Northwest Communication and Resolution Program Leader Retreat

Achieving Benefits, Avoiding Pitfalls

September 27-28, 2017

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WELCOME: DAY 2

Thomas Gallagher

Peter Dunbar

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CARE FOR THE CAREGIVER

Tim McDonald

Bruce Lambert

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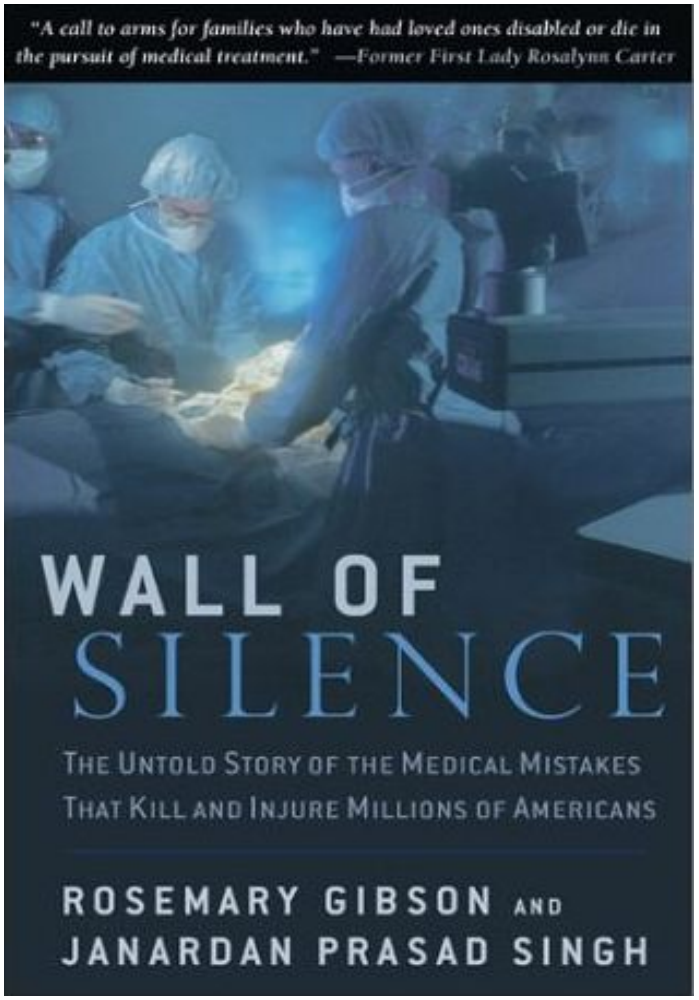
Making Matters **W**orse For Everyone



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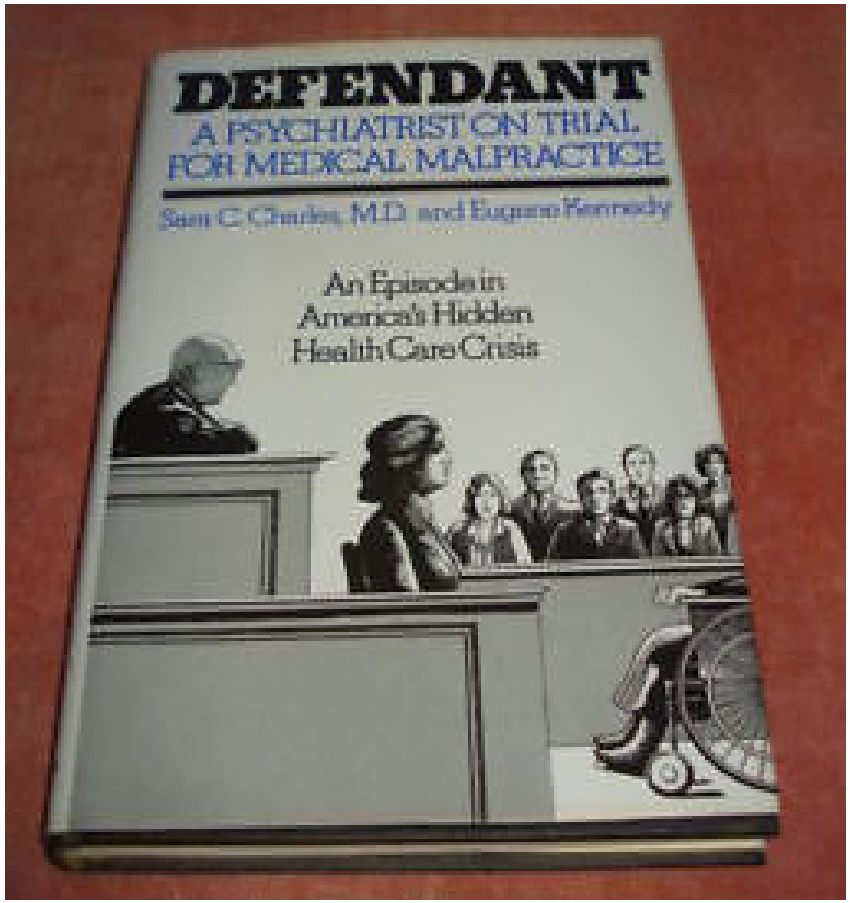
Defendant



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Defendant

In Sara's own words

"My first feelings after being charged with medical malpractice were of being utterly alone. I felt isolated from my colleagues and patients. I also understand that what I experienced…are common reactions of most doctors accused of negligence."

Impact of “The Wall”

“swallowed up life”

“demanded constant attention and study”

“multiplied attention and strain”

“generated pattern of broken sleep”

“felt integrity as a person and physician had been damaged and might be permanently lost”

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

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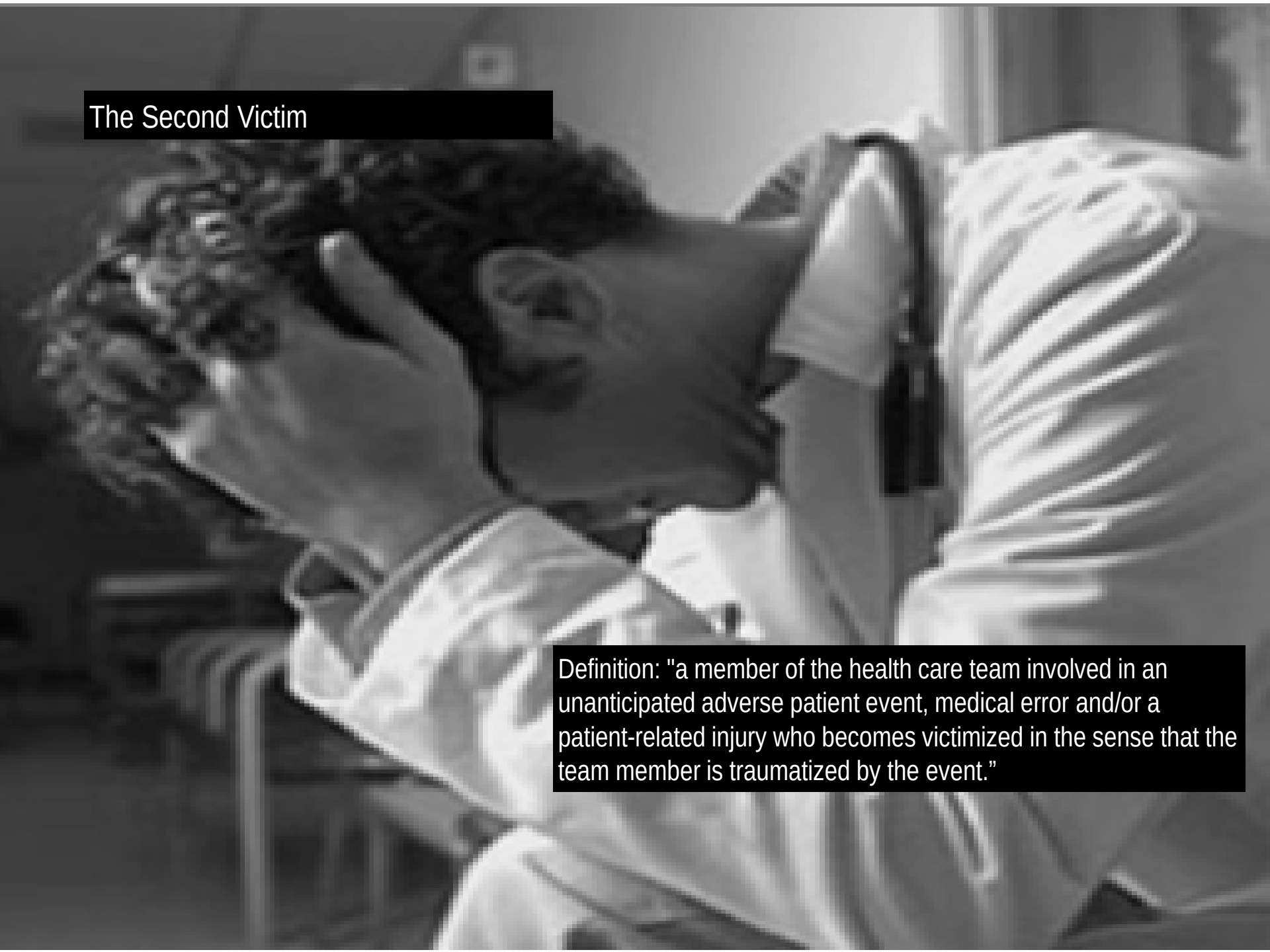
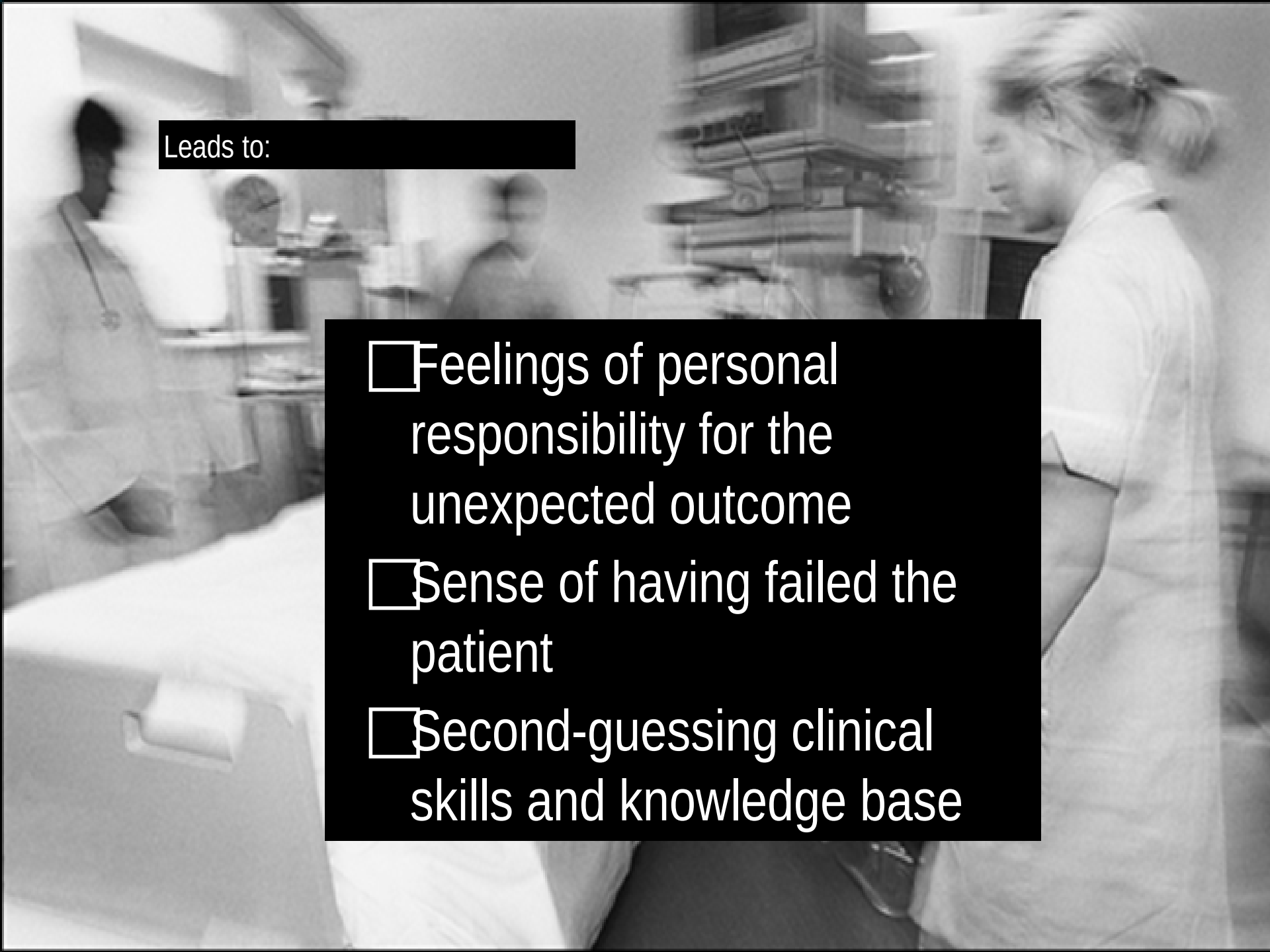
The Second Victim



Definition: "a member of the health care team involved in an unanticipated adverse patient event, medical error and/or a patient-related injury who becomes victimized in the sense that the team member is traumatized by the event."

History of the Problem

Adverse event investigations – individuals at the "sharp end" noted to be experiencing predictable behaviors post event



Leads to:

- Feelings of personal responsibility for the unexpected outcome
- Sense of having failed the patient
- Second-guessing clinical skills and knowledge base

How to identify those in need

Second victims often report similar symptoms, like:

- Extreme fatigue
- Sleep disturbances
- Memory/concentration problems
- Headaches or muscle tension
- Irritability
- Emotional numbing
- Flashbacks
- Loss of confidence
- Grief/remorse

Behavioral changes that can be more extreme:

- Changes in activity level
- Changes in appetite
- Drug or alcohol abuse
- Social withdrawal

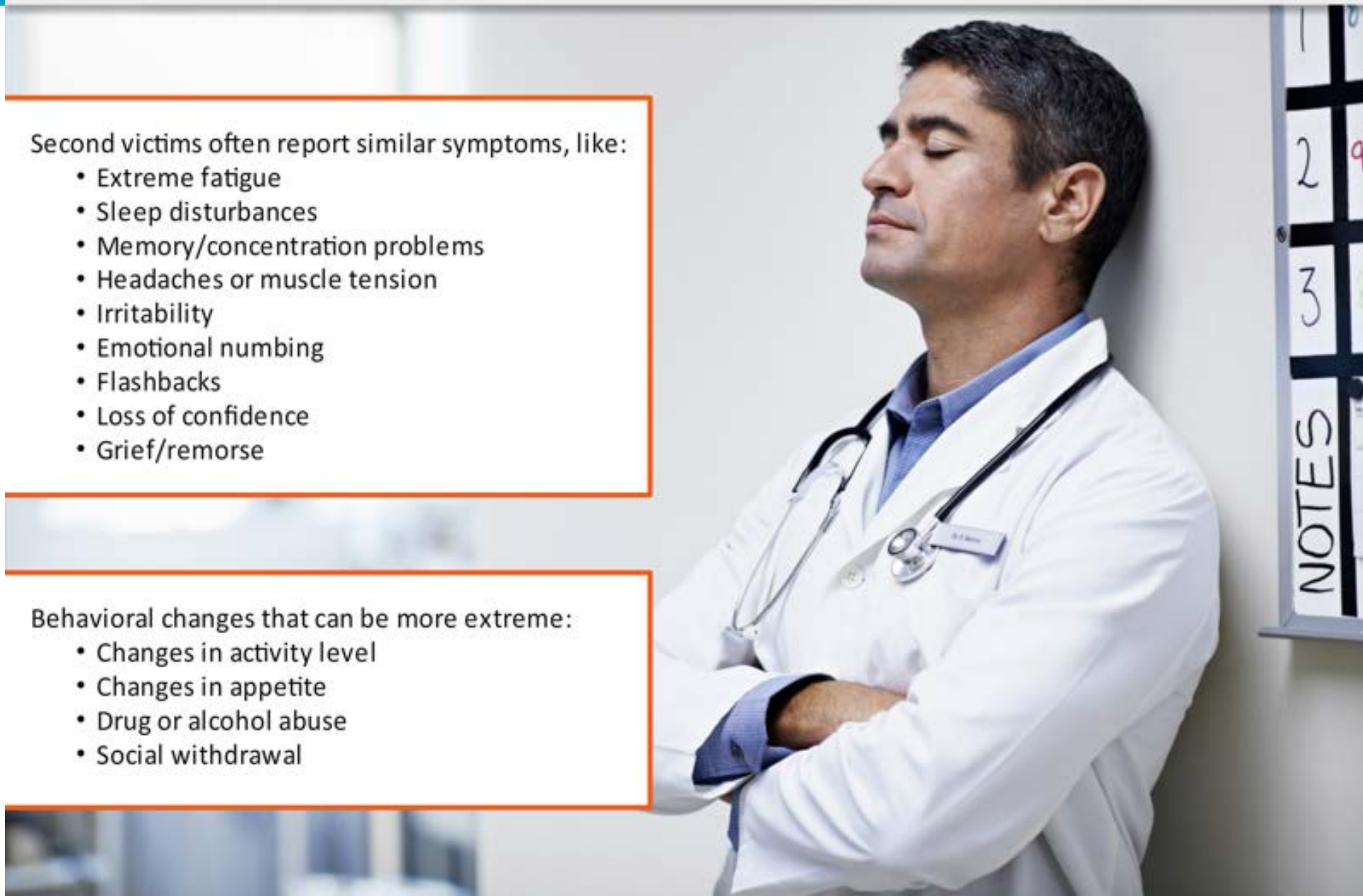
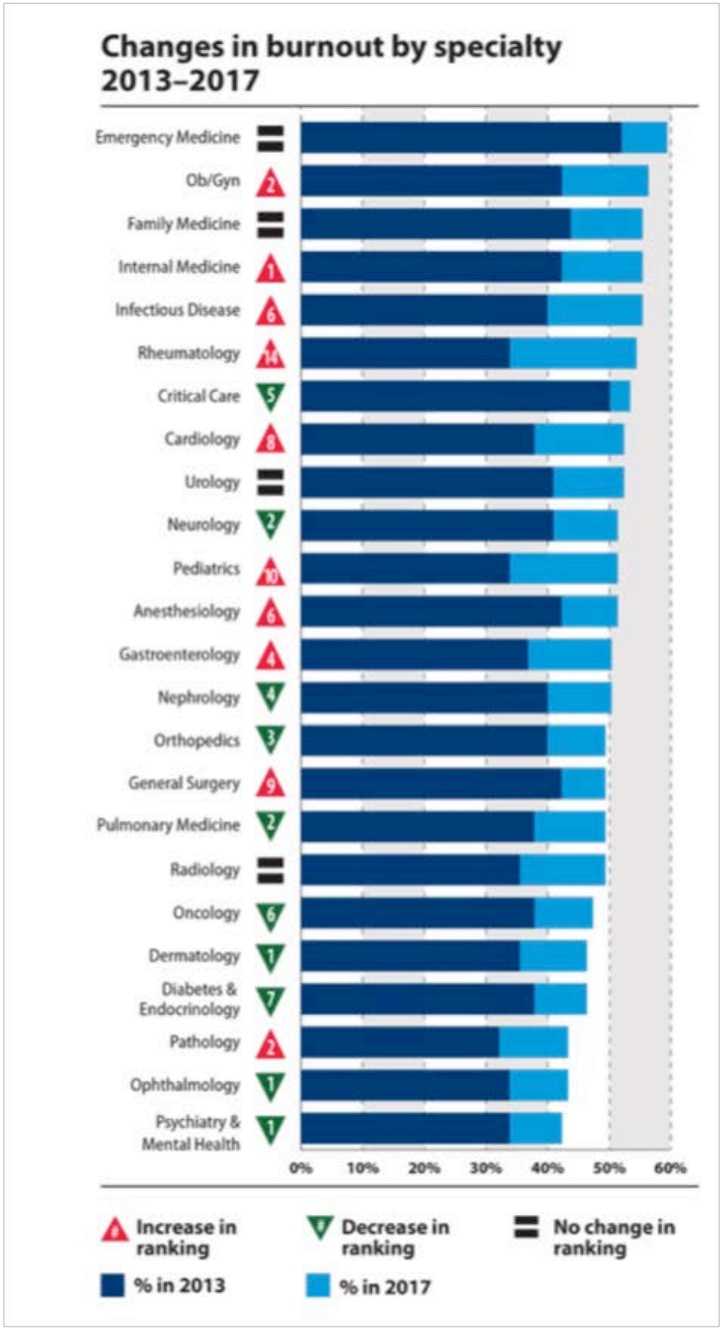


