - increased many fold
- Culture change – fear reduced – no longer teach DM

AHRQ Planning Grant - Massachusetts

- 1 Yr - 300K AHRQ Planning Grant - MMS / BIDMC
- Key informant interview study of 27 knowledgeable individuals from all leading stakeholder constituencies in Massachusetts
- Twelve significant barriers were identified along with multiple strategies to overcome each one
- Strategies for each barrier were then evaluated and prioritized to develop our Roadmap
- **CARe is the best of all options for liability reform, the right thing to do and broad support exists for change**

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Barriers to Implementation

Barrier*	# of Respondents
Charitable immunity law	22
Physician discomfort with disclosure & apology	21
Attorneys' interest in maintaining the status quo	20
Coordination across insurers	20
NPDB or state reporting requirements	19
Concern about increased liability risk	16
Forces of inertia	13
Fairness to patients	12
May not work in other settings	11
Insufficient evidence	8
Supporting legislation	8
Accountability for the process	5

** Other barriers, not listed, were mentioned by <4 respondents*

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Roadmap: Overcoming Barriers

- Enabling Legislation - to create a supportive environment for broad adoption
- Education - programs for all involved parties
- Leadership - from all key constituencies
- Best Practices - support consistency
- Collaborative Working Groups - key issues
- Data Collection and Dissemination

MMS/MBA/ MATA

Alliance

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Liability Reform Provisions of Ch. 224

- Six Month Pre-Litigation Resolution Period*
- Sharing all Pertinent Medical Records*
- Apology Protection - unless contradictory*
- Full Disclosure - significant complication*
- Pre-judgment Interest Reduction - T+2
- Charitable Immunity Cap Increase - 100k

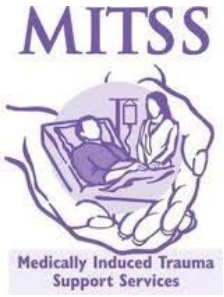
Signed into law as part of Chapter 224 - Payment Reform Legislation; Effective November 5, 2012

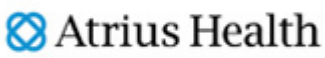
*** MMS, MATA & MBA Consensus**

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Massachusetts Alliance for Communication and Resolution following Medical Injury





"**CARe**" (Communication, Apology, and Resolution) is MACRMI's preferred way to reference the process.

What is Communication, Apology, and Resolution (CARe)?

- **Communicate** with patients and families when unanticipated adverse outcomes occur, and provide for their immediate needs.
- **Investigate and explain** what happened.
- Implement systems to **avoid recurrences** of incidents and improve patient safety.
- Where appropriate, **apologize** and work towards **resolution** including an offer of fair compensation without the patient having to file a lawsuit.

Transformational Change

Reactive	⇨	Proactive
Adversarial	⇨	Advocacy
Culture of secrecy	⇨	Full disclosure / transparency
Denial	⇨	Apology (healing)
Individual blame	⇨	System improvement
Patient/MD isolation	⇨	Supportive assistance
Fear	⇨	Trust
Defensive medicine	⇨	Evidence-based medicine

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Initial MACRMI Efforts

- Secured local funding
- Established Pilot Programs
- Launched Website
- Developed essential resources
- Hosted Annual Forums
- Clarified reporting requirements

Funding for Implementation

- AHRQ - $3M / 3Yr Demonstration Grant
  - $50M in ACA - no appropriation
- Local sources - all contributed
  - CRICO and BHIC for pilots
  - BCBS, HPHC, TAHP
  - Coverys, MMS & Reliant

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

The Massachusetts Pilot Sites

Site	#Beds	Location	Teaching (Y/N)
Beth Israel Deaconess Medical Center	642	Inner City	Y
BID-Milton	88	Community	N
BID-Needham	58	Community	N
Baystate Medical Center	716	Inner City	Y
Baystate Franklin Medical Center	93	Community	N
Baystate Mary Lane Hospital	31	Community	N
*Atrius Health**	*n/a*	*Ambulatory*	*N*
*Sturdy Memorial**	*128*	*Community*	*N*

**More recent programs not included in study*

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Website: www.macrmi.info

HORIZON INTERACTIVE AWARDS
BRONZE WINNER

MARCOM AWARDS

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

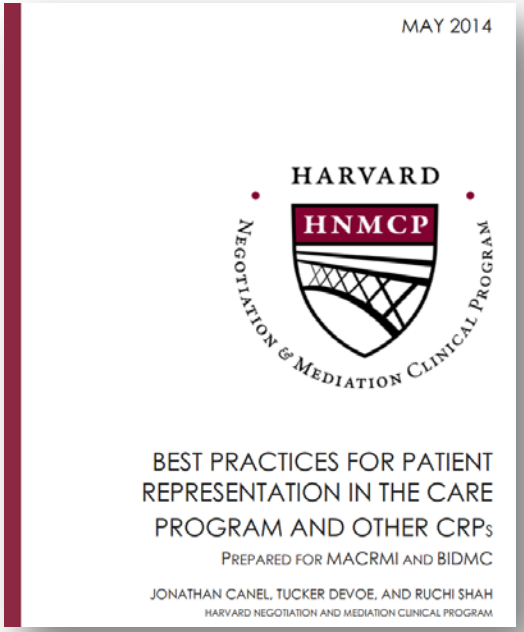
MACRMI Resources

- CARe Best Practices for institutions, patient interaction and patient representation
- Patient Brochure and Information Sheet
- Site Readiness Checklist
- Sample policies / procedures for implementing CARe FAQs for Patients, Providers and Attorneys
- Slide decks for teaching the concepts to clinicians - ID Badge instructions
- CARe Algorithms

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Best Practices for Patient Representation



- Legal representation should be encouraged during discussions of resolution

- Need Legal Community Buy-in
  - Providing attorneys with information about CARe and its benefits to help resolve cases early and collaboratively
  - Recommended hourly compensation

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

MACRMI Annual Forums (5th this past April)

ISSUE 01 SUMMER 2013

MACRMI News

Pilot Perspective

The first phase of the pilot CARe program implementation has been both a gratifying and learning experience for our BIDMC team. In such a large institution it's virtually impossible to shift the culture overnight. To maximize our chance of success, we focused on two major tasks: educating the leadership and front-line care providers about the goals and basic tenets of the CARe program, and defining along with our partners at Baystate the basic framework for identifying potential CARe cases as well as the institution's response to cases that were deemed suitable for CARe. This definition is important, since all adverse events deserve rapid communication to the patient and family and, when appropriate, an apology, but not all cases will be appropriate for full review by the hospital's insurer or discussions of financial compensation.

Going into the second half of our first year, we've learned a few key lessons. First, that ongoing communication with patients and

(Cont. on reverse)

this issue

The Forum panel participants commenting during the Open Q&A Session.

MACRMI Hosts its First Annual CARe Forum

On April 26, 2013, MACRMI hosted its First Annual CARe Forum at the Massachusetts Medical Society in Waltham, MA, to provide a larger audience with an in-depth look at the CARe approach. Speakers from Massachusetts and across the country came to educate the audience about CARe and programs like it. Over 150 clinicians, administrators, lawyers, and patients from around New England attended.

Dr. Alan Woodward, former president of Massachusetts Medical Society (MMS) and Chair of their Committee on Professional Liability, was first on the day's agenda, presenting the background and accomplishments of MACRMI. Dr. Kenneth Sands, Senior Vice President of Health Care Quality at BIDMC, then presented information about the CARe Pilot Sites, including the implementation process and the progress to date. Next, Dr. Michelle Mello, Professor of Law and Public Health at the Harvard School of Public Health and one of the nation's leading researchers in the field of medical liability, described the use of programs like CARe throughout the United States.

The Forum's keynote speaker was Jeffrey Driver, Chief Executive Officer of Stanford University Medical Network Risk Authority, LLC, and Chief Risk Officer of Stanford University Medical Center. Stanford has been using a program similar to CARe since 2005 called the PEARL Program (Process for Early Assessment and Resolution of Loss). PEARL involves some unique components: a 7-day ideal investigatory process flow; an online PEARL process request that can be launched by patients; and an independent patient advocate role for patient support and guidance in compensation meetings. Mr. Driver revealed a 38% reduction in overall liability costs and a 35% reduction in annual reported claims over 5 years.

The patient's perspective is essential to understanding adverse events, so a patient testimonial video was introduced by MITSS. Following the patient testimonial, Richard Boothman, Executive Director of the Office of Clinical Safety at the University of Michigan Health System, discussed the cultural shift he has seen at the University of Michigan after creating the "Michigan Model," an approach similar to CARe, for over a decade.

MACRMI's First Annual CARe Forum was an exciting and informative event. Videos of the slide presentations and speeches can be found on our website by clicking here, and downloadable slides are available here. By the next Forum, MACRMI expects to have many more accomplishments and hopes that more healthcare facilities will be implementing CARe and experiencing its benefits.

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

NPDB Reporting

NPDB-HRSA-HHS

Clarification that there must be a written demand for payment and that payment must be made on behalf of named MD

Added FAQs for CRPs in current guidelines

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Reporting Provision in State Budget

- Chapter 112 sect 5 of the General Laws is hereby amended by inserting the words: “provided, however, that payments made as part of a disclosure, apology and early offer program, shall not be construed to be reportable to or by the board against the physician, absent a determination of substandard care rendered on the part of said physician.

Proposed by MMS Signed 7/12/13

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Recent Efforts

- Continued work to disseminate the CARe model in MA, regionally and nationally
- Developed multiple additional resources
- Facilitated CARe Educational Forums for Attorneys and initiated list
- Completed pilot data collection / analysis on nearly 1000 CARe cases
- Collected 1 Yr of data on provider perceptions of the CARe process

MA / Regional Dissemination

- Partners Hospitals are planning to adopt CARe; NWH has launched and BWH, and BWH Faulkner are in planning phases
- Interest from several other MA hospitals and organizations including Coverys
- Yale attending MACRMI meetings and CHA applying for AHRQ grant to utilize our model

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

National Efforts

- CAI, the Collaborative for Accountability and Improvement has come together to work on National Implementation of CRPs (Best Practices, Communication, and Policy and Advocacy)

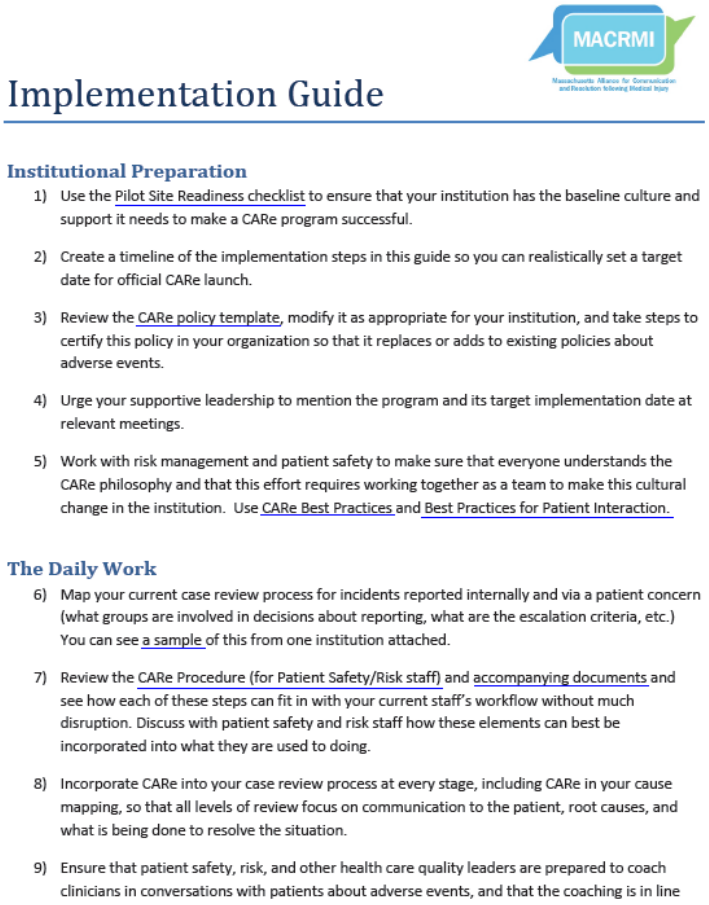
- MACRMI has presented at NPSF, IHI, AMA and in several states to increase awareness

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

CARe Implementation Guide

- Designed for institutions interested in implementing the CARe Program
- To be used with personal assistance from our implementation team
- Lays out timeline of important tasks, and links to relevant MACRMI resources for each step in the process



MACRMI

Implementation Guide

Institutional Preparation

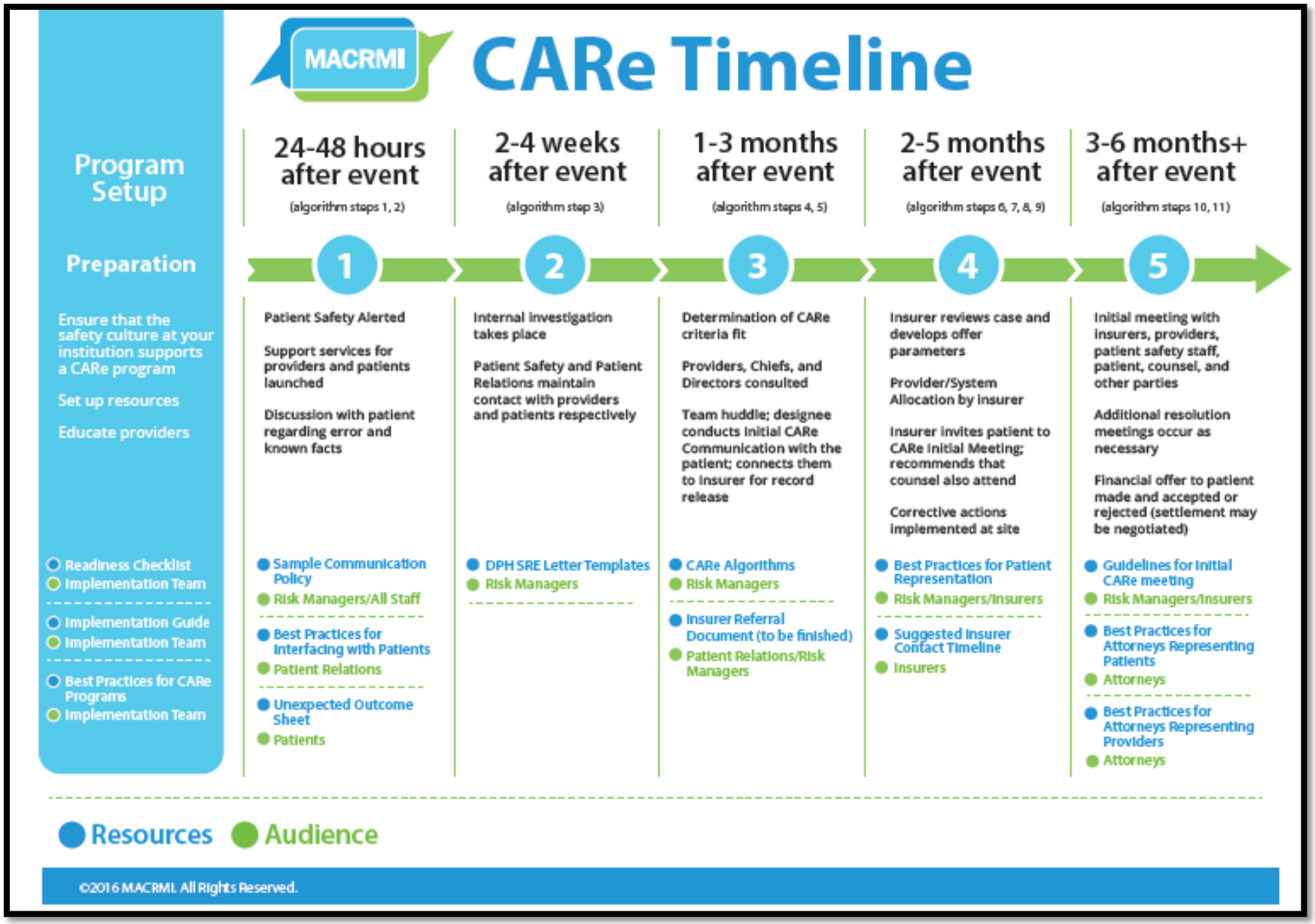
1) Use the Pilot Site Readiness checklist to ensure that your institution has the baseline culture and support it needs to make a CARe program successful.
2) Create a timeline of the implementation steps in this guide so you can realistically set a target date for official CARe launch.
3) Review the CARe policy template, modify it as appropriate for your institution, and take steps to certify this policy in your organization so that it replaces or adds to existing policies about adverse events.
4) Urge your supportive leadership to mention the program and its target implementation date at relevant meetings.
5) Work with risk management and patient safety to make sure that everyone understands the CARe philosophy and that this effort requires working together as a team to make this cultural change in the institution. Use CARe Best Practices and Best Practices for Patient Interaction.