TABLE 1] Symptoms Associated With Burnout Syndrome

Psychological Symptoms	Physical Symptoms
Frustration	Exhaustion/Fatigue
Anger	Insomnia
Fear	Muscle tension
Anxious	Headache
Inability to feel happy	GI problems
Being unprofessional	
Feeling overwhelmed	
Disillusionment	
Hopelessness	
Lack of empathy	
Feeling insufficient at work	



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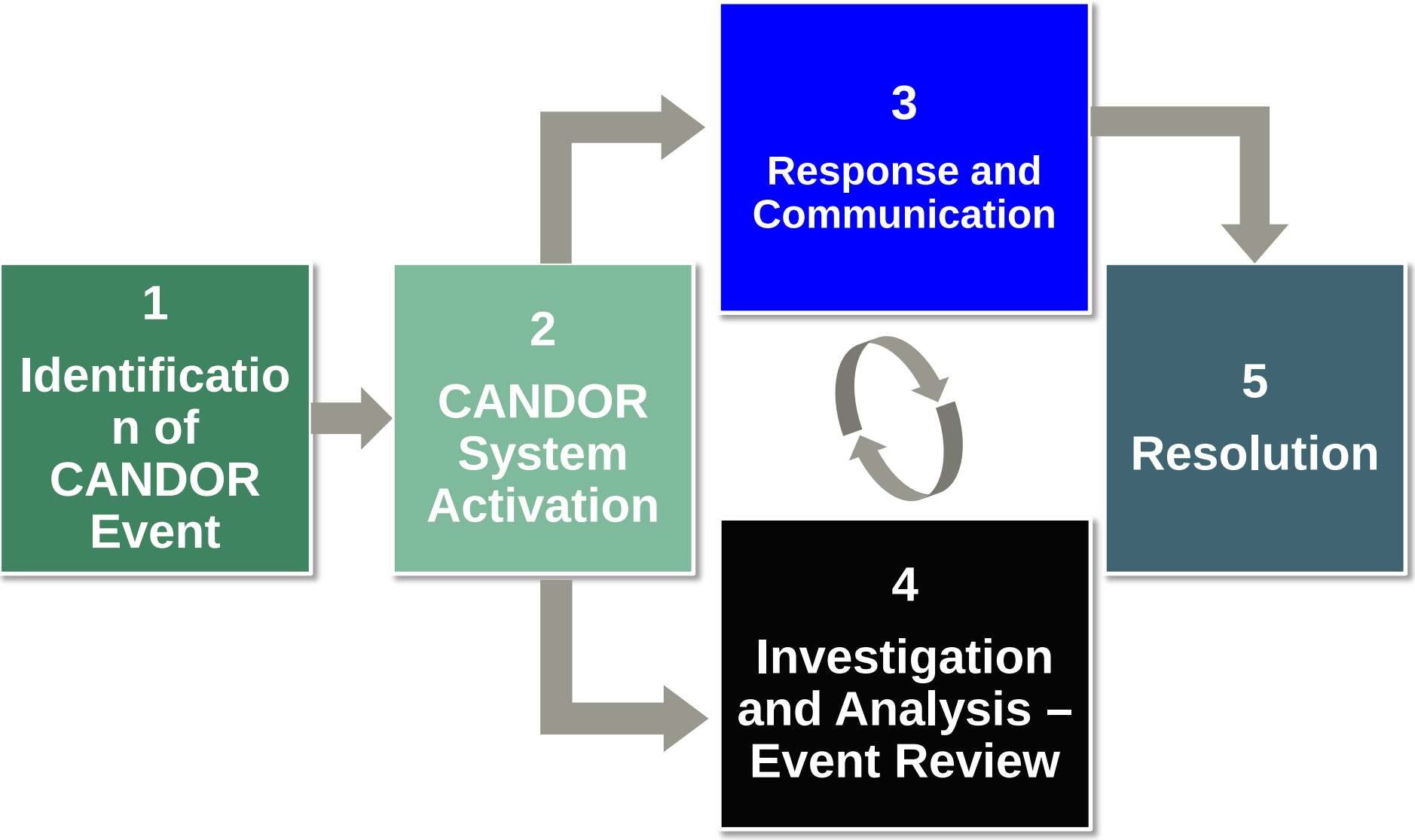

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The Paradigm Shift

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

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CFC Getting Started

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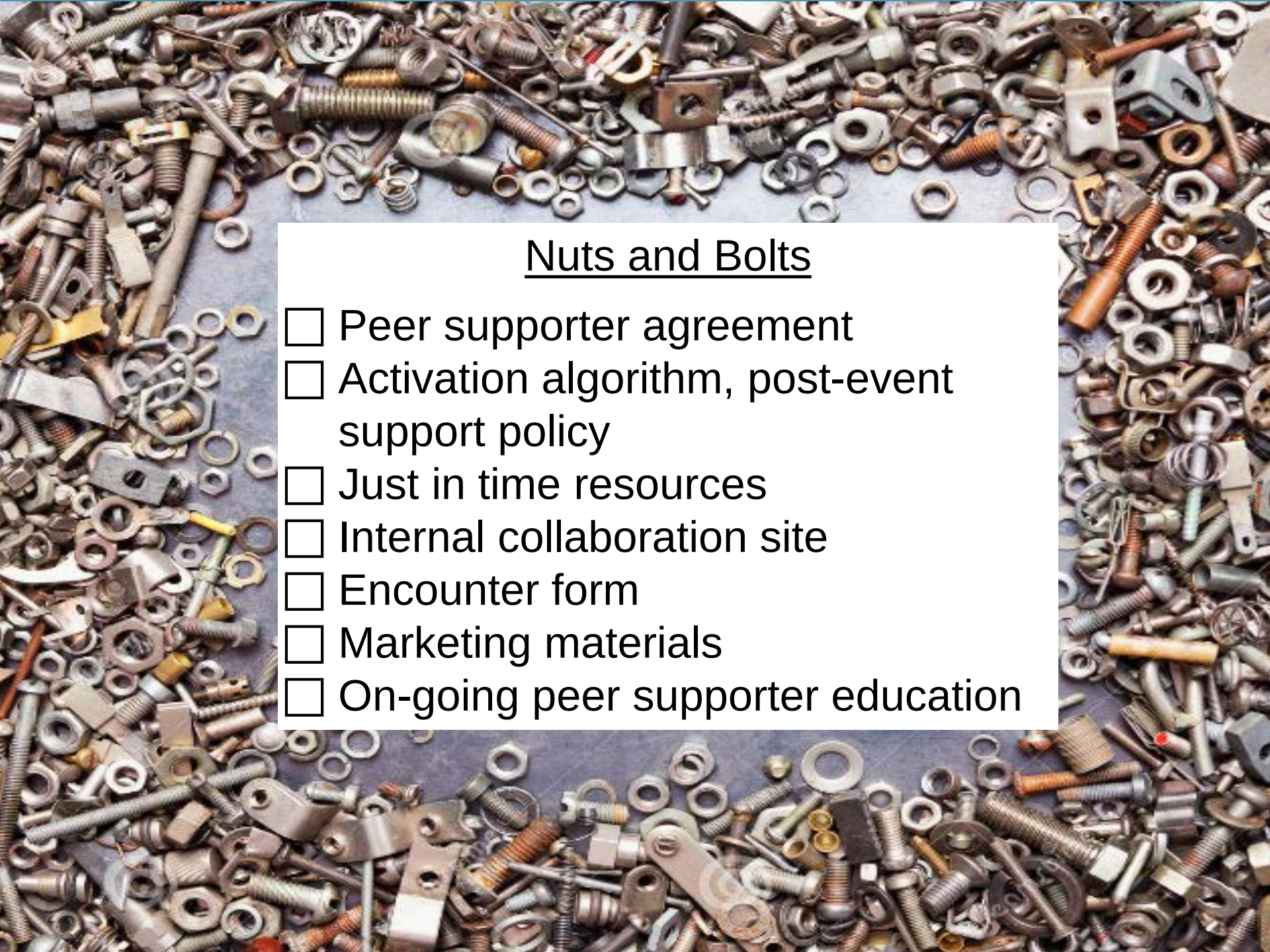
Care for the Caregiver Steering Committee

- Director
- Champions: physician, nurse, resident, other clinical, operations
- Executive sponsors: VP patient safety, VP HR, behavioral health service line leader
- Research/project coordinator
- Representatives
  - Behavioral Health
  - Employee health/EAP
  - Learning Institute
  - HR
  - CANDOR
  - Pastoral care
  - Risk Management
  - Patient Safety
  - Corporate communications

Care for the Caregiver

- Peer supporters nominated
  - Residents (OB, surgery, Med/peds, FM, EM)
  - Attendings (cardiology, IM, surgery, anesthesia, radiology, OB, MICU, ED, neonatology)
  - Nursing (SCC, CVCC, NICU, inpatient floor, psych, ED, L&D, MICU, PACU)
  - Respiratory therapy, pharmacy



Nuts and Bolts

- ☐ Peer supporter agreement
- ☐ Activation algorithm, post-event support policy
- ☐ Just in time resources
- ☐ Internal collaboration site
- ☐ Encounter form
- ☐ Marketing materials
- ☐ On-going peer supporter education

The Peer Supporter Agreement

Peer Supporter Agreement

I, _____, agree to serve as a **Care for the Caregiver Peer Supporter** for a minimum of one year. I agree to the following commitments:

1. Complete peer supporter training session(s) as scheduled.
2. Attend a minimum of 50% of monthly peer supporter team meetings per year.
3. Complete encounter form after each intervention in a timely manner (generally 1 week).
4. Except where superseded by law or otherwise stipulated in the team guidelines, maintain strict confidentiality regarding intervention services, including topics discussed and personnel involved.
5. Abide by the established team protocols and guidelines.
6. Follow through on assigned interventions once accepted
7. Provide at least a four week notice to the Care for the Caregiver steering committee if I no longer wish to serve as a peer supporter.

I have read and understand these commitments.

I understand that my role as a peer supporter is revocable at the discretion of the Care for the Caregiver Steering Committee based upon, but not limited to, any violation of the tenets of the Peer Supporter Agreement.

_____

Care for the Caregiver Peer Supporter Team Applicant (Signature) (Date)

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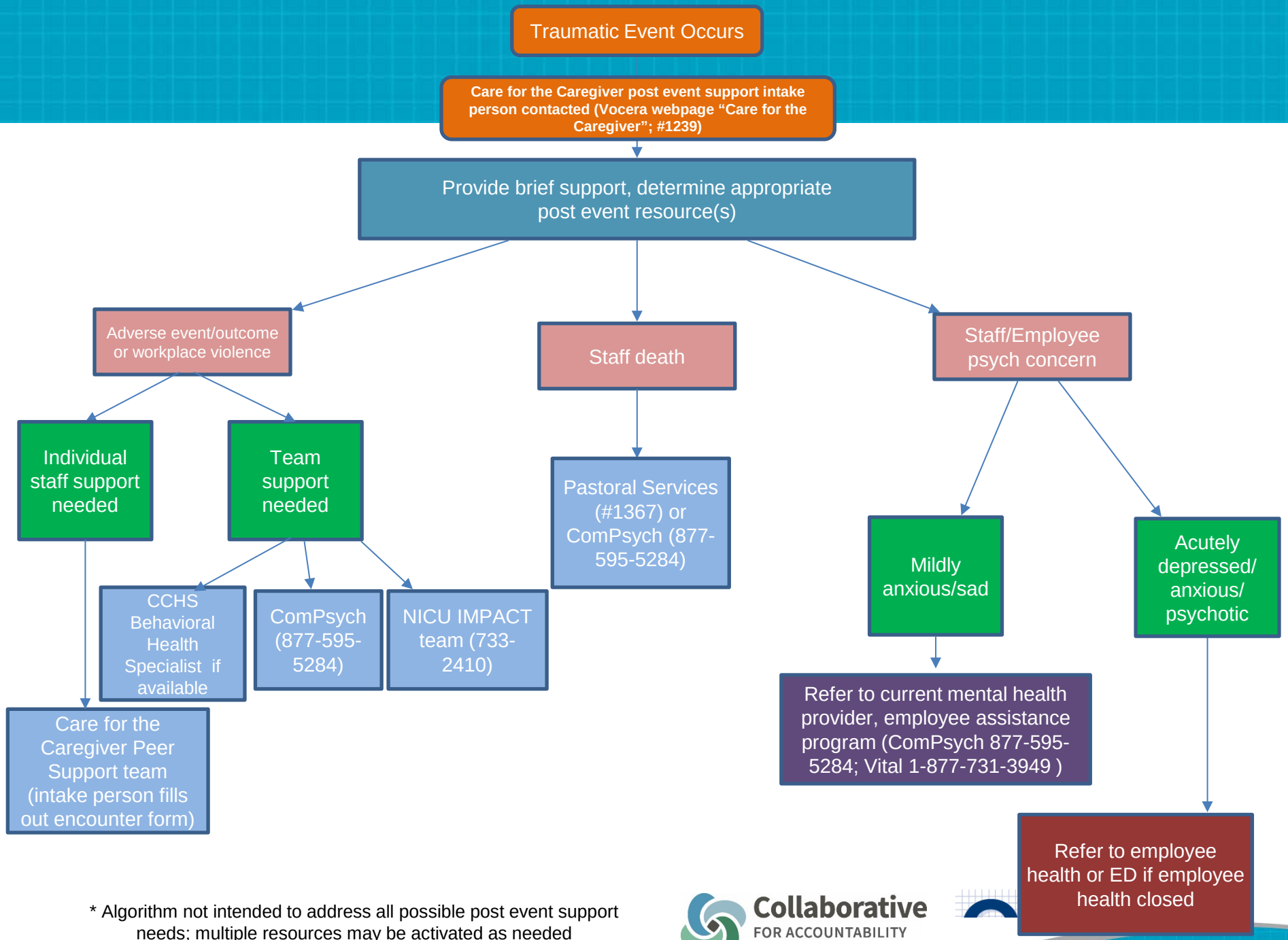

* Algorithm not intended to address all possible post event support needs; multiple resources may be activated as needed

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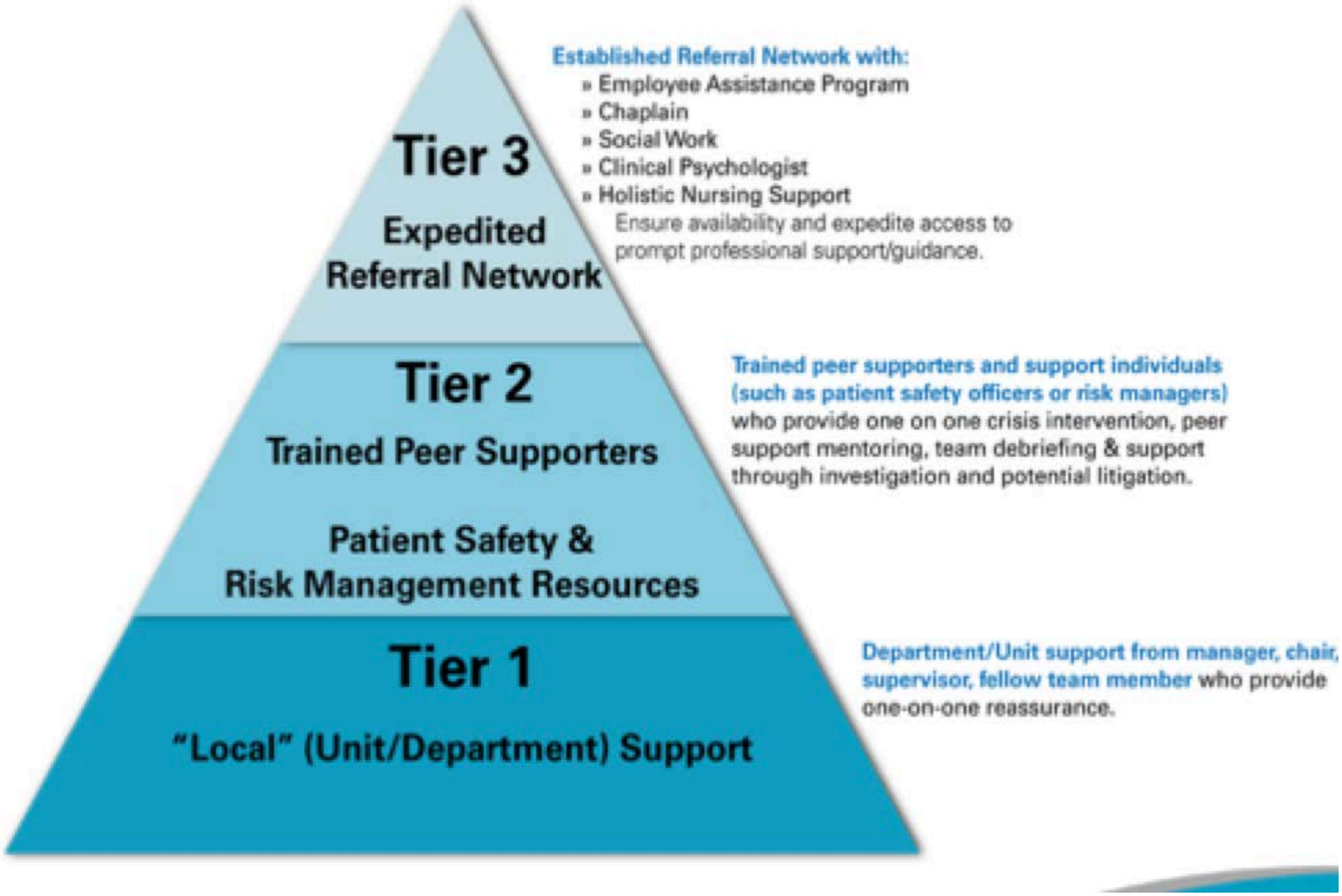
Tier 3
Expedited Referral Network
Established Referral Network with:
» Employee Assistance Program
» Chaplain
» Social Work
» Clinical Psychologist
» Holistic Nursing Support
Ensure availability and expedite access to prompt professional support/guidance.
Tier 2
Trained Peer Supporters
Patient Safety & Risk Management Resources
Trained peer supporters and support individuals (such as patient safety officers or risk managers) who provide one on one crisis intervention, peer support mentoring, team debriefing & support through investigation and potential litigation.
Tier 1
"Local" (Unit/Department) Support
Department/Unit support from manager, chair, supervisor, fellow team member who provide one-on-one reassurance.

Building Team of Peer Supporters

- Initial Nomination
- Communication Assessment with Feedback
- Communication Skills Training
- Ongoing Practice
- Follow-up Debriefs
- Data Collection
- Continuous Improvement

People Differ in How the Prefer to Be Helped, Comforted, and Loved

- Listening
- Concrete solutions
- Money
- Reassurance
- Exploration of worst case scenarios
- Touch (a hug, as appropriate)

School of Life: How to Help Those We Love

Many Ways To Help Those We Love

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The Eight Commandments of Peer Counseling

- Be nonjudgmental
- Be empathic (not a brick wall)
- Don’t give personal advice (don’t opine on legal matters related to the case; the investigation, etc.)
- Don’t ask questions that begin with “Why”
- Don’t take responsibility for other peoples problems
- Don’t interpret (when a paraphrase will do)
- Stick with the here and now
- Deal with feelings first

Salovey 1996

Challenges to Providing Peer Support

- Stigma to reaching out for help.
- High-acuity areas have little time to integrate what has happened.
- Fear of the unknown.
- Fear of compromising collegial relationships because of the event.
- Fear of future legal issues.

How to Provide Peer Support

- Talk through the experience.
  - Depends on speaking and listening
- Walk through the peer support interaction.
  - Introduction
  - Exploration
  - Information
  - Followup

Communicating with Peers: Best Practices

- Introduce yourself by name and role
- Find a private/appropriate place to talk
- Sit down
- Frame the visit with preliminary remarks
- Explain reason for conversation
- Ask what type of help they want or need
- Ask how they prefer to be supported when they are upset
- Proper nonverbal behavior
- LISTEN (silence is not bad)
- Accept the validity of their reaction
- Observe and comment, without judgment, on their behavior, mood, and affect

Don't

- Say you know how they feel
- Dwell on your own experience or emotions
- Attempt to investigate the event
- Make promises you can't keep
- Finger-point
- Do all the talking
- Minimize severity of event or intensity of feelings
- Try to make them feel any way other than how they are feeling

Cascade of CANDOR “Kindness”

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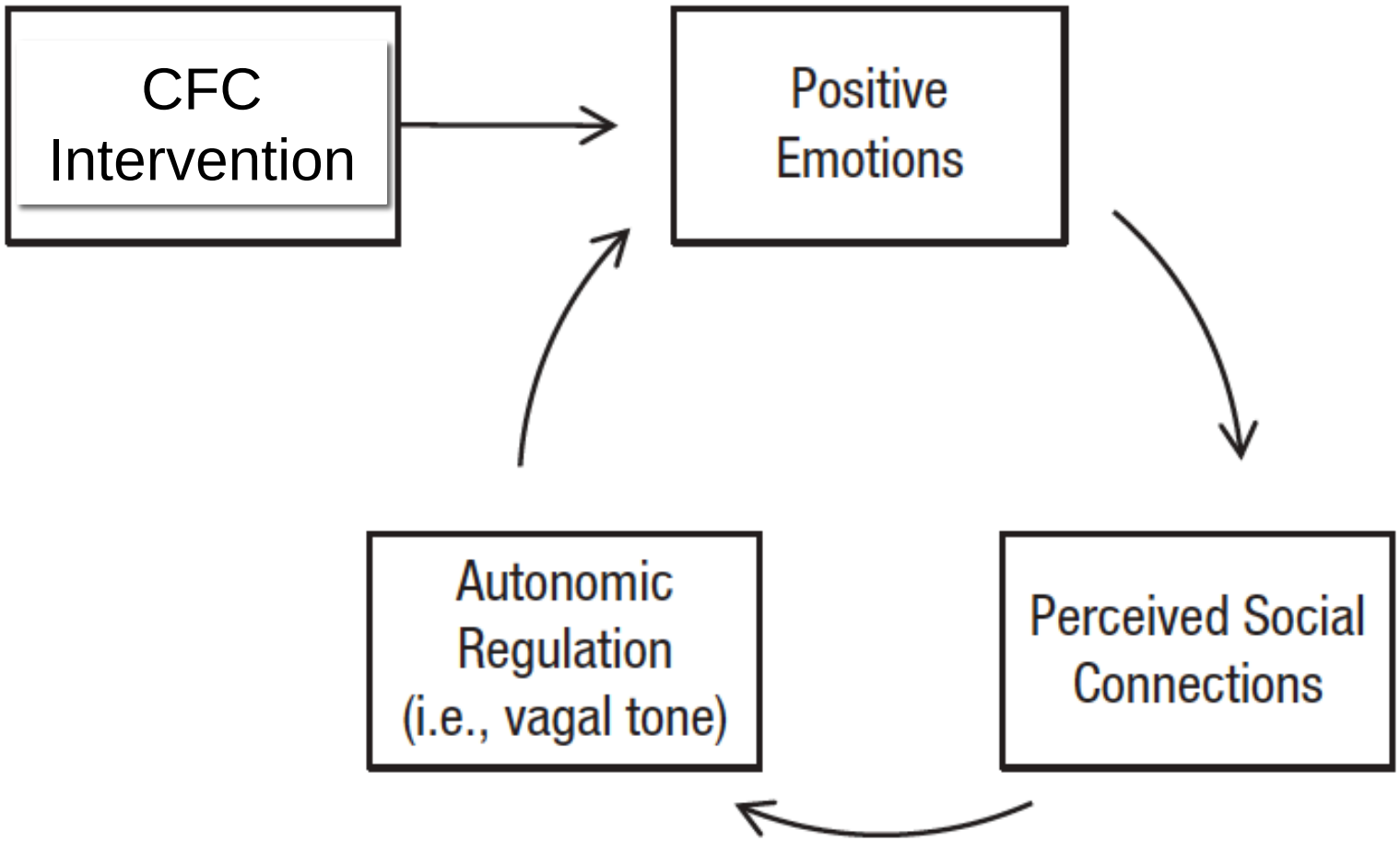
Reciprocal Kindness Loop



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Questions

RESOLUTION : THE FINAL STEP & ULTIMATE GOAL

Presented by
Heather Gocke, MS, RNC, CPHRM, C-EFM
Claire Hagan, MJ, CPHRM

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Objectives

- Understand the importance of laying a foundation of trust with patients and stakeholders in our relationships with them even before an unexpected medical outcome occurs
- Appreciate the values of having a shared vision with stakeholders of the value of prompt communication towards resolution with patients in the event of a serious unexpected medical outcome
- Understand the communication journey with the patient & families from the first conversation until the last, and the importance of planning when communicating the investigation findings when the care is found to be reasonable or unreasonable.
- Consider the various pathways in reaching a final resolution with stakeholders.
- Learn about BETA Healthcare Group's proactive approach in working with policyholders to encourage adoption of CRP practices known as BETA HEART, along with stakeholders in the communities around their insureds.

Assume you or your family member just had surgery during which something was “nicked & fixed”. If you would expect to be told even though the provider in their good clinical judgment thought everything would be fine…

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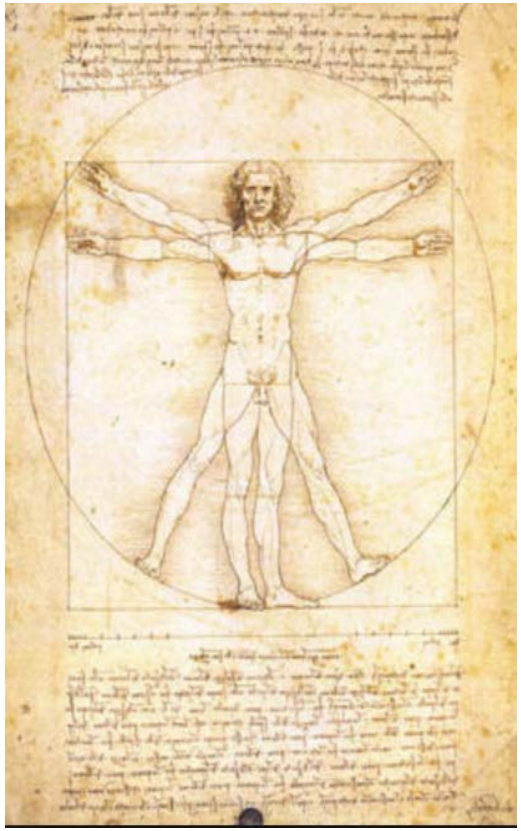
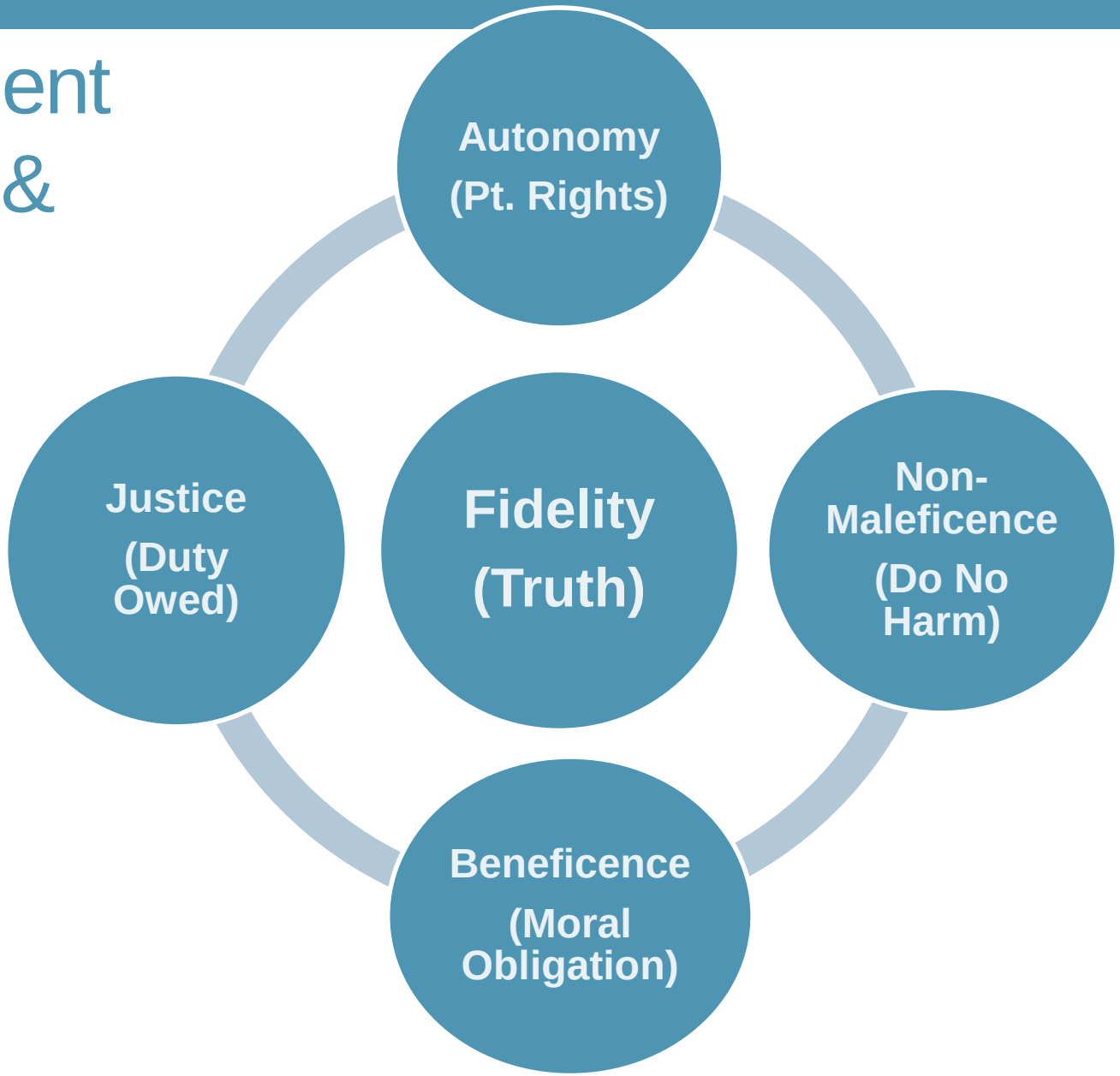
Provider-Patient Relationship & Ethics:





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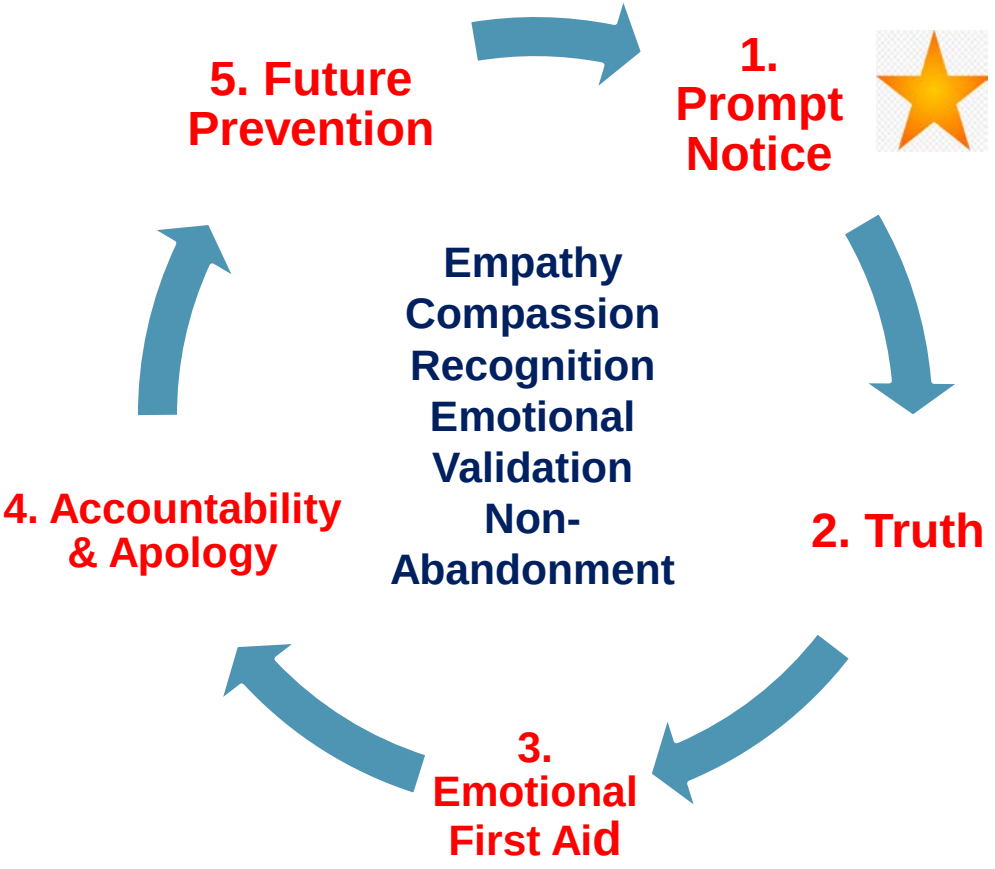
What Patients Want & Expect



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Compassion & Empathy What Does That Mean & Sound Like?

- Compassion is about trying to imagine how another person feels.
- Empathy is putting ourselves in the other person's shoes.
- Each of us experience disappointment, surprises and alarming news differently based on past life experiences.
- Compassion is being supportive, understanding and patient; it is allowing the patient to vent, ask questions and be angry.
- These principles apply to patients and caregivers following an unexpected medical outcome.

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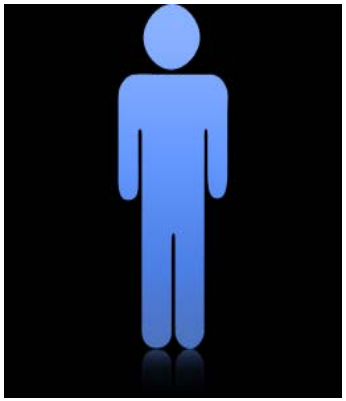
Who would be comfortable informing a patient or family within an hour of an unexpected outcome before knowing completely why or how it occurred?

This is the CRP expectation.