The Daily Work

6) Map your current case review process for incidents reported internally and via a patient concern (what groups are involved in decisions about reporting, what are the escalation criteria, etc.) You can see a sample of this from one institution attached.
7) Review the CARe Procedure (for Patient Safety/Risk staff) and accompanying documents and see how each of these steps can fit in with your current staff's workflow without much disruption. Discuss with patient safety and risk staff how these elements can best be incorporated into what they are used to doing.
8) Incorporate CARe into your case review process at every stage, including CARe in your cause mapping, so that all levels of review focus on communication to the patient, root causes, and what is being done to resolve the situation.
9) Ensure that patient safety, risk, and other health care quality leaders are prepared to coach clinicians in conversations with patients about adverse events, and that the coaching is in line

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Attorney Best Practices-Seminars-List

- MBA and MACRMI jointly developed Best Practices for Attorneys representing patients or providers in the CARe process
- Jointly sponsored seminars to educate attorneys about CARe
- Suggested list

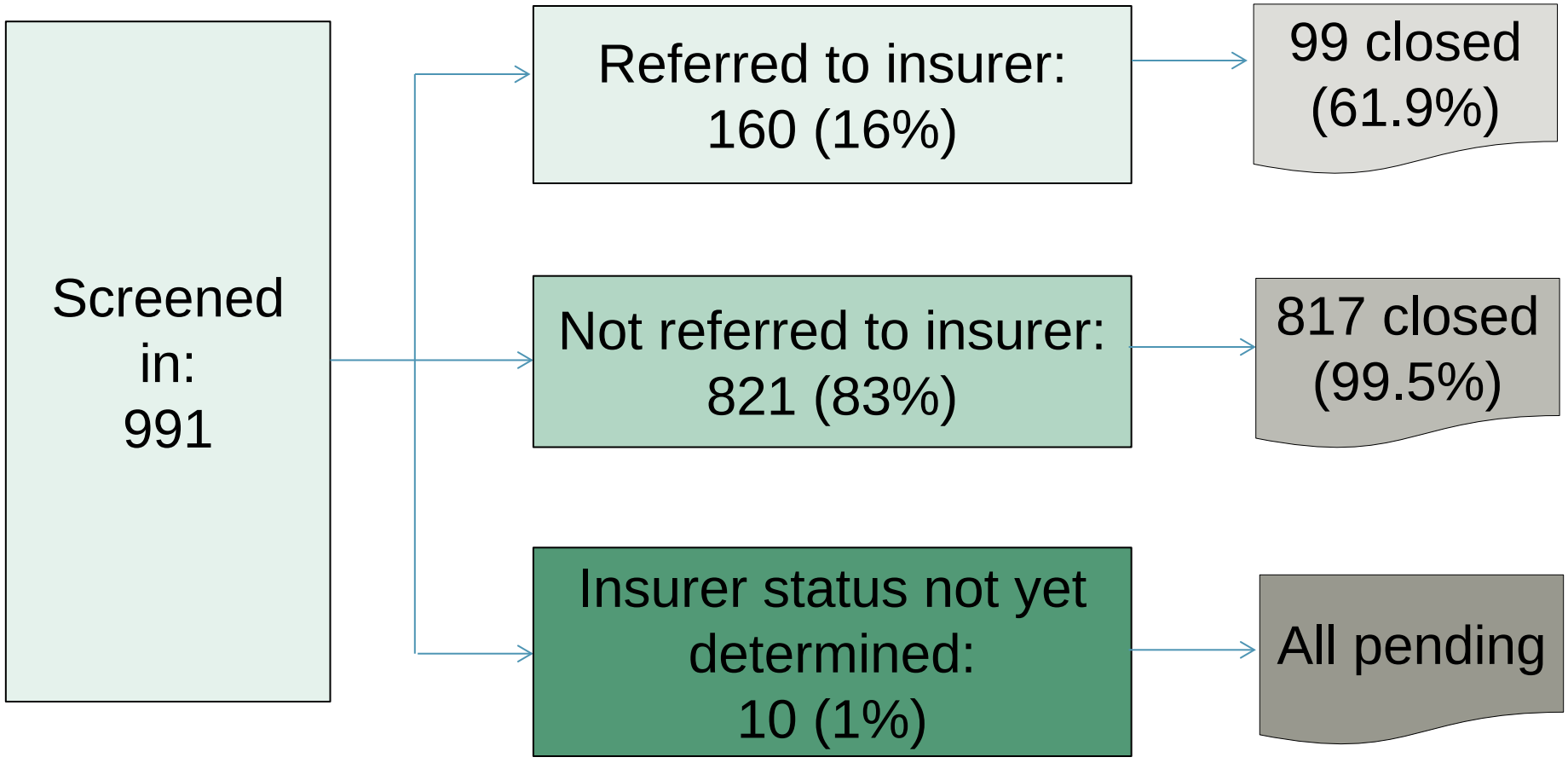
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Areas of Investigation

Data Collected	Outcomes
• Institution-level data on volume and costs of claims and lawsuits • Case-specific data for each adverse event that meets study criteria • Survey of providers involved in a CARe case • Interviews with key personnel • Monthly pilot site check-in calls	1. **Institutional and Case-level outcomes** 2. **Provider Satisfaction with CARe** 3. **CARe implementation experiences**

Preliminary Massachusetts Data



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Who First Reported the Event?

	n	%
Internally reported	705	71.1
Patient/family	249	25.1
Attorney	32	3.2
Patient's insurance company	4	0.4
Regulatory agency	1	0.1

Preliminary Conclusions

- CARe does not lead to an avalanche of new claims
- Most of the work of CARe is communicating about non-error events
- Compensation costs were modest and overall costs did not increase and may well result in cost savings in next few years
- CARe can be implemented without negative liability consequences even when hospitals are faithful to CARe protocol

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

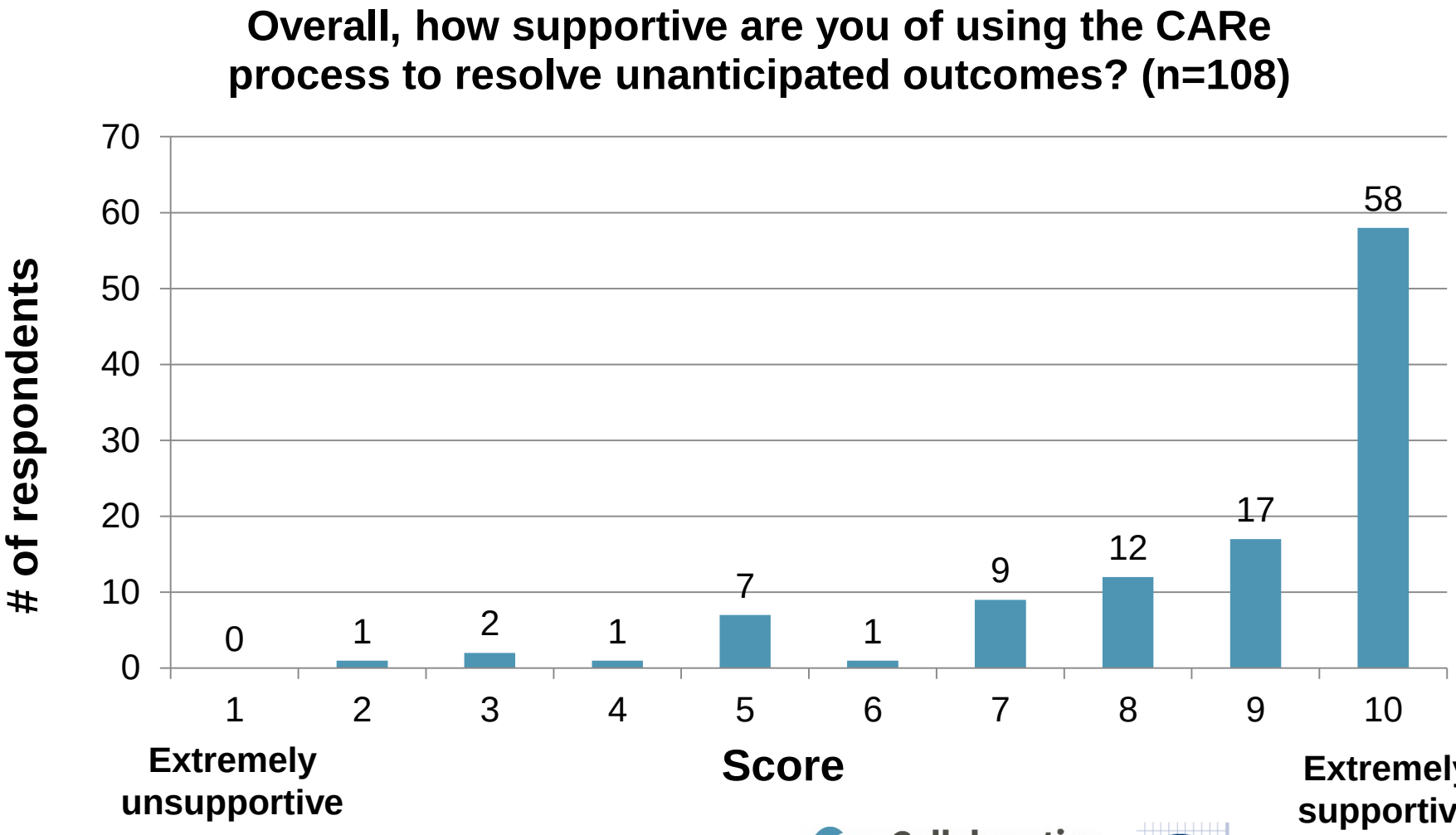
Provider Satisfaction Survey

- Responses received from 182 / 270 (67%)
- Respondent demographic snapshot:
  - **78%** physicians or physician trainees
  - **10%** <35 years old, **31%** 35-44, **35%** 45-54, **24%** >54
  - Top 3 clinical specialties: **Surgery**, **Ob/Gyn**, and **Internal Medicine**

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Providers are supportive of CARe overall



* 74 respondents said they did not know enough to answer this question.

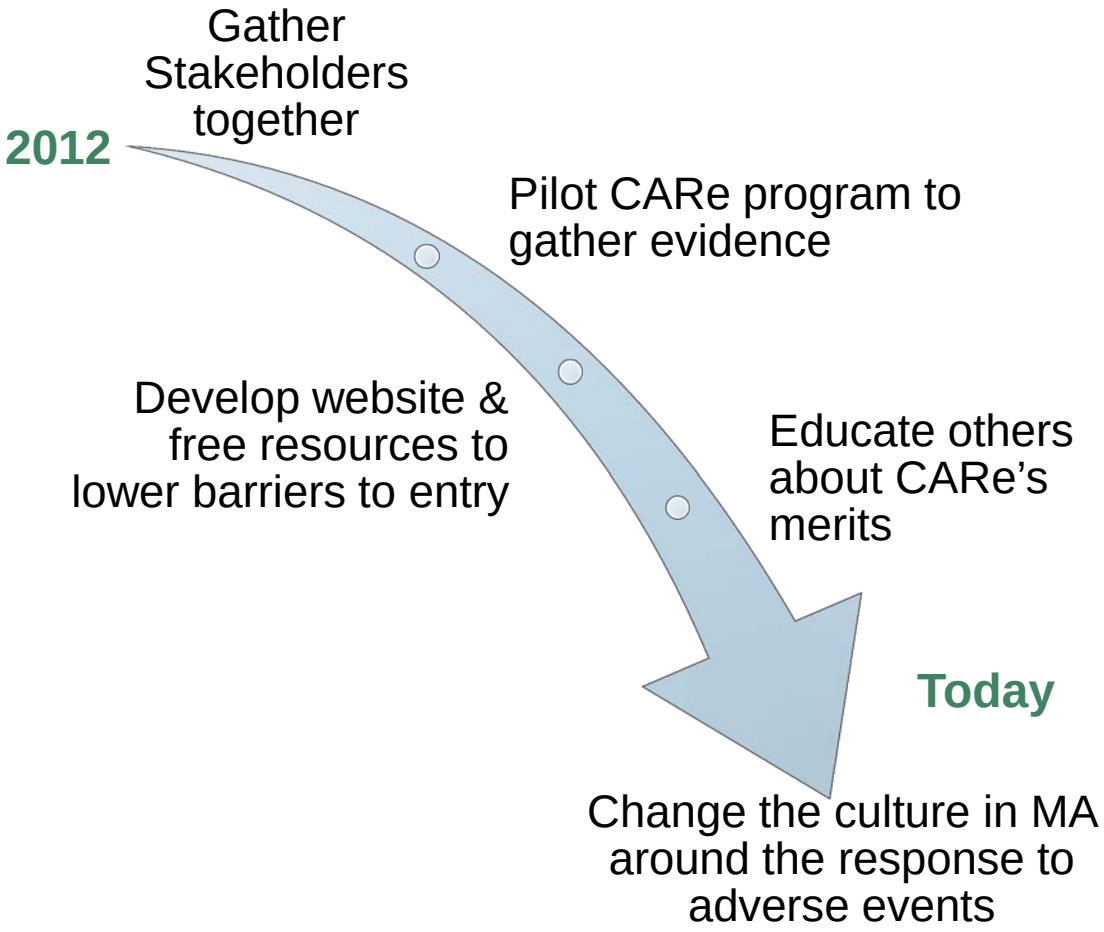
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Factors Facilitating Successful Implementation

- Deep engagement by high-level physician champions
- Strong buy-in from risk management
- Practical support and oversight by project managers
- No barriers erected by insurer
- Pre-existing just culture commitment
- Sense of community and support from MACRMI

MACRMI's Journey



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Where we're going…

- Developing Best Practices for Insurers
- Adding additional CARe sites in MA
- Continuing regional and national dissemination efforts (CAI)
- Submitting analyses for publication
- Maintaining MACRMI and its resources

Conclusion - Multiple Benefits

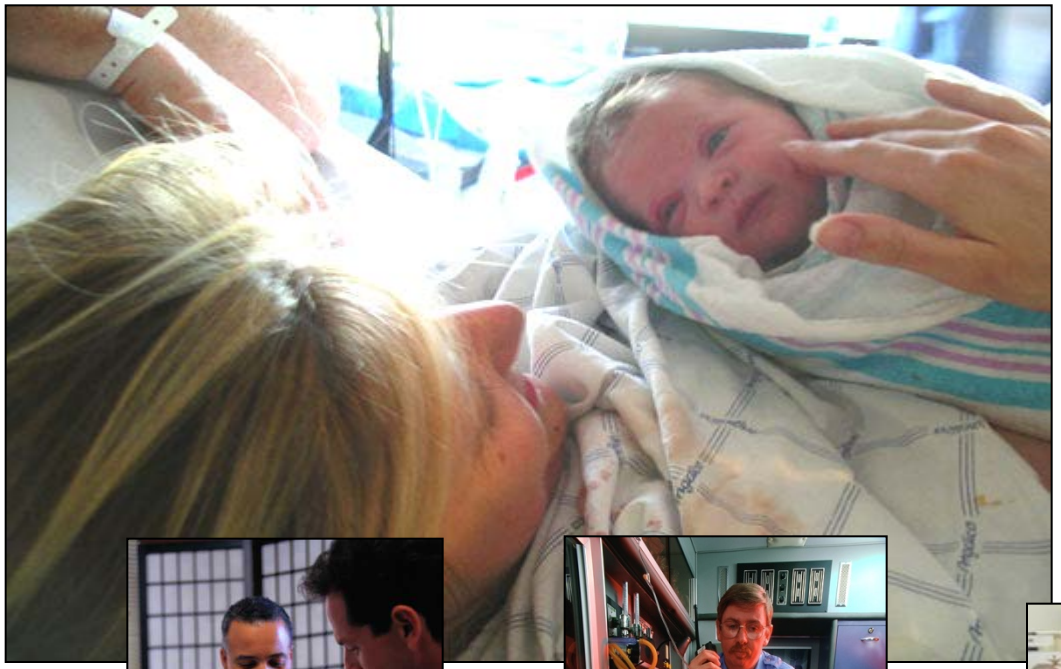
Right and Smart thing to do

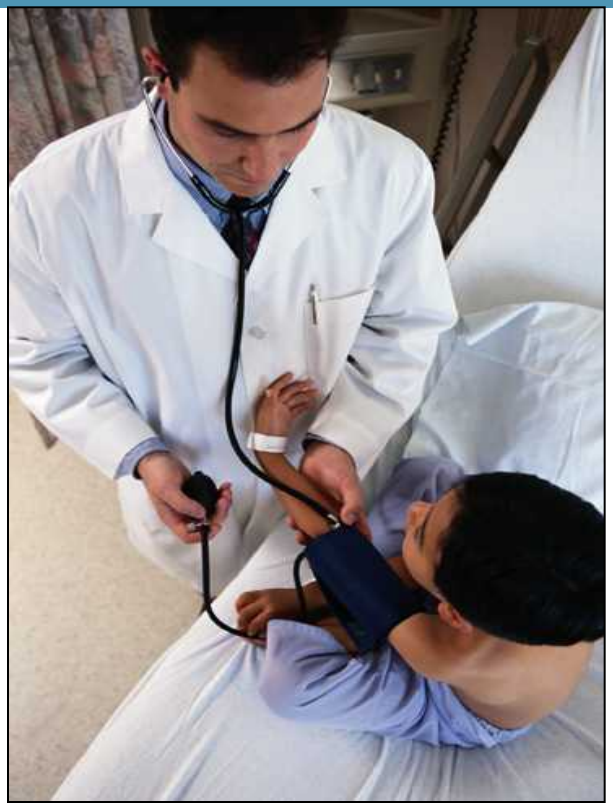
- For Patients (you)
- For Patient Safety
- For Providers
- For Hospitals / ACOs
- For Healthcare Access and Affordability

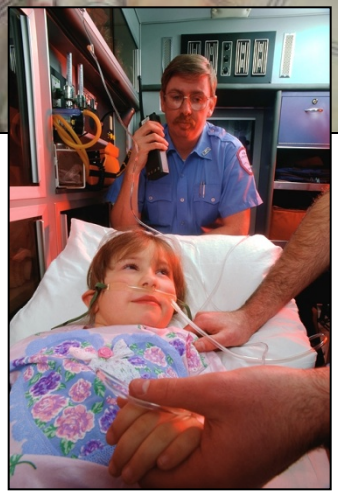
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Questions







Collaborative
FOR ACCOUNTABILITY
AND IMPROVEMENT

FOUNDATION FOR
HEALTH CARE QUALITY
www.qualityhealth.org

LUNCH

12:00-12:30 PM

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

THE ATTORNEY PERSPECTIVE

Joel Cunningham, JD (Luvera Law Firm)

John Rosendahl, JD (FAVROS)

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

CRP

1. Tell patients what happened
2. Try to put things right
3. Improve safety for the future

Plaintiff's Bar: Lack of Trust

1. Just another attempt at so-called "tort reform" (Camel's nose under the tent)

2. Real purpose is to discourage lawsuits, reduce payouts

3. If it increases recovery, medical insurance industrial complex will abandon it

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

How Can Plaintiff's Bar be Enticed to Use It

1. Completely voluntary – not legislative enforcement

2. Make process very simple and cost effective

3. Prove that it works for patients as well as healthcare providers

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

COMMUNICATION AND RESOLUTION PROGRAMS

One Insurer's Perspective

Deanna Tarnow, BA, RN, CPHRM
Senior Director, Risk Management and Patient Safety
BETA Healthcare Group

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

BETA Healthcare Group

- Largest professional liability insurer of hospitals on the west coast
  - >250 hospitals and healthcare facilities
  - > 50 medical groups
  - Nearly 6,000 physicians
- Worker's compensation for >40,000 healthcare workers in California
- Suite of alternative risk and insurance services
- Efforts focused on risk management and safety; patient and healthcare workforce

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

BETA HEART℠

Healing • Empathy • Accountability • Resolution • Trust

Purpose

Promote organization-wide culture change and instill trust, that results in improved partnerships with patients, patients' families and caregivers

Goal

Introduce a holistic approach to reducing harm in healthcare

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Where We Began

September, 2015
Communication and Disclosure Workshop
When Words and Actions Matter Most

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Groundwork and Due Diligence

- Internal work group - Senior leaders and project lead
- Core team - Internal work group + Board members
  - Met monthly
  - Developed process and methodology
- Researched current efforts nationally
- Created incentive structure
- Engaged California-based partners
- Hosted defense counsel meetings
- Drafted endorsement and policy language

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Culture	Event Investigation	Care for Caregiver	Communication & Transparency	Early Resolution
Annual measurement and analysis of staff perceptions of safety utilizing a baseline measurement strategy Includes sharing of results utilizing a debriefing process Adoption of a Just Culture philosophy and application of Just Culture principles in investigation of and organizational response to adverse events	Timely and thorough - supports a fair and accountable culture in context of high reliability Applies human factors science principles Includes development and application of cognitive interview skills Organizational accountability for development of safe systems Includes input from patient and families	Development of a peer support program Process for identification and support for individuals affected or involved in events Includes training of peer supporters	Response to patient and family is immediate Development of empathic communication process that includes open and ongoing dialogue after an adverse event Development of a communication resource team	When patient harm is the result of inappropriate care or medical error, a process for resolution prior to the filing of a lawsuit May include financial resolution or non-financial resolution such as inclusion in patient safety efforts, providing evidence of process improvements, etc.