The many stakeholders & Their Insurance representatives



Patient

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Supporters of Disclosure

- Most U.S. states have “I’m Sorry Laws”
- The AMA Journal of Ethics:

  Trust between a physician and his or her patient is at the very core of the patient-doctor relationship. Hiding from, obscuring, or omitting facts and details in conversations with patients, particularly in the face of a medical error, erodes that trust. **Full disclosure, whether it increases malpractice liability or not, is the appropriate ethical path.**

  http://journalofethics.ama-assn.org/2008/05/ccas4-0805.html
- Joint Commission
- Most professional liability malpractice insurance carriers teach principles of CRPs/Disclosure: BETA Healthcare Group, Physicians Ins., MedPro, CNA, The Doctors Co., and others)

Laying a foundation with INTERNAL stakeholders before an event occurs

- Meet with stakeholders to determine their knowledge and acceptance of the Communication & Resolution Process (CRP)
- Develop & circulate a list of all stakeholders, their risk management, insurance and claims representative contacts
- Assess whether group education/facilitation regarding CRP would be beneficial by an outside subject matter expert to foster CRP within your organization or practice

Working with internal stakeholders & their carriers

- Work towards developing an agreement and understanding concerning prompt internal notice when an unexpected medical event occurs
- Strive to reach agreement that stakeholders will promptly notify their respective risk management contacts who in turn will notify their liability carrier informing them of the medical event requiring investigation
- Following confirmation that the above steps have been taken by the respective parties, contact can then be made between external stakeholders to facilitate prompt investigation and ongoing communication towards coordination of the Communication & Resolution Process before a written claim or lawsuit is asserted.

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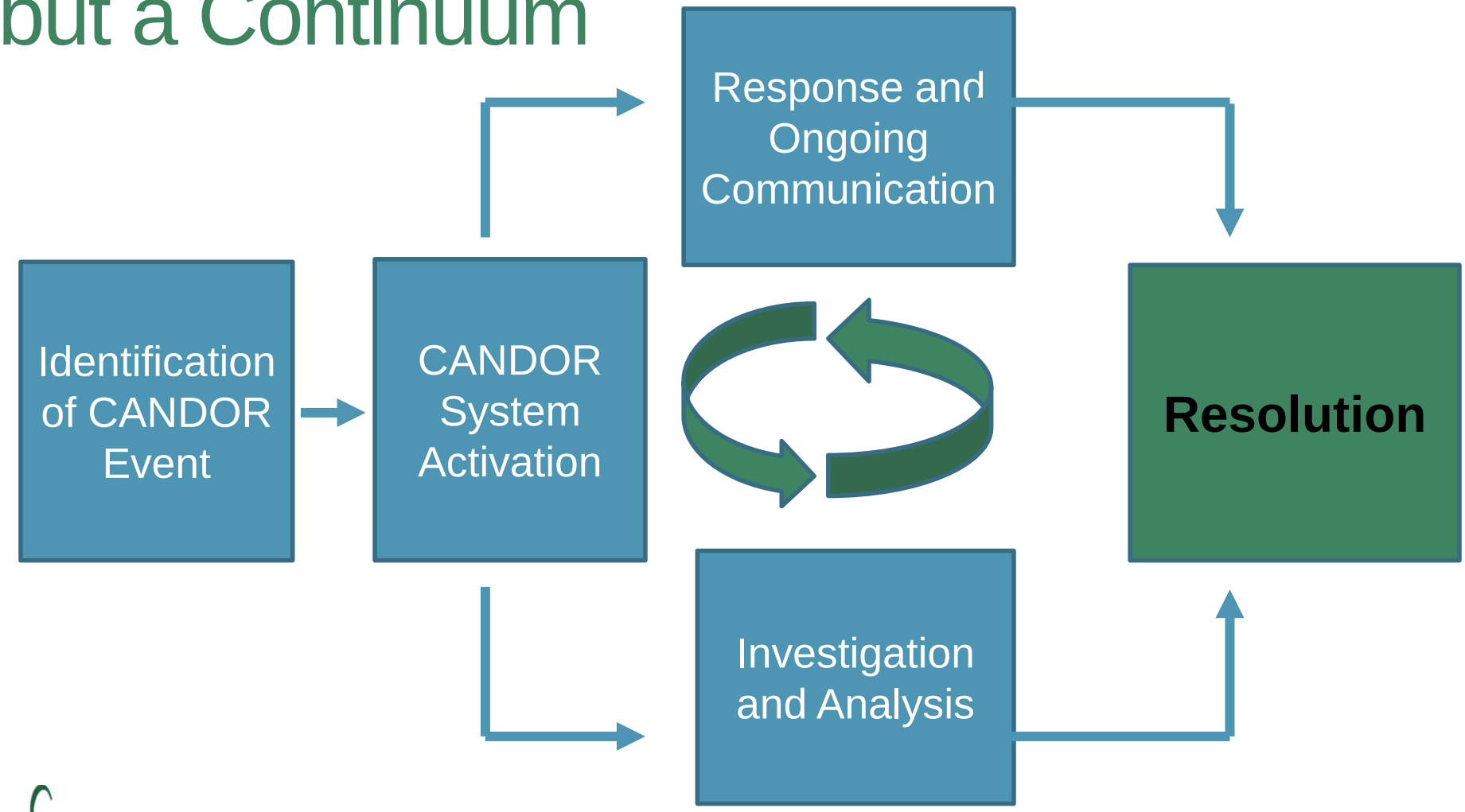
Disclosure Is Not an Event but a Continuum



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The Key Contact's Role with the Patient

- Generally speaking after the initial conversations with the provider following an unexpected event, **ongoing contact is often transitioned to a "Communication/Disclosure Lead"** (an AHRQ CANDOR term for someone who manages the communication & investigation behind the scenes and with the patient) within the healthcare organization.
- Understanding that **stakeholders and their liability carriers will need access to medical records**, the Communication/Disclosure Lead can explain to the patient or their family the involvement of external stakeholders and their need **to review the circumstances surrounding the care and unexpected event**. In the course of that conversation the **Communication/Disclosure Lead requests written authorization from the patient to release the medical records to the external stakeholders**.

Disclosure Lead's ongoing contact with patient & Stakeholders

- The Communication/Disclosure Lead's role is to maintain contact with the patient, providing emotional support and updating them on the status of the review.
- Once the investigation is concluded it is likely that **internal and external stakeholders, including insurance carriers or claims management contacts, would be communicating with each other and meeting** to discuss their respective findings regarding causation, liability and apportionment of liability, and seek agreement on next steps.

Unexpected Medical Outcomes

- Known Complications of Care
- Unrealistic Expectations
- Biological Variability
- Wrong Judgments without Negligence

- Clinical Performance Errors
- Clinical Judgment Errors
- System Errors
- Equipment Failures

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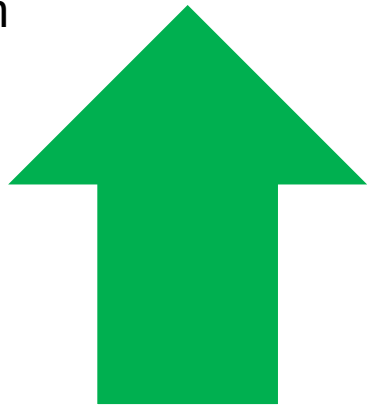
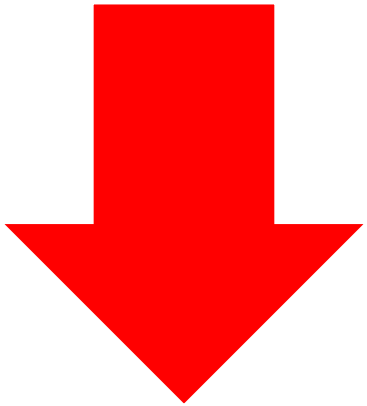
Following investigation: Two Pathways

Compassionate conversation with patient & family explaining what was learned after careful review of the circumstances surrounding the patient's medical condition and care. Answering questions and providing emotional support.



Care Reasonable

Compassionate conversation apologizing for error that lead to patient's injury, answering questions, explaining changes made to prevent reoccurrence and intentions to compensate patient for financial loss as well as pain and suffering.



Care Unreasonable

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When Care is Unreasonable & Multiple Parties Are Involved: Possible scenarios

Parties Agree to Proceed to Resolve Case Together

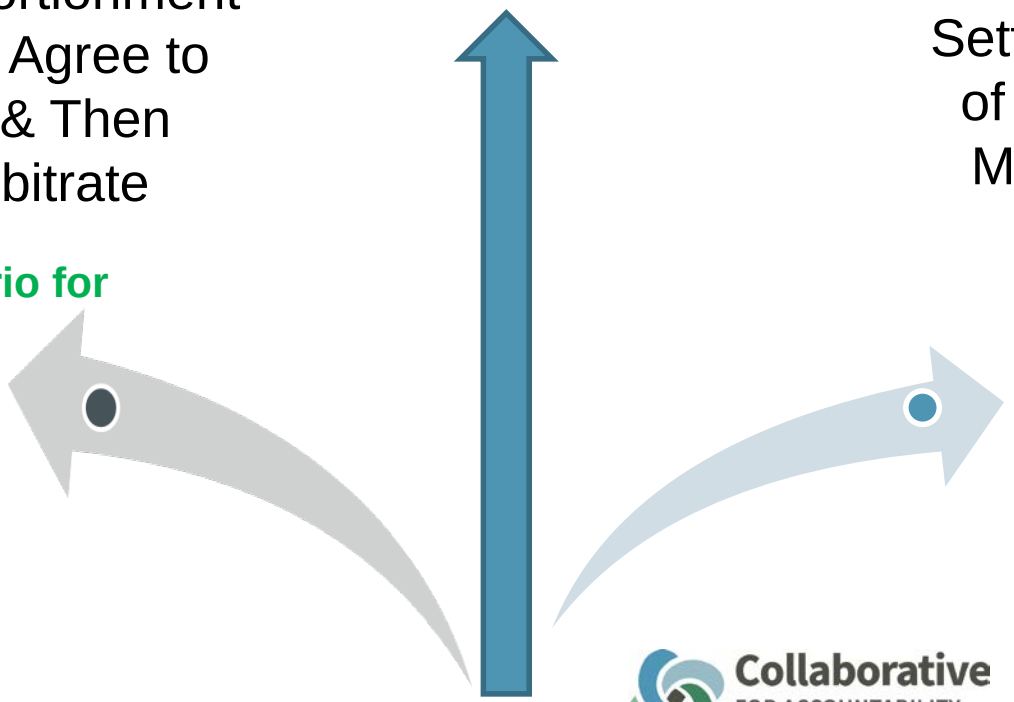
Best Scenario for Patient

Parties May Disagree on Liability or Apportionment of Liability but Agree to Settle Case & Then Privately Arbitrate

Best Scenario for Patient

Party "A" May Disagree to Participate in Settlement Running Risk of Litigation; Party "B" May Attempt to Settle Out on Their Own

Likelihood of Additional Emotional Trauma for Patient & Providers; Legal Expenses for Providers



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Stakeholders' Differing perspectives concerning resolution

Commercial Carriers, Independent Providers, Practices

- Some carriers have long history of "Deny & Defend Approach"
- Verdict research shows that individual providers have higher rates of defense verdicts at trial, therefore some carriers are more willing to take the risk of trying a case.
- Providers have National Practitioner Data Bank & state licensing considerations
- Most providers have "Consent to Settle" insurance policy provisions

Hospitals & Clinics

- Institutions are often defending care on multiple fronts which is more challenging
- Juries perceive Institutions as impersonal and having unlimited resources to "take care of the patient"
- Institutions have reputational risk of bad publicity within community
- Institutions have potential risk of losing lifetime relationships with patient & family

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Talking Points final meeting Example

- **Introduction of everyone in attendance and their roles**
- **Appreciation of family's patience while review completed**
- **Empathetic statement acknowledging the emotional or medical impact from the unanticipated event (frustration, inconvenience, aggravation, disappointment, etc.)**
- **Asking patient/family how they are doing**
- **Overview of the medical facts & care, & circumstances that led to our questions surrounding the care**
- **What we learned from our review**
- **What questions do you have for us?**
- **What additional information can we provide for you?**
- **Our sincere appreciation for allowing us this opportunity to meet (Follow up with letter or call post-meeting)**

Evaluating Harm

Physical

Emotional

Financial

Consider a Legacy in Memory of the Patient

Patients and families want to make sure this event never occurs to anyone else, which is the legacy of their suffering.

Making some significant process improvement or offering some tangible remembrance can have a significant impact to the patient or family.

- Examples:
  - Offering training in the memory of the patient
  - Inquiring about patient/family interest in working with Patient Safety Committee
  - Asking the patient or family for permission to videotape their story or present their story to staff or board members
  - Some permanent remembrance of the patient in a walkway, memorial or garden
  - Obtaining their written permission as a part of the final settlement release allowing us to tell their story for patient safety and quality purposes

Talking Points final meeting Example

- **Introduction of everyone in attendance and their roles**
- **Checking in with patient and family about how they are doing**
- **Appreciation of family's patience while review completed**
- **Our apology for the (frustrating, disappointing, unexpected…) experience surrounding their medical care**
- **Background of the medical care & events, & circumstances that led to our questions surrounding the care**
- **What we learned**
- **Our deepest and most sincere apologies for causing this tragic injury**
- **How this has impacted those involved**
- **Changes made as a result of this tragic loss**
- **Our intentions going forward to compensate you for your loss**
- **What else can we do to support you and your family at this time?**
- **Introduction of claim representative if present, or plans to have them contact the patient/family**
- **Our sincere appreciation for allowing us this opportunity to meet**

BETA Healthcare Group's journey to Early Resolution

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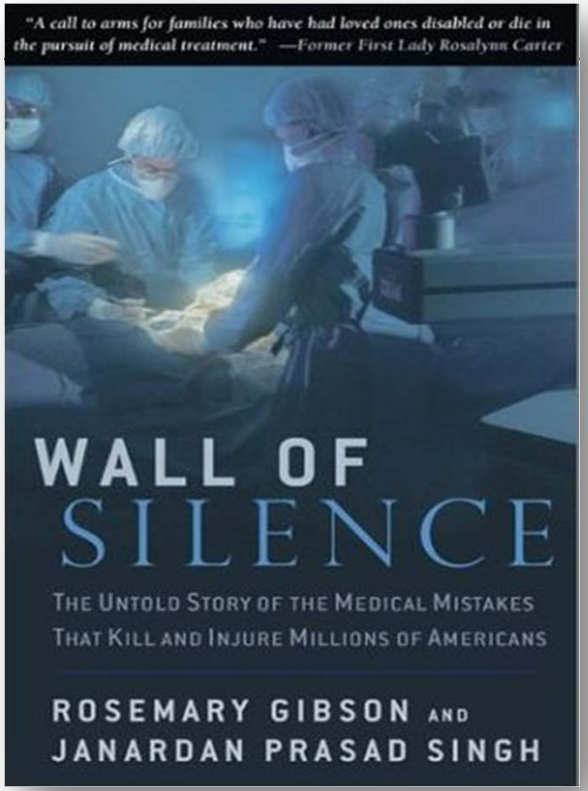
IT STARTED WITH A BOOK

- Getting our Board on board
  - Call for Board member participation in its development
- All Claims management staff attended disclosure and communication workshops
- Core group formed to create BETA's internal response system and process



Share Philosophy with Defense Counsel

- Elicited response from defense counsel
- 24 of 26 attended; all firms representing BETA Healthcare Group clients attended
- Board members and senior leadership present at both meetings
- Dispel perception that our model was “Sorry Works”
- How to use Counsel in different ways
  - Joint Defense Agreements
  - Damages
  - Negotiation – Mediation

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Carrier Meetings

- Invited all California-based carriers and self-insured systems to BETA for a discussion
- Roundtable to share at what point each Carrier believed their organization to be on CRP journey
- Interest expressed to continue stakeholder group discussions
- Now meet quarterly; continually broadening our membership
- Developed key contact list for notification
- Standing attendees now include:
  - Adventist Health, CEP, Dignity Health, MICA, MIEC, NorCal, ProAssurance Casualty, Prospect Medical Holdings, TEAMHealth, The Doctors Company, University of California Office of the President, VEP Healthcare
  - Rory Jaffe, MD, JD – Medical Director, CHPSO

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Bridging the Gap: Claims, Risk and Underwriting

- Created Early Resolution Task Force to address:
  - Necessary assurances all BETA HEART^{SM} components are in place
  - Protections
  - Reporting – NPDB and licensing boards
  - Who will set value on damages?
  - Will pre-claim events factor in to the “experience rating” to set premium?

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Addressing Protections

- While event is being investigated, report as “pre-claim” event to Carrier
  - Submit key information pertaining to investigation that is documented as “In Anticipation of Litigation”
- Carry out Collaborative Review Process
  - Internal root cause analysis or event review
- Follow peer review process
- Convene Stakeholder Consensus Meeting
  - Discussions/documentation fall under attorney client privilege
- Advise patient and/or family of their right to seek legal counsel at any time

A focus on the Immediate

- Engage BETA Claims staff to assist with determining immediate needs of patient and/or family

Focus on Damages

- Assess damages
- Consider:
  - Medical expenses (present and future)
  - Wage loss
  - Household services
  - General damages (pain and suffering)
- If appropriate, apportion liability working with other Carriers
- Present early offer

Reporting Requirements

- BETA Claims advises on the form and language of a Release of Liability that will bar any future claims
- If patient minor or dependent adult the settlement may require approval by a court
- Depending on status of patient, there may be an obligation to notify the Centers for Medicare and Medicaid of settlement
- Licensed providers on whose behalf a settlement is made may also need to be reported to their respective licensing boards*
- National Practitioner Data Bank reports are usually not triggered unless there is a written demand
- Unless a written demand is submitted, BETA maintains as a “pre-claim” event and, therefore, if all aspects are followed appropriately, does not factor in to experience rating

In addition to Ethically Sound Practice, there is a Financial Aspect of the Business Case

HCL Claims Profile For BETA Healthcare Group (BETArma And HealthPro)

Limited To Professional Liability Claims Only

All Claim Locations

Calendar Year	2012	2013	2014	2015	2016
Claims Opened	440	518	500	486	512
Claims Closed	**451**	**499**	**463**	**501**	**522**
Closed Without Indemnity	**81.%**	**81.%**	**82.%**	**87.%**	**81.%**
Average Defense Expenses – All Claims**					$28,396
Average Defense Expenses – No Indemnity Claims**					**$15,188**
*Average Defense Expenses - Indemnity Claims***					***$86,265***
Average Indemnity Payment – All Claims**					$63,959
Average Indemnity Payment – Indemnity Claims**	$256,652	$358,707	$324,030	$517,923	$344,193

Illustrating ROI
81% of 522 claims = 423
423 claims x $15,188 =
$6.4 million
in defense costs alone

Claims Experience with CRP's

- Fewer cases proceed to litigation after CRP
- Even when care was **unreasonable** & patient retained counsel, suit was rarely filed & claim was settled quickly
- CRP's save caregivers from enduring the stress & anxiety involved in the litigation process (2-4+ years depending on venue)
- Savings of $100,000's in litigation costs each year
- Cases resolve more quickly, sometimes without attorney involvement
- Stories shared have lasting impact (legacy for patient) on making necessary changes in practice or systems to prevent event from ever happening again

What We've Learned Following CRP's

Patients Report:

- Surprise at our honesty & transparency
- Appreciation for admitting responsibility
- A sense of trust with us because we came forward & told the truth
- A sense of acceptance that no one intended to cause injury

Physician & Staff Report:

- Although a scary process, they felt well supported
- Sometimes experienced a sense of forgiveness from the patient
- Ability to emotionally move on knowing they had the conversation with the patient
- Felt good about working for an organization that did the right thing & reached out to the patient when error was made

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Ideal Approach

- Collaborate with stakeholders for the sake of the patient. Chances are likely that you will be in future situations again with same stakeholders when tables are turned.
- Be compassionate. Let's not prolong the agony of an unexpected medical event for the patient or for the caregivers.
- Early resolution shows integrity and character personally & as an organization in "Doing the right thing."