Culture

- Includes measurement and analysis of staff perceptions of safety utilizing a scientifically validated survey instrument
  - >60% response rate required
  - Recommend SCORE survey instrument
  - Includes sharing of results utilizing a debriefing process
  - Requires designated survey lead
- Adoption of a Just Culture philosophy and application of Just Culture principles
  - Reflected in HR and adverse event policy

Culture Domains	Alpha Score
Learning Environment	0.935
Local Leadership	0.964
Burnout Climate	0.902
Personal Burnout	0.924
Teamwork	0.821
Safety	0.869
Work Life Balance	0.820

Engagement Domains	Alpha Score
Growth Opportunities	0.918
Workload	0.844
Job Uncertainty	0.894
Intentions to Leave	0.898
Advancement	0.885
Participation in Decision Making	0.881

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Rapid Event Detection, Analysis and Determination

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Rapid Event Detection, Analysis & Determination

Cognitive Interviewing Techniques

Based on Science of Memory Retrieval

Interviewee asked to mentally revisit the event picture through the eyes of an observer

Communication and Transparency

- Assess skills
- Develop core team
- Immediate
- Empathic
- Measure response time

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Care for Caregiver

Recognizing the impact of patient harm on those closest to the event – the healthcare provider

- Development of an organizational program
- Identifies and supports those impacted by the event
- Development of peer supporters
- Process for referral

Early Resolution

Must meet all harm event detection, investigation and determination of care criteria

- Process that re-establishes trust
  - Apology
  - Taking responsibility
  - Commitment to improvement
  - Reparation

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

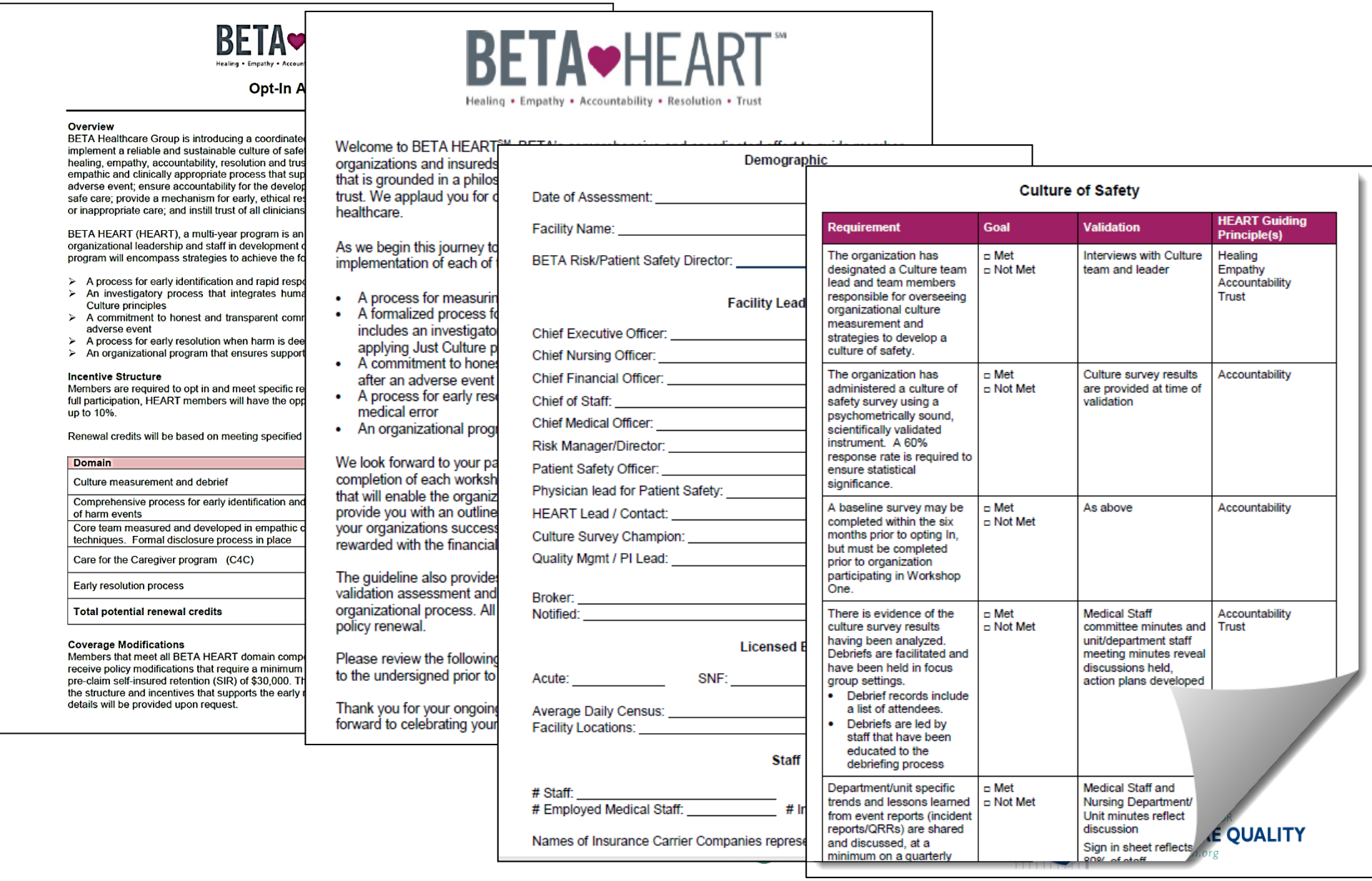
Partnership and support

- Host three consecutive two-day workshops
  - Up to eight participants from each facility
  - BETA covers travel costs for participating organizations
- Webinar based culture survey training
  - Survey prep / facility mapping
  - Executive leader results analysis
  - Debrief methodology
- Individual event analysis workshops
- Ongoing availability of communication assessments
- Developing peer supporter training modules
- Living toolkits for each domain

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Opt-In Agreement and Published Guideline



BETA HEART℠

Healing • Empathy • Accountability • Resolution • Trust

Opt-In A

Overview

BETA Healthcare Group is introducing a coordinate implement a reliable and sustainable culture of safe healing, empathy, accountability, resolution and trus empathic and clinically appropriate process that sup adverse event; ensure accountability for the develop safe care; provide a mechanism for early, ethical re or inappropriate care; and instill trust of all clinicians

BETA HEART (HEART), a multi-year program is an organizational leadership and staff in development program will encompass strategies to achieve the fo

- A process for early identification and rapid respo
- An investigatory process that integrates huma Culture principles
- A commitment to honest and transparent comm adverse event
- A process for early resolution when harm is dee
- An organizational program that ensures support

Incentive Structure

Members are required to opt in and meet specific re full participation, HEART members will have the opp up to 10%.

Renewal credits will be based on meeting specified

Domain
Culture measurement and debrief
Comprehensive process for early identification and of harm events
Core team measured and developed in empathic techniques. Formal disclosure process in place
Care for the Caregiver program (C4C)
Early resolution process
Total potential renewal credits

Coverage Modifications

Members that meet all BETA HEART domain comp receive policy modifications that require a minimum pre-claim self-insured retention (SIR) of $30,000. Th the structure and incentives that supports the early details will be provided upon request.

Welcome to BETA HEART℠. BETA's comprehensive and coordinated approach provides members organizations and insureds that is grounded in a philos trust. We applaud you for healthcare.

As we begin this journey to implementation of each of

- A process for measurin
- A formalized process fo includes an investigato applying Just Culture p
- A commitment to hones after an adverse event
- A process for early res medical error
- An organizational progr

We look forward to your pa completion of each worksh that will enable the organiz provide you with an outline your organizations success rewarded with the financial

The guideline also provides validation assessment and organizational process. All policy renewal.

Please review the following to the undersigned prior to

Thank you for your ongoing forward to celebrating your

Demographic

Date of Assessment: _____

Facility Name: _____

BETA Risk/Patient Safety Director: _____

Facility Lead

Chief Executive Officer: _____
Chief Nursing Officer: _____
Chief Financial Officer: _____
Chief of Staff: _____
Chief Medical Officer: _____
Risk Manager/Director: _____
Patient Safety Officer: _____
Physician lead for Patient Safety: _____
HEART Lead / Contact: _____
Culture Survey Champion: _____
Quality Mgmt / PI Lead: _____

Broker: _____
Notified: _____

Licensed B

Acute: _____ SNF: _____

Average Daily Census: _____
Facility Locations: _____

Staff

Staff: _____
Employed Medical Staff: _____ # In

Names of Insurance Carrier Companies represe

Culture of Safety

Requirement	Goal	Validation	HEART Guiding Principle(s)
The organization has designated a Culture team lead and team members responsible for overseeing organizational culture measurement and strategies to develop a culture of safety.	▫ Met ▫ Not Met	Interviews with Culture team and leader	Healing Empathy Accountability Trust
The organization has administered a culture of safety survey using a psychometrically sound, scientifically validated instrument. A 60% response rate is required to ensure statistical significance.	▫ Met ▫ Not Met	Culture survey results are provided at time of validation	Accountability
A baseline survey may be completed within the six months prior to opting In, but must be completed prior to organization participating in Workshop One.	▫ Met ▫ Not Met	As above	Accountability
There is evidence of the culture survey results having been analyzed. Debriefs are facilitated and have been held in focus group settings. • Debrief records include a list of attendees. • Debriefs are led by staff that have been educated to the debriefing process	▫ Met ▫ Not Met	Medical Staff committee minutes and unit/department staff meeting minutes reveal discussions held, action plans developed	Accountability Trust
Department/unit specific trends and lessons learned from event reports (incident reports/QRRs) are shared and discussed, at a minimum on a quarterly	▫ Met ▫ Not Met	Medical Staff and Nursing Department/ Unit minutes reflect discussion Sign in sheet reflects	

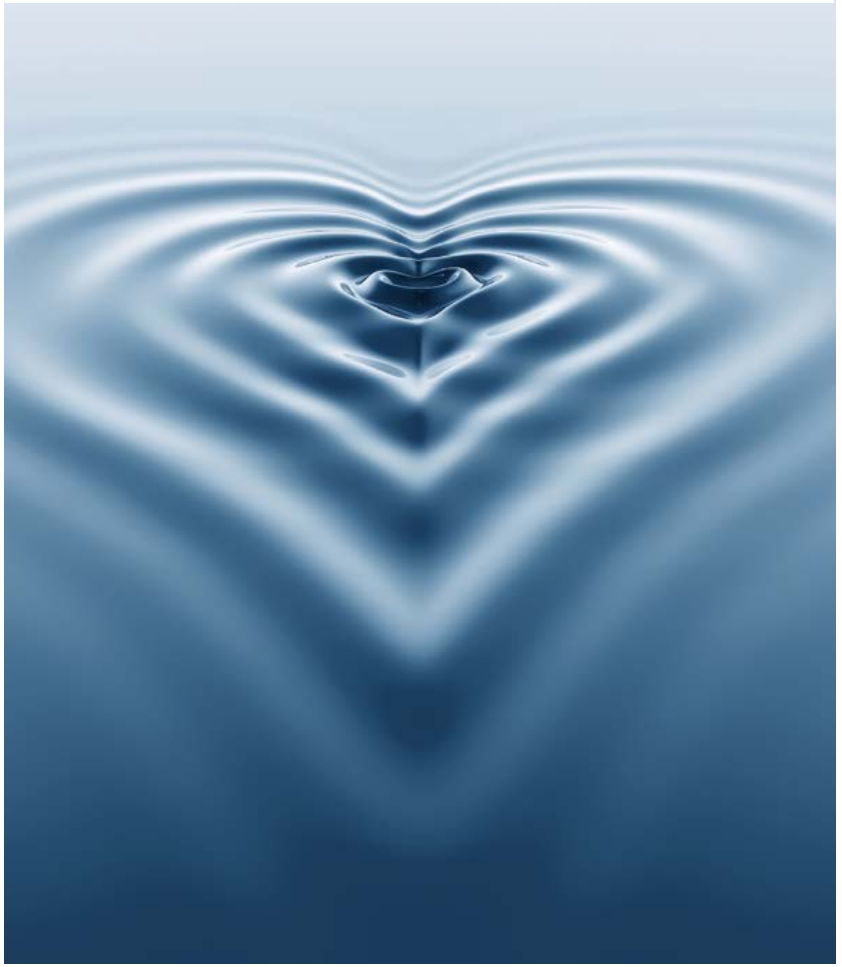
E QUALITY

Where We Are Today

BETA HEART℠

Healing • Empathy • Accountability • Resolution • Trust

- 21 hospitals
- 700+ gap analysis participants
- >13,000+ SCORE surveys returned
- 3 workshops covering five domains
- 459 participating HEART members attended workshops
- 82+ communication assessments
- 10 rapid event detection workshops
- 161 HEART webinar participants
- 5 toolkits developed
- September 7, 2017 launched Wave Two



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

THE INSURER PERSPECTIVE

Beth Gomez, RN, BSN, JD (Manager, Coverys Risk Management)

Eric Holm (Vice President, Claims, Physicians Insurance A Mutual Company)

Victoria H. Rollins, MHA, RN, CPHRM, CPPS (Director of Patient Safety Programs, The Doctors Company)

Deanna Tarnow, RN, BA, CPHRM (Director of Risk Management & Patient Safety, BETA Healthcare Group)

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

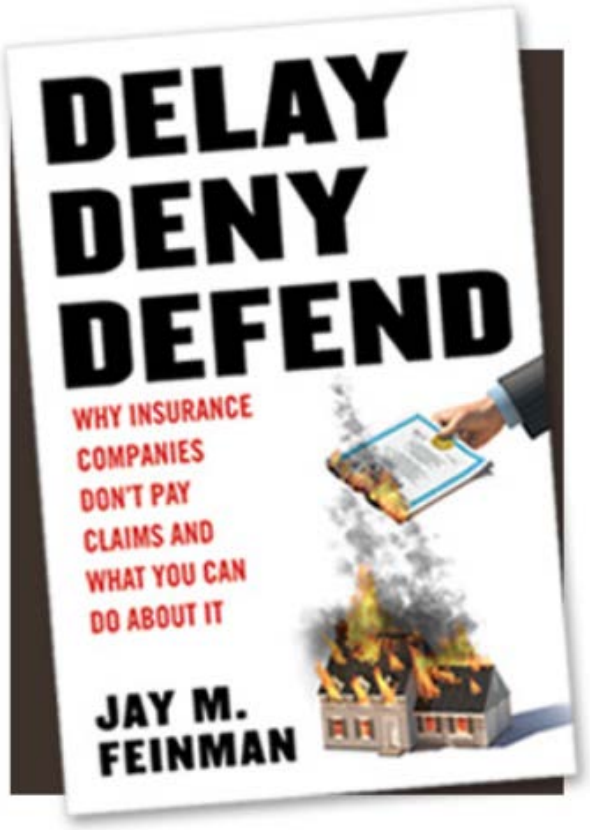
A RISK MANAGER'S PERSPECTIVE

Marcia Rhodes

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

https://www.hagen-law.com/blog/insurance-industry-no-pay-tactics-delay-deny-defend/



BUSINESS 12/13/2011 05:24 pm ET | Updated Dec 13, 2011

Insurance Claim Delays Deliver Massive Profits To Industry By Shorting Customers

Interviews from industry insiders demonstrated the intent of the strategy, a strategy developed by McKinsey Consulting. One insider, the author of "From Good Hands to Boxing Gloves", elaborated on the strategy. Essentially, it was a strategy of **Delay, Deny and Defend.**

1. Delay settlement offers until the injured party would have no financial alternative but to accept less than fair case value
2. Deny payment and liability in an effort to stall and enhance their settlement position.
3. Defend the case, even if with clear liability, to force attorneys to spend time and money on the file, making a successful verdict a financial loser for the attorney and plaintiff.

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

ASHRM Perspective

Mission: To advance patient safety, reduce uncertainty and maximize value through management of risk across the healthcare enterprise

- 2001 TJC adopts disclosure standard as part of new Patient Safety Standards
  - Mandated disclosure raised questions about ramifications – patient, care provider, legal
  - Not much in the literature about financial ramifications
- 2003 Released a series of three monographs on Disclosure of Unanticipated Events
  - The next step in better communication
  - Creating an effective patient communication policy
  - What works now and what can work even better

ASHRM 2013 Monograph

What's Changed?

- More states have apology laws (4 to 36)
- True psychological and pyscho-physical effects on providers recognized
- Evidence published that transparency and appropriate apology win trust and may reduce costs

What's Still the Same

- Legal considerations
- Disclosure is still hard
- Appropriate apology remains difficult

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

ASHRM - What Have We Learned

- “Transparency, open communication & disclosure are part of a continuum of communication”
  - Vulnerability makes it different from other difficult conversations
- To increase the willingness of providers to disclose, the culture must shift to support provider and staff human-ness”
- Disclosure is a process and not an event
- Most state apology laws are, in essence, empathy laws
- Lawsuits will still exist

CRP Ecosystem Components

- Health Care Institutions
  - Regulatory & Accreditation Requirements
  - Patient-Centered Care
    - Commitment to patient-autonomy
    - Transparency
  - Taking Care or Care Providers:
    - Just Culture
    - Support for Second Victims
- How We Pay for CRPs: Insurance & Self-Insurance
- How We Resolve Legitimate Disputes: The Legal System

Regulatory & Accreditation Factors

- “Adverse Event” Reporting
- Disclosure of Adverse Outcomes of Care
- Conditions of Participation/Patient Rights - Grievances
- Apology Law
- Settlement negotiations and Post-remedial measures cannot be used as evidence of wrong doing

Patient Centered Care

The IOM (Institute of Medicine) defines **patient-centered care** as:

> "Providing **care** that is respectful of, and responsive to, individual **patient** preferences, needs and values, and ensuring that **patient** values guide all clinical decisions."

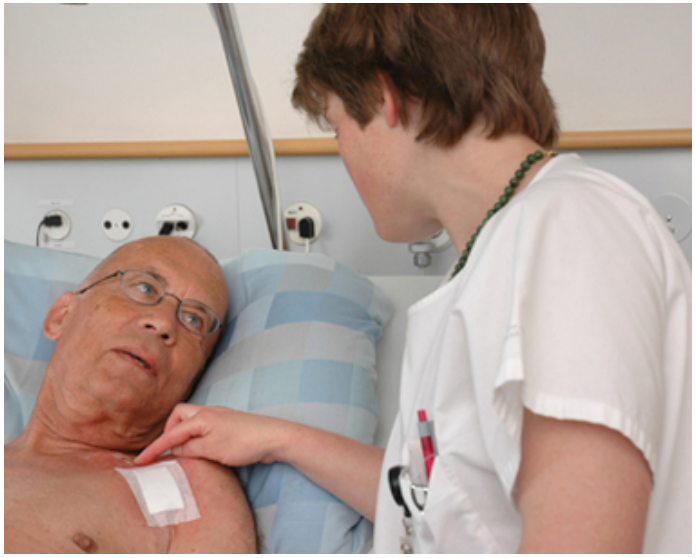
May 15, 2015

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

CRPs as Patient Centered Care

- Informed Consent
  - Supports patient autonomy
  - Forms the basis for the trust in a provider-patient relationship
- Transparency: Disclosure of all unanticipated outcomes is a continuation of the informed consent discussion
- Accountability: Natural extension of disclosure



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Accountability, Resolution & Patient Safety

- Why resolution matters
  - Requires us to actively listen and act on patient input
  - Validates that patients/families have been “heard”
  - It says the clinician/institution is accountable
  - Provides closure to patients/families who are grieving a loss of time, function or life
- Accountability & resolution in a Just Culture
  - Promotes a sense of justice for all – patient & clinician
  - Clinician participation in prevention helps them heal

Health Care Leaders are the Key

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

WHAT TYPE OF ECOSYSTEM SUPPORT IS NEEDED FOR CRPS?

- Risk Financing
- Legal System

Insurance & Self-insurance

- Transfer of financial risk is based in the “terms and conditions” of the insurance contract
- Key Provisions that drove the “Deny & Defend” mindset
  - The insurer accepts a premium and, in turn, promises to defend the insured
  - The insured promises not to compromise the defense of a claim or “prejudice a defense”
- Insurers are increasingly embracing CRPs
  - Insurers are market-driven AND
  - Must protect their financial assets

Insurers / Self-Insureds / Reinsurers

- Financial support for a CRP program to work within the insurance provisions so that coverage is not voided
- Provide consultation and support for disclosure, acknowledgement of harm and early mitigation efforts
- Develop a framework for dispute resolution with co-defendants' insurers or reinsurers
  - Is it time to set up a mediation process, arbitration panel, or private trial structure so that patients can be made whole and apportionment of fault can occur in an orderly way after the settlement?

THE LEGAL SYSTEM

Defense Lawyers

- Counsel clients to responsibly manage a CRP case
- Recognize CRP cases and promote early settlements
  - Provide input as to the reasonable settlement value for CRP cases
  - Discovery may still be needed to establish damages
- Collaborate with plaintiff's bar as necessary to work toward settlement
  - Negotiation of Medicare or third-party payer liens
  - Assist with mediation efforts as necessary
- Litigation if the parties can't agree

Plaintiff Lawyers

- Provide support & counsel to patients and their families:
  - Appropriateness of the explanation by the institution/provider
  - Reasonableness of settlement offers
  - Medicare or secondary-payer liens
  - Court-approval of settlements for minors
- Litigation if the parties can’t agree

CURRENT STATE

CRPs in WA

- Some progress has already been made:
  - CRP Certification Program is established
  - MQAC is trialing the CRP Certification Program and has incorporated CRP & Just Culture principles into its review processes
  - Many individual institutions and providers have adopted CRP approaches
- Greater trust and understanding is needed to broadly implement CRPs in WA
- Let's start where we all are in agreement – We want to reduce patient harm and achieve fair resolutions when harm does occur

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Are You In?