Final Thoughts & Questions

- Like snowflakes, no two CRP cases are alike.
- CRP's are never easy for either the patient or caregiver.
- When successful, a CRP can lead to emotional healing for everyone involved.
- Ease the way for patients & caregivers when an unexpected outcome occurs; there are plenty of great resources to help. Just ask.

QUESTIONS

Thank You!

Heather Gocke, MS, RNC, CPHRM, C-EFM
BETA Healthcare Group
Heather.Gocke@betahg.com

Claire Hagan, MJ, CPHRM
Providence St. Joseph Health
Claire.Hagan@providence.org

BREAK

9:50-10:00 AM

INNOVATIONS IN HANDOFFS

Patricia Kritek MD, EdM

Professor, Division of Pulmonary, Critical Care and Sleep Medicine

University of Washington

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What We Will Discuss

- Changing environment of healthcare & medical education
- Strategies for safe handoffs – IPASS as a model
- Next steps for safer handoffs

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Duty Hours and Handoffs

- 40% increase in handoffs since duty hours rules changed in 2003
- Average 5 day hospital stay → 15 handoffs
- Communication failures are a contributor in up to 60% of adverse events

Vidyarthi et al. *J Hosp Med*. 2006;1(4):257.
Arora et al. *Qual Saf Health Care*. 2005;14(6):401.

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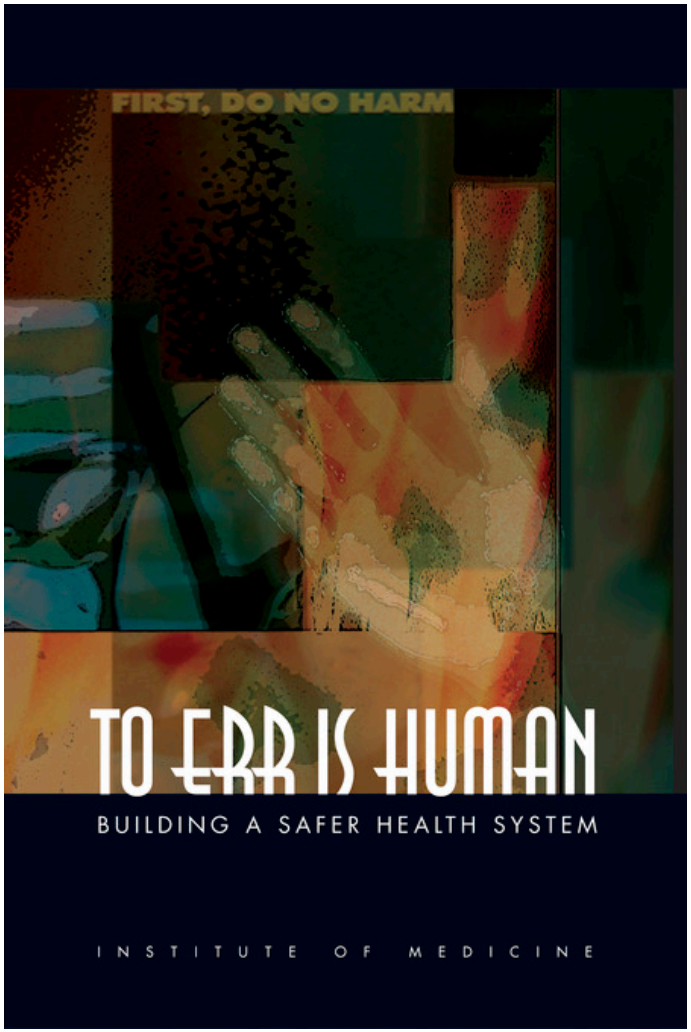
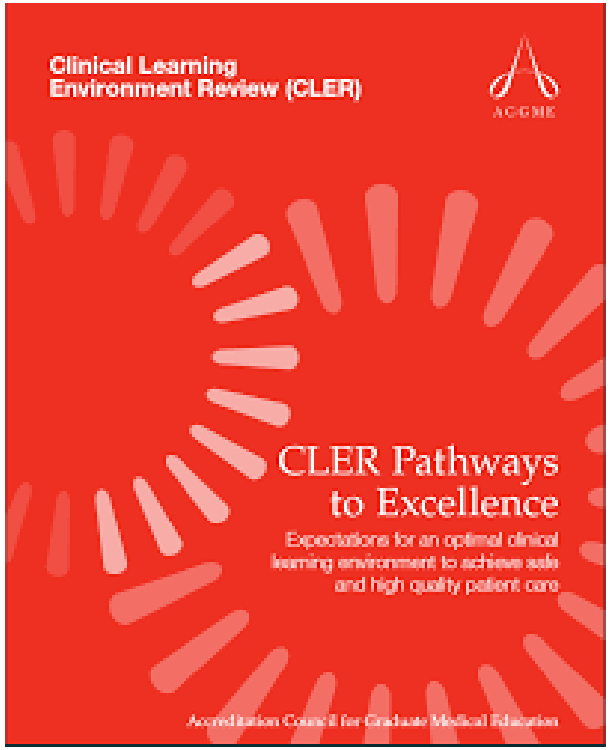
Prioritization of Handoffs



AHRQ



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Clinical Learning Environment Review (CLER)

- Patient Safety
- Health Care Quality
- Professionalism
- Supervision
- Well-being
- Care Transitions

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Clinical Learning Environment Review (CLER)

Patient Safety	Health Care Quality	Professionalism
Supervision	Well-being	Care Transitions

Adopted into Common Program Requirements

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Key Principles

- Structured tool to increase uniform processes and avoid omissions
- Face to face communication to allow questions and clarifications
- Augment verbal handoffs with a templated electronic tool
- Handoffs need to occur in a quiet and protected space
- Handoffs should be explicitly taught and observed
- Minimize unnecessary transitions of care

Graham et al. *JGIM*. 2013;28(8):986.
DiRienzo et al. *Acad Med.* 2012; 87(4):403.

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What We Will Discuss

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- Next steps for safer handoffs

IPASS

I-PASS
BETTER HANDOFFS. SAFER CARE.

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

- **I** — Illness severity
- **P** — Patient summary
- **A** — Action list
- **S** — Situation awareness & contingency planning
- **S** — Synthesis by receiver

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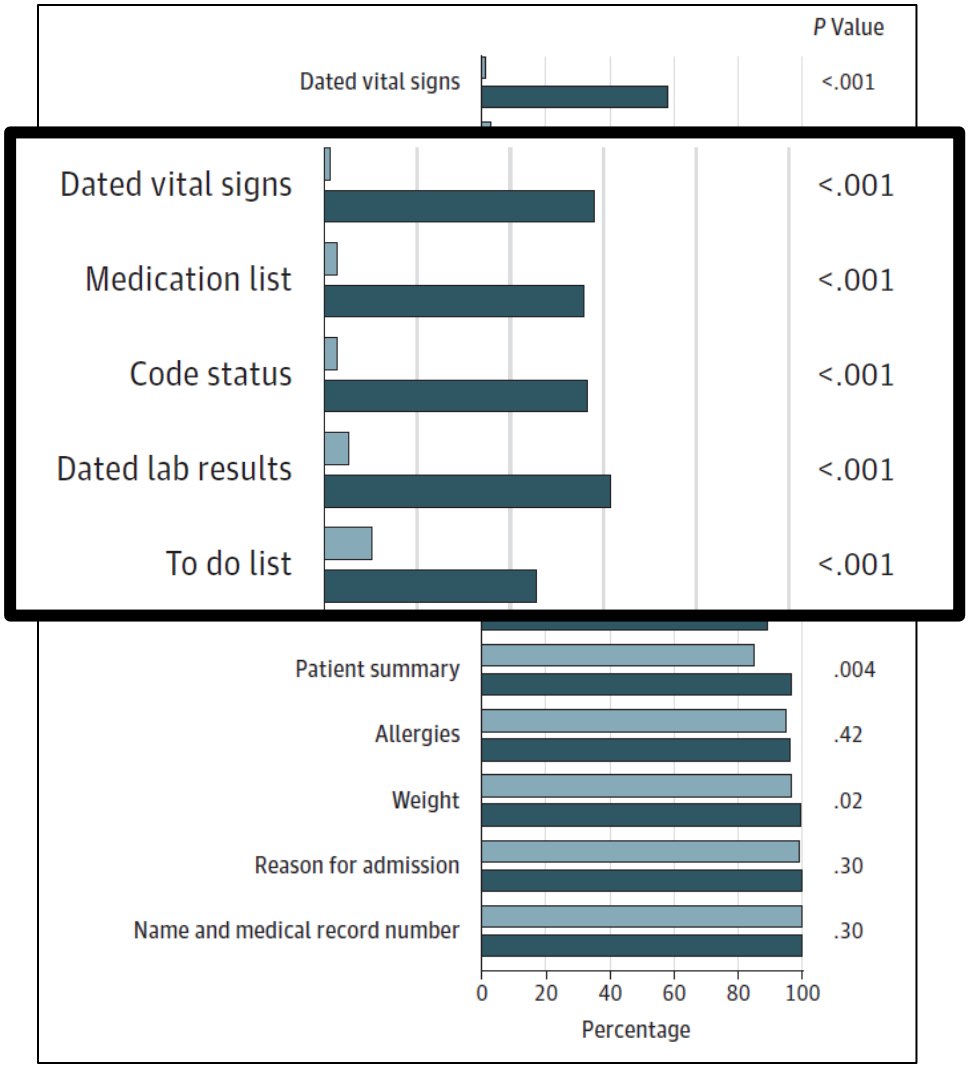
IPASS Impact – Written Handoffs



40 unique documents, 729 patient entries

11 or 14 elements showed improvement

Greater change on unit with computerized tool

Starmer et al. *JAMA*. 2013;310(21):2262.

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IPASS Impact – Verbal Handoffs

Characteristic	Before	After	P value
Number of handoffs	24	28	
Number of patients	341	489	
Duration of handoff, mean	32.3	33.2	.42
Quiet location, %	33.3	67.9	.02
Private location, %	50.0	85.7	.004

Handoffs intermittently observed by attendings

Starmer et al. *JAMA*. 2013;310(21):2262.

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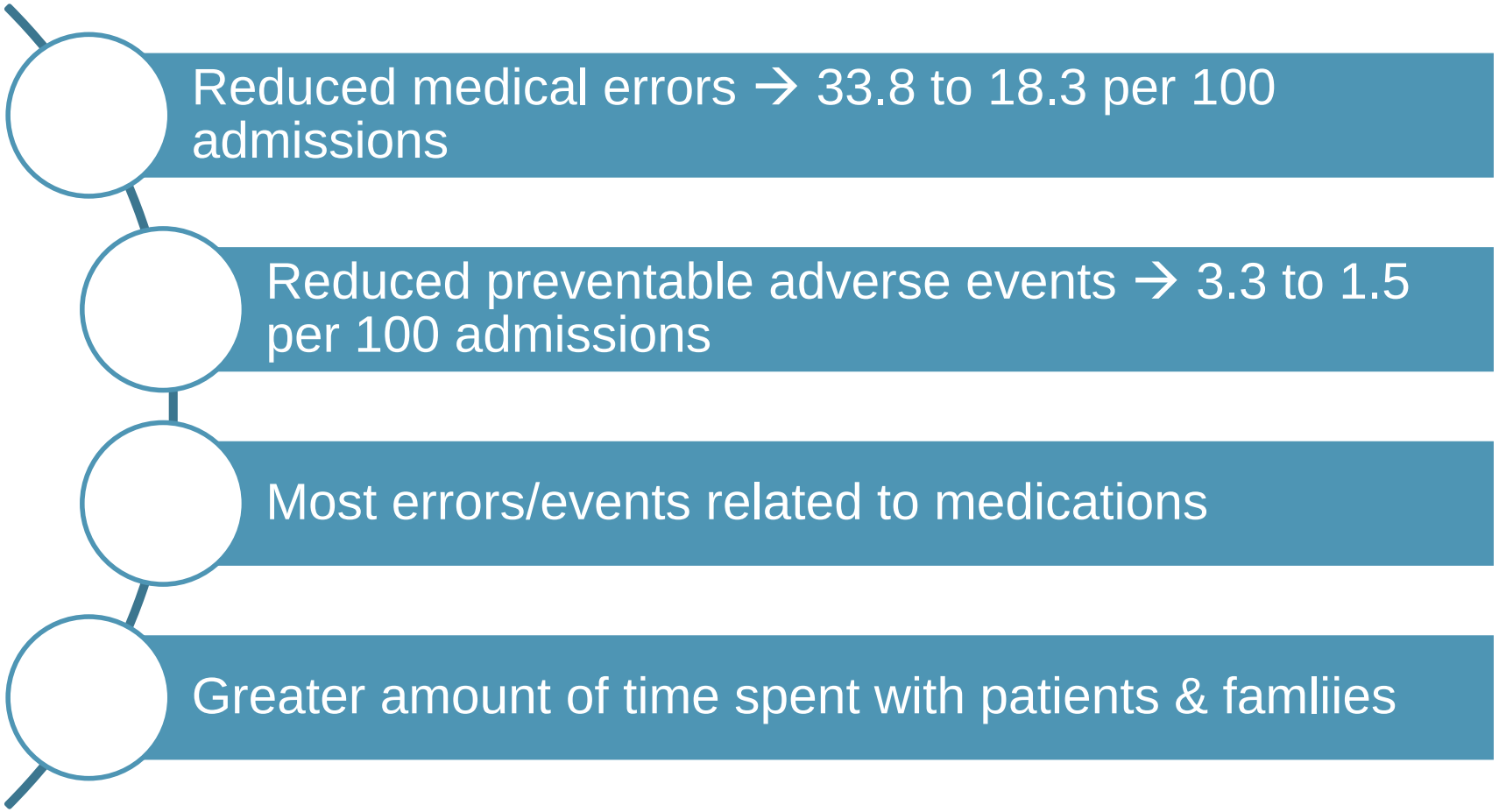
IPASS Overall Impact



Starmer et al. *JAMA.* 2013;310(21):2262.

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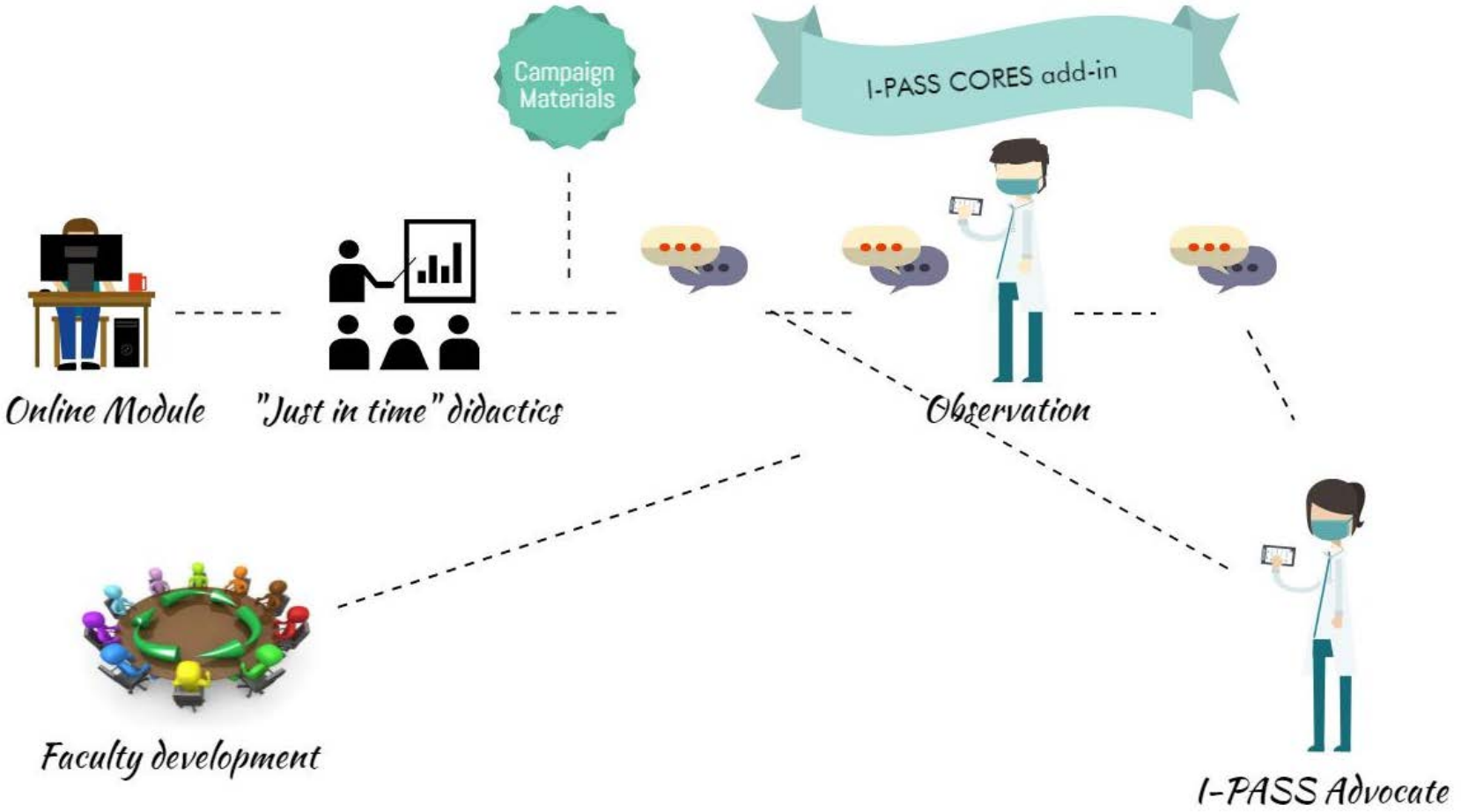
IPASS Handoff Bundle



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IPASS Handoff Bundle

Awareness	Education	Reinforcement
• Mnemonic • Logos	• 2-hour workshop • 1-hour simulation • Computer module	• Faculty development • Direct observation

Starmer et al. *NEJM*. 2014;371:1803.

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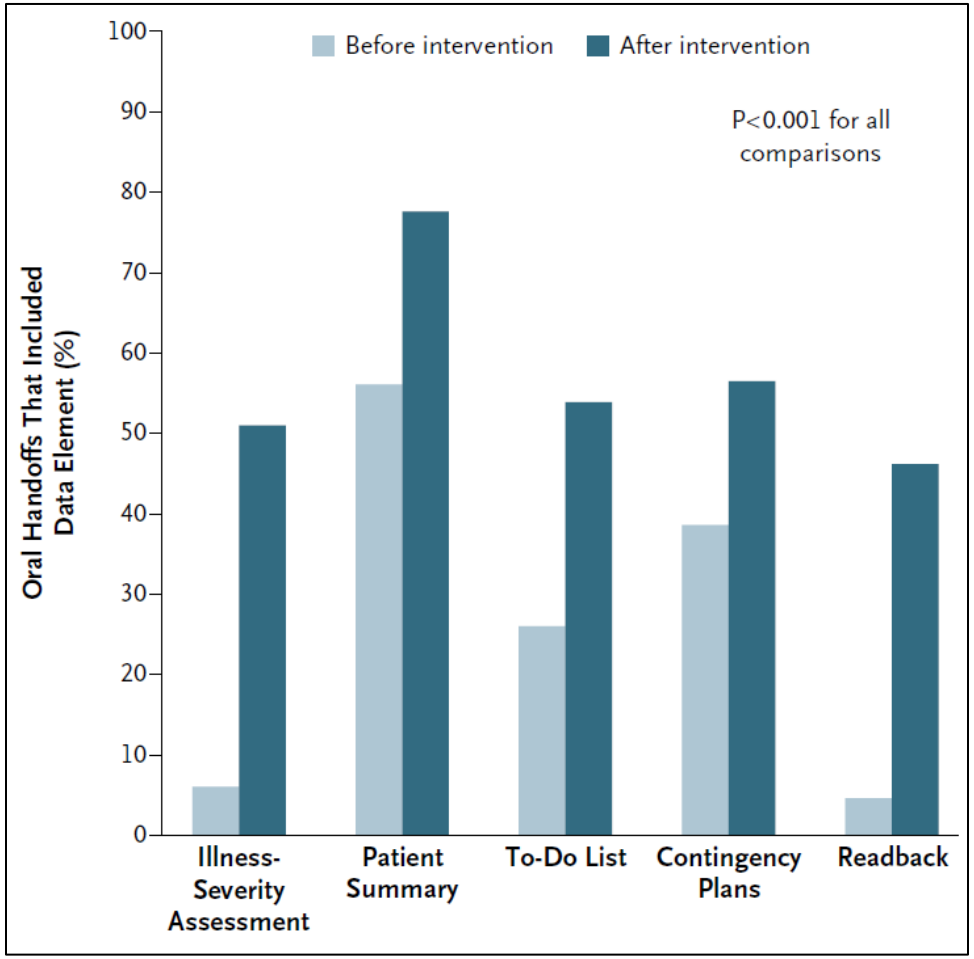
IPASS Impact – Multi-center Trial



Medical errors → 24.5 to 18.8 per 100 admissions

Handoffs consistently take the same amount of time

Starmer et al. *NEJM*. 2014;371:1803.

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Do We Teach This in Medical School?

Question	2012 (n=148)	2014 (n=117)	2016 (n=158)	P value
Did you receive education/training how to conduct a shift-to-shift handoff?	73%	75%	78%	NS
What methods of instruction were used? – Didactics	35%	42%	51%	0.0003
Has a faculty member ever observed you doing a shift-to-shift handoff?	24%	26%	30%	NS
Have used a standardized template for shift-to-shift handoffs used at your medical school?	22%	28%	35%	0.0001

Progress but definite room for improvement

Davis et al. *Am J Med Qual*. 2017; 1-7.

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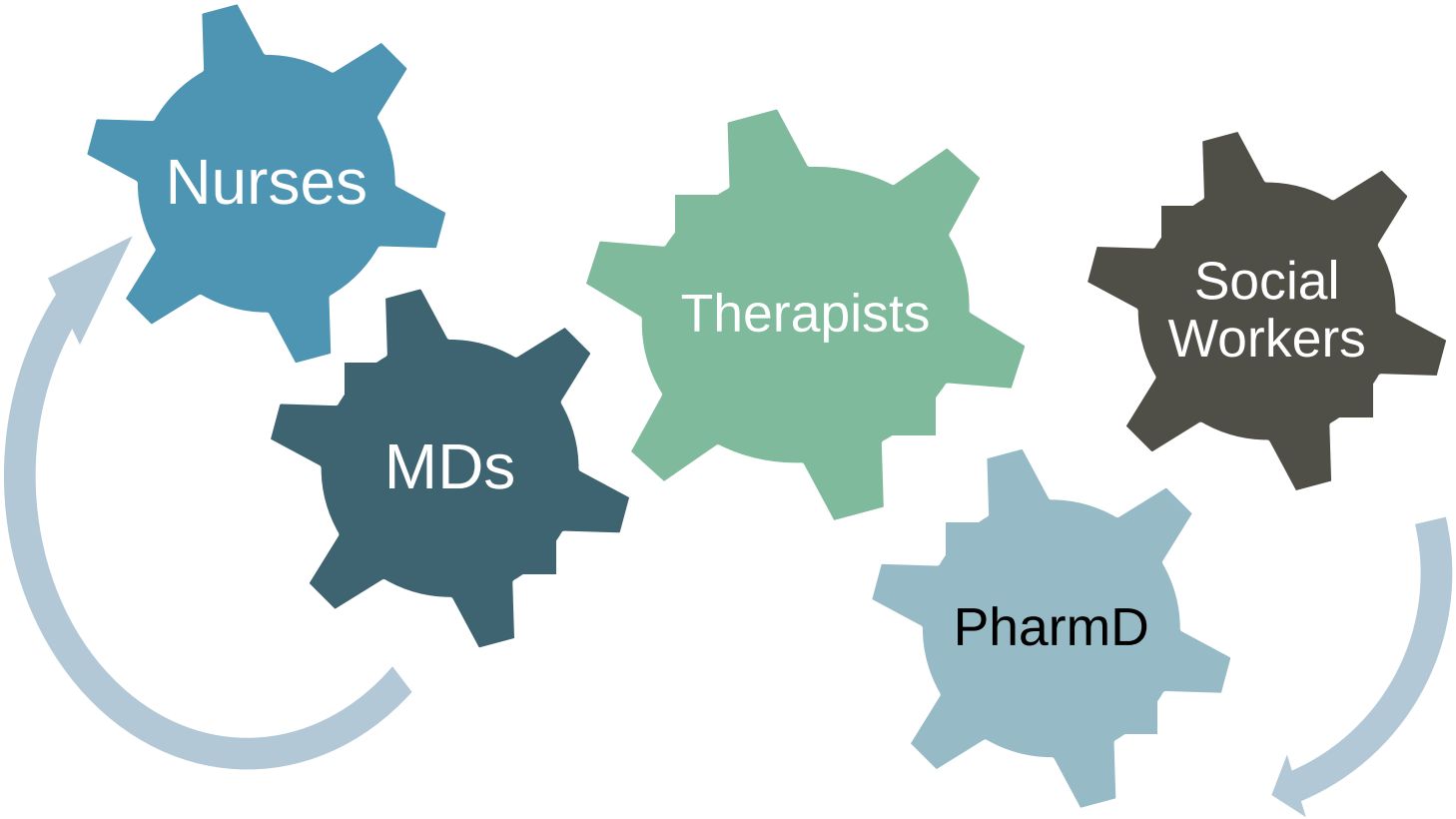
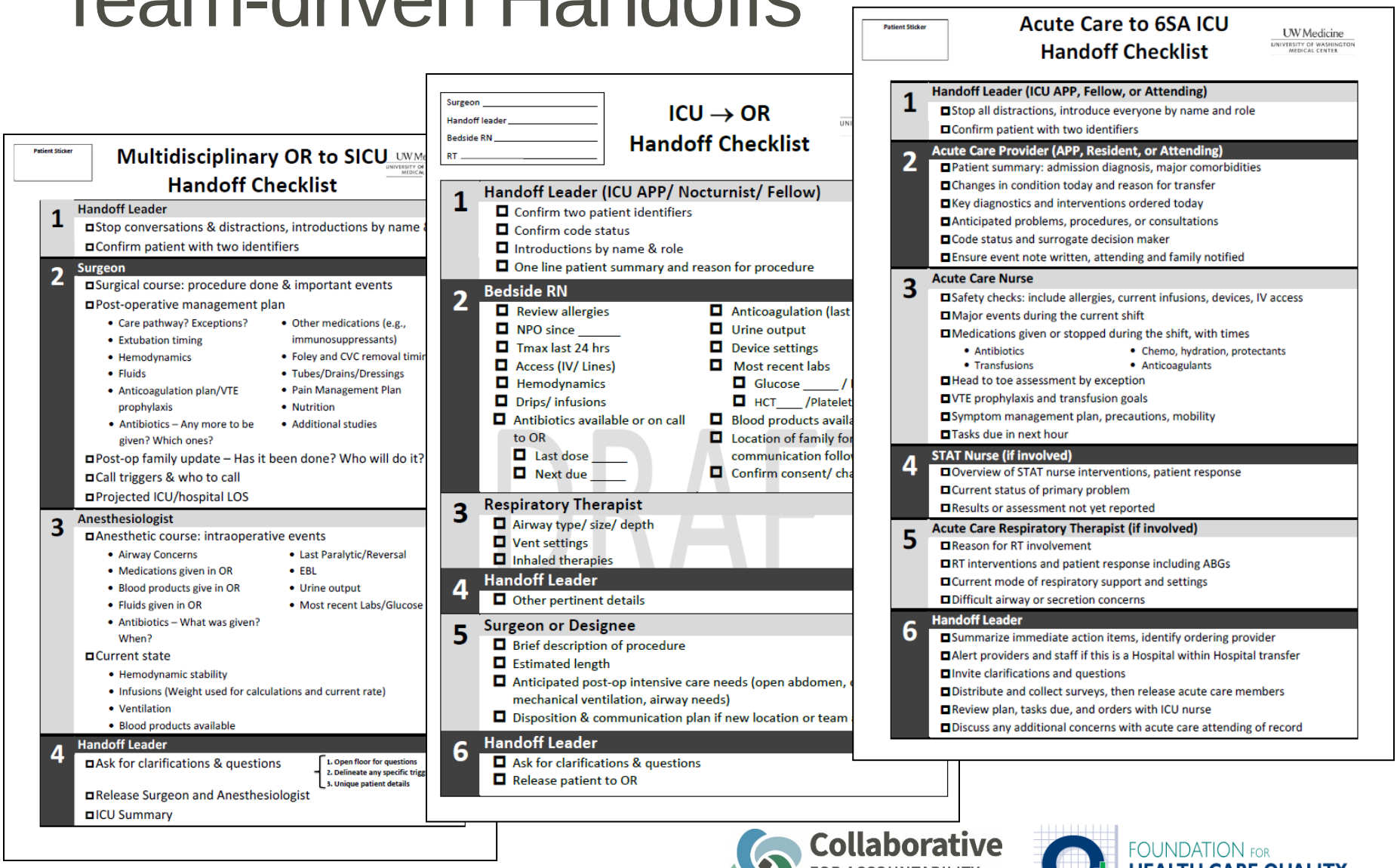
All Members of the Team Do Handoffs



Common language between disciplines may help

Team-driven Handoffs



Patient Sticker

Multidisciplinary OR to SICU Handoff Checklist

UW Medicine

1 Handoff Leader
- ☐ Stop conversations & distractions, introductions by name
- ☐ Confirm patient with two identifiers

2 Surgeon
- ☐ Surgical course: procedure done & important events
- ☐ Post-operative management plan
  - Care pathway? Exceptions?
  - Extubation timing
  - Hemodynamics
  - Fluids
  - Anticoagulation plan/VTE prophylaxis
  - Antibiotics – Any more to be given? Which ones?
  - Other medications (e.g., immunosuppressants)
  - Foley and CVC removal timi
  - Tubes/Drains/Dressings
  - Pain Management Plan
  - Nutrition
  - Additional studies
- ☐ Post-op family update – Has it been done? Who will do it?
- ☐ Call triggers & who to call
- ☐ Projected ICU/hospital LOS

3 Anesthesiologist
- ☐ Anesthetic course: intraoperative events
  - Airway Concerns
  - Medications given in OR
  - Blood products give in OR
  - Fluids given in OR
  - Antibiotics – What was given? When?
  - Last Paralytic/Reversal
  - EBL
  - Urine output
  - Most recent Labs/Glucose
- ☐ Current state
  - Hemodynamic stability
  - Infusions (Weight used for calculations and current rate)
  - Ventilation
  - Blood products available

4 Handoff Leader
- ☐ Ask for clarifications & questions
  1. Open floor for questions
  2. Delineate any specific trigg
  3. Unique patient details
- ☐ Release Surgeon and Anesthesiologist
- ☐ ICU Summary

Surgeon _____
Handoff leader _____
Bedside RN _____
RT _____

ICU → OR Handoff Checklist

1 Handoff Leader (ICU APP/ Nocturnist/ Fellow)
- ☐ Confirm two patient identifiers
- ☐ Confirm code status
- ☐ Introductions by name & role
- ☐ One line patient summary and reason for procedure

2 Bedside RN
- ☐ Review allergies
- ☐ NPO since _____
- ☐ Tmax last 24 hrs
- ☐ Access (IV/ Lines)
- ☐ Hemodynamics
- ☐ Drips/ infusions
- ☐ Antibiotics available or on call to OR
  - ☐ Last dose _____
  - ☐ Next due _____
- ☐ Anticoagulation (last
- ☐ Urine output
- ☐ Device settings
- ☐ Most recent labs
  - ☐ Glucose _____ /
  - ☐ HCT____ /Platelet
- ☐ Blood products availa
- ☐ Location of family fo communication follo
- ☐ Confirm consent/ cha

3 Respiratory Therapist
- ☐ Airway type/ size/ depth
- ☐ Vent settings
- ☐ Inhaled therapies

4 Handoff Leader
- ☐ Other pertinent details

5 Surgeon or Designee
- ☐ Brief description of procedure
- ☐ Estimated length
- ☐ Anticipated post-op intensive care needs (open abdomen, mechanical ventilation, airway needs)
- ☐ Disposition & communication plan if new location or team

6 Handoff Leader
- ☐ Ask for clarifications & questions
- ☐ Release patient to OR

DRAFT

Patient Sticker

Acute Care to 6SA ICU Handoff Checklist

UW Medicine
UNIVERSITY OF WASHINGTON MEDICAL CENTER

1 Handoff Leader (ICU APP, Fellow, or Attending)
- ☐ Stop all distractions, introduce everyone by name and role
- ☐ Confirm patient with two identifiers

2 Acute Care Provider (APP, Resident, or Attending)
- ☐ Patient summary: admission diagnosis, major comorbidities
- ☐ Changes in condition today and reason for transfer
- ☐ Key diagnostics and interventions ordered today
- ☐ Anticipated problems, procedures, or consultations
- ☐ Code status and surrogate decision maker
- ☐ Ensure event note written, attending and family notified

3 Acute Care Nurse
- ☐ Safety checks: include allergies, current infusions, devices, IV access
- ☐ Major events during the current shift
- ☐ Medications given or stopped during the shift, with times
  - Antibiotics
  - Transfusions
  - Chemo, hydration, protectants
  - Anticoagulants
- ☐ Head to toe assessment by exception
- ☐ VTE prophylaxis and transfusion goals
- ☐ Symptom management plan, precautions, mobility
- ☐ Tasks due in next hour

4 STAT Nurse (if involved)
- ☐ Overview of STAT nurse interventions, patient response
- ☐ Current status of primary problem
- ☐ Results or assessment not yet reported

5 Acute Care Respiratory Therapist (if involved)
- ☐ Reason for RT involvement
- ☐ RT interventions and patient response including ABGs
- ☐ Current mode of respiratory support and settings
- ☐ Difficult airway or secretion concerns

6 Handoff Leader
- ☐ Summarize immediate action items, identify ordering provider
- ☐ Alert providers and staff if this is a Hospital within Hospital transfer
- ☐ Invite clarifications and questions
- ☐ Distribute and collect surveys, then release acute care members
- ☐ Review plan, tasks due, and orders with ICU nurse
- ☐ Discuss any additional concerns with acute care attending of record

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Adapt IPASS – Critical Care

I	Illness Severity	• 'Fair': no major interventions anticipated • 'Watcher': monitoring hourly, with interventions possible • 'Unstable: Monitoring q 1/2 hour or less, with interventions likely • Discharge/Comfort Care
P	Patient Summary	• Age, gender, primary diagnosis, + comorbidities. • 24 hour events
		• Assessment by problem or system: Key topics: - Hemodynamic / volume status - Ventilator management. - Tubes/lines/drains - Antibiotics - Transfusion plan - Code Status, Family Contact
S	Situation Awareness and Contingency Planning	• What are anticipated problems in the next 24 hours? • Plan for anticipated problems: "if / then" statements.
S	Synthesis by Receiver	• Receiver asks questions and restates key issues + action items