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

BREAK

2:15-2:30 PM

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

EVENT REPORTING AND ANALYSIS

Dana Kahn, PharmD, BCPS, MHA
Administrative Director, Quality and Safety
Virginia Mason Medical Center
Timothy McDonald, MD, JD
Director, Center for Open and Honest Communication
MedStar Institute for Quality and Safety

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT
FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

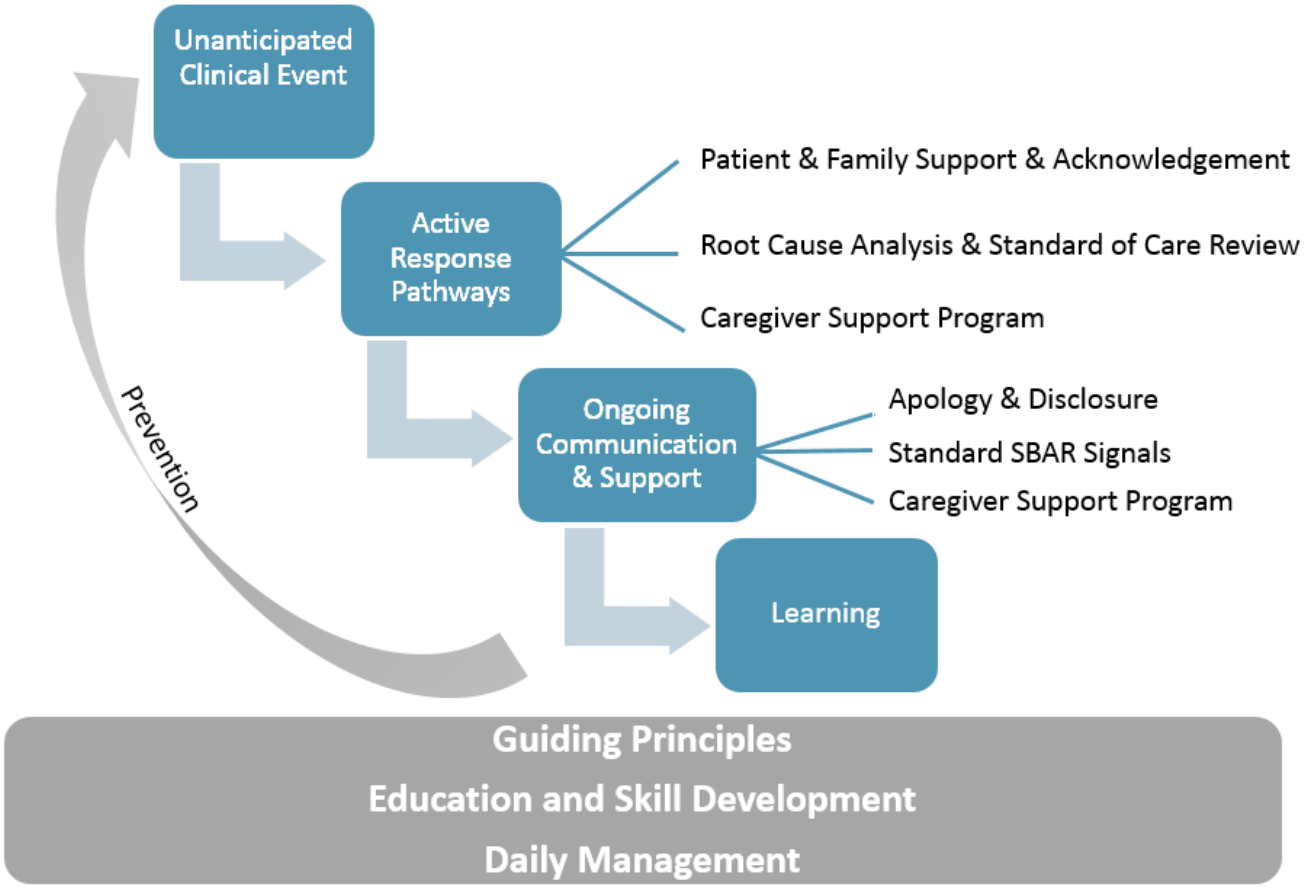
Virginia Mason Health System

- Integrated health care system
- 501(c)3 not-for-profit
- Virginia Mason Hospital (Seattle, 336 beds)
- Virginia Mason Memorial (Yakima, 226 beds)
- 38 Clinics
- Graduate Medical Education
- Research Institute
- Foundation
- Virginia Mason Institute

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Principled, comprehensive, and systematic approach to responding to unanticipated clinical events



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

“Stop the Line”

2002

A Defining Moment

SPECIAL 2005 PATIENT SAFETY GOAL ISSUE

CenterPIECES

Virginia Mason's Weekly Staff Newsletter

November 28, 2005

Mrs. Mary McClinton died in our care last year due to an error we made. Her life and untimely death were an inspiration to us to do everything possible to eliminate avoidable death and injury at Virginia Mason.

About this issue of CenterPIECES

This issue of CenterPIECES offers an overview of the work being done at Virginia Mason to make care safer and to recognize those who are doing that work. Many staff members are named in these pages, and our recognition also extends to the many staff members who are not personally named but whose efforts have been important to our patient safety goal.

Look for further recognition and updates on our 2005 patient safety goal – and information about our 2006 goal – in another special publication early next year. If you have any questions or comments about this issue of CenterPIECES, please contact Pat Schrepf at ext. 36090.

Our 2005 Patient Safety Goal
Ensure the Safety of our Patients:
Eliminate Avoidable Death and Injury

Above All, Do No Harm

— Hippocratic oath

When patients come to us for care, they expect that we will not harm them. A year ago, Mrs. Mary McClinton came to us with that expectation. We failed her. She died in our care due to an error we made.

We cannot undo that mistake, but we can, and have, promised her family, our patients, and ourselves that we will relentlessly work to eliminate avoidable death and injury at Virginia Mason. Anytime we feel that that job is too difficult or not possible, the example of this brave woman's life puts us back on track.

The first step in fulfilling our promise is to be thoroughly honest with ourselves about how we are doing. Frankly, we are in the early stages of becoming the organization we want to be – one that delivers safe care 100 percent of the time. But we are moving in the right direction and there is real progress – thanks to you.

We are recognizing all of our patient safety work teams in this special issue of CenterPIECES for their hard work in advancing our patient safety goals.

Gary S. Kaplan, MD, Chairman and CEO
J. Michael Rona, President

See back cover for an important announcement

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

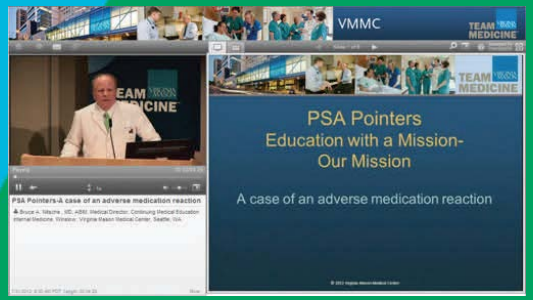
Promoting a Safety Culture

Annual Mary L. McClinton Patient Safety Award

"A Good Catch" Safety Award

Patient Safety Champion
Virginia Mason

Safety Huddles



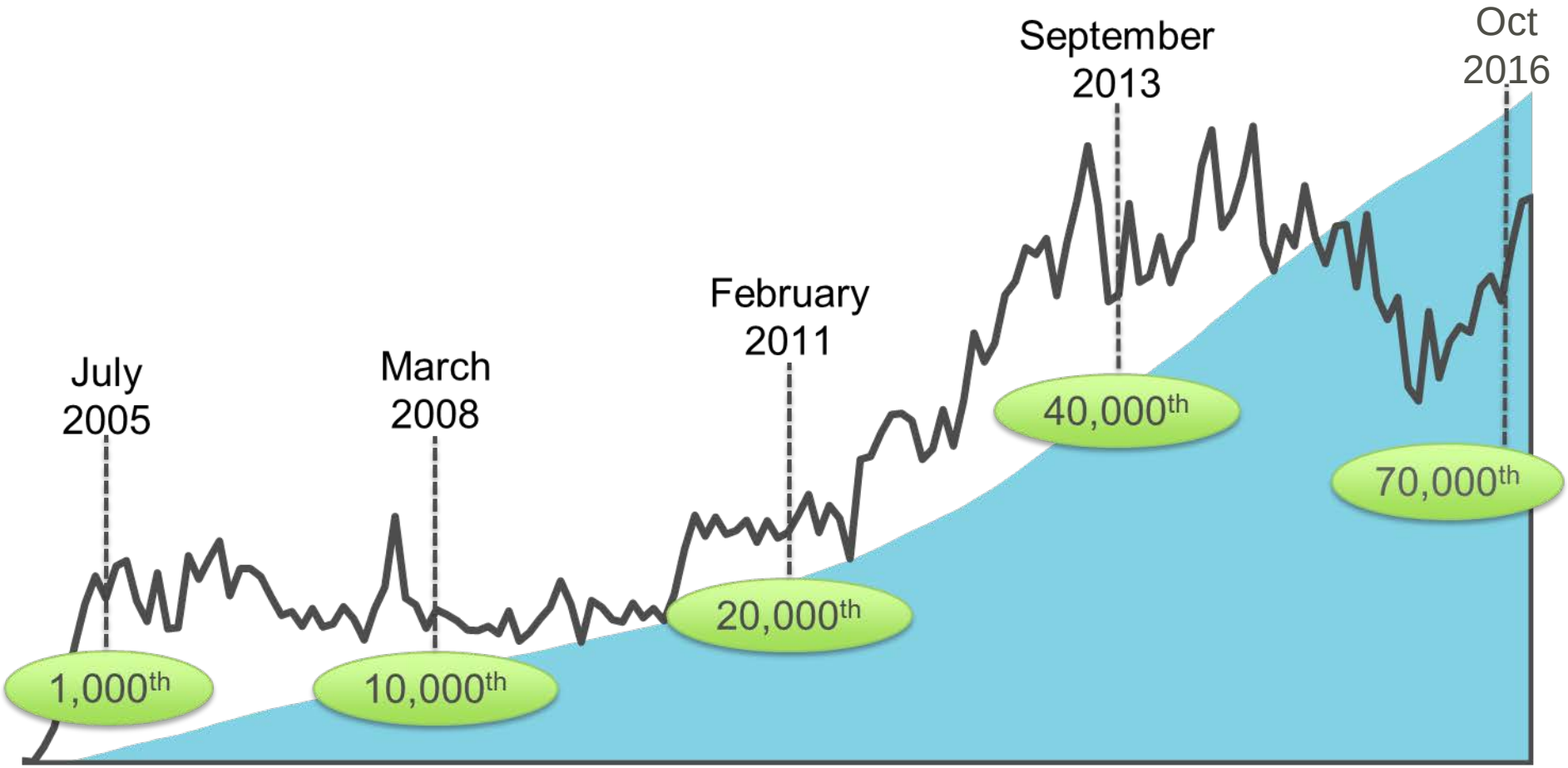
PSA Milestone Celebrations
75,000th PSA reported

Patient Safety Week

Virginia Mason

Darwin J. Liao Memorial Lecture in Patient Safety and Quality

Over 70,000 PSAs

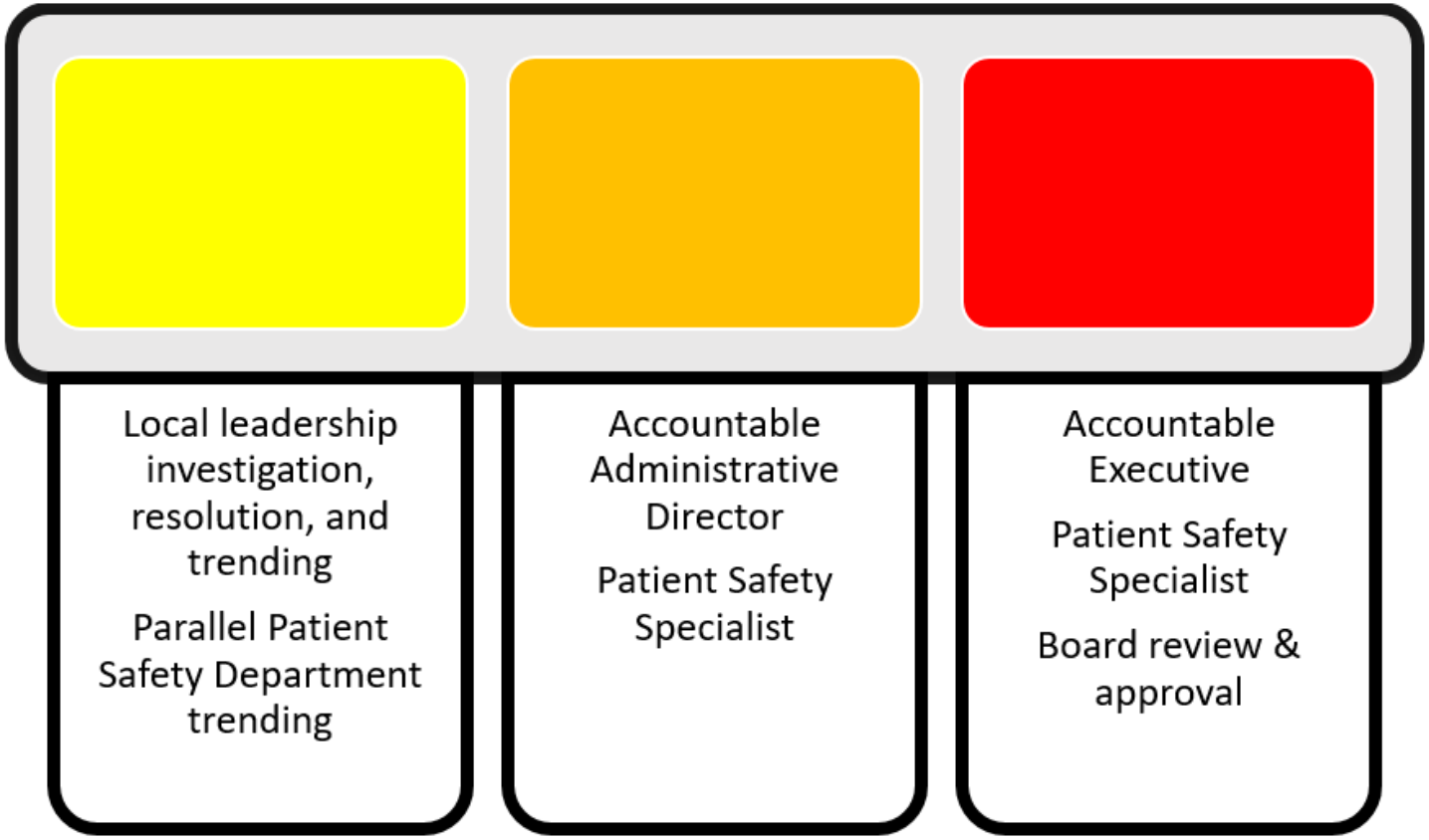


As of February 1, 2017: 73,048

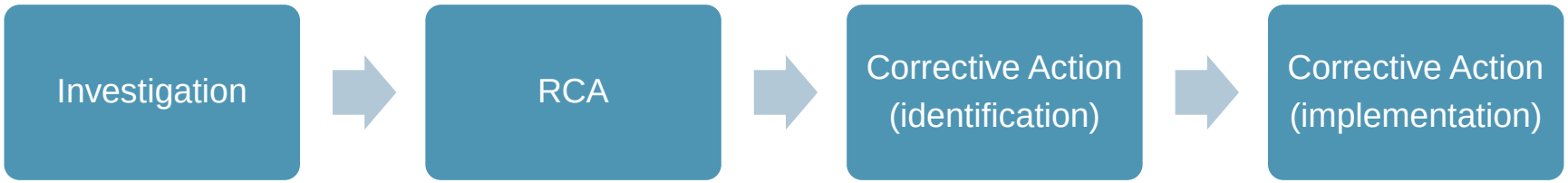
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

PSA categories



Key Phases



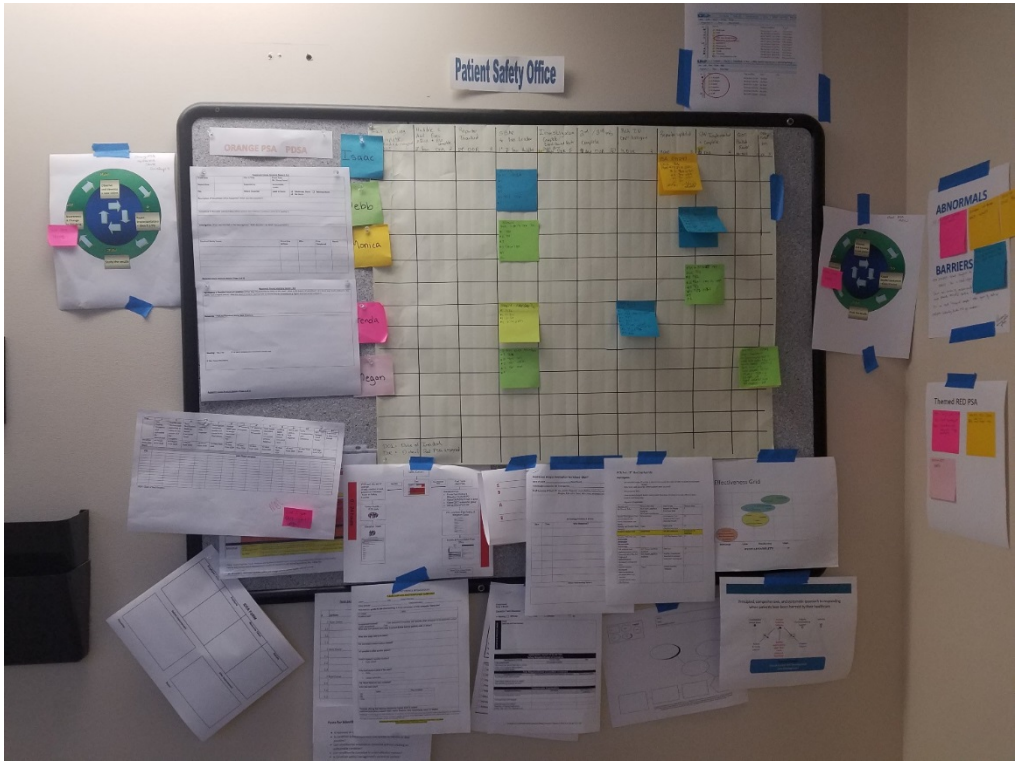
Escalation & Urgency

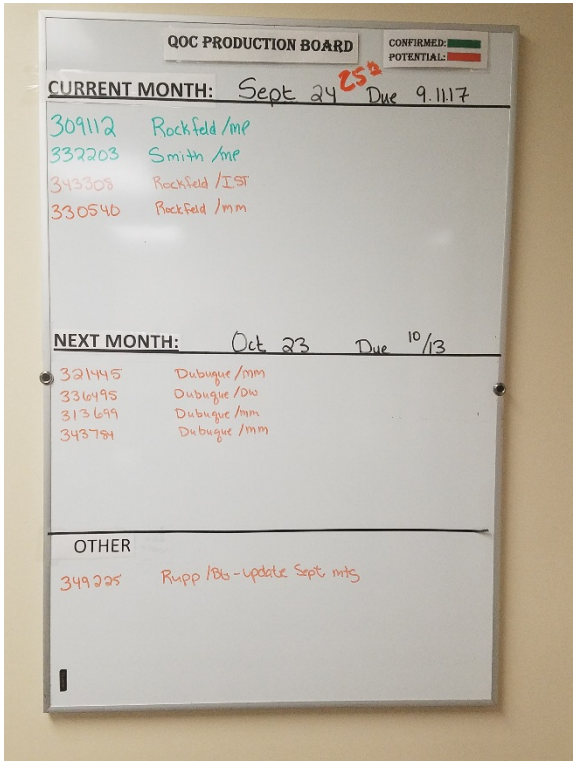
- Immediately
  - Patient/family ok?
  - Caregivers ok?
- Within 2 hours
  - Initial Fact-finding
  - Huddle with accountable executive
- Same day
  - Signal Quality Oversight Committee (Board level)
  - Thank the reporter

Causes & Corrective Actions

- Identify RCA Team
- Standard structured agenda
- Go/no-go gate if causes not identified
- Strength of Corrective Action Plans (CAPs)
- Do CAPs address the root cause(s)?
- Reasonable, achievable, measureable, sustainable?
- Implementation metrics
- Lessons learned

Prevent languishing event analysis with visual control and accountability





Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Key Takeaways

- Understand the patient perspective
- Require leadership accountability
- Engage your board
- Promote a culture of safety
- Make it easy for anyone to report a safety concern
- Establish standard processes and tools with timeline expectations

Reporting and Event Analysis in the Context of a Comprehensive Approach [CRP] to Patient Harm

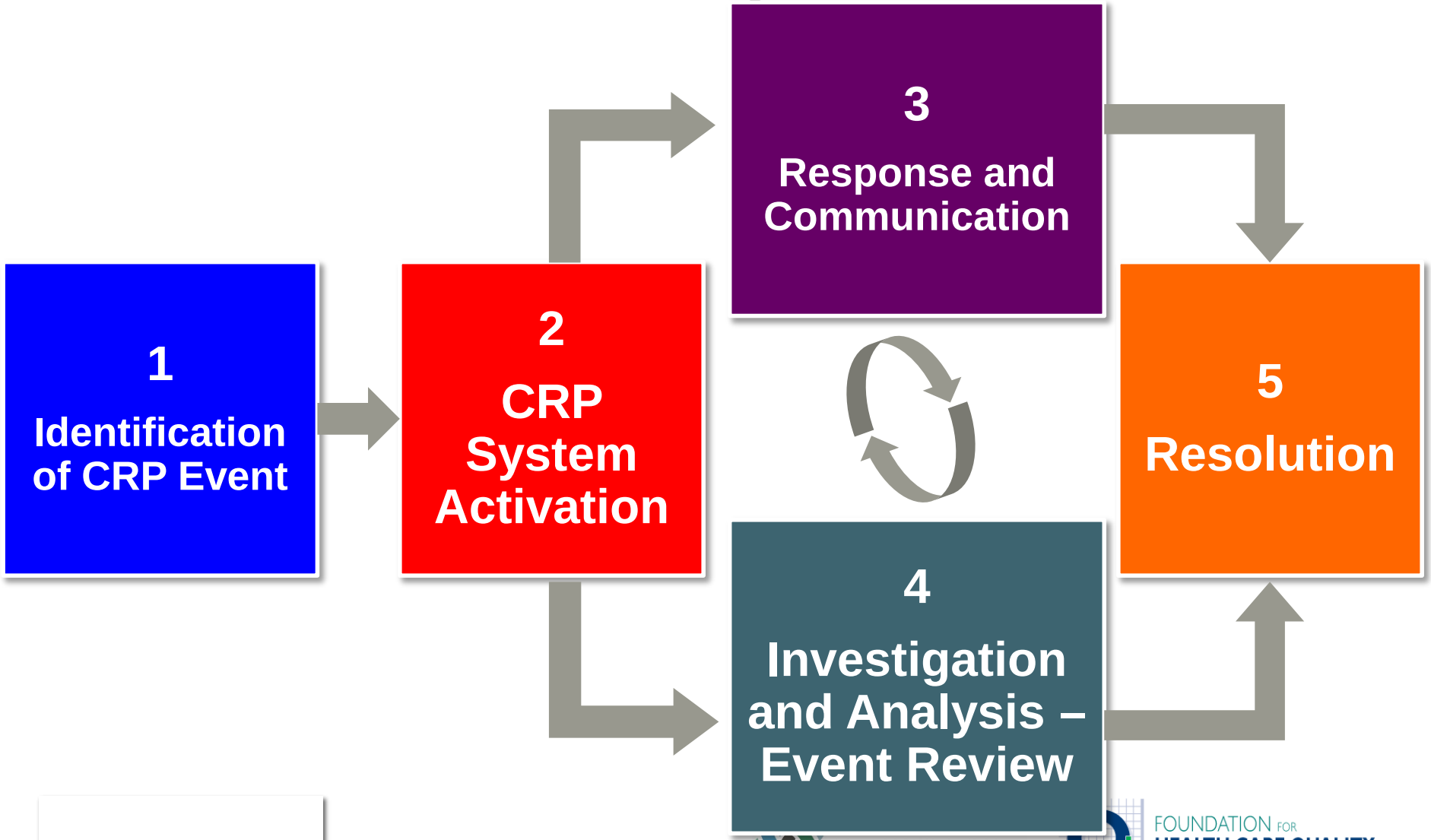
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Reporting and Event Analysis in the Context of a Comprehensive Approach [CRP] to Patient Harm

- Simply Put
- You Cannot Fix What You Do Not Know About

Flow of CRP Activity



The Paradigm Shift

Reporting	• from delayed • to immediate
Communication	• from delay, deny and defend • to immediate and ongoing
Event Review	• from shame, blame, and train • to human factors process redesign
Care for the Caregiver	• from suffering in isolation • to immediate support
Resolution	• from having to “fight for it” • to early offer

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

How does your organization identify serious harm events?

Unanticipated Outcomes - Urgency

Go Team

At the core of NTSB investigations is the "Go Team." The purpose of the Safety Board Go Team is simple and effective: Begin the investigation of a major accident at the accident scene, **as quickly as possible**, assembling the broad spectrum of technical expertise that is needed to solve complex transportation safety problems.

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

How does your organization approach event review?

Safety Attitudes

"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."

--Dr. Lucian Leape, Professor, Harvard School of Public Health
Testimony to congress

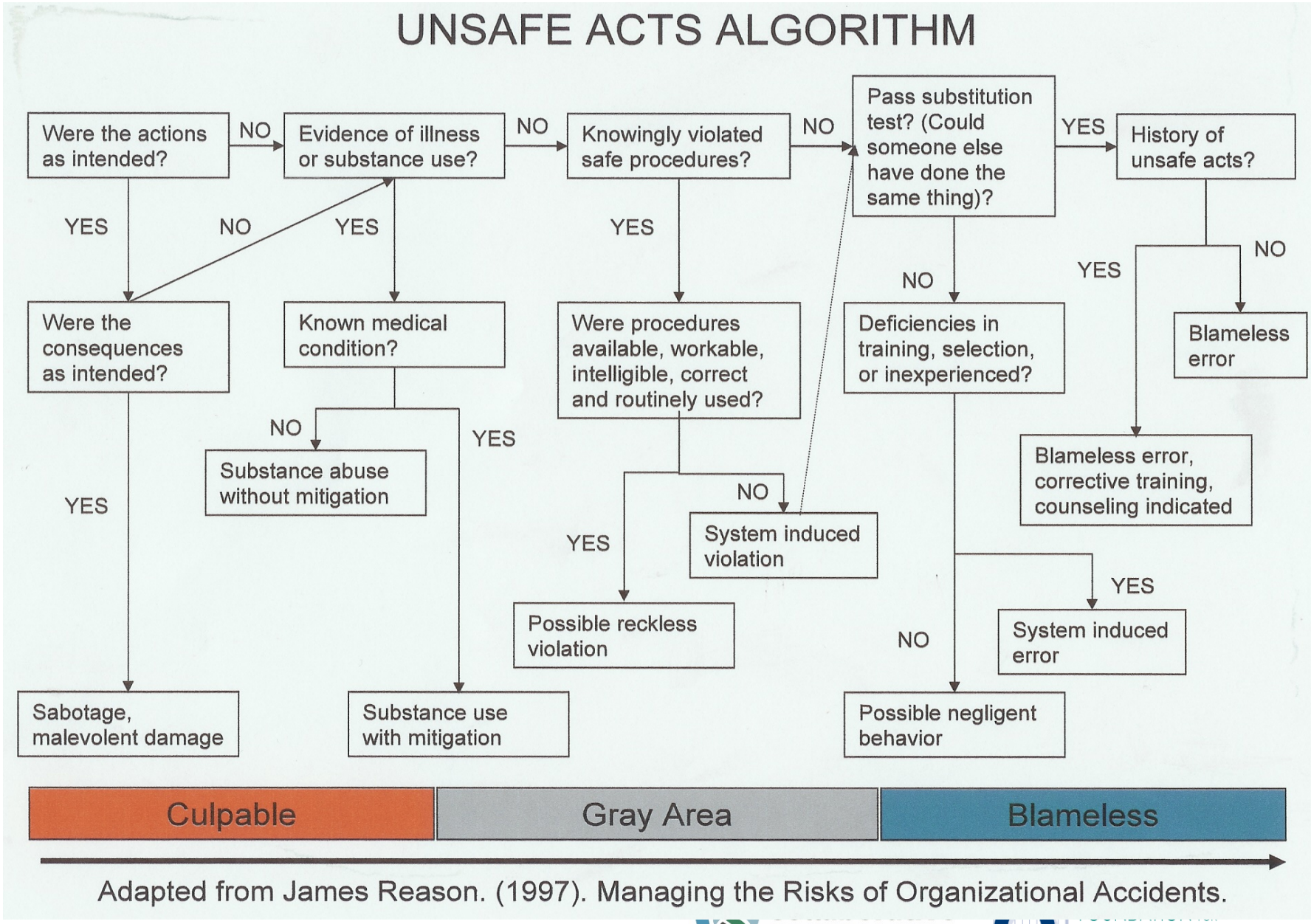
"Fallibility is part of the human condition. We *cannot* change the human condition. But we *can* change the conditions under which people work"

--James Reason, Ph.D.

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

What does your organization use to avoid the “blame, shame, and train” game?



Adapted from James Reason. (1997). Managing the Risks of Organizational Accidents.

Setting the Stage

We may need you to think very differently about event review in health care

To begin to view patient safety and risk management through the lens of safety science

Systems Approach: Human Factors Integration

Ask <u>What</u> is responsible…

…Not <u>Who</u> is responsible

- Then, focus on system solutions

"We don't redesign humans; we redesign the system within which humans work."

Annie’s story

Avoiding the blame game

Consideration of Human Factors

Consideration of Human Factors

- A non-clinical unexpected event

Human Factors Engineering and Safety

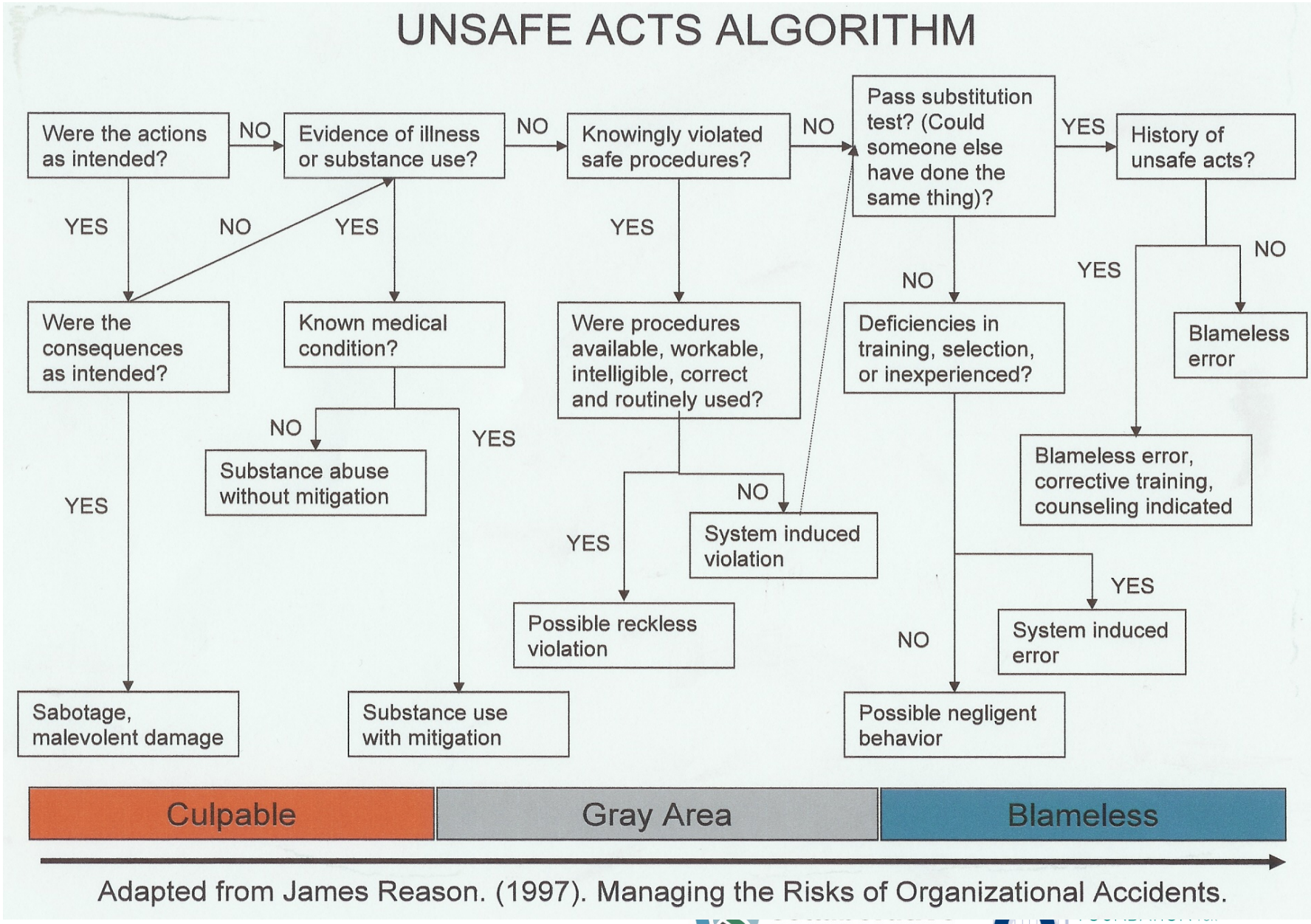
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Human Factors in a clinical setting

- 63 year old patient collapses whilst blood pressure is being taken after admission to hospital of feeling light-headed.
- Nurse unable to palpate a pulse
- Calls for help, starts CPR and calls for crash cart
- Asks for defibrillator
- Queries rhythm – v-fib
- Charges device
- Device shuts off in the midst of defibrillating
- Recharging device takes 2-3 minutes, patient defibrillated
- Nurse submits event report

Human Factor Issues in Healthcare


UNSAFE ACTS ALGORITHM
Were the actions as intended?
NO
Evidence of illness or substance use?
NO
Knowingly violated safe procedures?
NO
Pass substitution test? (Could someone else have done the same thing)?
YES
History of unsafe acts?
YES
NO
YES
NO
YES
YES
NO
YES
Were the consequences as intended?
Known medical condition?
Were procedures available, workable, intelligible, correct and routinely used?
Deficiencies in training, selection, or inexperienced?
Blameless error
NO
YES
Substance abuse without mitigation
Blameless error, corrective training, counseling indicated
NO
YES
YES
System induced violation
YES
Possible reckless violation
NO
System induced error
NO
Sabotage, malevolent damage
Substance use with mitigation
Possible negligent behavior
Culpable
Gray Area
Blameless
Adapted from James Reason. (1997). Managing the Risks of Organizational Accidents.

Moving Toward Event Review 2.0

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

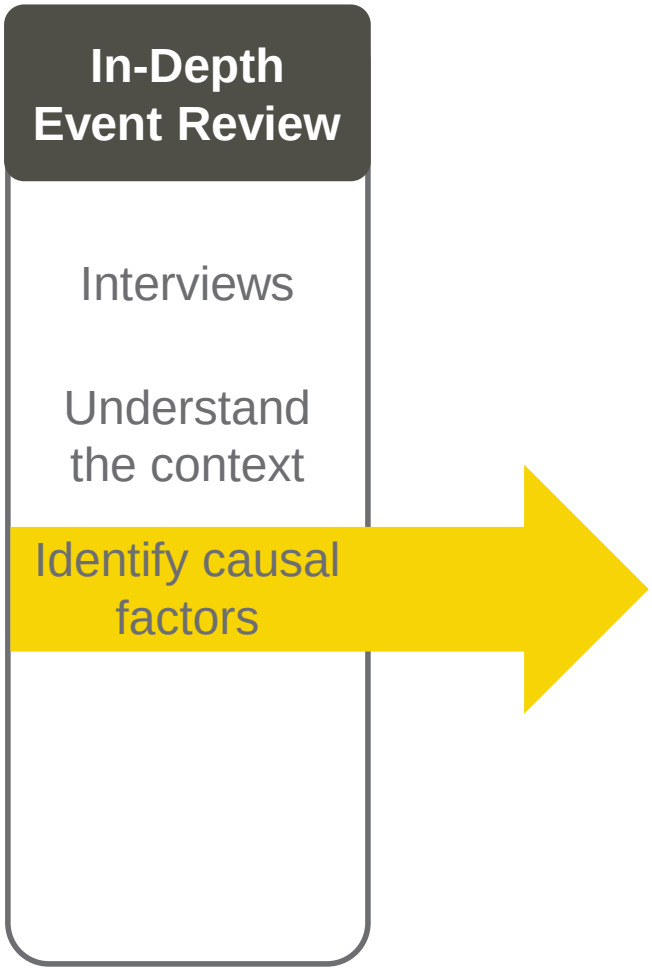
Moving Toward Event Review 2.0

Immediate Response	In-Depth Event Review	Confirmation & Consensus Meeting	Solutions Meeting	Followup
Inform system leadership Care for patient and family Care for caregiver Gather time-sensitive info	Interviews Understand the context Identify causal factors Identify core team	Templates, project management techniques and documentation		

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Event Review 2.0



Identify Causal Factors

The interviewer is the safety science leader

- Identify what they believe are the causal factors and bring them to the confirmation and consensus meeting.
- Guide this process and how you apply this knowledge can change the course of an event review.

If your final "causal factor" is "human error," you're not finished yet!

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Strong Actions

- Architectural/physical plant changes
- New device with usability testing before purchasing
- Engineering control or interlock (forcing functions)
- Simplify the process and remove unnecessary steps
- Standardize on equipment or process or care maps
- Tangible involvement and action by leadership in support of patient safety

Hierarchy of Actions- Adapted from the Department of Veterans Affairs
National Center for Patient Safety (NCPS)

Intermediate Actions

- Increase in staffing/decrease in workload
- Software enhancements/modifications
- Eliminate/reduce distractions (sterile medical environment)
- Checklist/cognitive aid
- Eliminate look and sound alikes
- Read back
- Enhanced documentation/communication
- Redundancy

Hierarchy of Actions- Adapted from the Department of Veterans Affairs National Center for Patient Safety (NCPS)

Weak Actions

- Double checks
- Warnings, labels, and signs
- New procedure/memorandum/policy
- Training
- Additional study/analysis
- Discipline

Hierarchy of Actions- Adapted from the Department of Veterans Affairs
National Center for Patient Safety (NCPS)

Sign From Gas Pump

Questions?