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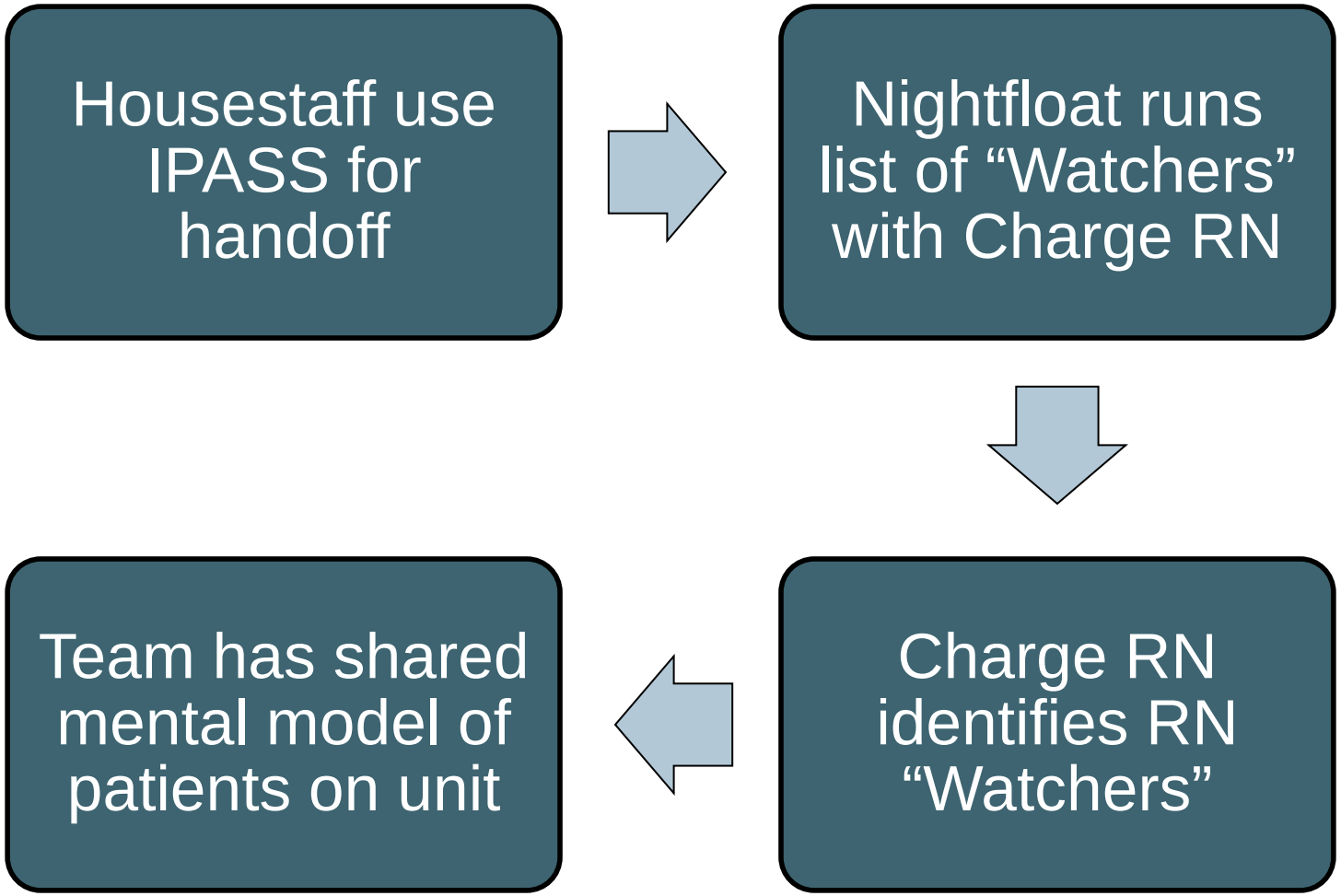
Adapt IPASS – MDs and RNs



http://ipassstudygroup.com/

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Take Homes on Handoffs

- Transitions of care are high risk times and we do more of them than we did in the past
- There are key principles that help make handoffs safer.
- One structured approach that has shown benefits is IPASS
- The future is more education to make this part of culture & building interdisciplinary bridges

THANKS!

pkritek@uw.edu

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Entrustable Professional Activity

1. Uses a ***template*** for the handover communication but can adapt based on patient, audience, setting, or context.
2. Generally ***documents patient information*** without errors of omission and/or commission.
3. Consistently ***transfers information*** regarding content, accuracy, efficiency, and synthesis.
4. ***Organizes*** **and** ***prioritizes*** information for handover communications.
5. Provides ***key aspects*** of the ideal handover to the recipient, including verbalizing the patient's illness severity and/or providing action planning and/or contingency planning.
6. Demonstrates ***situation awareness*** of both the team's total work load and the circumstances of the individual to whom one is transferring care.
7. Demonstrates awareness of ***known threats*** to handover communication (e.g., interruptions, distractions) by paying attention to the timing and location of the handover communication.

http://www.acgme.org/

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YOU CANNOT FIX WHAT YOU DO NOT KNOW ABOUT:
THE POWER OF COGNITIVE INTERVIEWING

Timothy McDonald MD JD

Director, Center for Open and Honest Communication

MedStar Institute for Quality and Safety

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Unanticipated Outcomes - Urgency

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Event Review

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		

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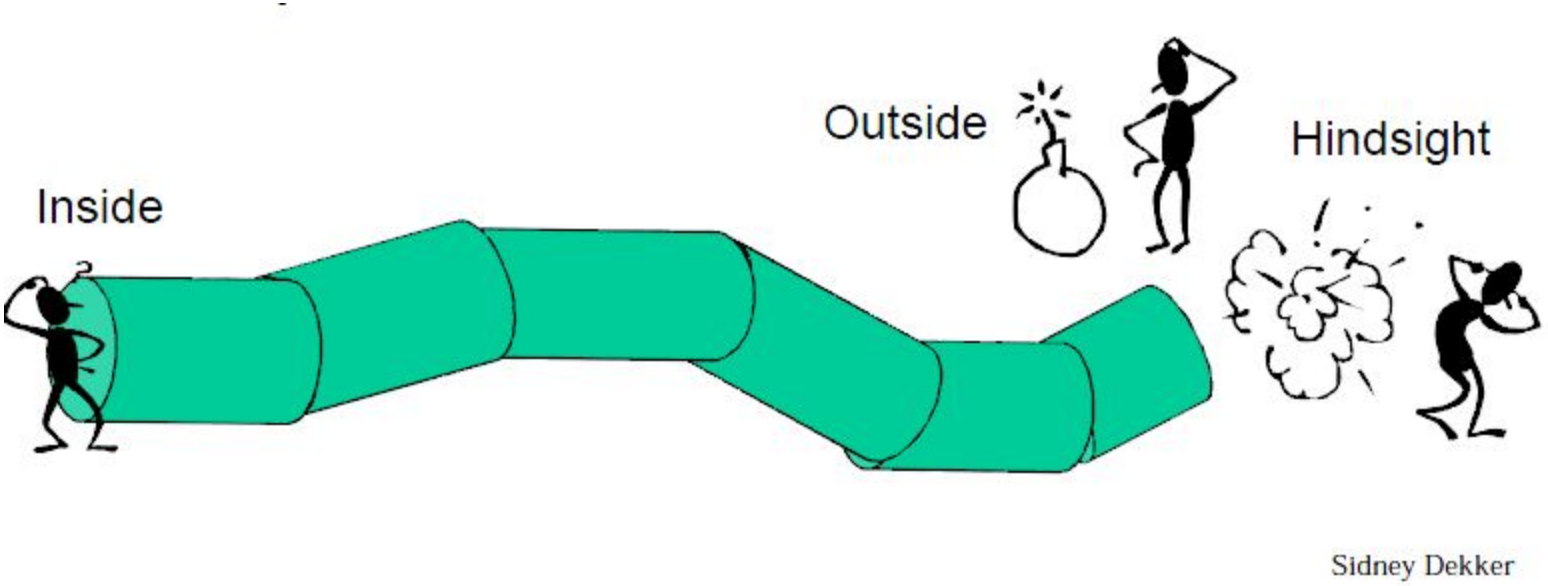
Hindsight Bias

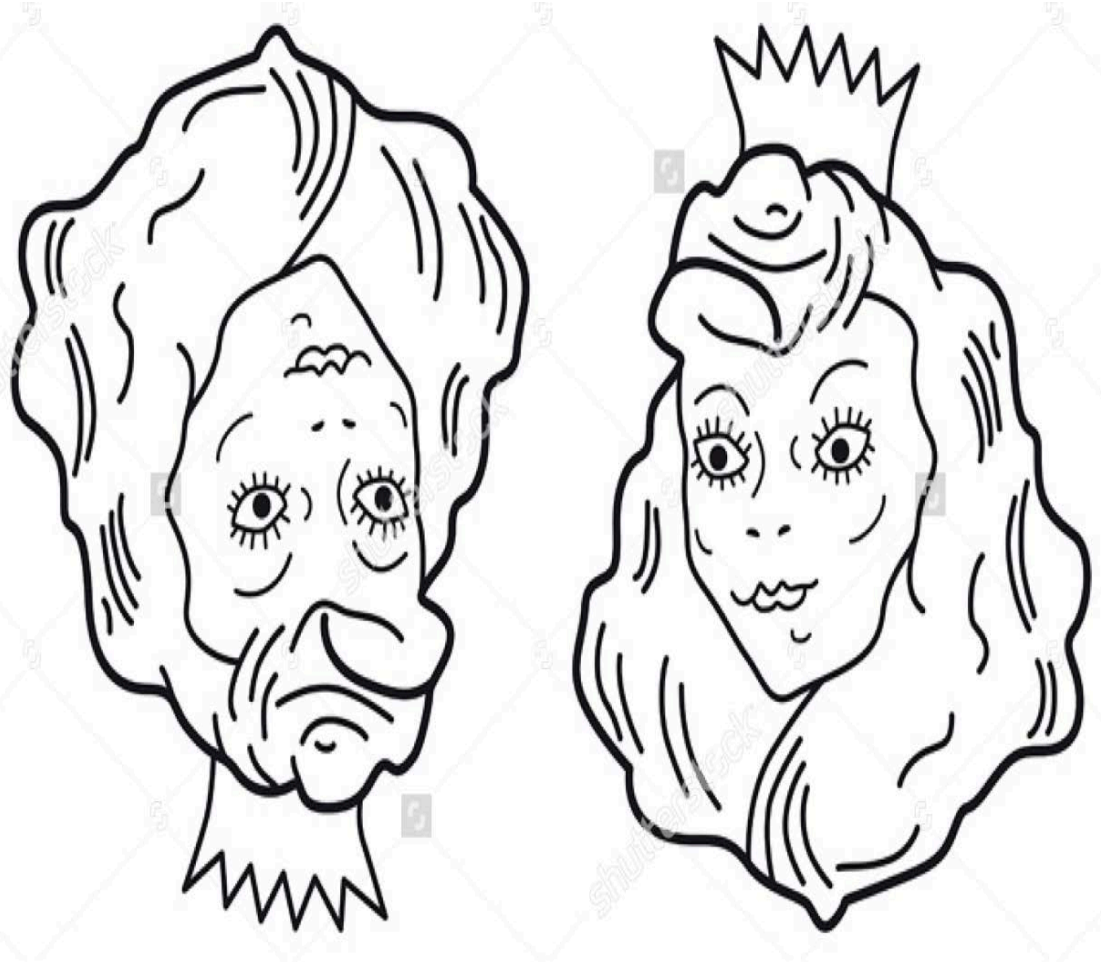


Sidney Dekker

A bit about bias

An exercise

- Take out a piece of paper
- Write down what you see?



Let's do it again

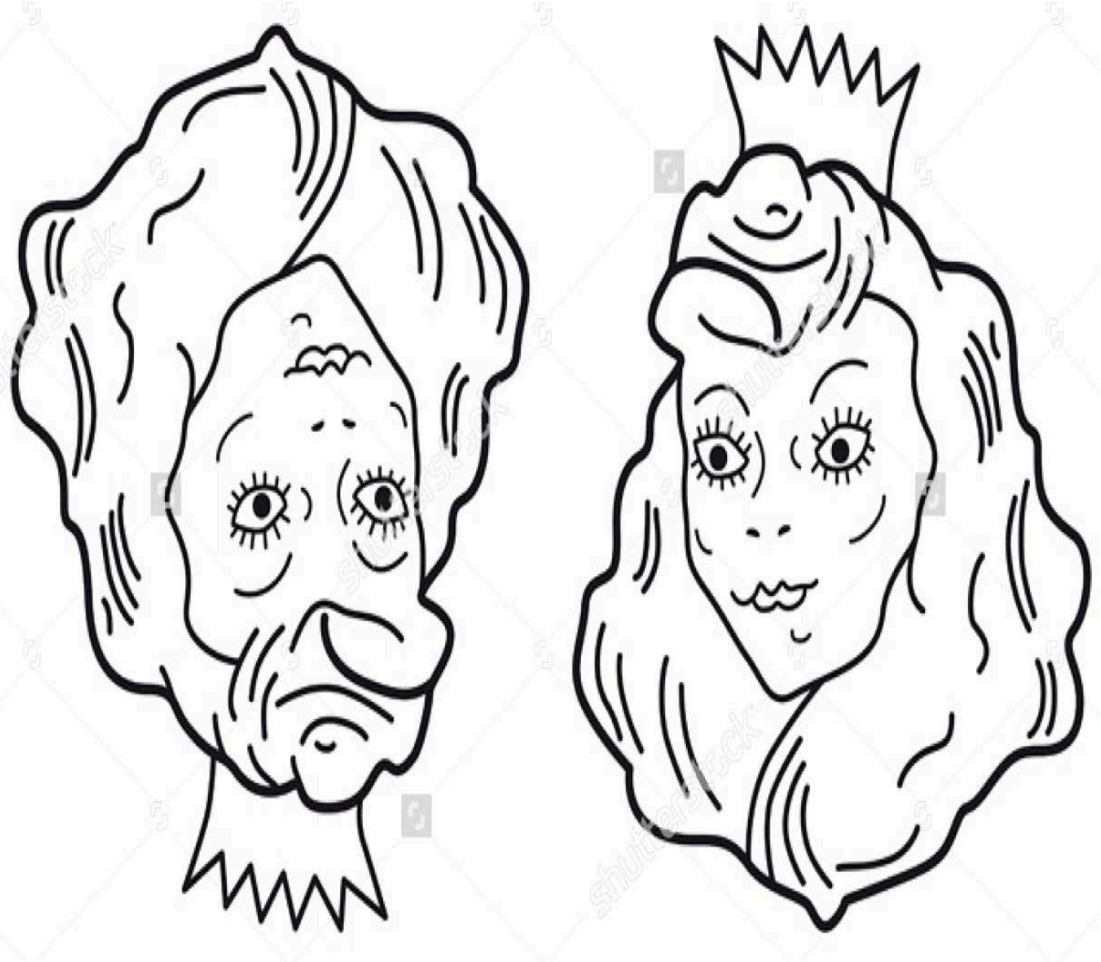
Let's do it again

- The power of pausing and taking a different perspective

The same picture from two different angles

Looking closer, taking time to observe more details

Same picture?



Woman or saxophone player?

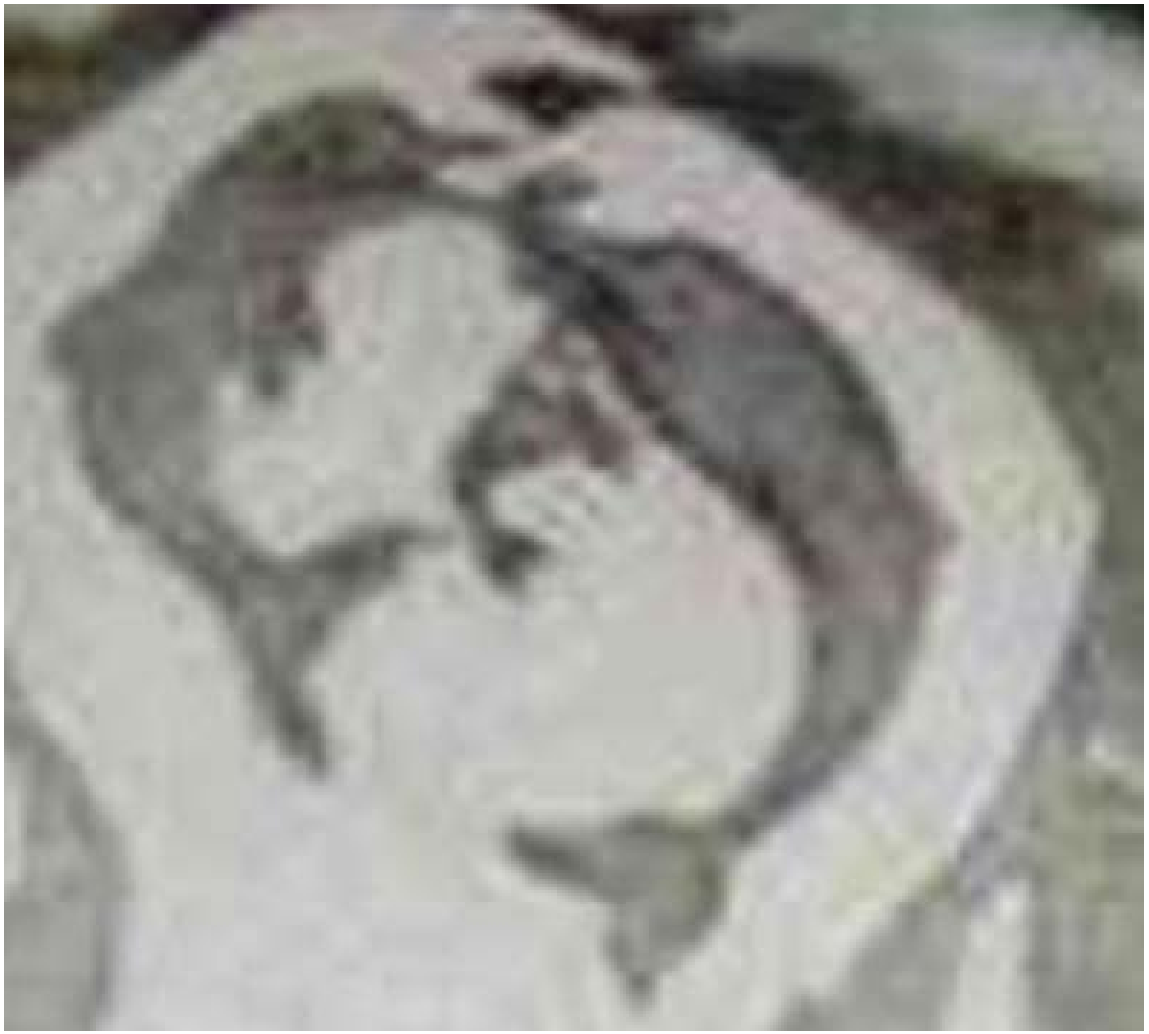
A face or a word?

A face or a word? Does this view help?

An intimate embrace?