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

OPEN AND HONEST COMMUNICATION

Tim McDonald

Bruce Lambert

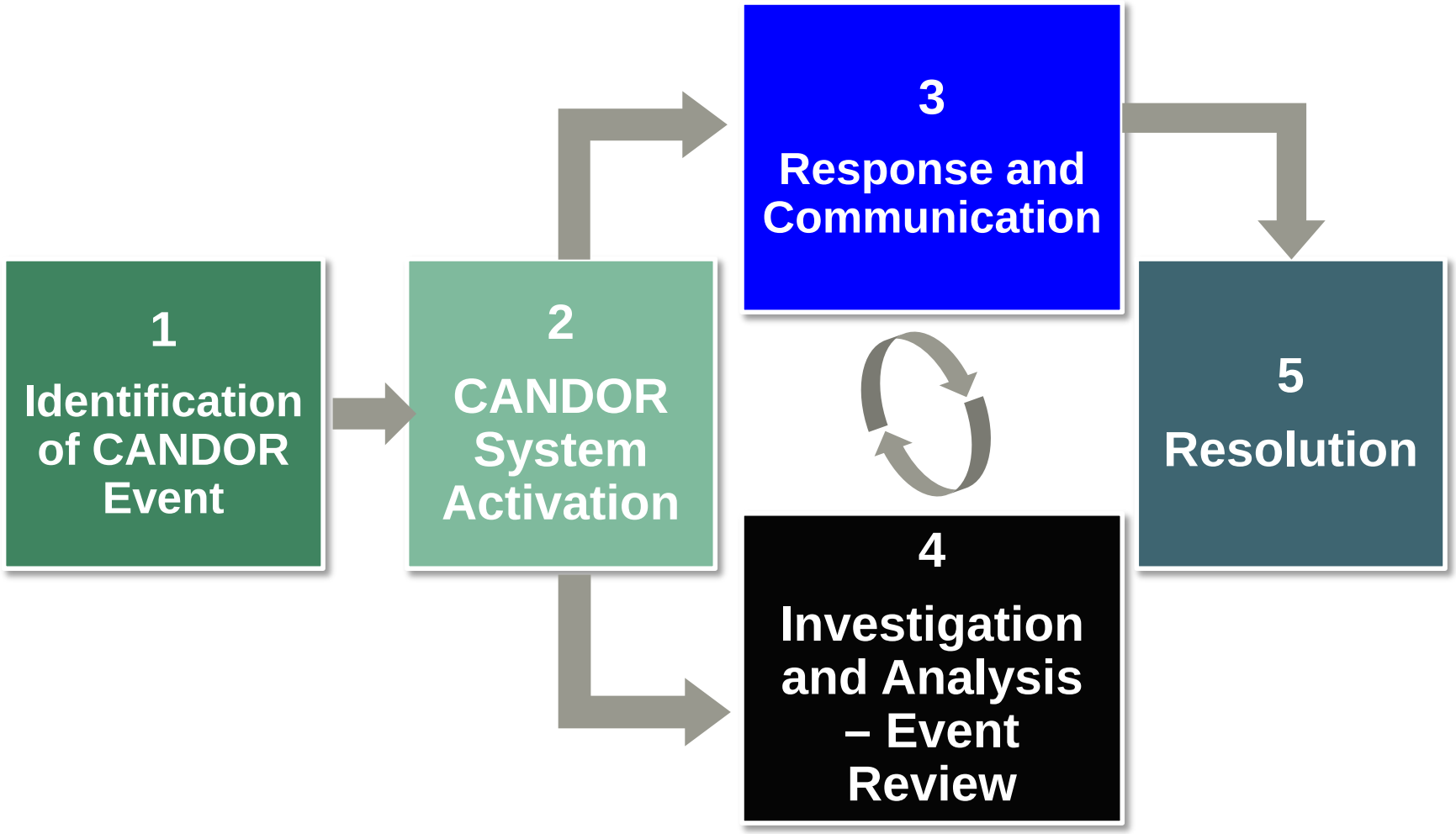
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Open and Honest Communication in Action

Why Are We Here?

CANDOR: Communication AND Optimal Resolution



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

The Paradigm Shift

Reporting	• from delayed • to immediate
Communication	• from delay, deny and defend • to immediate and ongoing
Event Review	• from shame, blame, and train • to human factors process redesign
Care for the Caregiver	• from suffering in isolation • to immediate support
Resolution	• from having to “fight for it” • to early offer

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Communication Central to the Paradigm Shift

Reporting	• from delayed • to immediate
Communication	• from delay, deny and defend • to immediate and ongoing
Event Review	• from shame, blame, and train • to human factors process redesign
Care for the Caregiver	• from suffering in isolation • to immediate support
Resolution	• from having to “fight for it” • to early offer

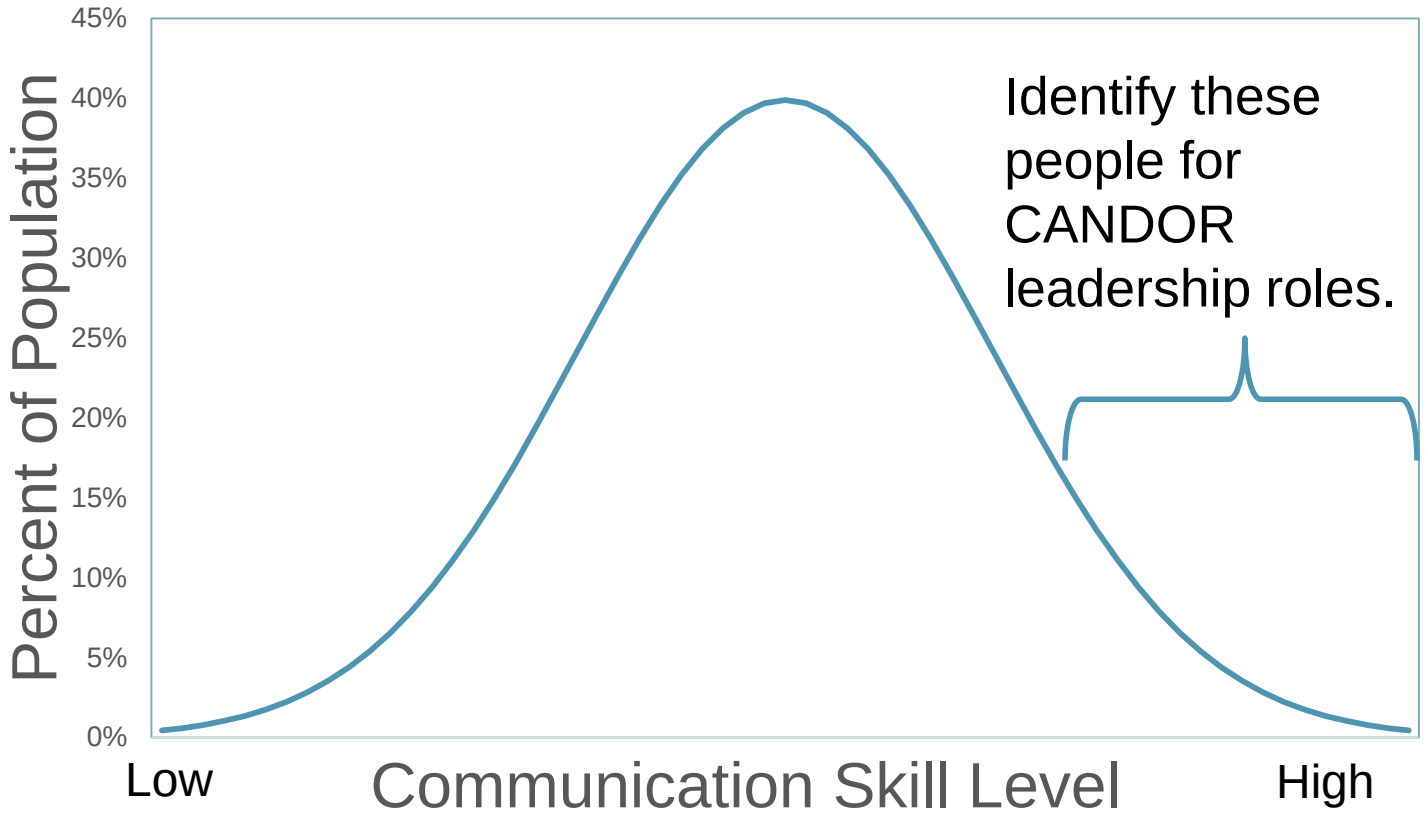
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Communication Skills Assessment

- Communication is the “C” in CANDOR
- People vary greatly in communication skill
- Skill differences can be validly and reliably measured
- Skilled communicators are best candidates for leadership roles for PCCS and C4C trainer positions

People Vary Greatly in Communication Skill



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Skill Differences Most Visible in Hard Situations

Easy: Describe your apartment

Hard: disclose a medical error to a grieving family

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Disclosure Requires High Level of Skill

- Disclosure situations are hard
  - Multiple, conflicting goals
  - High level of emotional arousal
  - High ego-involvement
  - Highly consequential
- Communication skill predicts malpractice risk
- Must identify organization's best communicators

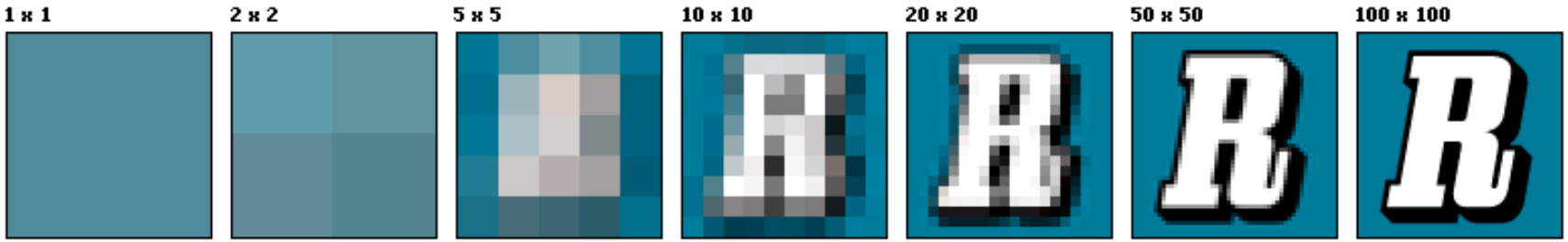
The Approach to Assessment

- Preliminary assessment of communication skill
- Measures we used have a long history
- But first, a quick course in communication theory!

Constructivism: A Theory of the Development of Communication Skill

- Represent the social world in terms of "constructs"
- Construct is a bi-polar dimension for representing the social world
  - kind/cruel, fair/unfair, happy/unhappy, considerate/inconsiderate, genuine/fake
- **Cognitive complexity** refers to the degree of differentiation, integration and abstractness of one's system of interpersonal constructs

Analogy #1: Image Resolution

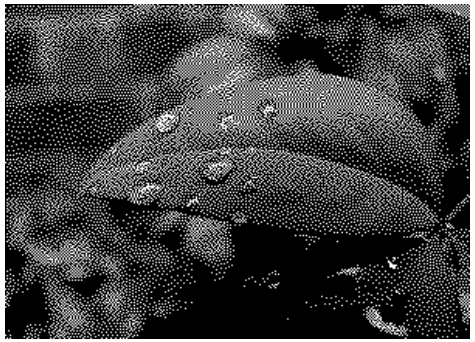


http://en.wikipedia.org/wiki/Image_resolution

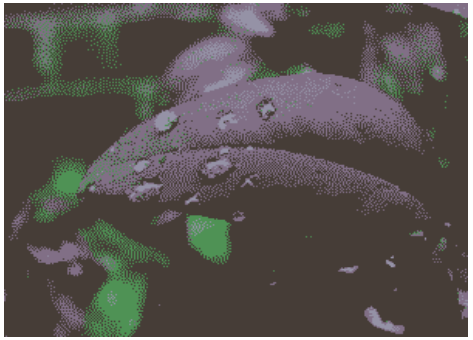
Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

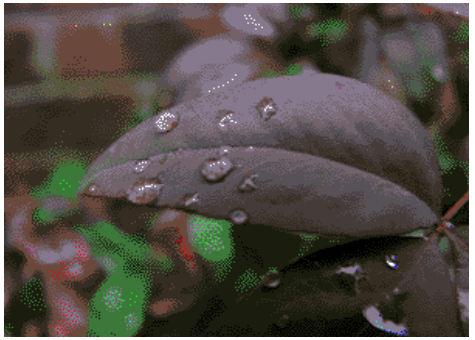
Analogy #2: Color Depth



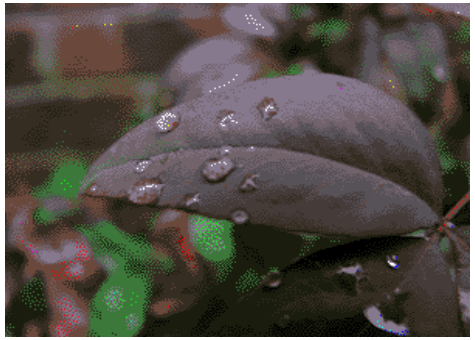
1 bit (2 colors)



2 bit (4 colors)



4 bit (16 colors)



8 bit (256 colors)

16 bit (16,777,216 colors)

http://en.wikipedia.org/wiki/Color_depth

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Cognitive Complexity

- Quality of social perception increases as constructs increase in number, abstractness, and integration
- From low-def black and white to high-def technicolor
- **More constructs => higher level of skill**

Measuring Interpersonal Cognitive Complexity

- Describe one liked and one disliked other
  - In as much detail as possible
  - 5 minutes each
  - Focus on habits, beliefs, mannerisms, not physical appearance
- Impressions can be scored for:
  - Number of constructs (“differentiation”)**
  - Abstractness of constructs
  - Level of integration of constructs

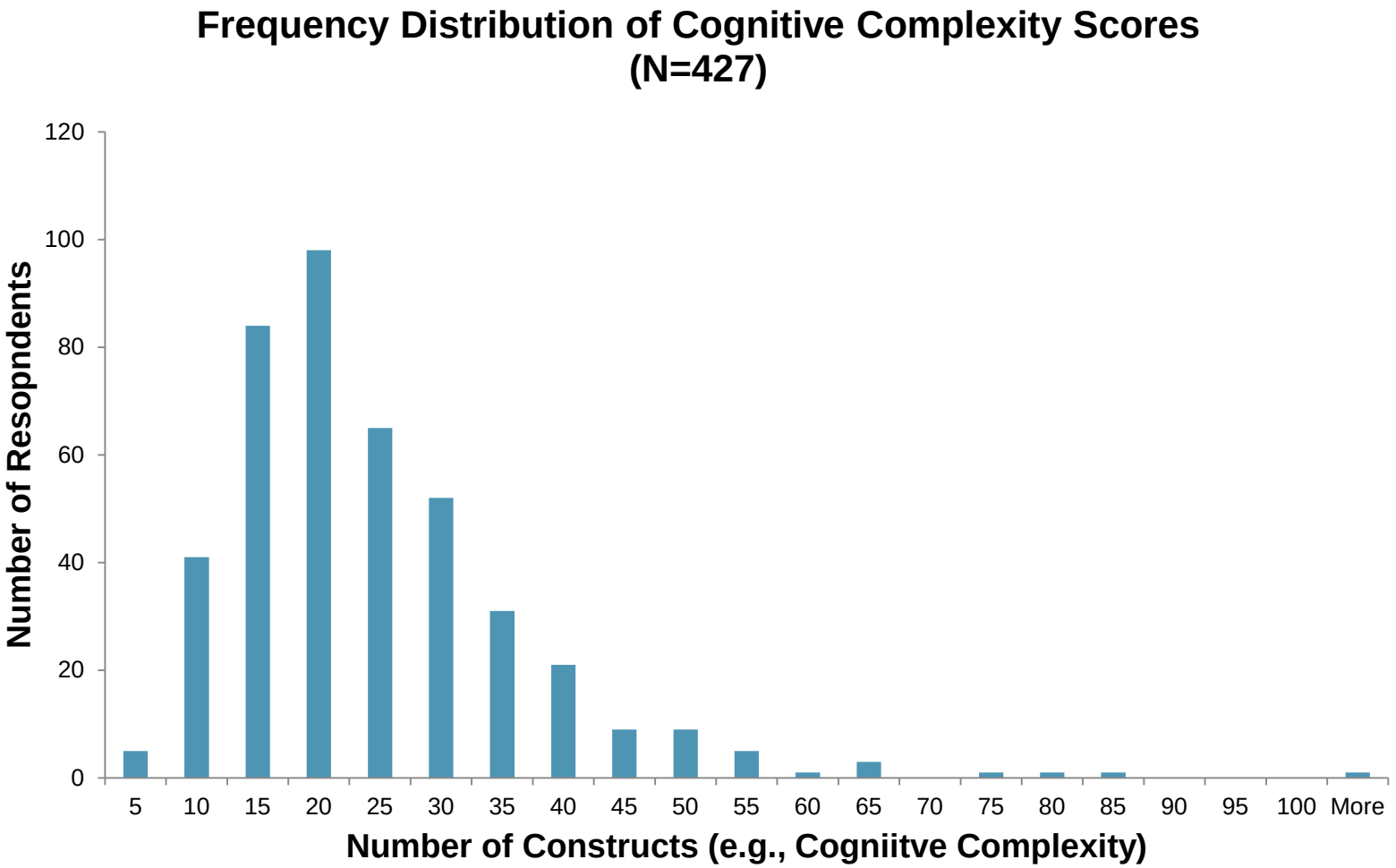
Low Complexity Impressions

- Genuine and sincere, taking people at face value and giving them the benefit of the doubt until they prove otherwise. Strong work ethic and team oriented. (6)
- Accepts blame, acknowledges others achievements, level-headed, trustworthy (4)
- Good listener (1)
- Narcissistic moron (2)

High Complexity Impression

intelligent, intellectual, relaxed, down-to-earth, approachable, genuine, humble, caring, kind, thoughtful, loving, free spirited, respectful, hilarious, insightful, discerning, intuitive, composed, deferent, patient, deep, pensive, considerate, multifaceted, complex, worldly, ambitious, dedicated, shy, inspirational, friendly, reliant, trustworthy, talented, infectious, comforting, faithful, motivational, introspective, pondering, committed, loyal, fun, bohemian, adventuresome, generous, articulate (47 constructs)

Cumulative Assessment Results



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Benefits of High Cognitive Complexity

- More organized and integrated impressions of others
- Greater ability to:
  - recognize others feelings and dispositions
  - integrate inconsistent information about others
  - understand others' thoughts and motivations
  - produce effective messages, accurately and completely interpret others' messages, structure conversational interactions (Burleson & Waltman, 1988)

Development of Constructs over the Lifespan

- From few to many
- From concrete to abstract
- From isolated to integrated
- Lifelong opportunity for learning, growth, development

Person-Centered Communication

- As cognitive complexity increases, people produce increasingly *person-centered* messages
- A person-centered message is adapted to the perspective, beliefs, attitudes, feelings, plans, goals, and intentions of the other person
- As person-centeredness of message increases, others tend to perceive the message as more effective, comforting, persuasive, etc.

The Logic of Message Design

- People differ in the way they reason from goals to messages
- Developmental progression in basic concepts of language and communication
  - Expressive: Language is a medium for expressing thoughts/emotions
  - Conventional: Communication follows social rules
  - Rhetorical: Communication is the creation and negotiation of social selves, situations, and contemplates future conversations

O'Keefe, B. J. (1988). The logic of message design: Individual differences in reasoning about communication. *Communication Monographs, 55, 80-103.*

Highly Person-Centered Message

"Hello, My name is SJ and I am (role)... Are you the parents of Mary? I need to speak with you about how Mary is doing - is this a comfortable time do that? For your privacy, I would like to go to a more private area - I will walk with you...**. I have an update on the procedure Mary had - an update that is difficult to share and may be overwhelming to hear** - and you may have a lot of questions. We will continue to answer all of them in more conversations to come. I will share what we know at this time. During the procedure, we noticed that Mary's vital signs that we monitor - her blood pressure, heart rate, and oxygen levels were changing. At one point, her heart rate dipped so low that we needed to perform CPR (explain) - that was the "Code blue" you heard overhead. Some time went by before we could restore her vital signs. Right now, Mary is stable and she is being taken care of and watched closely. **We have a special team of people who walk alongside patients and families when there is an unexpected event, and we will be walking alongside with you as well. (seeing their tears and concern)** I see your tears - this is hard to hear and we don't yet have all of the information but will be reviewing that. We also don't know yet, how Mary was affected by it. We will be monitoring her closely, and reviewing every aspect of what took place so we can keep you fully informed. We place a high value on clear communication, so we will stay in contact with you often. What questions do you have right now? I can check on how soon you can go in and be with her. Here is the number of someone you can connect with whenever you need to. We also have chaplains who can come and listen and pray with you if you like.

Highly Person-Centered Message

Mr. and Mrs. X, I am Dr. XX and was the leader of the resuscitation team that responded to the code blue that you heard**. I am sorry to say that your daughter Mary was the patient**, but you should know she has been resuscitated and is being transferred to the Intensive Care Unit. I am not exactly sure what happened at this time, but there was a period of time that Mary was not breathing. We always worry about medication issues and pre-existing conditions, but I assure you we are running tests and asking the other staff members questions in order to hopefully determine the exact cause of her distress. **You should know that she is currently in critical condition but stable**. I have transferred her care to the Intensivist Doctor in whom I have utmost confidence. In a few moments I would like to take you to see Mary. **You should know that she has a breathing tube which I inserted into her airway and we are using a ventilator to breathe for her. You will also notice several special IV lines to help monitor her.** She won't respond to you at this time which is expected but I encourage you to hold her hand and speak with her. I truly believe patients that are unconscious are aware of their surroundings. **While this is a huge burden to share with you, I welcome any questions you may have before we go see Mary.**

Highly Person-Centered Message

- Hello, my name is xxxx, and I'm a nurse and a member of the team taking care of Mary. We have a private waiting room over here, would you please follow me? (Assist the family to a private waiting room.) First, let me say that Mary has been stabilized, and we are watching her closely. Now for what happened: During the procedure, Mary stopped breathing and her heart rate fell. The doctors and nurses worked together to get her breathing again and normalize her heart rate and blood pressure. Right now, our focus is on monitoring her closely to ensure that she remains stable. She's still in the procedure room, but we will be taking her to ICU shortly. **I'm sure you have a lot of questions for us, and that you would like to see your daughter. At this time, I'd like you to take a moment to let this news sink in, formulate any questions you may have, and for you to call anyone you may need for support. Please be assured that I be back shortly to update you on the plan for her and let you know when you may see her. I know that this may be shocking to you and also frustrating that I don't have additional information for you, but please allow me to check on your daughter, talk to the doctors and nurses taking care of her, and I will return shortly.**

Not as Person-Centered

Hi Bill and Beth, sorry to meet you under these circumstances. Unfortunately, there was a period of time during the procedure when Mary did not receive adequate breathing support, which caused her heart to temporarily stop beating normally. We intervened and got her heart rate and blood pressure back to where they are supposed to be, though she is still sedated. We don't know yet if there was any sort of damage yet or how much, but we will keep you informed of everything we know as more information becomes available.

Not-So-Person-Centered-Messages

There appear to have been some complications with the procedure, and the team is now working on Mary. As yet, we don't know what the outcome will be.

Mary's heart rate got to low, and, as a precaution, the Code Blue team was called. Mary is out of danger now and will be fine.

Assessment Seeks to Identify Opportunities *For Further Training*

- Even great communicators need training in specific CANDOR tasks
  - Disclosure, resolution, comforting traumatized caregivers
- Assessment identifies “raw athletic talent”
- Training takes raw talent and refines it with respect to specific tasks and contexts

Assessment Seeks to Identify Opportunities *For Further Training*

- Even great communicators need training in specific CANDOR tasks
  - Disclosure, resolution, comforting traumatized caregivers
- Assessment identifies “raw athletic talent”
- Training takes raw talent and refines it with respect to specific tasks and contexts

Summary

- Individuals differ in ability to perceive social situations and produce effective messages
- Differences most apparent in situations with multiple competing goals
- Skill differences can be validly and reliably measured
  - Cognitive complexity
  - Message-design logic
- Highly skilled communicators may be good candidates for communication leadership roles
- All are needed for CANDOR success, regardless of skill level

References

Burleson, B. R. (2006). Constructivism: A general theory of communication skill. In B. B. Whaley & W. Samter (Eds.), *Explaining communication: Contemporary theories and exemplars*. Mahwah, NJ:Erlbaum.

Burleson, B. R. (2003). Emotional support skills. In J. O. Greene & B. R. Burleson (Eds.), *Handbook of communication and social interaction skills* (pp. 551–594). Mahwah, NJ: Erlbaum.

Burleson, B. R., & Waltman, M. S. (1988). Cognitive complexity: Using the role category questionnaire. In C. H. Tardy (Ed.), *A handbook for the study of human communication: Methods and instruments for observing, measuring and assessing communication processes*. Westport, CT: Ablex.

Crockett, W. H. (1965). Cognitive complexity and impression formation. In B. A. Maher (Ed.), *Progress in experimental personality research* (Vol. 2, pp. 47–90). New York: Academic Press.

Delia, J. G., O'Keefe, B. J., & O'Keefe, D. J. (1982). The constructivist approach to communication. In F. E. X. Dance (Ed.), *Human communication theory: Comparative essays* (pp. 147–191). New York: Harper & Row.

McDonald TB, Helmchen LA, Smith KM, et al. Responding to patient safety incidents: the "seven pillars". *Qual Saf Health Care. Dec 2010;19(6):e11.*

O'Keefe, B. J. (1988). The logic of message design: Individual differences in reasoning about communication. *Communication Monographs*, 55, 80–103.

O'Keefe, D. J., Shepherd, G.J., & Streeter, T. (1982). Role category questionnaire measures of cognitive complexity. *Central States Speech Journal*, 33, 333-338.

Woods, M. S. (2004). *Healing words: The power of apology in medicine*. Oak Park, IL: Doctors in Touch.

AHRQ CANDOR Toolkit Communication Assessment Guide. https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/module5-guide.html

Communication after harm

Communication 101

Patients need

- Truthful, accurate information
- Emotional support, including apology
- Follow-up, potentially compensation

Health care workers need

- Communication coaching
- Emotional support

Process, not an event

- Initial conversation
- Event analysis
- Follow-up conversation

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Let’s start with a non-clinical situation


you
FITNESS
JENNY CRAIG

Discussion

Key Communication **Planning Skills**

- Most common failure – lack of planning
- Solicit team members' views
- Plan roles for discussion
- Advocate for full disclosure
- Anticipate questions
- Avoid jargon and blame

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Case Study

- An internist at your hospital admitted a patient yesterday afternoon with a asthma. The doctor wrote the patient's admitting orders while she was in a hurry to get home for the evening. The sloppily written "10U" order for 10 units of insulin was read by the nurse as 100 units of insulin, 10 times the patient's normal dose. The patient received 100 units of insulin last night and was found three hours later unresponsive with a blood sugar of 35. The patient was successfully resuscitated and transferred to the intensive care unit. This morning he is feeling well and is transferred back to the floor.

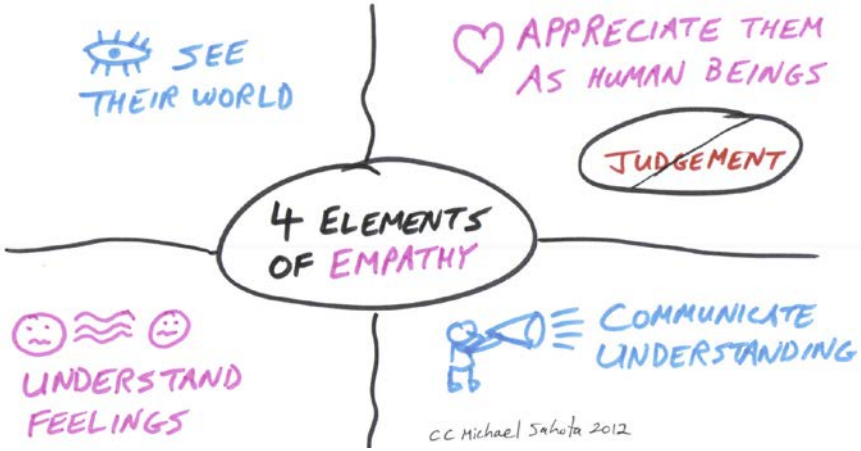
In Preparation: Questions to Consider (Huddle)

- What are the goals of the interaction?
- When should you respond to the patient/family?
- Who should respond to the patient/family?
- What questions do you anticipate getting from the patient/family?
- What emotions do you anticipate, how will you name and validate them?
- What are you going to say to the patient/family?
- What information should be shared/discussed?
- Who continues to respond to the patient/family as more information is discovered?
- How do you respond to your caregivers?

Video Debrief

What Do We All Want? Empathy

- **Be Curious**
- We want to be heard.
- We won't listen until we are heard. Address emotions first.
- Don't try to fix things.
- What skill accomplishes that? Questions are often the answer.
- Reflective listening is not intuitive.



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

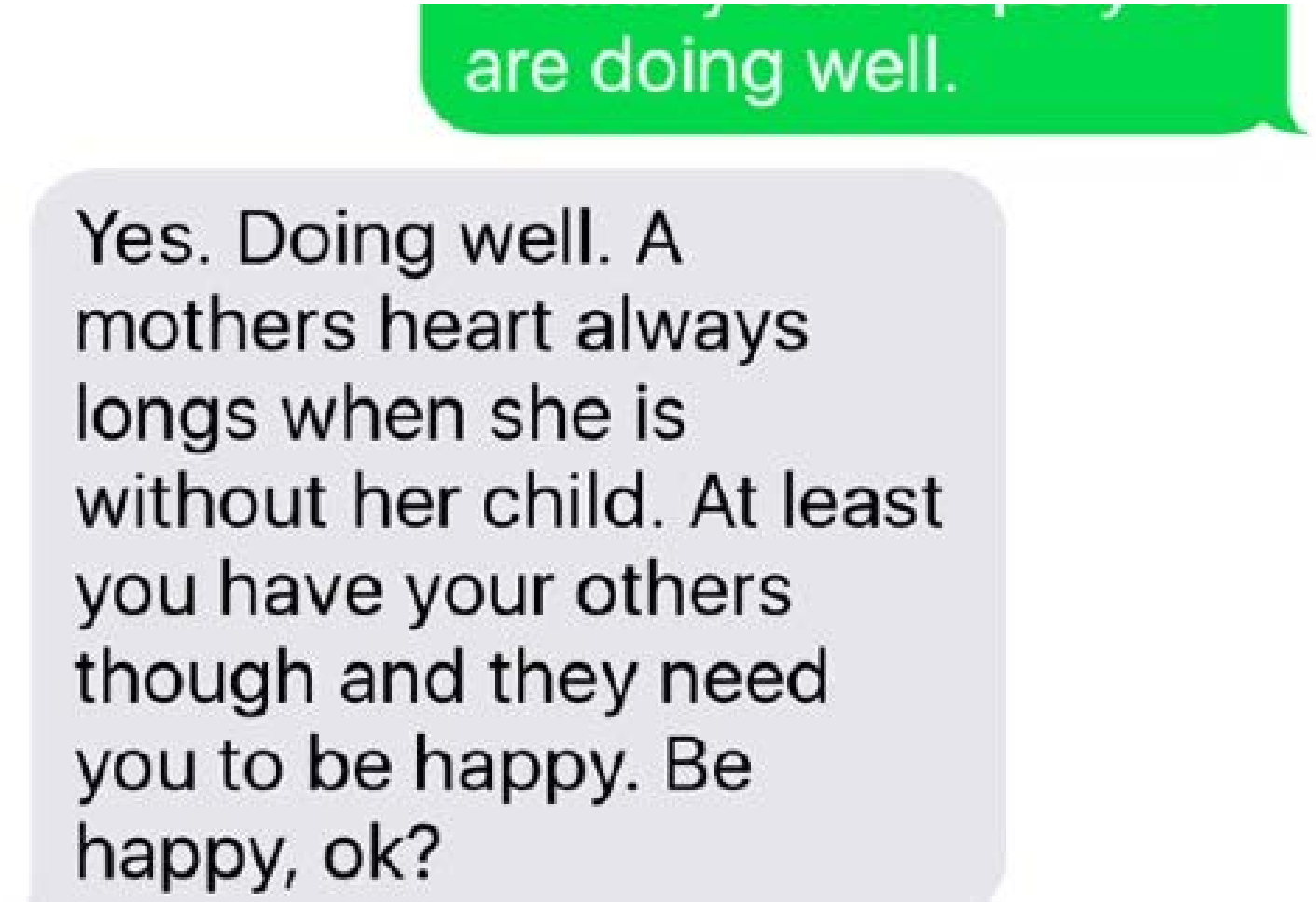
Helping Requires Humility and Vulnerability

- "Humble Inquiry is the fine art of drawing someone out, of asking questions to which you do not already know the answer, of building a relationship based on ***curiosity and interest*** in the other person."
- Asking not telling
- Find out what's needed, and supply that
- Do for the person what they cannot do for themselves
- Be prepared to help in any way you can
- Don't assume you know what help is wanted or needed
- ***Helping***, and ***Humble Inquiry*** by Edgar Schein

Empathy versus Sympathy

A Non-Empathic Response

A Non-Empathic Response



The Key is Listening

Questions

A Culture of Safety and Disclosure

Our promise: “Simply the right care”

Alexander M. Hamling, MD, MBA, FAAP
Pediatrician
Physician Lead for Culture of Disclosure

Pacific Medical Centers
Seattle, WA

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Faculty Disclosure

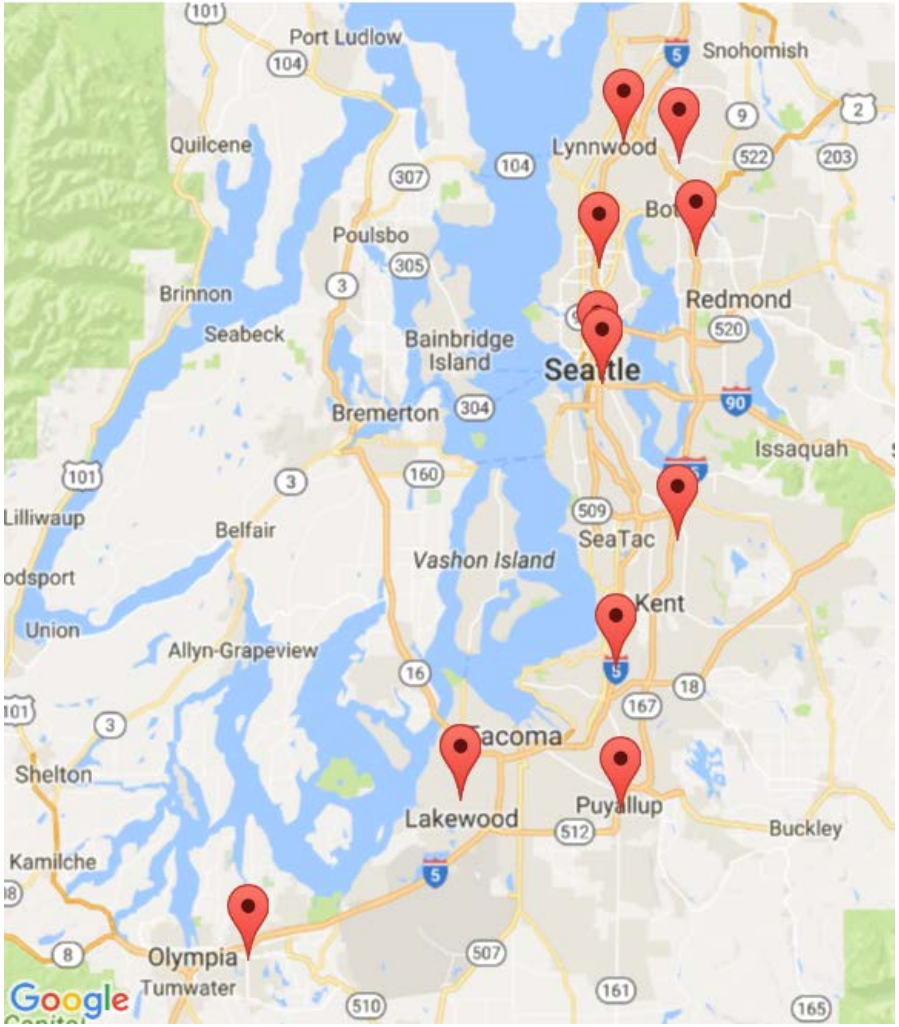
Alexander Hamling has no relevant financial relationships to disclose.

In addition, Alexander Hamling will not discuss off-label use of medical devices or products.

Outline of Lecture

- Pacific Medical Center's (PacMed's) goals for an organizational change
- Choosing the right curriculum
- First draft of policy and practice
- Second draft of policy and practice
- Further and future development and spread of our Culture of Disclosure
- Unusual occurrence examples
- Case demonstrations and resolutions

Pacific Medical Centers



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Goals for Organizational Change

- Clinical Excellence, Quality Improvement, Patient Safety and Transparency
  - It's just good patient care
  - Detection and reporting with a focus on process improvement
  - Prevention of incident reoccurrence
- Align with current operations and patient safety initiatives
- Promote culture shift to include all current and new employees
- Increase patient, provider, and employee satisfaction and engagement
- Minimize litigation or risk management issues by early intervention, transparency and communication

Develop a Culture of Disclosure

1. Create a culture of openness for disclosure – Est. 2015
   - Teach the rationale for openness and transparency
   - Appreciate others' (patients, providers, staff) perspectives and needs
   - Review and practice the qualities of an effective disclosure
2. Teach how determining the causes of an adverse outcome informs the path to resolution
   - Care reasonable vs. care unreasonable models and tracks
3. Enhance and practice these skills for engaging in effective disclosure conversations with patients and families in a range of situations

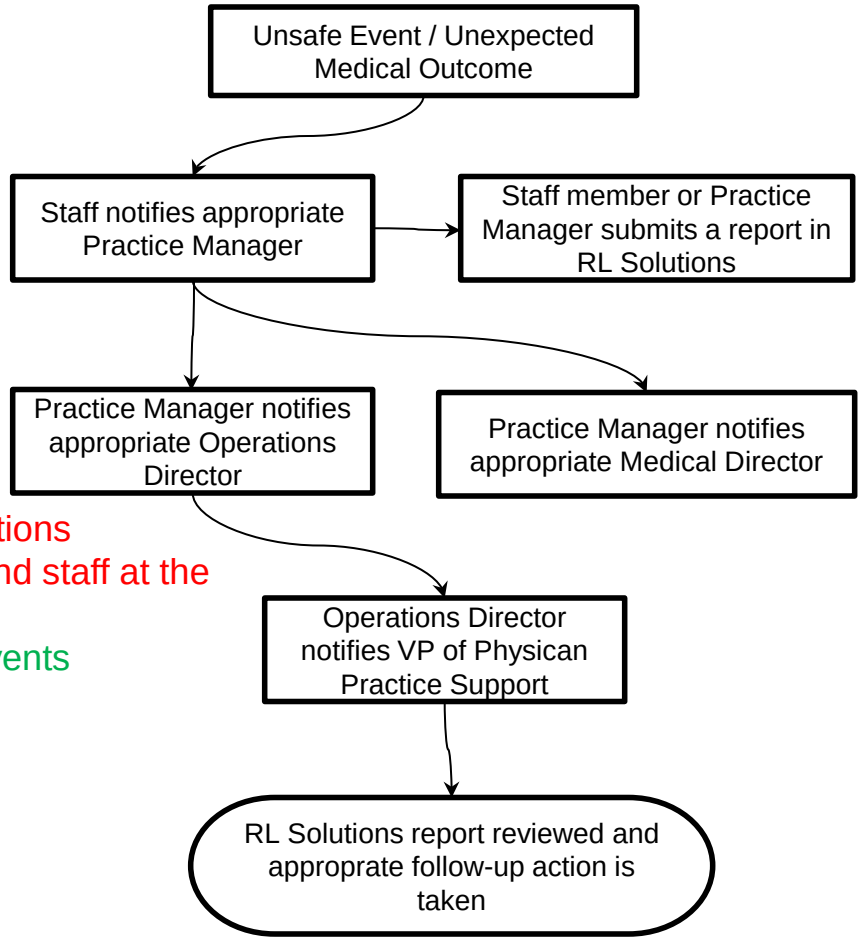
Unexpected Medical Outcomes

- Unexpected medical outcomes occur when known risks associated with a patient's medical condition or treatment result in disappointing results.