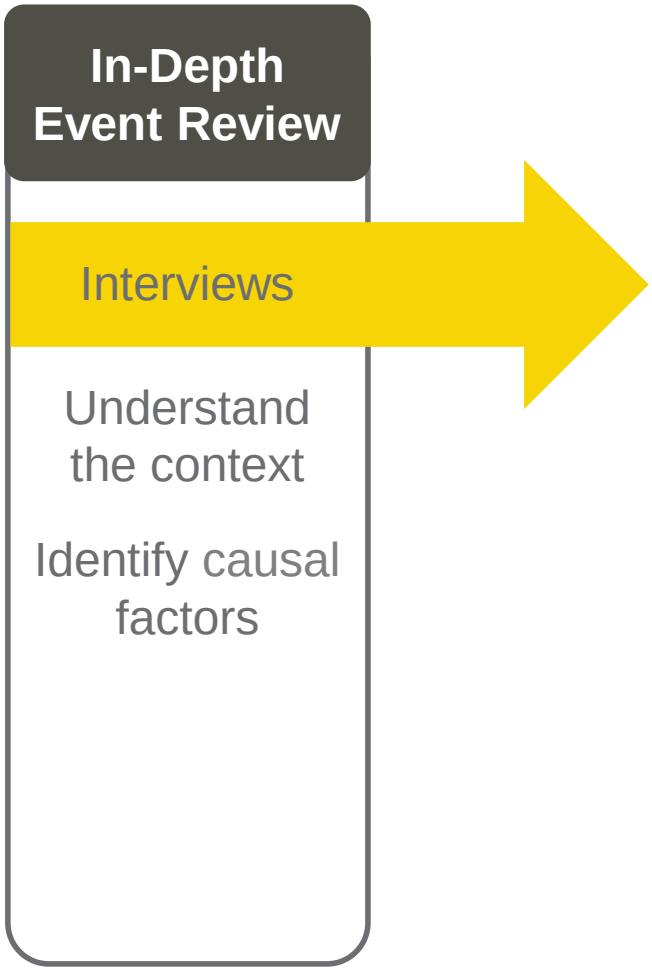
An intimate embrace? Or nine dolphins?

Or nine dolphins? Does this help?



Age and context make a difference?

Event Review - IMPORTANT!



Interviews – Mindset and Approach

- What qualities do you need to have?
  Genuine curiosity

No prejudgment – what you hear first is never the full story

Trust is essential to getting the full story

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Goals of the Interview

- Your job is to find the true contributing factors and then figure out what can be fixed to prevent this from happening again.
- What was supposed to happen, what usually happens, what happened this time?

We Cannot Fix What We Do Not Know About

- Event analysis
  - Avoid Bias
  - Focus on process and systems that facilitated the errors or mistakes
  - Seek facts, not fault
  - Observe everything
  - Understand the “whole
  - Collect time sensitive information
  - Quick reaction and review is essential
  - Early Interviews are essential
  - Interviewer should prep before interviews

Key Cognitive Interviewing Principles

Principle

- We have limited mental resources for concentration

Implication

- Focused concentration
- Minimize internal and external distractions

Key Cognitive Interviewing Principles

Principle

- A memory consists of three stages: encoding, storage, retrieval

Implication

- Just because its in the memory store, doesn't mean it will be magically recalled – it must be actively sought for
- Some "forgetting" caused by inappropriate retrieval versus CI guided retrieval

Key Cognitive Interviewing Principles

Principle

- A memory is linked to all physical and personal contexts that existed at the time

Implication

- Try to recreate the context of the original event – "to be back there" – as if they are experiencing it again

Common Elements

- Developing rapport
- Asking open-ended questions
- Asking neutral (not leading) questions
- “Funneling” the interview
  - Begin broad, then narrow down

Enhancing Recall

- Ask for same information in many different ways
  - Visual, auditory, forward, backward
  - Ask witness to take other perspectives on event
  - Probe as many aspects or dimensions of the memory as possible
  - Do not pressure witness when they are uncertain
  - Caution against guessing
- Stay with one scene at a time

An example

Line removal air embolism case

- 53 year old patient with large dialysis catheter
- Catheter in right IJ removed by hospitalist
- Patient coughs and develops SOB within minutes of line removal
- Full cardiac arrest then resuscitated
- Taken to CT – reveals massive air embolism
- Hotline called
- Medical records indicate standard procedure followed.
- Interview 12 hours later

Line Removal Air Embolism Case

- What do you want to know?
- What approaches will you use?

Video example

- Write – what went done well
- Identify opportunities

Debrief

Possible solutions?

Questions?

Basic facts of the clinical case

- 53 year old female with myesthenia gravis admitted with severe muscle weakness
- Admitted for plasmapheresis to remove “offending antibodies” from her blood
- Requires placement and every other day use of a dialysis catheter to remove and replace blood that is “cleaned”
- After 10 days, strength returns and dialysis catheter [line] needs removal prior to discharge
- Resident is asked to remove the line
- Immediately after line removal patient goes in to cardiac arrest and needs transfer to another facility
- Nurse and resident involved need to be interviewed.
- According to the electronic health record the removal went according to plan but there are some issues.
- Communication must occur with patient’s family as soon as possible

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?

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MEGA CASE PART 4: RESOLUTION

Presented by
Heather Gocke, MS, RNC, CPHRM, C-EFM
Claire Hagan, MJ, CPHRM

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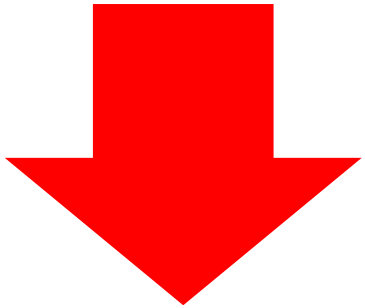
Compassionate conversation apologizing for error that lead to patient's injury, answering questions, explaining changes made to prevent reoccurrence and intentions to compensate patient for financial loss as well as pain and suffering.



Care Unreasonable

Scenario: Break-out Groups Plan Family Meeting

- Ongoing contact has been made with the family intermittently since the patient's death
- It is now 6-8 weeks since the funeral
- Disclosure Lead reaches out to the family to arrange meeting to share what has been learned
- Break-out groups must now plan family meeting & discuss **what factors should influence the offer**
- Meet for 15-minutes

Considering Harm Done

Physical

Emotional

Financial

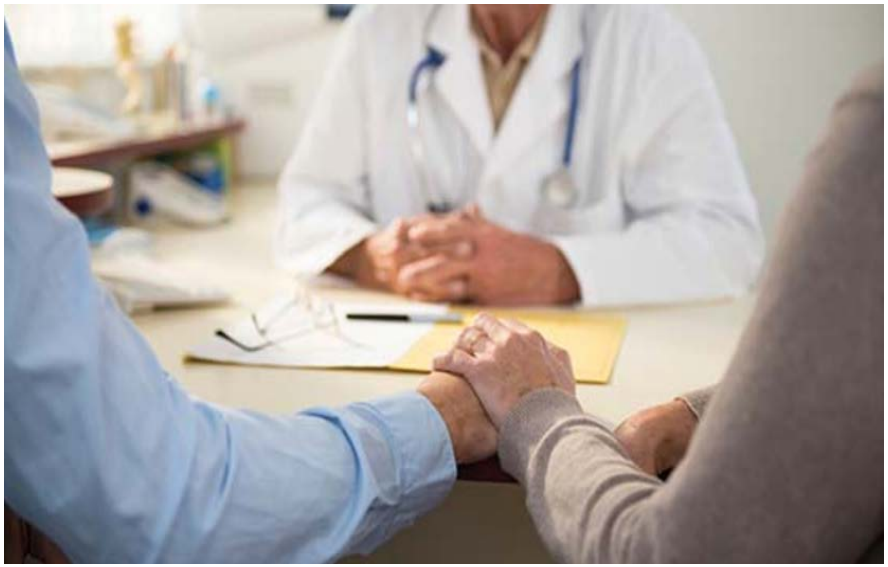
Consider a Legacy To Honor the Patient

Patients and families want to make sure this event never occurs to anyone else, which is the legacy of their suffering.
Making some significant process improvement or offering some tangible remembrance can have a significant impact to the patient or family.

- Examples:
  - Offering training in the memory of the patient
  - Inquiring about patient/family interest in working with Patient Safety Committee
  - Asking the patient or family for permission to videotape their story or present their story to staff or board members
  - Some permanent remembrance of the patient in a walkway, memorial or garden
  - Obtaining written permission as a part of the final settlement release allowing us to tell their story for patient safety and quality purposes

Preparing For final meeting & DEBRIEF

- After drafting Talking Points transmit to meeting leader for review
- Meet with meeting leader to finalize Talking Points, assure leader is well informed about the facts of the case and how the meeting will be structured
- Meet with health care team who will be attending the patient/family meeting, review Talking Points and explain what will be conveyed and answer any questions
- Provide team with emotional support for what may be a very emotionally charged or difficult interaction for everyone concerned. Consider legacy remembrance. Consider seating arrangement



BREAK-OUT

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SAMPLE TALKING POINTS

- Introduction of everyone in attendance and their roles
- Checking in with patient and family about how they are doing
- Appreciation of family's patience while review completed
- Our apology for the (frustrating, disappointing, unexpected…) experience surrounding their medical care
- Background of the medical care & events, & circumstances that led to our questions surrounding the care
- What we learned
- Our deepest and most sincere apologies for causing this tragic injury
- Patient/family questions
- How this has impacted those involved
- Changes made as a result of this tragic loss
- Our intentions going forward to compensate you for your loss
- What else can we do to support you and your family at this time?
- Introduction of claim representative if present, or plans to have them contact the patient/family
- Our sincere appreciation for allowing us this opportunity to meet

BREAK

2:45-3:00 PM

GAP ANALYSIS AND LEADING CHANGE

Tim McDonald

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Leading Change

Kotter's Principles

Kotter's Principles

- Create sense of urgency
- Pull together guiding team and stakeholders
- Develop the change vision and strategy
- Communicate for understanding and buy-in
- Empower others to act
- Produce short-term wins
- Don't let up
- Create a new culture

Lessons Learned From The Field

- AHRQ Demonstration Grant - private hospitals with open, non-employed medical staffs.
- Private liability insurance for many clinicians
- Some success
- Many failures
- Many lessons learned

What have we learned?

CANDOR Gap Analysis tool: is there a sense of urgency? How ready is the organization?

- Used during implementation of CRP in 10 Chicago area hospitals before and after
- Modified and used in 14 hospitals during pilot – 4 in California
- Subsequent use in more hospitals in CA, MD, IL, OH, AZ, NV, OR
- More than 100 GAs
- Useful for identifying points of focus and areas at risk
- Can be used for ongoing measurement

Gap Analysis Background

- Review of important documents, including recent survey results
- Facilitated focus groups of key different stakeholders
- Areas of discussion include
  - High Reliability Domains: Culture, Leadership, Improvement
  - National Quality Forum Safe Practices
    - Identification and mitigation of risks and hazards, including event reporting and analysis
    - Informed consent
    - Communication, disclosure, and resolution following harm
    - Caring for caregivers

Value of Reviewing Policies

Unanticipated outcome: A result that differs significantly from the anticipated result of a treatment or procedure that results in potential (physical or emotional) harm, discomfort or inconvenience to the patient. When a patient is informed in advance about risk potential, the fact that it occurs no longer renders the outcome unanticipated.

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

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Gap Analysis Background

- High Reliability Domains: Beginning, Developing, Advancing, Approaching
  - Culture
    - Trust and teamwork
    - Accountability
    - Identifying unsafe conditions
    - Strengthening systems
    - Assessment
  - Performance Improvement
    - Methods
    - Training
    - Spread
  - Leadership
    - Board
    - CEO/Management
    - Physicians
    - Quality Strategy
    - Informatics

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Gap Analysis Background

- Report creation
  - Specific results for several hundred questions
  - Identification of common themes
  - High Reliability assessment
  - SWOT analysis
  - Next Steps

Gap Analysis
Aggregate Results from > 100 hospitals

- Lack of board or leadership support predicts failure
- Medical staff engagement event review and communication is critical to success and highly variable across organizations
- Medical malpractice insurers for private physicians seem to be a barrier in most organizations
- In general, hospital claims and legal staff are less supportive than risk and patient safety staff
- Safety culture is highly variable across organizations and within organizations – “just culture” awareness varies from system to system

Gap Analysis
Aggregate Results from > 100 hospitals

- Strong support across all organizations for communication following harm
- Few organizations have comprehensive disclosure policies
- The approach to disruptive behavior is highly variable
- Barriers to reporting of events include fear and apathy
- No organization routinely obtains input from patients and families as part of event review or root cause analysis

Gap Analysis
Aggregate Results from > 100 hospitals

- Less than 10% of organizations are collecting and analyzing data based upon race, ethnicity, or preferred language
- Most organizations rely on EAP to provide support for care givers in distress or following patient harm
- Especially amongst medical staff, the desire for a reliable care for caregiver process is high

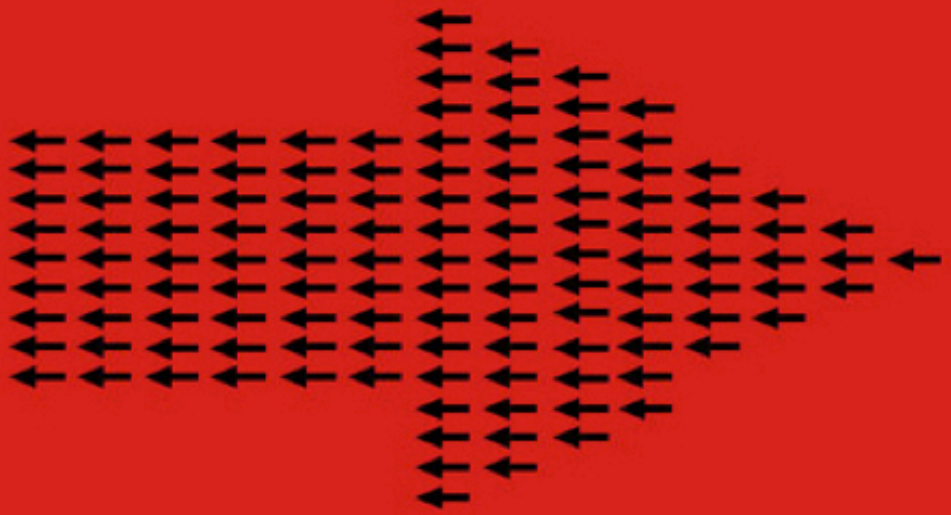
Example of a “ready” hospital

- It is reported that the hospital Board is engaged in the development of quality goals and the quality plan and they regularly review adverse events and progress on quality goals – quality and patient safety is a top priority for the Board.
- In comparison to all other 40 hospitals assessed during the Gap Analysis process the relationship between physicians and nurses at this hospital was the most positive.
- The physicians’ primary medical malpractice insurance carrier is NOT perceived as a barrier and expressed willingness to cooperate with the hospital’s insurance program.
- Frontline staff report great joy in working with their colleagues and 100% of those interviewed could describe how Just Culture applied to them – including a patient transporter.
- Physicians “own up” when unexpected events occur.

Example of a “not-so-ready” hospital

- The community Board is not fully engaged in the development of quality goals and the quality plan; the Board does not regularly review specific or serious adverse events or detailed progress on quality goals.
- Very few physicians engaged in the interview process – the smallest number of any of the 40 hospitals nationally visited.
- The staff report that the physicians refuse to follow safe practices and threaten to leave the hospital and “take their patients elsewhere” in the event they are held accountable.
- During the interview process there was active resistance from physicians to patient safety and CRP-type activities.

Culture eats strategy for breakfast



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Implementation

- Pre-Implementation Phase
- Implementation Steps
- Post Implementation Efforts

Back to Kotter's Principles

- Create sense of urgency
- Pull together guiding team and stakeholders
- Develop the change vision and strategy
- Communicate for understanding and buy-in
- Empower others to act
- Produce short-term wins
- Don't let up
- Create a new culture

Implementation

- Pre-Implementation Phase
- Implementation Steps
- Post Implementation Efforts

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Event identification and human factors event analysis
  - Communication after harm training
  - Peer support training
  - Resolution training
  - Operationalizing
- Post Implementation Efforts

Communication is the key

- Communications assessment tool
- Measures emotional intelligence
- Assesses cognitive complexity
- Identifies highly skilled communicators in complex social situations
- Balances out the “special colleague” issue

Communication Skills Assessment

- Cognitive complexity
- Message Logic
- Identifies personnel especially adept at delivering complex messages

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - **Event identification and human factors event analysis**
  - Communication after harm training
  - Peer support training
  - Resolution training
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Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Event identification and human factors event analysis
  - **Communication after harm training**
  - Peer support training
  - Resolution training
  - Operationalizing
- Post Implementation Efforts

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Event identification and human factors event analysis
  - **Communication after harm training**
    - Immediate responders
    - Process not an event
    - Triggered by harm
    - With or without error or mistake

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Communication after harm training
  - **Peer support training**
  - Resolution training
  - Operationalizing
- Post Implementation Efforts

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Communication after harm training
  - **Peer support training**
    - Similar to communication training
    - Different personnel
    - Emotional first aid from “peer”

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Communication after harm training
  - Peer support training
  - **Resolution training**
  - Operationalizing
- Post Implementation Efforts

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Communication after harm training
  - Peer support training
  - **Resolution training**
    - Special skills
    - Need authority
  - Operationalizing
- Post Implementation Efforts

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Communication after harm training
  - Peer support training
  - Resolution training
  - **Operationalizing**
- Post Implementation Efforts

Implementation

- Pre-Implementation Phase
- Implementation Steps
  - Identify communicators/coaches for training
  - Communication after harm training
  - Peer support training
  - Resolution training
  - **Operationalizing**
    - Policies, procedures, processes [“hot line”] ‘tracer methods’, personnel
- Post Implementation Efforts

Implementation

- Pre-Implementation Phase
- Implementation Steps
- Post Implementation Efforts

Implementation

- Pre-Implementation Phase
- Implementation Steps
- Post Implementation Efforts
  - Ongoing advice and support
  - Debriefs after big events
  - Celebrate small wins
  - Data data data
  - Assess for for integrity

Back to Kotter's Principles

- Create sense of urgency
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Questions

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MOVING FORWARD IN THE NORTHWEST: REACTOR PANEL

Claire Hagan, MJ, CPHRM (Manager of Risk Management Programs, Providence Health & Services)

Alexander Hamling, MD (Pediatrician and Culture of Disclosure Physician Champion, Pacific Medical Centers)

Thomas Miller, MD (Medical Director of Quality and Safety, Overlake Medical Center)

Randy Moseley, MD, FACP, FHM (Medical Director of Quality at Wenatchee Valley Medical Center)

Wanda Paisano (Director of Quality & Risk, Patient Safety, Providence St. Mary Medical Center)

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DAY 2 CLOSING

Tom Gallagher

Peter Dunbar

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THANK YOU!

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