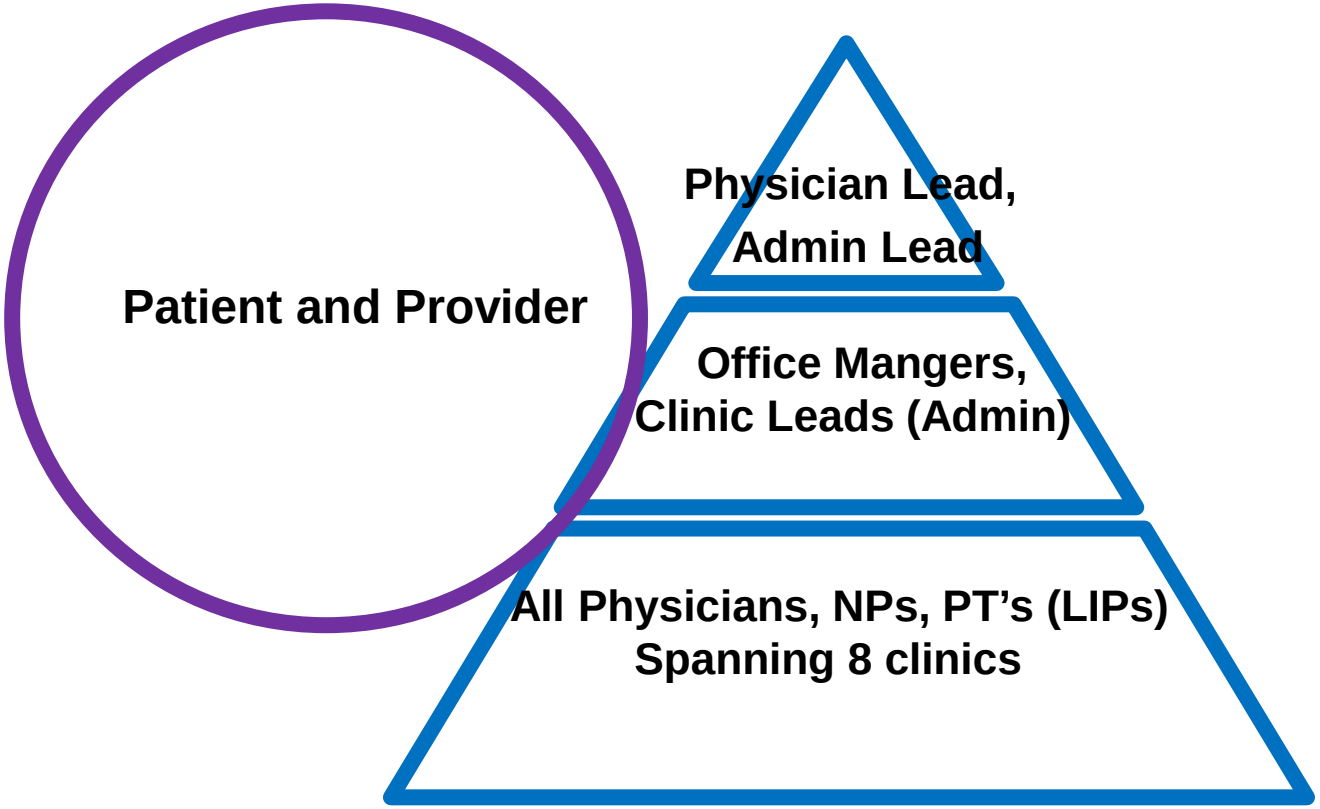
- Despite our best intentions, sometimes medical injuries occur due to human and system errors.

First Draft:

1. “Admin heavy”
2. Focused on “Chain of Command” notifications
3. Failed to put the patient and physicians and staff at the center
4. Reinforced the data keeping/logging of events



Working within the Culture of Disclosure



Patient Expectations Following an Unexpected Outcome

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Who is responsible for patient safety?

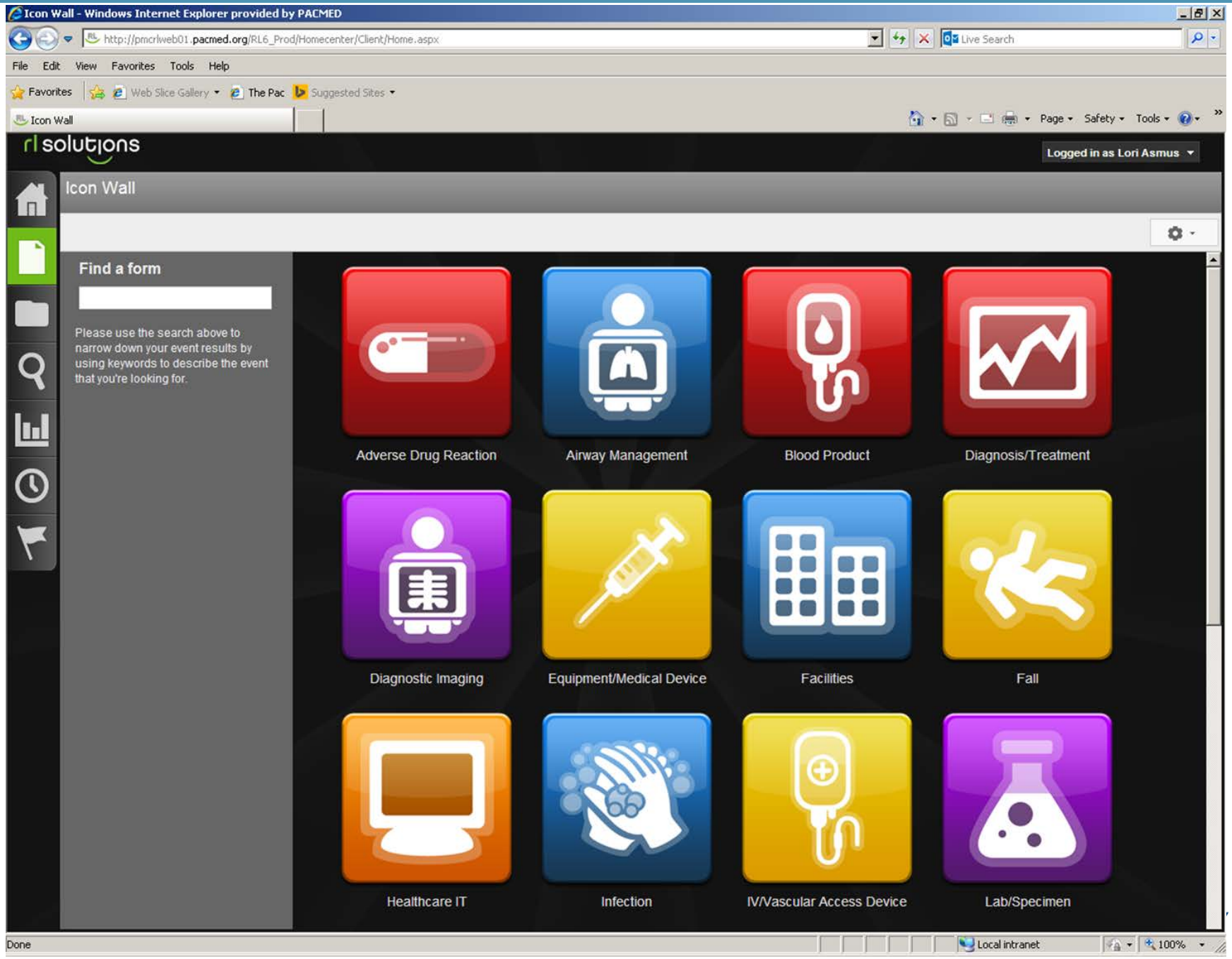
- **Everybody**!

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Where to turn for Help

- Depends of severity of the situation
  - Practice Manager
  - Physician Leader
    - Medical Director
    - Dr. Alex Hamling (Trained as Disclosure Lead)
    - Dr. Shailaja Reddy (Trained as Disclosure Lead)
  - VP of Strategic Services / Risk Management
- They are there to coach and assist with making assessments, supporting staff & developing an overall plan.
- They are the front line resources to determine the best approach for communications with the patient, staff and other stakeholders


Icon Wall - Windows Internet Explorer provided by PACMED
http://pmcrlweb01.pacmed.org/RL6_Prod/Homecenter/Client/Home.aspx
File Edit View Favorites Tools Help
Favorites
Web Slice Gallery
The Pac
Suggested Sites
Icon Wall
Page
Safety
Tools
rl solutions
Logged in as Lori Asmus
Icon Wall
Find a form
Please use the search above to narrow down your event results by using keywords to describe the event that you're looking for.
Adverse Drug Reaction
Airway Management
Blood Product
Diagnosis/Treatment
Diagnostic Imaging
Equipment/Medical Device
Facilities
Fall
Healthcare IT
Infection
IV/Vascular Access Device
Lab/Specimen
Done
Local intranet
100%

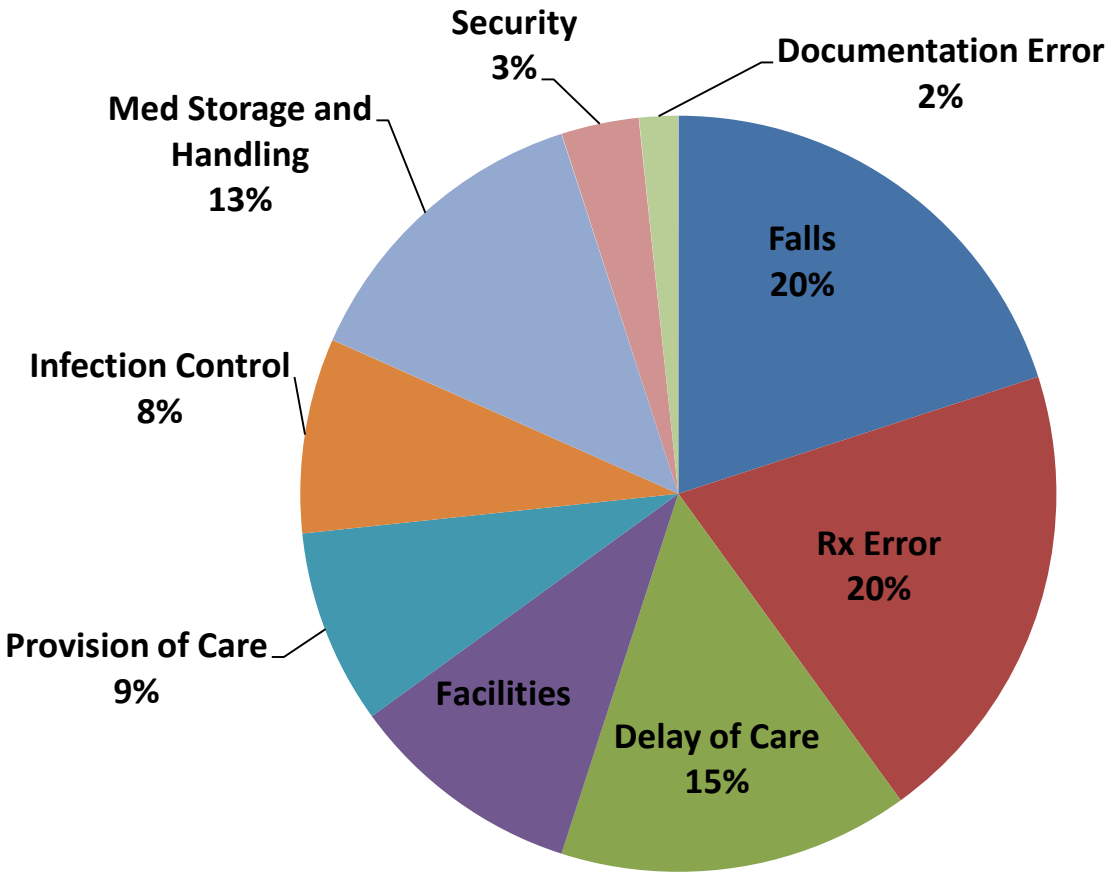
Examples of Incidents

- From Q3 2016

- Falls
  - Tripping on scale, falling while transitioning stand/sit, falling in parking lot, fall during PT, tripping while entering elevator
- Medication Error
  - Wrong vaccine administered, Rx order miscommunication, wrong Rx refilled, under-dosing during infusion
- Delay of Care
  - Use of expired thin-prep requiring repeat PAP, lab order delay,
- Med Handling / Storage
  - MDV not used appropriately, no BUD, unsecured Rx, missing Rx, no labeling of meds in a syringe
- Provision of Care
  - Infiltration of IV during infusion, pressure ulcer from ill-fitting splint, use of broken speculum, injury during venipuncture
- Infection Control
  - Bed bug exposure, Medivator error
- Documentation Error
  - Mislabeling of lab specimen, wrong lab results given
- Security
  - Doors left unlocked, theft of clinic cash and PHI
- Facilities
  - Torn carpet causing fall, fire alarm malfunction, bee hive outside of entrance causing stings

Report Breakout
Q3 - 2016

60 Reported Patient Safety Events



Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Pacific Medical Centers – CoD Success

- Born from the idea of improving patient safety, root cause analysis, and reducing financial loss
- Obtain buy-in from Senior Administration, CMO, Clinic leads
  - Saturday all provider training day occurred for 100+ providers.
- Publicize Physician Lead, Admin Lead, and two supports members
  - "*Train the Trainer*" education days were held for 4 key members
- Conduct focused presentations to 20-30 providers
- "*Situational Mangers"* training - Office Managers, Clinic Leads, and 4 LIPs
- Develop modules for onboarding/orientation

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

In 2017 PacMed is transitioning to tools developed by AHRQ: ***C****ommunication* ***and O****ptimal* ***R****esolution* (**CANDOR**) process.

https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/index.html#module5

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

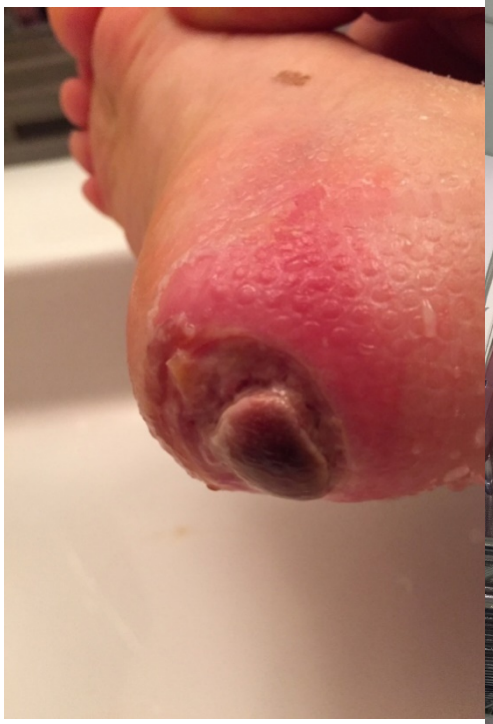
FOUNDATION FOR HEALTH CARE QUALITY
www.qualityhealth.org

Questions?

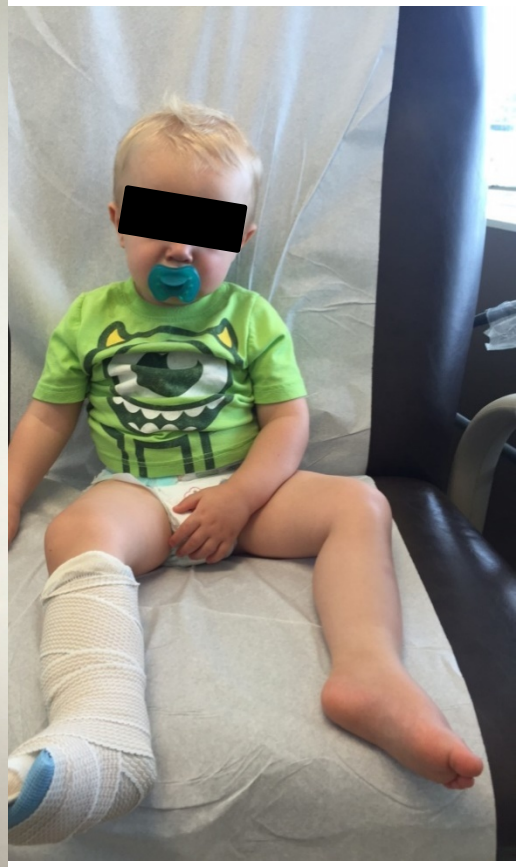
Physician Lead CoD Examples

- Forehead dermatitis from bandage and scaring.
- Ptosis surgery post op healing.
- Automatic office chair injury to foot and leg.
- Improper splinting technique with development of a heel ulcer.
- GYN hysteroscopy billing/follow up.
- Cataracts lens replacement outcomes.
- Twinrix improper dosing schedule (72 patients.)
- Colonoscopy follow up (~40 patients.)

ALEE + TEAM




PRIMARY CARE
PEDIATRICS
SPLINT SUPPLIES
3 in
7,6 cm
REF
73003
3 in x 15 ft
7,6 cm x 4,5 m



Resources

- Institute for Healthcare Communication
  http://healthcarecomm.org/
- RL Solutions
  http://www.rlsolutions.com/
- CANDOR
  https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/index.html#module5
- PacMed.org
- Alex Hamling
  hamling@gmail.com

Enactment

- Scenario
- Patient: Olivia Dawson
- Encounter: post-surgical following treatment of gynecological bleeding
- Location: Patients room
- Relevant facts: Patient admitted for vaginal bleeding.
- Mass excised from cervix, bleeding becomes profuse, and surgeon tosses the specimen on the back table, but you neglect to tell nurses about specimen.
- Bleeding successfully controlled amidst hectic OR activity including blood transfusion.
- Circulating nurse goes on break, neglects to tell relieving nurse that specimen has not been received from scrub tech.
- Lab calls later in day to say no specimen was found in submitted container.
- Surgeon had initial conversation with patient, who became upset and asked to speak to someone “in charge”

Enactment [continued]

- Task: Patient has asked to speak to people “in charge”
- Consequences of error
  - Because of lost specimen patient will need to return to OR
  - Re-biopsy may or may NOT yield a diagnosis
  - Treatment plan is “on hold” until definitive diagnosis can be made

In-Depth Simulation

- Set up
  - "Real" environment
- Ground rules
  - Learning mode: "Putting practice before us"
    - Foundation of gratitude
    - "They're in the hot seat but we're all sweating it out"
  - Participation awareness
  - Respect multiple perspectives
- Debriefing structure
  - Curiosity driven
  - Actor feedback – rare opportunity

In Preparation: Questions to Consider (Huddle)

- What are the goals of the interaction?
- When should you respond to the patient/family?
- Who should respond to the patient/family?
- What questions do you anticipate getting from the patient/family?
- What emotions do you anticipate, how will you name and validate them?
- What are you going to say to the patient/family?
- What information should be shared/discussed?
- Who continues to respond to the patient/family as more information is discovered?
- How do you respond to your caregivers?

Debrief

DAY 1 CLOSING

Thomas Gallagher

Peter Dunbar

Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT

FOUNDATION FOR HEALTH CARE QUALITY www.qualityhealth.org